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THE INTELLECTUAL DISABILITY (COMPULSORY CARE AND REHABILITATION) ACT; AN INNOVATIVE REGIME?

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I. ABSTRACT

On 1 September 2004 the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) came into operation. It was accompanied by its criminal justice companion, the Criminal Procedure (Mentally Impaired Persons) Act 2003. This legislation has significant implications for the small group of intellectually disabled people who commit criminal offences. It is innovative, by way of being the first legislation of its type to provide separate care and rehabilitation options for intellectually disabled individuals, distinct from those available under the umbrella of the mental health system. Internationally, New Zealand is the first to adopt stand-alone legislation to provide for the individualised treatment of intellectually disabled offenders. Furthermore, the Criminal Procedure (Mentally Impaired Persons) Act 2003 gives effect to the procedural changes envisaged in the IDCCR Act, which provides the Court with suitable, individualised treatment orders for intellectually (and mentally) disabled offenders with diminished culpability.

Although the IDCCR Act is clouded in controversy, it is a vast improvement to the non-existent legislative guidance previously afforded to intellectually disabled individuals. This paper explores the contentious history and evolution of the IDCCR Act. It then examines the legislative scheme of the Act while scrutinising the new concept of intellectual disability; the key criterion leading to compulsory care and detention.

The question remains whether the Act can appropriately balance the competing interests of public safety and the intellectually disabled offender's human rights, within the context of a coercive regime.

Word Length

The text of this paper (excluding abstract, table of contents, footnotes, bibliography and appendices) comprises approximately 13,320 words.

II. INTRODUCTION

In 1999, after extensive debate over a series of events following the change of mental health regime, the Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill (IDCC Bill)[1] and its companion, the Criminal Justice Amendment (No 7) Bill (CPA Bill),[2] were introduced in parliament. These Bills have since embarked on an unconventional legislative journey, coming into effect on 1 September 2004[3] as the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR) and the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPA).

Since their urgent introduction to Parliament significant alterations have been undertaken. Of particular concern is the reform of the IDCC Bill, which essentially confines its jurisdiction to offenders only in adherence to fundamental individual rights.[4] Severe public opposition to the IDCC Bill at Select Committee prompted the reform.[5] These changes were presented in supplementary order paper 160, submitted only hours before the bill's third reading in the House. Arguably this procedure resulted in the scope of the legislation being whittled away by the removal of civil commitment orders. Those individuals with an intellectual disability who pose a serious risk to themselves or others but have not yet committed an offence are excluded from the jurisdiction of the Act.

This attempt to narrow the target group affected by legislation avoids addressing the concerns by service providers, some families of intellectually disabled individuals, the criminal justice system and the public, that a small

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[1] Initially introduced to Parliament as the Intellectual Disability (Compulsory Care) Bill 1999. Its name was subsequently changed to the Intellectual Disability (Compulsory Care and Rehabilitation) Bill 1999, on recommendation of the Select Committee in 2001.
[2] Initially introduced to Parliament as the Criminal Justice Amendment (No 7) Bill 1999. On recommendation of the Select Committee and given repeal of the Criminal Justice Act 1985 amendments to Part 7 were embodied into stand-alone legislation. This was renamed the Criminal Procedure (Mentally Impaired Persons) Bill 1999.
[3] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, Part 11 came into effect on 1 July 2004. Only concerned administrative matters.
[4] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 1998) 14.
[5] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, no 329-2 (the select committee reports).

percentage of the civil population require compulsory care orders or at least access to similar secure facilities as are made available by the new IDCCR Act for offenders only. These compulsory care orders have some similarities to the compulsory treatment orders under Part II of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA (CAT) Act). The inclusion of the civil population sparked fears that the target group intended to be captured under this legislation may become unnecessarily extended, undefined and in effect symbolise a return to a model of institutionalisation. This position would be in contrast to contemporary thinking moving towards a socially responsible community care system to manage those individuals with an intellectual disability or mental illness, who display deviant behaviour. While the exclusion of non-offenders from the IDCCR Act is a perplex and emotional issue, the obvious question comes to light, why intellectually disabled individuals are treated so differently from mental health users and whether the development of stand-alone legislation is necessary, for such a confined target group.[6]

Therefore, this legislation has significant implications for the small group of intellectually disabled people who commit criminal offences,[7] for the first time providing distinct compulsory care and rehabilitation options from those available under the umbrella of the mental health system. Internationally, New Zealand is the first to adopt stand-alone legislation to provide for the individualised treatment of intellectually disabled offenders.[8] Furthermore, the CPA gives effect to the procedural changes envisaged in the IDCCR, by providing suitable, individualised treatment to intellectually (and mentally) disabled offenders with diminished culpability.

Although the IDCCR Act is clouded in controversy, it is a vast improvement on the non-existent legislative guidance afforded to intellectually disabled individuals.

[6] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill: Target Population" (1 October 1997) HSP 97/31/6 7.

[7] The Ministry of Health predict between 50 to 100 individuals will be subject to the Intellectual Disability (Compulsory Care and Assessment) Act 2003. Ministry of Health http://ww.moh.govt.nz/disability (last accessed 20 July 2004).

[8] "What the new legislation means for the Directorate" (February 2004) *Disability Services Newsletter* 4.

A. *Objectives of this Paper*

First, this paper explores the evolution of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and the important social policy considerations thereof. The issues intended to be remedied by the passage of intellectual disability legislation are considered. The primary focus in this section concerns the proposed use of coercive powers by the Intellectual Disability (Compulsory Care) Bill over the non-offending population, who present a serious risk to themselves and society.

Of concern is the strong public disapproval of the substance of the IDCC Bill and its impact on the civil rights of a vulnerable sector of society. These concerns contradict the alleged objective of intellectual disability legislation, to supposedly alleviate public alarm at the lack of adequate legislative provision and guidance to deal with intellectually disabled individuals who offend, or who are perceived a danger to society and themselves. Effectively the IDCC Bill proposed a civil commitment regime in ignorance of fundamental rights and non-discriminatory treatment of intellectually disabled individuals, which led to its early demise.

Second, the scheme of the Act is analysed and the related areas of contention are addressed, including the introduction of new terms and primary key roles. This includes the definition of *intellectual disability* the key criterion bringing an individual within the jurisdiction of the IDCCR Act. The specialised roles of the care co-ordinator and the specialist accessor are explored to assess the level of procedural and substantive safeguards afforded to those subject to the Act's powers. As the jurisdiction is limited to a small group of intellectually disabled offenders, the facilities afforded may be minimised. This proves even more difficult for child offenders who are also subject to the Act, raising additional concerns as they must be subject to facilities specially geared up for adults.

The primary question to be considered is whether the Act strikes a balance between the fundamental purpose of the State to protect the public

against harm and their social responsibility to provide suitable options for the detention and albeit care, of this particularly vulnerable group of individuals who become subject to retribution under the criminal law.

II. THE GENESIS OF THE INTELLECTUAL DISABILITY (COMPULSORY CARE AND REHABILITATION) ACT 2003

Widespread public fear had mounted in the 1990s following the enactment of the Mental Health (Compulsory Care and Assessment) Act 1992 (MH (CAT) Act). This enactment was perceived as permitting the release of special patients with an intellectual disability, some of whom went on to seriously re-offend.[9] While the actual number of re-offenders were very few, the public emotion generated by these individual's dangerous and antisocial behaviour convinced the government to explore legislative options for their appropriate detention.[10] This resulted in a selection of papers being undertaken to determine suitable amendment or enactment to address this legislative flaw. Whilst public safety concerns were the dominant motivation for the enquiry, the maintenance of rights and the specialised care needs for the small group of intellectually disabled persons affected by such change were also of fundamental importance.

A. The Mental Health Amendment Bill 1994, the notorious foundation for intellectual disability legislation?

The earliest of these papers was carried out by the Law Commission in 1994 to investigate mental health and criminal justice issues arising in the community.[11] The thrust of the report was whether the existing coercive powers available under the MH (CAT) Act, the Criminal Justice Act 1985 (CJA) or any other enactment, could confer a power to detain some individuals who continued to present a substantial risk to the public, even though they were entitled by law

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[9] Warren Brookbanks "New Zealand's Intellectual Disability (Compulsory Care) Legislation" in Kate Diesfeld and Ian Frekelton (ed) *Involuntary Detention and Therepeutic Jurisprudence* 529, 534.

[10] New Zealand Law Commission *Community Safety: Mental Health and Criminal Justice Issues* (NZLC E31V Wellington, 1994) 7. See Brookbanks, above, 534; (less than 37 nationwide).

[11] New Zealand Law Commission, above, 15.

to be released.[12] Simultaneously, Cabinet was considering the proposal of the Mental Health Amendment Bill 1994 (MHA Bill) which was introduced soon after the release of the report.

A significant portion of the report's findings were used in the consideration of the MHA Bill. The impetus of the Bill was seen as an attempt to protect society by addressing the existing legislative gaps applicable to individuals with an intellectual disability or personality disorder.[13] The MHA Bill intended to achieve this by extending its current coercive powers under the MH (CAT) Act to arbitrarily include and detain intellectually disabled and personality disordered individuals assessed *likely* to commit an offence.[14] Upon its progression through parliament, the Bill faced strong opposition raising concerns that it created "a new form of preventative detention for people who were considered dangerous, and also mentally abnormal in some ill-defined sense, whose secure confinement could not at present be authorised".[15] There was a real risk that the legislation could give rise to the few secure units and hospitals still in operation to be filled with untreatable, dangerous patients who would be better served in prison, while treatable patients would be unable to access proper services.[16] A considerable burden would also be imposed on existing psychiatric services, where in-patient beds would be constantly filled with those individuals with an intellectual disability or personality disorder, being subject to unnecessary medical treatment, unlikely to ever be *cured* and released.[17]

There were additional fears that the provisions of the MHA Bill would warrant unnecessary interference with the civil rights and liberties of an individual. As the terms were also criticised as being "grossly over-complicated"

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[12] New Zealand Law Commission, above, vii.
[13] Warren Brookbanks "New Zealand's Intellectual Disability (Compulsory Care) Legislation" in Kate Diesfeld and Ian Frekelton (ed) *Involuntary Detention and Therepeutic Jurisprudence* 529, 536.
[14] Brookbanks, above, 536.
[15] John Dawson "The Mental Health (Compulsory Assessment and Treatment) Amendment Bill: the new psychiatric preventive detention" (1994) 412 LawTalk 5, 9.
[16] New Zealand Law Commission *Community Safety: Mental Health and Criminal Justice Issues* (NZLC E31V Wellington, 1994) 64.
[17] See Brookbanks, above, 536.

inconsistencies were envisaged in the management and the admittance of individuals, as mental health workers perceived the MHA Bill as being extraordinarily difficult to administer.[18] Similar concerns and fears identified in the MHA Bill were also raised during the passage of the IDCCR Act, instigating major reform of the IDCC Bill.

