INTELLECTUALLY HANDICAPPED OFFENDERS AND THE NEW ZEALAND CRIMINAL JUSTICE SYSTEM

BRIGID MCARTHUR

LEGAL WRITING
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PART I. INTRODUCTION

Recognising the law as a form of social control with the criminal justice system as its enforcement agency, the essential theme of any questions about it must be the problem of individual responsibility. The concept of individual responsibility, which provides the tacit foundation of this control by means of an abstract body of norms, implies a certain freedom of choice in one's actions and accountability for that choice. Thus only if it is assumed that everyone is capable of making a rational decision as to their actions, is capable of complying with the expectations of the law and is of equal competence before the law, can justice be guaranteed. There are, however, members of society who do not meet these criteria.

While New Zealand's criminal law and criminal justice system do recognise that not all individuals can be held fully responsible for their anti-social behaviour and that not all are equally competent before the law, the case of the intellectually handicapped offender can present unique problems in the administration of justice.

This paper examines the significance of a person's intellectual handicap in his or her involvement with the criminal law, passage through the criminal justice system and possible diversion to the mental health system. Its ultimate aim is to assess whether, in all cases, justice can at present be guaranteed.

PART II. INTELLECTUAL HANDICAP

To discuss the potential significance of intellectual handicap in criminal justice and the system's treatment of I.H. offenders, it is essential to proceed with a sound background knowledge of the nature and consequences of the condition.

A. Intellectual Handicap - Definition

The term "intellectual handicap" and its corollary "the intellectually handicapped"[1] are generally used in this paper in preference to the variety of other terms applied to the condition (chiefly, "mental retardation", "mental deficiency", "mental subnormality").

It is a term commonly used in New Zealand and is also that preferred by the New Zealand Society for the Intellectually Handicapped Inc.,[2] the organisation working to meet the needs and promote the welfare of the intellectually handicapped in New Zealand. Furthermore, this terminology is seen as including the personal and social consequences of the condition, which are as significant in this study as the fact of the retardation itself.

Intellectual handicap is a condition which has proven extremely difficult to define as it does not appear "in the same form, to the same degree, at the same moment, because of the same circumstances, and with the same consequences for all [IH people]."[3] The difficulty is exacerbated by the fact that so many different specialist groups are interested in the medical, behavioural and educational manifestations of the condition.

Despite the lack of agreement among the various disciplines, the American Association on Mental Deficiency proposed a definition which has met with the approval of most professional groups. It states that "mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in one or more of the following: (1) maturation, (2) learning, and (3) social adjustment."[4]

Critical portions of the definition were explained:

1) "General intellectual functioning" implies that the individual has been evaluated with an instrument, or test, which is of sufficient scope to consider as many of the measurable traits of intelligence as possible or practical.

2) "Developmental period" extends from conception to age sixteen.

3) "Maturation" refers to the rate and degree to which development of basic skills most commonly associated with infancy and childhood occur.

4) "Learning" refers to the ease with which the individual is able to gain knowledge through experience.

5) "Social adjustment" refers to how well the individual is able to exercise independence in self-maintenance within the community and in employment.

The N.Z.S.I.H. accepts the following working definition:
"The term 'intellectual handicap' refers to people who are unable to lead independent lives in the community because of reduced intellectual functioning and impaired social adaptation."

"Impaired social adaptation" refers to difficulties in meeting the standard of competence, independence and social responsibility that is expected of a given age group in our society.

B. The Levels of Intellectual Handicap

Although impaired social adjustment and social competence are as important as the psychometric criteria in defining intellectual handicap, the IH are often classified according to degree of retardation on the basis of their IQ scores. While such classification is not a reliable indicator of the degree of intellectual handicap and therefore provides little other than a basis for stereotyping, it is in wide use throughout the world, including New Zealand.