Inevitably, the concerns and the failure to obtain significant public support lead to the almost universal rejection of the MHA Bill.[19] Critics have claimed that the provocative MHA Bill was never really abandoned as vestiges may be found within the IDCC Bill and may possibly still remain in the IDCCR Act, which is a cause of significant concern.[20] However the IDCCR Act is by far a more modest approach than the extremely arbitrary and coercive regime envisaged under the guise of an amendment to the MH (CAT) Act.

1. Considerations leading to stand-alone intellectual disability legislation

While this earlier model proved unsuccessful, the defects in the management of intellectually disabled individuals remained, warranting further scrutiny. In 1995, a background paper into the development of intellectual disability legislation was commissioned by the Ministry of Health. Its focus was the investigation of appropriate legislation to meet the needs of individuals with an intellectual disability who were found to present a serious risk to society.[21] The paper was both comprehensive in its approach and in its recommendations. It advocated for a "one stop" statutory model that would address all major procedural issues concerning the management of the offending target group within a philosophy of care and protection.[22] The author described this concept as the "charter" approach adopting a global provision of management and support for intellectually disabled individuals who display challenging

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[18] Brookbanks, above, 535.
[19] Brookbanks, above, 536.
[20] Brookbanks, above, 537.
[21] Ministry of Health: Warren Brookbanks *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:* Discussion Paper (Wellington, 1995).
[22] Ministry of Health, above, 79.

behaviour.[23] Such a model was based on existing guardianship and protection legislation such as the Protection of Personal and Property Rights Act 1988 (PPPR Act) and the Children, Young Persons and Their Families Act 1989 (CYPFs Act) which currently operates to service the needs and care requirements of many intellectually disabled, impaired and incapacitated individuals. Except the proposed model would be complemented with the addition of coercive powers to effectively detain and control problem behaviour.[24]

Subsequent papers in 1996[25] and 1997[26] however, narrowed this broad view to focus on just a compulsory care model, much like the earlier discarded Mental Health Amendment Bill 1994. The exception however was that new legislation was concerned only with the needs of individuals with an intellectual disability (as opposed to a personality disorder as earlier considered) who were currently excluded from any legislative provision.[27] In general there was an absence of comparative models abroad for which to mirror prospective intellectual legislation upon.[28] Consideration then turned to the possibility of amending existing guardianship legislation to include intellectually disabled individuals but was also flatly rejected, the authors having far greater ideals in sight. Ultimately the concept of an innovative compulsory care regime to be incorporated as distinct, stand-alone intellectual disability legislation was advanced.[29]

III. THE NECESSITY FOR INTELLECTUAL DISABILITY LEGISLATION INTERVENTION

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[23] Brookbanks, above, 537.
[24] Brookbanks, above 537.
[25] Ministry of Health *Proposed Legislation to Facilitate the Compulsory Assessment, Care and Support of Persons with Intellectual Disability: A Position Paper* (Wellington, 1996) 4.
[26] Ministry of Health: John Dawson *The Shape of Intellectual Disability Legislation: Report to Ministry of Health* (Wellington, 1997) 22.
[27] New Zealand Law Commission *Community Safety: Mental Health and Criminal Justice Issues* (NZLC E31V Wellington, 1994) 69.
[28] Ministry of Health: Warren Brookbanks *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:* Discussion Paper (Wellington, 1995) 59.
[29] Warren Brookbanks "New Zealand's Intellectual Disability (Compulsory Care) Legislation" in Kate Diesfeld and Ian Frekelton (ed) *Involuntary Detention and Therepeutic Jurisprudence* 529, 536.

In essence intellectual disability legislation arose from the need to fill the legislative gap created by the exclusion of the intellectually disabled[30] from the mental health regime.[31] The Court often faced special difficulties when dealing with intellectually disabled defendants in the criminal justice system and deciding their appropriate orders, especially when considering factors such as the appropriateness of their detention in prisons, the potential danger to the public and the seriousness of the harm.[32]

The legislative gap concerns the exclusion of individuals solely with an "intellectual handicap" (term has since been changed to 'intellectual disability') from coming within the definition of "mental disorder;" the entry and exit criterion to the MH (CAT) Act.[33] The previous Mental Health Act 1969 specifically incorporated intellectual disability as a criterion warranting compulsory treatment.[34] However, the latter MH (CAT) Act appropriately excluded intellectual disability on the understanding that it consisted of a learning disability usually of a permanent nature and as such was untreatable, falling outside the policy of mental health law.

The lack of specific legislation placed judges in a conundrum when deciding the fate of an intellectually disabled offender. The courts were often forced to strain the language of Part VII of the Criminal Justice Act 1985 (CJA) to find the defendant either unfit to plead, insane or incapable of participating in the defence aspects of the trial pursuant to their being 'under a disability',[35] in the broad sense of the term.[36] This would enable the Court to detain the individual under the deemed status of 'special patient'[37] subject to compulsory assessment, detention and psychiatric care.[38] An example of this practice is

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[30] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 4.
[31] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 4(e).
[32] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill: Target Population" (30 September 1997) HSP 97/98 2.
[33] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.
[34] Mental Health Act 1969, s 2.
[35] Criminal Justice Act 1985, s 115(1)(a).
[36] Criminal Justice Act 1985, s 109.
[37] Criminal Justice Act 1985, s 115(2)(a).
[38] See *Police v P* [1997] DCR 823, Judge Moore.

illustrated by the decision of *Police v P*,[39] where, even though the court accepted that the defendant suffered from an intellectual disability and could not appreciate the severity of his acts, nonetheless he was deemed a special patient of the MH (CAT) Act, detained in a hospital under a compulsory care order. This was due to his repetitive offending, nature of the acts committed and the substantial risk to society if he was released into the community.

Alternatively an intellectually disabled individual was often misdiagnosed as suffering from a personality disorder, bringing them within the jurisdiction of the compulsory orders provided by the mental health regime.[40] Both approaches proved futile as the detainees, upon receiving their six monthly review, were no longer found to possess the requisite mental standard to remain subject to the MH (CAT) Act's compulsory powers. Frequently these individuals were released back into the community with inadequate supervision and care, sometimes presenting a significant risk to public safety.[41] In other instances the courts were forced to impose an immediate custodial sentence, sometimes unnecessarily or place them into a designated supervised community facility usually geared up for those suffering from psychiatric or mental illness.[42]

The Court's have often expressed their dissatisfaction and reluctance to award these options, noting the inappropriateness of such orders to individuals, who because of their intellectual disability and usually inadequate services offend.[43] The likelihood of the defendant re-offending, the perceived danger to public safety and the lack of appropriate specialised community care compelled psychiatric detention and imprisonment orders, as they were the only secure facilities available for intellectually disabled offenders. Studies into such accommodations for this group have often found them unsuitable and

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[39] *Police v P* [1997] DCR 823, Judge Moore.
[40] Mental Health (Compulsory Assessment and Treatment) Act 1992, Part 4.
[41] Karl Geiringer "An Attempt to Link Together Issues Relating to the Proposed Introduction of Compulsory Care Legislation for Intellectually Disabled People" (2000) 2 JA Medico-Legal Soc 76, 78.
[42] *R v M* (T 66/94) 1994 12 CRNZ 328; *Re JNM* [1997] NZFLR 88.
[43] *R v T [a mental patient]* (1992) 9 CRNZ 507; *Re JNM* [1997] NZFLR 88; *Police v P* [1997] DCR 823.

inhumane.[44] When incarcerated into the general prison population intellectually disabled individuals are prone to sexual and physical abuse from inmates, often fail to receive suitable care and are unlikely to comprehend the punitive measure imprisonment is intended to achieve.[45]

A. Concerns emanating from service providers and caregivers

Further concerns were highlighted by service providers and (usually employed) caregivers who were uncertain about the scope of their authority to detain, secure, restrain, or treat challenging and potentially harmful behaviour of some intellectually disabled individuals, without their consent.[46] Arguably these concerns were founded on the inequity of services and non-existence of guidelines and legislative protections[47] to adequately cater for the management of a small group of intellectually disabled individuals in the community, whose challenging behaviour may ultimately lead to the committal of an offence.[48] Service groups called for clarified legislative guidance, perhaps in the form of a civil commitment regime to provide some legal protection.[49] This negative reaction was presumed to have been inspired by the recent emphasis on the 'rights' of health consumers including the intellectually disabled, by the application of rights provided by the Code of Health and Disability Services Consumers' Rights Regulation 1996 (HDC Code of Rights) under the auspices of the Health and Disability Commissioner Act 1994.[50] The fear that such groups may be found to have acted either unlawfully or in breach of individual rights even though they acted reasonably, professionally and in good faith is implausible.[51] Whether legislative intervention was the only mechanism

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[44] Law Reform Commission *People with an Intellectual Disability in the Criminal Justice System: Courts and Sentencing Issues: Discussion Paper* (New South Wales, 1994) http://www.lawlink.nsw.gov.au/lrc.nsf/pages/DP35CHP3 (last accessed 17 July 2004).

[45] Ministry of Health: Warren Brookbanks *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: Discussion Paper* (Wellington, 1995) 45.

[46] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill: Target Population" (30 September 1997) HSP 97/98 4.

[47] Cabinet Minute, above, 3, para 6.

[48] Cabinet Minute, above, 3, para 11.

[49] Ministry of Health: John Dawson *The Shape of Intellectual Disability Legislation: Report to Ministry of Health* (Wellington, 1997) 10.

[50] HDC Code of Health and Disability Services Consumers' Rights Regulation 1996 governed by the Health and Disability Commissioner under the Health and Disability Commissioner Act 1994.

[51] Ministry of Health, above, 10.

available to arguably deflect potential liability arising from service providers' and caregivers' conduct also appears unconvincing.

However prior to the draft of the IDCCR Act legislative provisions were found to already exist to aid the care of individuals with intellectual disability while providing some protection for carers. These included:[52]

- the common law doctrine of necessity; and
- justifications for crisis interventions in the Crimes Act 1961; and
- section 126 of the Health Act 1956 authorising the removal of a person to a place of health and safety; and
- the PPPR Act, which established personal orders and the appointment of a welfare guardian by the Court to enable decisions in the best interest of the individual to be made.

These may serve to subside fears of service providers and caregivers that their physical actions, for example restraint, can be employed in rare instances, without fear of attracting civil or criminal reprimand.[53] However, the predicament faced by this group involves the absence of clear guidelines or national policy governing *how* intellectually disabled individuals who may display harmful behaviour should be managed and the subjective analysis of *what* constitutes harmful or dangerous behaviour warranting intervention in the first instance. While these provisions identified above may be relied upon to a degree, they are not well known, can be difficult to apply (as several factors need to be present) and are generic, meaning they do not exist primarily to act as a deflective 'legal flak-jacket' for the service development and delivery to those individuals with an intellectual disability.[54]

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[52] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill: Target Population" (30 September 1997) HSP 97/98 4.
[53] Cabinet Minute, above, 4.
[54] Ministry of Health, above, 1.

IV. INTRODUCTION OF INTELLECTUAL DISABILITY LEGISLATION

Collectively these issues and concerns were instrumental in the development of intellectual disability legislation. In 1999, the controversial IDCC Bill (and its criminal justice companion, the CJA Bill) was introduced to Parliament four years after its philosophical predecessor the Mental Health Amendment Bill 1994 was defeated.[55] The IDCC Bill, however, proved novel in its approach to establish a separate statutory regime aimed specifically at the management of some individuals with an intellectual disability considered in need of compulsory and specialised care.[56] Due to the fundamental importance of bridging the identified legislative gap and in order to placate the fears of the public the IDCC Bill was introduced under urgency, proceeding directly to the Health Select Committee (Health Committee) for consultation and review.

The IDCC Bill proposed to compel individuals to accept care programmes, whilst setting up a framework to protect against abuse and limit the interference of rights and freedoms of those intellectually disabled individuals subject to its powers.[57] Together with the CJA Bill it provided additional disposition options for the Court when faced with intellectually disabled offenders.[58]

Upon introduction to Parliament the IDCC Bill was regarded as a rather lengthy piece of legislation consisting of 183 clauses. The IDCC Bill was viewed as a complex and substantial piece of legislation to governing assessment, compulsory orders and the interface with different statutory regimes including the CJA, CYPFs Act and the MH (CAT) Act. This has since been reformed to a mere 150 provisions and remains a complex and vital piece of social legislation. In addition the IDCC Bill adopted a similar legislative

[55] Warren Brookbanks "New Zealand's Intellectual Disability (Compulsory Care) Legislation" in Kate Diesfeld and Ian Frekelton (ed) *Involuntary Detention and Therapeutic Jurisprudence* 529, 531.
[56] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, no 329-2 (explanatory note) I.
[57] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, no 329-2, cl 3.
[58] Criminal Procedure (Mentally Impaired Persons) Bill 1999, no 328-2, cl ????.

framework as provided for under the MH (CAT) Act. This was essentially based on the assessment and compulsory detention for a vulnerable class of individuals in either secure and, or community facilities.[59] While this attracted a degree of criticism from concerned stakeholders the legislation in its final form can be considered far less intrusive than the extensive compulsory powers to treat and detain under the existing MH (CAT) Act.

Further, the initial focus of the IDCC Bill's philosophy was to create legislation based on a custodial care model which has since been modified to reflect a more appropriate care and rehabilitation scheme.[60] This adhered to established international practice, in recognition of the impact the surrounding environment and an individual's participation in day-to-day living can influence a changed behaviour.[61]

A. *The perceptions of Cabinet*

Although its conception spanned two governments, much of the IDCC Bill's policy which was to provide specialised care and detention options for a small group of intellectually disabled persons, remained unchanged upon its introduction.[62] At Cabinet level substantial deliberation was undertaken in order to determine the appropriate scope of proposed intellectual disability legislation and its associated fiscal implications.[63] Difficulties had arisen concerning the accurate identification of individuals who may become subject to the legislation given its anticipated jurisdiction to capture both offenders and non-offenders.[64] Accordingly this resulted in the target population fluctuating between 37 to 300 persons residing in the community, prison and psychiatric facilities.[65] Public safety concerns which convinced legislative intervention in the first instance

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[59] Ministry of Health *Proposed Legislation to Facilitate the Compulsory Assessment, Care and Support of Persons with Intellectual Disability: A Position Paper* (Wellington, 1996) 5.

[60] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) 21.

[61] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill-Service and Fiscal Implications (Paper B)" (26 February 1998) SOC 98/3 2.

[62] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill-Target Population" (30 September 1997) HSP 97/98 1.

[63] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill and Funding" (14 July 1999) SOC 99/M10 (extension paper) 1.

[64] See Cabinet Minute "Intellectual Disability (Compulsory Care) Bill-Service and Fiscal Implications (Paper B)" (26 February 1998) SOC 98/3 2.

[65] Cabinet Minute, above, 2.

favoured the inclusion of those intellectually disabled individuals considered likely to, but who had not yet, committed an offence to come within the proposed legislation.[66] This was the prime area of contention for Cabinet and proved the source of significant debate by academics, service providers and the public upon the passage and reform of the original IDCC Bill at Health Committee stage.[67]

Although a significant portion of the original IDCC Bill did not survive to enactment, it is important to note the fundamental human rights, social and policy considerations that were at issue. Whether the controversy surrounding the creation of intellectual disability legislation has abated due to the significant diminution of the IDCC Bill's powers [in light of their intended objectives of creating a model environment of varying levels of care and support,] must be considered throughout this paper.

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[66] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill-Legislative and Administrative Framework (Paper A)" (2 March 1998) SOC 98/2 3.

[67] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) 11.

B. Contentious areas of the Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999

The main areas of controversy surrounding the original IDCC Bill concerned its compulsory care philosophy and the broad target group intended to be captured by its powers. Initially the jurisdiction of the IDCC Bill proposed:[68]

> … the compulsory care of individuals with an intellectual disability
>
> - Who are charged with an imprisonable offence…(offender group)
> - and whose behaviour poses a serious risk of danger to themselves or others, although they have not been charged with an offence, and who will not voluntarily access the care and support services needed for their own or others' protection (non-offender group).

The inclusion of the latter non-offender group to accept compulsory care and support services introduced a civil commitment component within the legislation arguably in cohesion with its clear mandate, to protect the safety of the public.[69] However, this proved an area of much concern during the passage of the IDCCR Act and was inevitably discarded upon recommendation of the Health Committee.[70] This was primarily due to the likely infringement of individual rights and liberties by the unequal treatment of intellectually disabled persons under the proposed law.[71]

In total, 55% of submissions to the Health Committee supported the concept of compulsory care legislation, limited only to the offending group.[72] 21% completely opposed the entire concept, preferring instead an amendment to existing mental health or guardianship legislation and improved services for

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[68] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, no 329-2 (explanatory note) II.
[69] Warren Brookbanks "New Zealand's Intellectual Disability (Compulsory Care) Legislation" in Kate Diesfeld and Ian Frekelton (ed) *Involuntary Detention and Therapeutic Jurisprudence* 529, 538.
[70] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, no 329-2 (the select committee reports).
[71] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) 11.
[72] Ministry of Health, above, 7.

intellectual disability.[73] An example of such a view can be represented by advocates for the intellectually disabled, the IHC who agreed that "reform is needed in sentencing and dispositional options for offenders with an intellectual disability" but maintained that amendment to existing mental health or welfare legislation to be more advantageous than the creation of this extensive piece of legislation.[74] Like many submitters to the IDCC Bill the IHC disagreed vehemently with the inclusion of non-offenders in the legislation, the general contention being the devotion of further resources and improvement of current support services would inevitably lead to the amelioration of challenging behaviour.[75]

Alternatively, suggestions were made to amend the existing guardianship legislation known as the PPPR Act, to authorise in times of crisis, orders of restraint and compulsory care. These were to be performed by the welfare guardian and Criminal Court, for the protection of both the individual and the public.[76] However, the PPPR Act was regarded as a "privatised version of guardianship legislation not appropriate for the delivery of secure care"[77]. In addition there were also suggestions of amending the MH (CAT) Act potentially to recall intellectual disability within its scope.[78] The general uneasiness of such an approach can be seen by the response of Rescare Canterbury who commented:[79]

> ...that the Draft Bill framework for administering compulsory care has been [modelled] on that for the administering of the Mental Health (CAT) Act 1992, is obvious and not to be applauded.

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[73] Ministry of Health, above, 7.

[74] IHC "Submission to the Health Select Committee on the Intellectual (Compulsory Care) Bill 1999" 3, 11.

[75] IHC, above, 3-6; and see: Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) 8.

[76] Ministry of Health, above, 13.

[77] Ministry of Health: John Dawson *The Shape of Intellectual Disability Legislation: Report to Ministry of Health* (Wellington, 1997) 20.

[78] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) para 3.2.

[79] Rescare Canterbury "Submission to the Health Select Committee on the Intellectual (Compulsory Care) Bill 1999".

These conflicting opinions express the difficulties and complexity of any legislative reform involving the care of individuals with an intellectual disability.

1. The suitability of the target population of the Intellectual Disability (Compulsory Care) Bill 1999

Of the 210 individuals intended to be included under the IDCC Bill, the Ministry of Health submitted that between 50-100 intellectually disabled individuals were predicted to be within the offender group, including 3 young persons under the age of 17 years. Nearly double this number (100 – 160) were expected in the civil non-offender group, including 10 young persons in the care of, or known to the Department of CYPFs.[80] Notably these figures provide some variance between the initial 37 individuals whose release in the community prompted governmental review and the recently assessed target group contemplated under the IDCC Bill.

To address this concern the principles developed by the IDCC Bill maintained that its use would only occur as an intervention of last resort when no other alternatives could be made.[81] Compulsory care orders would only be imposed on individuals within the non-offending group when behaviour was exhibited to constitute:[82]

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[80] Cabinet Minute "The Intellectual Disability (Compulsory Care) Bill and Funding to Address Service Gaps" (7 August 2000) SPH 00/115 2. These figures were supported by the findings of Olive Webb & Angus Capie who conducted a survey to identify the target population and current services available to intellectually disabled individuals, deeming the targeted group to consist of, "*approximately 200 individuals nationwide*".

[81] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, no 329-2 cl 25.

[82] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, no 329-2 (explanatory note) I.

- ...a serious danger to the health and safety of that person or of others; and
- that cannot be effectively managed without the compulsory powers of this Bill.

There was however some discrepancy of the number of intellectually disabled individuals perceived as *dangerous,* likely to be captured by the proposed legislation.[83] Essentially this arose because there appeared to be no causal connection required between the intellectual disability and the perceived dangerousness of the individual.

At Health Committee these ideas were fleshed out. The IHC in their submission to the Health Committee declared that, by including the civil population, the Bill in effect introduces a process of arbitrary detention, compulsory assessment and containment, based on the public's perception of dangerousness, which amounts to a serious breach of liberty.[84] Additionally the Mental Health Commission rejected the imposition of a compulsory care regime for non-offenders claiming that:[85]

> ...the original intent of the Bill was to provide better services for people with an intellectual disability who had offended or who, without adequate support, would be likely to offend. The first objective requires a range of options for care other than prison and the second could be achieved by provision of a wider and more effective range of support services...Bill should redress the imbalance for people who have an intellectual disability, not create the basis for further discrimination.