The World Health Organisation recognises five categories of mental retardation:

borderline	-	IQ	71-75
mild	-	IQ	52-70
moderate	-	IQ	36-51
severe	-	IQ	20-35
profound	-	IQ	below 20 [5]

Independent of the classification based on IQ scores, four general levels of intellectual handicap have been established - mild, moderate, severe and profound. A useful description of these levels was included in the Report of the President's Committee on Mental Retardation:[6]

> The mildly mentally retarded group would include individuals who, in all likelihood, are identified by the public school system as retarded. Depending upon the general behaviour of these individuals and the programs available in the school system, they may or

> may not be placed in special classes. Moreover, after completion of school, commonly they are absorbed into the total adult population and are not readily identifiable. These are individuals who generally work in competitive jobs and who, provided they have no physical or emotional problems in addition to their retardation, are able to lead independent lives.
>
> The moderately mentally retarded ... are more limited in their capabilities. Generally they will be identified before entering school and need special pre-school and school programs. These children are most likely to be placed in classes for the trainable mentally retarded. As adults, they usually are able to live and work in the community, but need some type of sheltered environment or supervision in order to function optimally.
>
> The severe and profound levels [include individuals] many whose problems can be identified at, or shortly after, birth. Individuals functioning at this level are much more dependent, need more intensive programming and frequently have physical problems in addition to the retardation in mental development.

The practical utility of definitions and categorisations of intellectual handicap should not be overestimated. The accepted definitions are purposely broad in order to encompass all levels of intellecual handicap; the categorisation of the IH into mild, moderate, severe or profound groups amounts to no more than a label which denotes in general terms the type of IH person concerned. Accordingly, the relevance of categorisation to the criminal justice system must be very general.

Categorisation is, however, necessary in the present study of IH offenders. As shall be seen, the behaviour and deficiencies to be expected of a mildly IH person cannot be placed on the same footing as those to be expected of a severely IH person. Nor can criminal justice be applied to or affect individuals within the different categories in the same manner.

The groups most likely to come into contact with the criminal justice system and likely to present the greatest difficulties are the midly and moderately retarded, the ultimate question always being whether the principles and methods of the criminal justice system can be properly applied to them and, if not, what course of action is appropriate. All groups are, however, of concern to this study. Differentiation is made wherever appropriate.

C. Problems Related to Intellectual Handicap and the Consequences thereof

As has been indicated, the IH are not a homogeneous group. Special care must be taken in attempting to categorise IH adults, the concern of this paper, given the great disparity between each individual's background and characteristics.

Smith has noted a number of circumstances contributing to individual and group differences among IH adults and which may play a role in shaping their character and destiny:[7]

1) The different degrees of multiple disability present at birth, including the level of congenital mental subnormality.
2) The type of environment with which the IH adult was associated during the childhood and adolescent years. For example, if proper diagnosis and comprehensive treatment were provided in a relatively enriched environment, the IH person is more

likely to reach adulthood with more positive signs and a more favourable prognosis than those persons whose surroundings were less stimulating during the vital formative years.

3) How the IH adult sees himself or herself in an occupational sense, socially, personally and intellectually. The more positive the self-concept, the better the IH adult will be able to function in an effective and independent manner.

4) The family environment in which the IH adult was reared. For example, the more accepting, supportive and healthy the family environment, the better the person's future adult behaviour and his or her chances for success and self-sufficiency.

5) The type of educational programme to which the IH person has been exposed. As the IH adult is provided with a stimulating and properly sequenced series of educational experiences beginning at the earliest possible period and extending into adulthood, he or she can reasonably be expected to develop progressively higher levels of skill, both quantitatively and qualitatively, as he or she moves into adulthood.

Bearing these differences in mind, there is a wide range of characteristics and problems commonly associated with intellectual handicap which may affect an IH person's behaviour and may, in given circumstances, lead to behaviour ordinarily labelled as criminal.

Many IH are unable to judge the appropriateness of their responses to a particular situation and to foresee the consequences of their actions. For example, an IH person may not understand that the goods attractively displayed in a shop cannot simply be taken if they appeal to him or her. More commonly, the behaviour of an

IH person, such as acting in an overly friendly manner towards a total stranger, can be seriously misinterpreted by society. An IH person may not know when or how to choose between right and wrong; indeed, he or she may not be aware of the difference between right and wrong behaviour. Further, the person may be easily influenced by others in whom he or she places unquestioning trust. An IH person will not necessarily know how to deal with a new situation, not only because of the reduced intellectual functioning but also because of a lack of previous opportunities to practice appropriate responses.