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[83] Ministry of Health: Olive Webb & Angus Capie *Identification of Target Population and Stock take of Current Services in place to meet the needs of people with an intellectual disability whose behaviour poses a serious danger to the health or safety of that person or of others: Report to the Ministry of Health* (Wellington, 1996); as referred to in "Submissions to the Health Select Committee on the Intellectual (Compulsory Care) Bill 1999": IHC, 5; and Dr Stephanie du Fresne (Consultant Psychiatrist with Intellectual Disability Services and Director of Forensic Psychiatry, Healthcare Otago).

[84] IHC "Submission to the Health Select Committee on the Intellectual Disability (Compulsory Care) Bill 1999" 2.

[85] IHC submission, above, 4.

IHC further contended in opposition of the Bill and in recognition of the unfair treatment of intellectually disabled individuals as:[86]

> No other groups in the general population, with the exception of people with a mental illness, are subject to compulsory detention…Even groups whom the public perceives are intimidating and dangerous, eg gangs, are protected from such capricious arrest or detention. Intellectual disability is not a mental illness.

These concerns raise two substantial points: the first, that the creation of separate legislation indicates government's intention to care for those with an intellectual disability in a different setting to mental health. This is in recognition of particular care (opposed to medicinal), support and rehabilitation to improve this group's behaviour and management of their disability, without severe risk to themselves or society.[87] If this was not intended, a more simple process of legislative amendment to existing provisions would have been the better option. To do otherwise, and recall intellectual disability into the mental health regime would only add to the confusion and misconception that intellectual disability is a form of mental illness. This is in addition to the current negative stigma faced by intellectually disabled individuals, who strive to be recognised in society as 'normal' people, capable of leading 'ordinary lives', with equal rights.[88]

There was also support for the contradictory proposition that intellectually disabled individuals as normal people preferred to be sent to prison if found to offend.[89] This view, while admirable, lacks practicality and fails to appreciate that this group is particularly vulnerable and as noted earlier, even more so when placed in mainstream facilities.[90]

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[86] IHC submission, above, 2.
[87] See: American Association on Mental Retardation *Definition, Classifications and Systems of Supports* (9 ed, Washington DC, 1992) 1; accompanying four assumptions essential to the application of the definition.
[88] Ministry of Social Development *New Zealand Disability Strategy* (Wellington, 2001) 14.
[89] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) 8; oral submission heard by People First.
[90] Ministry of Health: Warren Brookbanks *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:* Discussion Paper (Wellington, 1995) 45.

Second, the finding of dangerousness to bring individuals within compulsory care orders is a vexing topic. Currently this assessment is only used in mental health law and has been complained of for its unreliability and inconsistencies.[91] The enquiry is predominantly dependent on a clinical assessment of the abnormality suffered and the imminence of the perceived harm, which may be indicated by the individual's current and previous behaviour, often influenced by public perception.[92] Recent findings into the issues related to the prediction of danger proposed by mental health users has determined only 50% accuracy; no better than chance.[93] Of significant concern is the probability of similar failings being applied to another vulnerable sector of society, especially when considering the lack of expertise to carry out the initial assessment.[94] Also, there has been no established causal link between a propensity to offend and the condition of intellectual disability, signalling the likelihood of offending is no different to the committal rate of general society.[95] Studies also show that individuals in institutions were more likely to be determined as dangerous than those assessed in community facilities.[96] This proved indicative of the belief that environmental conditions can impact detrimentally on an intellectually disabled individual's disposition. In addition the concern arose that once within a secure environment the likelihood of release may be rare.

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[91] M Brown "Serious Offending and the Management of Public Risk in New Zealand" (1996) 1 BJ Crim 36.

[92] *Re JK [mental patient]* [1994] NZFLR 679, Judge Ellis held that "serious" enhanced the use of danger by introducing components of imminence and consequence which could have "important results" and in *In the Matter of T* [1994] NZFLR 946, the likelihood of the event occurring in the reasonable foreseeable future, were factors to assist serious danger being present as cited in S Bell and W Brookbanks *Mental Health Law in New Zealand* (Brookers, Wellington, 1998) 17.

[93] M Brown "Serious Offending and the Management of Public Risk in New Zealand" (1996) 1 BJ Crim 37.

[94] Sue Gates "Why is it necessary for the expert witness to testify within their own science?" (1999) 3 BFLJ 25.

[95] Gunn J and Taylor P (eds) *Forensic Psychiatry: Clinical, Legal and Ethical Issues* (Butterworth-Heinemann, Oxford, 1993); and Department of Corrections: Brandford S *Intellectual Disability among New Zealand Prison Inmates: Report to the Department of Corrections* (Wellington, 1997).

[96] New Zealand Law Commission *Community Safety: Mental Health and Criminal Justice Issues* (NZLC E31V Wellington, 1994) 44.

In general, there was widespread support for the imposition of compulsory care orders for individuals within the offending group.[97] Arguably this group had already committed an offence and, by doing so, had sacrificed their right to remain "free" in society from an order of compulsory detention and care to safeguard the public and recognise the harm or damage caused.

2. *Exclusion of children*

Another area of grave concern was the inclusion of children, or youths with an intellectual disability in the civil population, subject to compulsory care orders under the IDCC Bill. 83% of submissions opposed the intended extent of the proposed IDCC Bill which hoped to include children within its grasp.[98] There were claims that the Bill in its early state contravened the New Zealand Bill of Rights Act 1990 (BORA), the HDC Code of Rights and the United Nations Convention on the Rights of the Child, on the grounds of unlawfully discriminating against children and young people with intellectual disabilities and including them within a system that is predominantly geared up for adults.[99] The preferred and widely accepted option for dealing with persons under the age of 17 years, regardless of whether they have a disability or not, is by the guardianship and care provisions provided under the CYPF Act.[100]

Given the very small number of identified young persons supposedly in need of care, the proposed intellectual disability legislation could be easily criticised for casting its net too wide in an attempt to capture categories of people who are already covered by existing legislation. Or the question whether the inclusion of problematic children in the IDCC Bill is a result of exhausted resources and is merely a response to budget pressures and the inability to financially protect such individuals. Further support can be found by the negative public image of the Department of CYPFs of often failing the very young people under their supposed care and supervision. This is in instances

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[97] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) 7.
[98] Ministry of Health, above, para 8.1.
[99] See generally: Ministry of Health, above, 15.
[100] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill and Funding" (14 July 1999) SOC 99/M10; "Extension of the Intellectual Disability (Compulsory Care) Bill to include persons under 17 years and funding for compulsory care services under the legislation" 3.

when the young person is able to clearly articulate and communicate their concerns only to be ignored.[101] Major doubts arise concerning the capacity of this Government Department to be able to properly care, understand and provide for the needs and behaviour of young people with an intellectual disability. This is especially given the likelihood that their intellectual disability will impair their ability to clearly express and communicate their feelings and needs. The inadequate provision of resources both financial and service-driven is of clear concern to the viability of allowing children to be within the care of the IDCC Bill.

C. The controversy of rights at issue

Originally the IDCC Bill was considered in part to be a "bill of last resort" because it permitted state intervention into the livelihood and freedoms of some individuals with an intellectual disability in the community.[102] In essence the Bill contained coercive powers to compulsorily detain intellectually disabled individuals and impose individualised care plans for both offenders and non-offenders who were considered at risk to themselves and the public. As noted earlier, these powers were analogous to those found in mental health legislation.[103] However upon review by Health Committee non-offenders were removed from the scope of the proposed IDCC Bill because of likely human rights breaches.[104] While the IDCC Bill was modelled initially on existing mental health legislation the two pieces of legislation are procedurally and for substantial matters fundamentally different.[105]

1. The imposition of coercive powers on non-offenders

However one view, staunchly in favour of such coercive powers covering non-offenders stated that "for those in danger of offending, the timely intervention proposed may prevent their exposure to the trauma of arrest and its

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[101] "Coral Burrows" Dominion Post Article 2004.
[102] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, no 329-2 cl 25.
[103] Mental Health (Compulsory Assessment and Treatment) Act 1992, s48.
[104] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) 7.
[105] Ministry of Health: John Dawson *The Shape of Intellectual Disability Legislation: Report to Ministry of Health* (Wellington, 1997) 5.

consequences"[106]. In rebuttal, the timely intervention can occur without the imposition of a civil commitment regime by improved service delivery, financial support and skilled resource to promote and appropriately care for an intellectually disabled person's needs. This may also include assisting families and caregivers who may provide primary support to the individual. The fear of systemic abuse and the potential degradation of intellectually disabled individual's rights further support the adoption of non-coercive measures for individuals who have not committed an offence.

The interaction between the Police and individuals with an intellectual disability is also an area of concern.[107] Further education measures and systems must be implemented by Police, to aid them in the possible identification and treatment of an intellectually disabled offender. In such cases, the individual will often require additional support and aid to help them participate in the investigation process, which can for general society invoke a negative response.[108] Without mechanisms in place to facilitate this route, an intellectually disabled individual may be inappropriately incarcerated and mistakenly held legally responsible for an act they may not have committed. Some individuals have a tendency to agree to questions in an effort to please the questioning party, with no comprehension of the consequences of their statements.

2. The accepted position in favour of upholding individual rights

In contrast the accepted position by stakeholders supported the exclusion of intellectually disabled non-offenders on the grounds of discrimination by their inequitable treatment under the proposed law and potential to be arbitrarily detained by reason of possessing an intellectual disability.[109] Fears of arbitrary

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[106] Janet and David Stephens (parents of severely intellectually disabled David Stephens currently imprisoned) "Submission to the Health Select Committee on the Intellectual Disability (Compulsory Care) Bill 1999".

[107] Ministry of Health: Warren Brookbanks *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: Discussion Paper* (Wellington, 1995) 22-26.

[108] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill-Target Population" (30 September 1997) HSP 97/98 3.

[109] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 2000) 11; New Zealand Bill of Rights Act 1999, s 19.

detention,[110] unnecessary medical treatment[111] and breaches of international and national rights obligations[112] were also identified as key factors supporting this approach ultimately leading to substantial reform of the IDCC Bill. As identified by the Ministry of Health:[113]

> The right of the community to be protected from harm inflicted by others must be balanced against the fundamental right of the individual not to be arbitrarily detained as affirmed by section 22 of the New Zealand Bill of Rights Act 1990. Extensions to the powers of the State to detain a person must be justifiable.

As the corollary to a compulsory regime is the deprivation of personal liberty and freedom, public support for the enactment of the IDCC Bill was always going to be an arduous campaign, regardless of the provision of additional health consumer rights conferred under the HDC Code of Rights incorporated within the proposed legislation.[114]

Additionally, the imposition of a preventative detention model to provide care for intellectually disabled persons in general would be inconsistent and contradictory to the current trend of 'normalisation' and deinstitutionalisation following the closure of psychopaedic hospitals in favour of a system of community care.[115] This concern was also voiced by advocacy groups and experts in intellectual disability, that the non-offender group would instead benefit by the provision of more resources and an improved range of specialised care, than the inauspicious return to a model of re-institutionalisation.[116] As people with an intellectual disability are an extremely heterogeneous group, they can each have diverse needs and require variable levels of support, (which are

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[110] Mental Health Commission "Submission to the Health Select Committee on the Intellectual Disability (Compulsory Care) Bill 1999" 4.
[111] Health and Disability Commissioner "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999" 5.
[112] Mental Health Commission, above, 4.
[113] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 1998) 18.
[114] The Health and Disability Commissioner Act 1994; Code of Health and Disability Services Consumers' Rights Regulation 1996.
[115] National Advisory Committee on Health and Disability *To Have An 'Ordinary' Life Kia Whai Oranga 'Noa'* (A Report to the Minister of Health and the Minister for Disabilities Issues, September 2003).
[116] IHC "Submission to the Health Select Committee on the Intellectual Disability (Compulsory Care) Bill 1999" 3.

likely to decrease given the appropriate aid) sometimes for the rest of their lives.[117]

Specialist psychologists have concluded that, if individuals with, for example, a moderate intellectual disability and are not assisted in the communication and resolution of their needs, they are most likely to become frustrated and physically aggressive.[118] Likewise the profoundly disabled are at a high risk of injury to themselves due to their debilitating intellectual disability and often incompetent levels of care.[119] These individuals are the likely contenders to come within the scope of the non-offender (civil) population who often display challenging behaviour to warrant State intervention.[120] Such types of intellectually disabled individuals can hardly be considered within the objective of upholding public safety. It is more likely they are included within legislation because of the perceived need to legitimise restrictive practices by those employed to care for them on a formal basis.

Therefore the creation of stand-alone legislation specifically targeting intellectually disabled individuals who find themselves before the courts and the alternative provision of dedicated facilities to advance their specialised care, must be initially applauded.

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[117] The National Advisory Committee on Health and Disability, above, 10.

[118] Dr Stephanie du Fresne "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999". See also: Olive J Webb and Liz Rogers "The health care of people with intellectual disabilities" (2003) 29 NZFP 188, 190-193.

[119] Ministry of Health: Warren Brookbanks *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: Discussion Paper* (Wellington, 1995) 15-18. See also: Dr Stephanie du Fresne "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999".

[120] Karl Geiringer "An Attempt to Link Together Issues Relating to the Proposed Introduction of Compulsory Care Legislation for Intellectually Disabled People" (2000) 2 JA Medico-Legal Soc 76, 88.

D. *Fiscal implications of the exclusion of non-offending / civil group of intellectually disabled individuals*

Of further interest was the funding allocated for the operation of intellectual disability legislation. As noted earlier there was some disparity based on the number of individuals perceived to be within the scope of the Bill.[121] The National Government had initially put aside $50 million for the implementation of intellectual disability legislation over a 3 year period, split between Vote Health and Vote Courts.[122] The Ministry of Health claim that the allocated funding will remain, even though a significant proportion of the original IDCC Bill's jurisdiction has been removed.[123] Minimal savings are forecast,[124] as the majority of the budget is allocated to the creation and development of support services unrelated to the implementation of the proposed legislation and related target group.[125]

However, there has been no indication of the type of services envisaged by the appropriated funds and who will be applicable to access them. As non-offenders are now excluded from the Bill, there is considerable apprehension by concerned families and professionals that more individuals will be brought before the courts to access the secure facilities and the compulsory care orders only available under the IDCCR Act.[126] Also, given the limited authority of service providers and welfare guardians to restrain or control intellectually disabled individuals with adverse behavioural tendencies, it seems unlikely that any revolutionary developments of current service delivery can be made, especially without the express consent from the concerned individual. This view is further affirmed by the creation, operation and administration of forensic facilities for those intellectually disabled people who offend under the Act as

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[121] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill-Service and Fiscal Implications (Paper B)" (26 February 1998) SOC 98/3 1.
[122] Cabinet Minute "The Intellectual Disability (Compulsory Care) Bill and Funding to Address Service Gaps" (24 July 2000) SPH 00/109 9.
[123] Cabinet Minute "The Intellectual Disability (Compulsory Care) Bill and Funding to Address Service Gaps" (7 August 2000) SPH 00/115 1.
[124] Cabinet Minute "The Intellectual Disability (Compulsory Care) Bill and Funding to Address Service Gaps" (24 July 2000) SPH 00/109 2. Projected Net Savings $m: 1.907 first year; 0.197 second year; 0.197 third year.
[125] Cabinet Minute, above, 7.
[126] Cabinet Minute, above, 1.

well as the focus on the sourcing of expertise to govern this regime.[127] Regardless, the overall intent to improve service development for non-offenders must be welcomed, as such growth will also benefit the continued support of the offending group, when released and being rehabilitated back into society.

V. SCHEME OF THE INTELLECTUAL DISABILITY (COMPULSORY CARE AND REHABILITATION) ACT 2003

After significant debate and alteration the IDCCR Act in its final form was passed in 2003. The Act introduces a new regime of appropriate care and specialised facilities applicable only for a small group of intellectually disabled individuals who seriously offend. The purposes of the Act are three-fold:[128]

> (a) to provide courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, an offence; and
>
> (b) to recognise and safeguard the special rights of individuals subject to this Act; and
>
> (c) to provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to this Act.

Essentially the IDCCR Act provides a system of compulsory care and rehabilitation for individuals who have an intellectual disability and who become involved in the criminal justice system. While the imposition of ongoing compulsory care and rehabilitation orders are depicted, the Act attempts to restrict the deprivation of individual rights of those subject to its orders by having in place adequate safeguards, opportunities for review of decisions made about their care and treatment and also, expertise in intellectual disability to make the initial and subsequent assessments for committal and release.

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[127] See: Diploma in Care Co ordination and Management (Intellectual Disability) www.education.auckland.ac.nz (last accessed 4 August 2004); .

[128] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 3.

This part will examine four main areas of the IDCCR Act that give rise to significant debate concerning the improved shape of the legislation: the entry threshold to the Act (including the integration with the CPA); the care and rehabilitation structure; the existence of protections afforded for stakeholders; and finally the continued inclusion of children within the Act's jurisdiction.

A. *Threshold for the intellectually disabled offender*

In order to come under the jurisdiction of the IDCCR Act, an individual must first have an intellectual disability and have been charged, or convicted of, an offence.[129] Second, the offence must be imprisonable invoking the provisions of the CPA, the criminal justice companion to the IDCCR Act.[130] Individuals can then be made subject to the provisions of the Act by a court order made in criminal proceedings or by changing the applicable regime, from the Penal Institutions Act 1955 for prison inmates, or the MH (CAT) Act for special patients or former special patients, to the IDCCR Act. They are then deemed care recipients or special care recipients on the basis of the required level of supervised or community care.[131]

During the course of the criminal proceeding the individual must be found either 'unfit to stand trial' or 'acquitted on account of insanity' pursuant to a mental impairment.[132] However before the court can find the defendant to possess these standards, the act or omission complained of must be proved and established on the balance of probabilities.[133] This provides an additional safeguard ensuring sufficient evidence exists to prove the defendant is physically responsible before any finding of unfit to stand trial can be made. The court then makes inquiries to determine the appropriate order to be imposed within 30 days, detaining the individual on bail, hospital or in a facility during this lengthy period.[134] Evidence must be provided from at least one health assessor (in most circumstances one must be a psychiatrist), about the defendant. If the defendant

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[129] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 4(1).
[130] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 5; Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 4.
[131] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 6.
[132] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 23.
[133] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 9.
[134] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 23(4).

is found to contain an intellectual disability they must then be assessed under Part 3 of the IDCCR Act, which provides for a personal needs assessment, to form an appropriate care and rehabilitation plan, which identifies available services capable of providing the necessary care, for the court.[135] Inevitably, the court is pressured to make a care recipient order to invoke the compulsory care regime under the IDCCR Act when faced with an intellectually disabled offender.

B. The definition of intellectual disability; is the appropriate balance struck?

The definition of "intellectual disability" is considered the key criterion leading to compulsory care under the Act. This innovatory concept is comprehensively stated in section 7 of the IDCCR Act as:

> (1) A person has an intellectual disability if the person has a permanent impairment that–
> (a) results in significantly sub-average general intelligence; and
> (b) results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and
> (c) became apparent during the developmental period of the person.
>
> (2) Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.
>
> (3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed–
> (a) as 70 or less; and
> (b) with a confidence level of not less than 95%.
>
> (4) The skills referred to in subsection (1)(b) are-
> (a) communication:
> (b) self-care:
> (c) home living:
> (d) social skills:
> (e) use of community services:
> (f) self-direction:
> (g) health and safety:

[135] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 24(5).

(h) reading, writing, and arithmetic:

(i) leisure and work.

(5) For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.

In general, in order to have an intellectual disability the individual must have a permanent impairment[136] that manifests in their childhood or teenage years[137] resulting in a significantly impaired ability to understand and learn new or complex information or skills and require support in their everyday life.[138] The definition of "intellectual disability" introduced by the IDCCR Act is a new concept for New Zealand's legal and social system. The definition adopts the internationally accepted standard of mental retardation[139] as prescribed by the American Association on Mental Retardation[140] and the World Health Organisation.[141] The standard recognises that, while intellectually disabled persons are accepted as being untreatable in the sense of 'curing an illness', there exists a substantial link between the environmental support an individual receives and their improved cognitive functioning. Arguably this recognition imposes a 'liability to treat' intellectually disabled individuals with appropriate ongoing personal care, perhaps indefinitely, indicating a significant financial burden on the state.[142] Given the confined target group predicted to be affected by this legislation and the significant allocation of resources to redevelop and create facilities to augment existing services, this burden may easily be absorbed and is probably already accounted for.[143]

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136 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s7(1).

137 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s7(1)(c).

138 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s7(1)(b); s7(4).

139 In the United States, mental retardation is an accepted term for intellectual disability. The United Kingdom prefers learning impairment and learning disability. New Zealand follows Australia's lead and uses intellectual disability.

140 American Association on Mental Retardation *Definition, Classifications and Systems of Supports* (9 ed, Washington DC, 1992) 1.

141 *World Health Organisation,* 1992.

142 Karl Geiringer "An Attempt to Link Together Issues Relating to the Proposed Introduction of Compulsory Care Legislation for Intellectually Disabled People" (2000) 2 JA Medico-Legal Soc 76, 85.