Related to this are problems in abstract thinking, such that an IH person has difficulty in grasping complex ideas or expressions and may have difficulty in adapting to unfamiliar people and surroundings.

An IH person may have difficulty in focusing attention on a specific task for a long period of time and may be easily distracted by peripheral external stimuli which to the average person would be of little or no importance at the particular moment. The short memory of many IH aggravates this problem.

Even where the IH person suffers from no secondary speech impairments, he or she may have difficulty in communicating thoughts and ideas to others.

These cognitive inadequacies which may restrict the IH person in satisfactorily responding to a particular situation or problem are at odds with their social, emotional and other personal needs. IH adults have the same basic types of needs, wishes and attitudes as the rest of the adult population. Whereas their physical and material needs are usually met satisfactorily, other vital needs

are often overlooked. Those of particular potential concern are love, belongingness, recognition by others, usefulness, praise, opportunities to be actively and meaningfully involved in a task, freedom to satisfy one's curiosity and to learn about new and interesting things.[8] The consequences of these needs not being satisfied on a regular and intentional basis may be serious.

The extent of previous failures, rebuke, rejection by others and general feelings of inadequacy may result in a number of damaging secondary character traits. The IH person may develop any one or more of the following: low tolerance for frustration, unwillingness to consider new ideas, approaches to a problem or engagement in new activities, regression to earlier more satisfying and successful styles of behaviour, low concepts of self-worth, ability and chance for success, a general lack of spontaneity.[9]

The frequency and magnitude of the problems noted will result in different types of behaviour according to the particular IH person. Unstable and antisocial behaviour may accompany all degrees of retardation, except the most profound, in which existence is almost completely passive.[10] It may take the form of temper outbursts, aggressive or destructive behaviour towards other people, the person himself or objects, sullenness, withdrawn or isolationistic behaviour. The types of antisocial behaviour that may accompany intellectual handicap are considered more fully in Part III.

There are certain other problems which IH people may have which are not necessarily related to their mental and emotional difficulties. Unusual facial features, an unusual gait, poor co-ordination, speech, hearing or visual impairments and epileptic seizures are examples of the range of disorders from which some IH persons suffer.

D. The Prevalence of Intellectual Handicap in New Zealand

The most recent figures showing the prevalence of intellectual handicap in New Zealand are those published in 1976 by the Research Foundation of the N.Z.S.I.H. as the result of a nationwide survey.[11]

The survey sample consisted of those IH persons below sixty five years of age who lived in, or whose home address was in, one of the representative regions surveyed.[12] For the purposes of inclusion in the survey, the IH met one or more of the following criteria:

1) Those excluded from ordinary schooling, or unable to obtain regular, independent employment because of intellectual limitations.
2) Those living in psychopaedic, psychiatric or public hospitals with a primary diagnosis of mental retardation.
3) Those receiving an invalids benefit on the ground of mental retardation.
4) Those considered to be moderately or more severely retarded according to WHO classification, either from formal psychometric testing or as judged by expert professional opinion and treated as mentally retarded.

All available official and voluntary sources were used to identify and locate the IH in each of the survey regions. The National Health Statistics Centre provided records and addresses of all those in psychopaedic and psychiatric hospitals with a diagnosis of mental retardation. It was more difficult to locate all of the IH in the community, though most were known to such agencies as the Psychological Service of the Department of Education, Child

Health Clinics, the Department of Social Welfare, the NZSIH, and a number of other community agencies.

It should be observed that the majority of IH persons in New Zealand do come to official notice at some stage or other in their life. Exception has to be made for some borderline cases and perhaps some cases where an IH person is born to a family of low socio-economic status, in a remote rural environment. If not identified as IH at birth or in early childhood by medical or childcare personnel, official identification will most often occur in the school years when the child is found to have impaired intelligence and learning difficulties. More rarely, identification will occur upon application to the Department of Social Welfare for an invalids benefit. At any stage of his or her life, the IH person may become involved, or at least known to, IHC or another community organisation. This will most often be upon the initiative of parents, relatives or friends.