143 Geiringer, above, 85.

1. Definitional criteria leading to better service provision

Debate has also arisen over the correct use of the definitional criteria as taken from the AAMR published in 1992.[144] The definition of mental retardation as stated in the AAMR (preferable term in New Zealand "intellectual disability") is accompanied by four assumptions considered essential to its application. While these are stated clearly in the explanatory note to the draft Bill of the IDCCR Act, dispute has arisen over the fourth assumption which for no clear reason omits the last part of the statement as contained in the AAMR. The fourth assumption in its entirety should have read:

> With appropriate supports over a sustained period, the life functioning of a person with intellectual disability will generally improve.
>
> ...[s]ome individuals only need support intermittently...and...a lack of improvement should be the basis for determining whether current supports are effective and whether changes are necessary? *(omitted from the explanation of the definition intellectual disability)*

One might question what policy goals might be achieved by de-emphasising the capacity of intellectually disabled to improve?[145] Clearly the inclusion of this description in legislation may lead to an even heavier burden being placed on the expected service delivery by providers and result in more excessive costs and diverse obligations upon the State. Perhaps at this early stage when the IDCCR Act is already criticised for its complexities and length, the more straightforward approach may be to encapsulate this philosophy in service guidelines for providers, caregivers and families of intellectually disabled individuals.

As a side point, in 2002 the 10th edition of the AAMR was published with a slightly reformed definition of "intellectual disability".[146] The New Zealand definition remained untouched in regards to any changes in adherence to this new

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[144] Donald Beasley Institute "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999".
[145] Geiringer, above, 85.
[146] American Association on Mental Retardation *Definition, Classifications and Systems of Supports* (10 ed, Washington DC, 2002) 1.

international statement. Ironically the accompanying assumptions to the definition under the 2002 version, were increased to five statements but did not appear to address the requirement of supports to improved cognitive functioning as scrutinised above.

In addition service guidelines for the IDCCR Act are envisaged as the more tolerable approach to facilitate the capacity of intellectually disabled individuals to improve. As these were not available at the writing of this paper it is likely they will conform to a "clear statement of principles governing the provision of services to consumers and the objectives for the[ir] future development..".[147] The promulgation of guidelines and standards, including the standards of care and treatment of care recipients are to be made by the Director-General of Health.[148] However, as services for intellectual disability tend to come within the broad heading of "disability services" any practice guidelines must correspond with the vision encapsulated in the New Zealand Disability Strategy (NZDS) and related subsequent reports such as the *Community membership for adults with an intellectual disability; To have an 'ordinary' life.*[149] The underlying principle that by improving the consistency, quality and delivery of services by adhering to an ideal of respect and equality for the individual with an intellectual disability will ultimately lead to their reintegration into the community and in turn, improve their life. It is implied that in order to achieve these objectives the implementation of service standards and best practice guidelines are required to cultivate a healthier relationship between disabled individuals and the Government, communities and support agencies.

Additionally any service guidelines for the health and disability sector must be informed by the duties imposed on service providers and the corresponding rights of health consumers, embodied in the HDC Code of Rights. Undoubtedly disability issues and more specifically intellectual disability issues, are currently placed in a favourable position demonstrated by the formation of

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[147] Ministry of Health: Warren Brookbanks *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:* Discussion Paper (Wellington, 1995) 9.
[148] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 148.
[149] See: http://www.moh.govt.nz/disability and http://www.odi.govt.nz/publications (last accessed 20 July 2004).

dedicated governmental agencies to deal with disability issues and the focus of national strategy and policy plans to improve the overall position of individuals with an intellectual disability in society.

Service guidelines laying out how services should be performed and in what disability settings are fundamental concerns given the objectives of the IDCCR Act can only be achieved by the imposition of care and rehabilitative services. Given the four assumptions essential to the finding of intellectual disability as stated by the AAMR maybe more of a discretionary service guideline model may be created to conform with ideals of adaptable and accommodating levels of care to improve the general well-being of the intellectually disabled individual.

2. *Family law perspective*

In addition the definition "intellectual disability" has been complained of from a family law perspective as being rather detailed, complex and as such, heavily reliant on a medical assessment instead of turning on legal issues to determine its existence.[150] This position is contrary to the legal definition of "mental disorder" under the MH (CAT) Act and the incapacity and incompetence standards set out in the PPPR Act that are commonly used to facilitate the protection, treatment, care and property of individuals with an intellectual disability by the appointment of a welfare guardian.[151] While it is accepted that the Family Court has significant experience in the assessment of intellectual disability within the context of the MH (CAT) and PPPR Act's, the finding of intellectual disability for the purposes of the IDCCR Act brings an incomparable consideration to the Family Court. Findings of a permanent impairment in the developmental stage of the individual coupled with the clinicians report deciding their deficiency in key skill areas, all contribute to the Court's assessment of an intellectual disability to be present.[152] This differs from the current concept of

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[150] Alan Gluestein "Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 – A Family Practitioner's Perspective" in (The New Regime of Criminal Procedures and Compulsory Care Governing Mentally Impaired and Intellectually Disabled Persons Seminar, ADLS, Auckland, 27 July 2004) 30, 33.
[151] Alan Gluestein, above, 32.
[152] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 7.

intellectual disability as incidental to the substantial jurisdiction or competence threshold issues in existing legislation.

However at the end of the day the Family Court must decide the fate of an individual with intellectual disability before them. While the findings of a clinician are both valid and scientific the reasoning of the Court must also weigh up the intrinsic values of society and the responsibility of the State to protect its citizens, both the defendant and the general public. Empirically the Court has been able to reshape the diagnostic analysis of clinicians into a plain language, Oxford dictionary format, in support of their making a legal assessment of what may be an intricate and historically medical term.[153] Therefore the ability of the Family Court to be able to manipulate the definitional criteria from a medical to a legal foundation is highly likely, given the developments and treatment by the Court's of similar medico-legal terms, for example the finding of mental disorder.

3. *The inapplicability of intelligence quotient test*

While the principles of the definition are generally accepted on an international scale, there are some elementary flaws in New Zealand's approach. Significant concerns were raised of the potentially restrictive application of the definition of intellectual disability. This was realised firstly by the requirement of an intelligence quotient (IQ) test and secondly, by limiting the test to a threshold of 70 or less. In submissions on the IDCC Bill, IHC and the Donald Beasley Institute (intellectual disability research institution) queried the practical value and validity of the IQ test to contribute to the assessment of intellectual disability. The Donald Beasley Institute further complained that the definition "…is based on incorrect assumptions and misunderstanding about the nature of intellectual disability…", nervous that the IQ test will be the only objective measure to determine whether intellectual disability is present.[154]

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[153] *Waitemata Health v Attorney-General & Anor.* [2001] NZFLR 1122 (CA).
[154] Donald Beasley Institute "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999".

Second, the narrowness of the IQ score could mean that borderline cases will be excluded from the compulsory care and rehabilitation orders provided by the Act.[155] This may mean that intellectually disabled individuals will continue to enter the prison system inappropriately.[156] As noted earlier, the mild or borderline cases are the most significant group targeted by the IDCCR Act as likely to offend and to continue doing so, unless appropriate services are developed.[157] Guidelines on the application of the Act have attempted to iron out this deficiency by claiming that it is "usual for clinicians to allow a standard error of plus or minus 5 in determining IQ", therefore broadening the threshold requirement for the IQ test, determinative of the significantly sub-average intelligence as 75 or less. This recognition should improve concerns that the IQ test is not strictly imposed and is not intended to serve as a barrier of entry.

In addition the inclusion of the phrase in subsection 7(2) of the IDCCR Act commencing "Wherever practicable, a person's general intelligence must be assessed…" introduces some flexibility into the assessment and use of IQ tests. This section suggests that an IQ test is not a mandatory requirement to determine the state of disability of an individual and may not always be practical given an individual's state of distress, inability or infirmity to communicate and participate in the tests. Alternatively this may also apply in rare instances where the clinician decides it is unnecessary perhaps due to the clear existence of other factors determining intellectual disability to be present. The focus should be placed on the ability of the individual rather than the convenience of the clinician. It must be remembered that the IQ test is one of many assessments in the IDCCR Act when used collectively will assist the Court to make a finding of intellectual disability.

The deliberate insertion of standard psychometric tests used by clinicians to assist in determining intellectual disability allows the assessment procedure to remain adaptable to changing practices and techniques of the day, in

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[155] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 1998) 18.
[156] Ministry of Health, above, 18.
[157] Dr Stephanie du Fresne "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999". See also: Olive J Webb and Liz Rogers "The health care of people with intellectual disabilities" (2003) 29 NZFP 188, 190-193.

acknowledgement of the deviating standards intellectually disabled people possess. In contrast the increase of the threshold can impact on those eligible to be diagnosed with an intellectual disability, which may involve an additional burden on allocated resources and suitable service provision by the State. Arguably the significance of these concerns are lessened by the exclusion of the civil commitment component as contained in the earlier legislative draft. The existence of additional clinical and exclusionary criteria also contribute to the determination of intellectual disability.

4. *The statutory exclusion provisions*

An individual, who has a personality or mental disorder, acquired brain injury or simply feels no remorse or guilt over harm they have caused unto others, is not considered to contain an intellectual disability for the purposes of the Act.[158] This attempts to distinguish between intellectual disability, mental illness (governed by the MH (CAT) Act) and those who are simply bad for no medical related reason.

Individuals with a personality disorder are clearly excluded from the Act. As noted earlier there were concerns that the foundations of the IDCCR Act could be traced back to the defeated Mental Health Amendment Bill 1994 which attempted to controversially reintroduce intellectual disability and personality disorder into the realm of mental heath legislation. During the introduction of the IDCC Bill the exclusion of personality disorder was unclear raising similar fears that this diverse group intended to also be covered by this new legislation. However in adherence to established opinion that it is manifestly different to intellectual disability and is extremely difficult to define, all traces of the term have been removed.[159] Further support for the policy of exclusion can be found by the recommendations of the Law Commission in *Community Safety: Mental Health and Criminal Justice Issues, 1994* which affirmed that:

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[158] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 8.
[159] Warren Brookbanks "New Zealand's Intellectual Disability (Compulsory Care) Legislation" in Kate Diesfeld and Ian Frekelton (ed) *Involuntary Detention and Therepeutic Jurisprudence* 529, 542.

> ...dangerous personality disordered people of ordinary intelligence who commit offences should be dealt with by the criminal justice system in the ordinary way (unless mentally disordered as well).

However advocates of Autistic Spectrum Disorder (known as a personality disorder) appealed to be included within the jurisdiction of the IDCCR Act, to enable access to a specialised care regime as opposed to mainstream imprisonment.[160] This raises the concern that in some anomalous instances individuals diagnosed with personality disorders should be allowed to participate in services provided under the IDCCR or MH (CAT) Act's. As personality disorder is deliberately excluded from mental health and now, intellectual disability legislation, more research must be undertaken to ensure this group is being adequately provided for by their inclusion in the general criminal justice system.

Second, those individuals with an acquired brain injury are also excluded from intellectual disability legislation as they are considered to be "adequately covered by the provisions of the MH (CAT) Act 1992" on the grounds of cognitive disorder.[161] However, it has also been admitted that there are "service gaps" for individuals with a brain injury (or personality disorder) leaving such individuals without recourse to any specialised care regime.[162]

At first glance the exclusion of individual's with a head injury appears inconsistent with the assessment of intellectual disability. An individual with an intellectual disability must have a permanent impairment weakening their ability to learn which may never be cured but can be generally improved. This is analogous to an individual with a head injury who also has a permanent impairment which may or may not reduce their ability to learn but will likely be improved by appropriate levels of care and support. There is also strong support for the assertion that regardless of the etiology of the intellectual disability the

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[160] Ministry of Health *Intellectual Disability (Compulsory Care) Bill: Report on Submissions to the Health Committee* (Wellington, 1998) 19.

[161] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill-Legislative and Administrative Framework (Paper A)" (2 March 1998) SOC 98/2 3.

[162] Cabinet Minute "Intellectual Disability (Compulsory Care) Bill: Target Population" (30 September 1997) HSP 97/98 6.

brain's lifelong capacity to change and adapt will not be affected.[163] While there is no one cause for intellectual disability the exclusion of persons with a head or brain injury may simply be attributed to restricting individuals from accessing the type of specialised care envisaged under the IDCCR Act. Further support for this contention can be found in the submission to the IDCC Bill by specialists in intellectual disability who contended that:[164]

> individuals who suffer from brain injury or intellectual impairment through severe substance abuse present significantly different issues from those with an intellectual disability in the early stage of their development period and require very different specialist services…the setting up of specialist services required.

Finally, in the instances of dual diagnosis of mental illness and intellectual disability, the MH (CAT) Act overrules. However, should the individual be "cured" of their mental disorder, they may then become subject to a compulsory care order by reason of their intellectual disability under the IDCCR Act and be further detained in the interests of maintaining public safety.

C. Compulsory care orders and the limited protections

Once satisfied that the defendant comes under the IDCCR, a needs and cultural assessment (if the applicant is Maori) must be undertaken resulting in the creation of a care and rehabilitation plan. The plan identifies the individual's social, medical, health and safety needs including the extent of supervision required and the suitable facility type, to assist their rehabilitation within a secure environment to prevent self-harm and any danger to the public.[165] In addition a care program must also be composed, laying out the objectives of the care regime and the approach to be taken.[166] This may then result in the issue of a compulsory care order by the court.[167] While this seems a straight forward process the level of consultation can have a delaying effect on the formation of

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[163] Karl Geiringer "An Attempt to Link Together Issues Relating to the Proposed Introduction of Compulsory Care Legislation for Intellectually Disabled People" (2000) 2 JA Medico-Legal Soc 76, 84.
[164] Dr Stephanie du Fresne "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999".
[165] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 5.
[166] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 26.
[167] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, Part 4.

the plan and program and prove a hindrance to the care recipient receiving timely support. However, without such consultation the objectives of the Act would be fallible as the absence of appropriate consultation may prove detrimental to their ability to be appropriately cared and realise their future goals. There is also the possibility for individuals with ulterior motives than the care recipient's best interests, to influence the assessment made by giving incorrect or prejudicial information. Again, this can be invalidated by compelling diagnostic and psychological assessment of clinicians who specialise in treating and caring for individuals with intellectual disability. Additionally the views of advocates may also be sought to assist in the creation of an individuals care and rehabilitation plan.

Dependent on the nature of the offence, the risk to the public and the individual determines the status and level of care required under the compulsory care order.[168] The Act provides two levels of care for intellectually disabled offenders, either *secure care* in a secure facility or hospital, or *supervised care* based in the community. A compulsory care order can be made for up to 3 years duration but may be extended by the Family Court upon the finding that the care recipient continues to present a serious danger to the public.[169]

New statutory roles to facilitate the IDCCR are also introduced to give effect to the special care requirements of the intellectually disabled, which include the Care Co-ordinator, Care Manager, Health and Specialist Assessors. The most vital is the Care Co-ordinator, responsible for the overall operational administration of the Act including dealings with the Family Court and the concerned individual for compulsory care orders. This role is also responsible for the development of the care and rehabilitation plan and general administration of the operation of a compulsory order. It appears though that the Care Co-ordinator holds a monopoly over the application of compulsory care orders even in the instance of a change of regime, which is inconsistent with

[168] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 5.
[169] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 46 and see: s 85 for ongoing detention.

other protective legislation.[170] The only additional safeguard is the proviso that medical consultants are also available to provide a second opinion in relation to medication required to manage a care recipient's condition.[171]

Initially there were concerns over the resourcing of appropriate facilities and sufficiently skilled professionals trained in the field of intellectual disability to fulfil these roles. Fears mounted that systematic failures and breaches of human rights[172] would surely arise, due to the inadequate training and unskilled human resources.[173] Psychologists specialising in intellectual disability raised additional concerns over the misconception of specialised services as demonstrated by the use of psychiatrists and directors of institutions to act as expert witnesses in civil commitment hearings involving an intellectually disabled person.[174] Often their evidence was relied upon as the substantial basis of the court order imposed, regardless of their scientific and technical expertise in intellectual disability matters of evidential value.[175]

However, given the downsizing of the Act's original jurisdiction,[176] the closure of intellectually disabled and mentally disordered institutions and the international attention the IDCCR Act has attracted, it seems likely that a sufficient supply of operational and management staff will be located. Whether they will possess the ideal level of expertise is debatable.

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[170] Alan Gluestein "Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 – A Family Practitioner's Perspective" in (The New Regime of Criminal Procedures and Compulsory Care Governing Mentally Impaired and Intellectually Disabled Persons Seminar, ADLS, Auckland, 27 July 2004) 30, 33.
[171] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 41(5).
[172] New Zealand Bill of Rights Act 1990, s11 (the right to refuse medical treatment) and s22 (the right not to be arbitrarily arrested or detained).
[173] Dr Stephanie du Fresne "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999".
[174] Sue Gates "Why is it necessary for the expert witness to testify within their own science?" (1999) 3 BFLJ 25, 27.
[175] Sue Gates, above, 27.
[176] Intellectual Disability (Compulsory Care [and Rehabilitation]) Bill 1999, (the select committee recommendation). Originally the Bill included the civil commitment of intellectually disabled individuals who posed a serious risk of danger to themselves and others.

VI. THE INTERACTION WITH THE CRIMINAL PROCEDURE (MENTALLY IMPAIRED PERSONS) ACT 2003

The IDCCR and the CPA Acts are intended to operate in close synergistic alliance,[177] in order to provide for the treatment of those lacking in criminal culpability pursuant to a mental impairment, found unfit to stand trial or not guilty by insanity.[178] The CPA basically encapsulates Part 7 of the Criminal Justice Act 1985, to encompass those with an intellectual disability under the broad criteria of mental impairment.

Mental impairment is purposely left undefined and open to the courts' interpretation for procedural fairness. This raises three concerns first, the association between the terms mental impairment and mental disorder, a potentially misleading expression that might wrongly suggest that intellectual disability is included under the mental health regime. This erodes any progress attempted to recognise intellectual disability as a distinct and separate state. Second, the courts may follow the Australian approach to the application of mental impairment, that has resulted in limiting the term to mental conditions that affect cognitive processes only, in order to exclude unmeritorious cases.[179] Third, the broad nature of mental impairment provides added difficulties by potentially including those suffering from temporary or intermittent states in the form of drug or alcohol intoxication, to qualify under mental impairment and thereby be found unfit to stand trial. Given the particular vulnerability of the individuals subject to this legislation, more guidance needs to be sought on the boundaries of such a broad term.

The CPA also establishes innovative procedures to streamline and minimise the impact of the criminal process in recognition of the vulnerability of those under a mental impairment. Before a fitness inquiry can be made a special hearing must be conducted to find the defendant physically responsible in the

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[177] Warren Brookbanks "Mentally Impaired Offenders in New Zealand – Recent Developments" in (The New Regime of Criminal Procedures and Compulsory Care Governing Mentally Impaired and Intellectually Disabled Persons Seminar, ADLS, Auckland, 27 July 2004) 1, 5.
[178] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 23.
[179] WJ Brookbanks "Submission to the Health Committee on the Criminal Justice Amendment Act No 7 Bill 1999".

first instance, on the **balance of probabilities**.[180] Additionally, the procedure for entering an insanity plea can be accepted on its face by the consent of the prosecution. Once a finding is held, the court makes inquiries and receives evidence from at least one health assessor (one must be a psychiatrist) to determine whether a special care recipient or special patient order should necessarily be invoked in the best interests of the public and individual.[181]

Another new disposition option provided by the CPA and IDCCR is the creation of the hybrid order that enables the court to sentence an offender under the Act for a prison term and also detain them under the jurisdiction of the IDCCR or MH (CAT) Act's.[182] Should the term of imprisonment end whilst the offender is detained in a facility or hospital, the order automatically becomes a compulsory care order and vice versa. Where an individual is detained for compulsory care and no longer required to remain subject to the order, then they revert back to their prison sentence to fulfil the outstanding term or to the court, to stand trial for the offence.[183] Little direction is supplied from a clinician's perspective:[184]

> The determination of which option is most appropriate remains the domain of the Court, it remains unclear in what circumstances might cause the Court to opt for one option over the other and what role experts might have in advocating (if at all) for either.

The intention of the order appears to remedy the situations where an offender is referred to the MH (CAT) or IDCCR Act's compulsory regimes, and upon being found to no longer attain the required mental state is released back into the community. This can occur after a six month period, the minimum period set for compulsory review of orders, even though the individual may still pose a significant danger to the public.

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[180] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 9. The defendant is not required to attend the hearing.
[181] Criminal Procedure (Mentally Impaired Persons) Act 2003, Part 2, Court orders.
[182] Rees Tapsell "Mentally Ill Offenders: A Clinician's Perspective" in (The New Regime of Criminal Procedures and Compulsory Care Governing Mentally Impaired and Intellectually Disabled Persons Seminar, ADLS, Auckland, 27 July 2004) 21, 28.
[183] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 34.
[184] Rees Tapsell, above, 28.

VII. PROTECTIONS AFFORDED UNDER THE INTELLECTUAL DISABILITY (COMPULSORY CARE AND REHABILITATION) ACT 2003

Mechanisms intended to safeguard individual's rights under the Act generally follow those contained in the MH (CAT) Act.[185] These consist of a statement of specific rights for care recipients; an initial review by the court of the compulsory care order; six monthly clinical reviews and the independent supervision of a district inspector to uphold individual rights (also designated district inspector under the MH (CAT) Act). A High Court Judge may also inquire into matters under the Act, similar again to those provided under mental health legislation. Additionally, all care recipients are considered health consumers under the HDC Code of Rights and as such, are entitled to those rights afforded including appropriate levels of service standard.