The survey authors estimated the national prevalence rate of intellectual handicap as 3.5 per thousand of the population.[13] Marked variations were reported in the prevalence rate at different ages, as is shown in the following table:

IH By Age	Number	Percentage	Prevalence per Thousand of Population
0-4	189	7.89	2.25
5-9	362	15.11	4.20
10-14	339	14.15	4.07
15-19	373	15.57	5.14
20-29	497	20.74	4.17
30-39	256	10.68	2.85
40-49	192	8.00	2.16
50-64	188	7.85	1.78
TOTAL:	2396	100.00	3.29

The authors attributed the low prevalence rate in early infancy to difficulties in detection, and the decline in prevalence from early adulthood onwards to the shorter life expectancy of many profoundly retarded. To be noted is the peak rate in the 15-19 year age group and the relatively high prevalence in young adults. This was thought to be possibly due to an influx of young adults into sheltered workshops and care centres or to the granting of the invalids benefit.

Intellectual handicap was found to be more prevalent amongst males than females. Whereas the New Zealand population at the time of the 1971 census was almost equally divided between males and females, 1293 IH males were included in the survey as opposed to only 1103 IH females. IH males thus exceeded IH females by 7.92%. This preponderance of males occurred at all ages up to forty. No clear reasons were suggested for this discrepancy. It may be that our society is more aware of inadequacies among males than among females because of differences in role expectations.

The survey also revealed racial differences in the prevalence of intellectual handicap. Whereas according to the 1971 census 7.9% of the national population was Maori, the Maori IH formed 11.3% of the survey sample. European and other races accounted for 88.73% of the IH population.

General demographic trends were reflected in the age distribution of Maori and European IH. At the time of the survey half of the Maori population was under fifteen years of age, compared with nearly one third of the total population. Similarly, half of the Maori IH were under fifteen compared with slightly more than one third of Europeans. The prevalence of intellectual handicap among Maori children aged between five and fourteen years was significantly greater than the prevalence among European children of similar age. Between the ages of fifteen and twenty-nine the proportionate distribution of the two races was very much the same, but past the age of thirty, the prevalence of intellectual handicap was significantly lower among Maori adults than among Europeans.

As to the prevalence of different degrees of retardation, it was found that 19.2% of the IH were mildly retarded, 37.51% were moderately retarded, 29.62% severely and 8.64% profoundly. The degree of retardation was not known for 5.03% of the IH population surveyed. These figures must, however, be qualified. In particular, the reportedly low prevalence of mild retardation is inconsistent with other overseas findings which would place most IH persons within this category.[14] First, it must be pointed out that an assessment of mild mental retardation is commonly not made until late childhood or early adulthood, therefore very few mildly retarded infants were included in the survey sample. Secondly, the figures reflect to a certain extent the fact that a number of the milder cases will not have met the criteria for inclusion in the survey. Moreover, some will not have been known to the official agencies.

There was found to be a disproportionately high number of young and older adults among the mildly retarded. This was said to reflect the influx of some school leavers and older adults into dependent conditions and surroundings.

No significant differences were found in the proportionate distribution of Europeans and Maoris among the different degrees of retardation.

Although many IH are free from physical disorders, many have poor physique, muscular weakness and poor motor co-ordination. The degrees of physical and intellectual handicap are generally closely related. A great majority of the sample (72.6%) suffered speech impairments, ranging from stammering to an inability to form other than single words.[15]

The survey authors also reported on problems of behaviour control, an area particularly relevant to this study. A distinction emerged between minor problems such as disobedience, stubbornness, temper tantrums, anxiety and excessive dependence, and major problems such as aggressiveness, destructiveness, unpredictability and violence.

More than half of the IH were found to present no undue problems of behaviour control; close to one third presented minor problems, and one eighth were found to present major problems. The incidence of problems in behaviour control was closely related to age. Major problems were reported in 13.55% of young adults and in 8.33% of adults aged thirty and over. Minor problems were found in 31.62% of young adults and in 28.79% of adults aged thirty and over. The incidence of such problems was again closely related to the degree of retardation.