Of concern is the non-existence of any Review Tribunal body of medical and legal professionals to act as another layer of protection and independent review. This is an important feature in light of the medico-legal definitions found in the Act, which in these early days seem to favour medical expert opinion as the ultimate decision-maker. The proposition was put forward during the Act's passage to extend the role and jurisdiction provided by the Mental Health Review Tribunal (MHRT) (with the addition of professional[s] specialising in intellectual disability) to service the intellectually disabled. As the IDCCR Act proposes to involve approximately 50 to 100 intellectually disabled offenders, the impact on the workload and financial demands of the MHRT would appear to be slight. The corresponding safeguard and appeal process would provide a major benefit for those subject to compulsory care orders, providing further checks and balances on their health and safety.

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[185] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, Part 5.

Whether this may be a mechanism to be introduced in the future operation of the IDCCR Act may rest on the successful performance of the other procedural safeguards, key personnel and system operations. Such practice would ensure the fundamental freedoms and liberties of those placed in secure and supervised care are not severely breached.

VIII. THE APPROPRIATENESS OF CHILDREN STILL SUBJECT TO THE IDCCR ACT

Controversially, child and youth offenders are also subject to the jurisdiction of the IDCCR. The IDCCR takes priority over the Children and Young Persons and their Families Act 1989 (CYPFs); an Act that ultimately provides for the welfare and guardianship of children and young people.[186] While this has sparked some debate over the appropriateness of their addition, CYPFs verify only 3 youths would fit the criteria under the Act and face difficulty living and interacting in the facilities currently provided for.[187] The inclusion of children in the IDCCR triggers fears that they may become subject to the same compulsory treatment as adults including seclusion and physical restraint, in an environment not equipped for their specialised needs.[188] The potential risk to children may come in the forms of untrained staff to cater for their unique needs, their relationship and interaction with other adult care recipients and lack of suitable facilities catering and accommodating for children only.

Part 2 of the IDCCR Act, in particular section 12, outlines the applicable principles that govern decisions affecting children pursuant to the powers of the Act. Reference is made to the involvement of the child's family group to participate in the making of decisions affecting that child.[189] Consideration of the child's wishes are to be balanced with the extent those wishes can reasonably

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[186] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 12; s 138.
[187] WJ Brookbanks "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999".
[188] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 61; s 62; s 63.
[189] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 12(a).

be ascertained and are considered appropriate in the circumstances.[190] While these provisions impress the importance of family involvement in the decision-making process it is unclear the degree of participation the family will have upon the creation of care and rehabilitation plans for the child pursuant to the IDCCR Act.[191] This appears in contradiction to the functions and purposes of the operation of a "family group conference" (FGC) integral to the advancement of the concerned child under the protection and guardianship powers of the CYPFs Act.[192] The FGC endeavours to bring together the child's family in an informal meeting to participate and help formulate the creation, implementation and review of care and protection plans in support of their child while under the care of CYPFs. When involving child and youth offenders, often the FGC will include the victim and their support network in recognition of the harm and damage committed and to facilitate the healing and rehabilitation process for both parties.

While the merits and success of such a system has recently come under attack by a study into the effectiveness of the youth justice system, the participation of child and youth offenders in FGC's can still be attributed to a decline in subsequent re-offending behaviour and be less likely to be convicted as an adult.[193] The failure to incorporate such a scheme in the IDCCR Act can be attributed to the differential treatment proposed for individual's with an intellectual disability who offend. It would appear the whole philosophy of the Act endeavours to create a care and support environment the only coercive part would be the compulsorily component to force the individual to accept treatment whilst being detained in a secure or community facility. One might go even further to claim the Act tends to shift the *culpability* from the intellectually disabled individual to the systemic failure of service providers, caregivers or the State to adequately provide proper environments of care and rehabilitation. In practical terms the FGC may provide little assistance to the plight of an intellectually disabled child who is considered to have limited capacity to

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[190] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s12(d).
[191] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s20; s22.
[192] Children, Young Persons, and their Families Act 1989, Part 2; s 28.
[193] Nikki Macdonald "Youth justice system failing" (4 October 2004) *The Dominion* Wellington 1; Study into the effectiveness of the youth justice system by the Ministry of Social Development.

understand the damage or harm that has been caused and instead may result in their challenging behaviour to deteriorate further.

The failure of the IDCCR Act to clearly prescribe the level of consultation with parents and families of an intellectually disabled child subject to compulsory care is disappointing. Unfortunately families and caregivers are likely to feel some frustration with the application of the IDCCR Act and their ability to remain involved and consulted in decisions affecting the care and protection of their child. However, given the extreme vulnerability of children with an intellectual disability, the intention under the Act to provide them with one-on-one support and care for their long-term rehabilitation into society should be highly commended. Nevertheless the inability to clearly identify the finer points to achieving this ideal inflates public concern that children should not be included within an Act that is geared up for adults with an intellectual disability offend.

IX. IMPLICATIONS FOR THE GENERAL PUBLIC?

In essence the IDCCR Act brings positive change for intellectually disabled individuals, their caregivers and the general public. The creation of this distinct legislation recognises the sensitivities of an intellectually disabled individual and the hardships they encounter when confronted by the law, especially under the criminal justice system. Hence alternative options are embraced to provide the courts with appropriate facilities other than prison.

While this Act received significant numbers of submissions during its passage, there were none submitted from the perspective of the victim of an intellectually disabled offender's act. This perspective needs to be further explored to highlight the grave risk intellectually disabled individuals present to the general public.

Intellectually disabled individuals have been involved in acts of murder, assault, sexual violation and property damage.[194] Several of these cases have been amplified by the media, to imply that intellectually disabled individuals (as a whole) are dangerous and should be feared.[195] In reality, only a small proportion of intellectually disabled persons commit serious criminal acts.[196] Regardless, the release of such individuals back into the community after serving time in prison or psychiatric facilities has caused public outrage.[197] Public concern has influenced the creation of the so called 'hybrid orders' (as noted earlier) potentially imposing an indefinite detention term under the guise of a compulsory care order. As far as the public are concerned the new orders and facilities that compel the intellectually disabled offender to detention, care and rehabilitation are not only appropriate but are crucial to enhance public safety threatened by the risk of re-offending and rehabilitative failures (for the

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[194] Ministry of Health: Warren Brookbanks *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: Discussion Paper* (Wellington, 1995).
[195] See Colin Burgering " National Secure Units (Regional Intellectual Disability Secure Services) in New Zealand: An SRV Perspective" (2001).
[196] Ministry of Health: Warren Brookbanks *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:* Discussion Paper (Wellington, 1995).
[197] "Community reassured over residents' care" (21 April 1998) *The Nelson Mail* 3.

intellectually disabled) provided by imprisonment. Whether these measures reintroduce a form of institutionalisation for a small group of vulnerable individuals in conflict with national and international policy of upholding individual rights, liberties and freedoms for individuals with a disability, seems an unfortunate but necessary control.

In addition, the IDCCR and CPA Acts impliedly create the term 'intellectually disabled offender'. This could have a detrimental effect on government social policy to support intellectually disabled individuals in the community and promote their acceptance to the public as being 'ordinary' individuals who should have the opportunity to have an 'ordinary life'.[198] By singling out this class of offenders the misconception that those with an intellect disability are dangerous and need continual detention may be born. This notion must be dispelled to ensure intellectually disabled individuals as a whole are not inadvertently discriminated against.

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[198] National Advisory Committee on Health and Disability *To Have An 'Ordinary' Life Kia Whai Oranga 'Noa'* (A Report to the Minister of Health and the Minister for Disabilities Issues, September 2003).

X. *CONCLUSION*

The creation of distinct legislation providing a regime of care specifically for those with an intellectual disability reflects well-established international thinking that intellectual disability is fundamentally different to mental illness.[199] The IDCCR Act is an innovative piece of legislation and should be supported for its intention to provide a separate legislative track for intellectually disabled offenders who were previously left in limbo between being competing inappropriate placements of imprisonment or detention in psychiatric services. Even though the Act is couched in fuzzy terms of care, support and rehabilitation, it must be clearly understood that it is a complex and coercive piece of legislation. As such it can impinge detrimentally upon the individual rights and freedoms of intellectually disabled individuals who may become subject to its compulsory orders.

However the powers conferred under the IDCCR Act are narrow and only pertain to those who offend, have an intellectual disability and are either unfit to stand trial (or insane) or by change of applicable regime. The Act is not a comprehensive scheme for intellectually disabled offenders. It lacks compulsory care measures for those with an intellectual disability and diminished capacity, who may exhibit 'challenging' and 'dangerous' behaviour towards them self or the public and refuse appropriate treatment.[200] A civil commitment component was included in an early draft of the Act but was removed before enactment for reasons of breaching fundamental human rights.[201] As a result the IDCCR Act creates a disparity by failing to cater for those intellectually disabled individuals who do not offend, yet have the same high and complex needs.[202]

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[199] Warren Brookbanks "Mentally Impaired Offenders in New Zealand – Recent Developments" in (The New Regime of Criminal Procedures and Compulsory Care Governing Mentally Impaired and Intellectually Disabled Persons Seminar, ADLS, Auckland, 27 July 2004) 1, 5.
[200] Compare: Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.
[201] Human Rights Commission "Submission to the Health Committee on the Intellectual Disability (Compulsory Care) Bill 1999".
[202] The Select Committee addressed this anomaly by advising that some of the available funding should be allocated to provide similar resources for non-offenders.

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There appears a strong preference for improved and additional specialised intellectual disability services to counteract the need for legislative intervention. This is undergoing development and given sufficient time, will improve the management of those individuals in need but currently excluded from the care and rehabilitation scheme of the IDCCR Act. It is unlikely though that non-offenders will have the same degree of consistent support both clinical, environmental and fiscal which is essential to their improved disposition. Clearly the injection of funds, just like the creation of an Act will not by itself serve to improve the position of an intellectually disabled individual in society. It is however a step in the right direction. With further involvement of the primary needs of intellectually disabled individuals on the ground, the IDCCR Act may pave the way to a more robust and comprehensive regime that addresses collectively the shifting and specialised service needs of this vulnerable group.

While the IDCCR Act faced significant opposition to its enactment, its final form is a more balanced and attentive model that New Zealanders may be proud of. The thrust of the Act upholds public safety concerns by the imposition of compulsory care and detention orders coupled with the aim of rehabilitation and the reduced likelihood of re-offending. This is complemented by the commitment to continue to invest into the improved management of intellectually disabled individuals in the community also in need of care. Equally it also clearly endeavours to safeguard against unnecessary State intervention by the provision of specific rights in Part 5 and Part 6; while also recognising the individual rights of intellectually disabled offenders subject to its powers. It would appear that for the interim an appropriate balance between these two conflicting ideals may be struck.

Finally, the IDCCR Act (and accompanying provisions in the CPA Act), is a complex and by its nature, contentious piece of legislation which brings opportunity and progress for the development of intellectually disabled individuals in New Zealand.

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