Minor problems occurred most frequently among the mildly and moderately retarded, and in approximately one third of each of these categories. They decreased with the severity of retardation. Major problems of control occurred fairly consistently in all categories.

Of further relevance are the survey's findings on the residential care of IH people. Obviously the greater the contact with the community, the greater the possibility of contact with the criminal justice system. Of the IH in the sample, it was found that 53.5% lived at home, 39.9% were cared for in hospitals and 6.6% were full-time residents of IHC and other hostels.[15a]

Significant differences were reported in the patterns of residential care of Maori and European IH. Of the IH in the non-Maori group, 52.3% were cared for at home and 41.2% were cared for in hospital. The corresponding figures for the Maori group were 63.2% and 29.6%. The proportions in hostel care were not significantly different. These figures reflect the concept of the extended family in Maori culture. Of all the IH living at home and thus in greater contact with the community, almost one half were moderately and almost one quarter mildly retarded.

Of those in hospital care, the authors note only in respect of the mildly retarded that some had been committed by the courts because of deviant or unacceptable behaviour in the community.

E. Common Conceptions of the Intellectually Handicapped

General public attitudes to the IH range from pity and over-protectiveness to fear, rejection and a perceived need to segregate this group from the mainstream of society. These derive largely from the perpetuation of a number of myths, and may affect the treatment of an IH person at various stages in the criminal justice system.

Those misconceptions relating to anti-social behaviour of the IH are more appropriately discussed in Part III in the context of the relation between intellectual handicap and criminality.

1. "An IH person can be identified by his or her looks and behaviour."

There is as enormous a variation in appearance among the IH as there is among the general population. While some IH can be identified by their physical features, such as those with Down's Syndrome, and some have physical handicaps in addition to the intellectual handicap, others are perfectly normal in appearance. The appearance of a person is no sure indication of intellectual handicap or of the degree of handicap.

Nor are behaviour or personality reliable indicators. While all are of reduced intelligence, some IH are slow and placid, others nervous and kinetic. Some project joyous and sunny personalities, others depression and gloom.[16]

2. "Intellectual handicap is hereditary"

This is simply not true. IH parents may have children of normal intelligence, just as parents of normal intelligence may have IH offspring.

However, research does support the view that intellectual handicap may be familial, in the sense that families with low socio-economic status and a poor living environment are more prone to having retarded children who then grow up and have retarded children of their own.[17] The most obvious factor in this cultural-familial cause of intellectual handicap is poverty, related to malnutrition, inadequate or inappropriate stimulation in childhood, low level of education, poor ante-natal and post-natal medical care, and health problems generally.

3. "Intellectual handicap is irreversible."

It is true to say that intellectual handicap is incurable. However, where it is a result of emotional deprivation in early childhood, the condition is reversible to some extent for those mildly retarded who suffer no brain damage if proper environmental treatment is provided at as early a stage as possible.[18] All IH people are seen as capable of improvement.

4. "Intellectual handicap is a contagious disease."

Intellectual handicap is not a disease. It is a condition which may result from any number of circumstances that have the possibility of occurring before, during or after the birth of the child. It cannot be "caught" as a result of touching or being near someone identified as IH.

5. "The IH are more highly sexed than normal people."

Research has shown conclusively that the IH have the same sexual drive as other people.[19] Sexual drive and intensity vary as among others. The misconception may be based on the frequent inability of the IH to control their sexual urges or to channel them in what is regarded as an acceptable manner.

6. "The IH are more violent than other people."

The IH are not more inherently aggressive or violent than other people. They react violently in the same situations in which others would be violent, for example, when frustrated, angry, afraid or threatened. This is discussed more fully in Part III A.

7. "The IH have criminal tendencies."

See Part III A.

8. "Intellectual handicap is the same as mental illness"

Intellectual handicap and mental illness are not the same. Mental illness is an emotional disturbance or psychiatric condition resulting from disease or psychological or social problems; it may be temporary or permanent, curable or incurable. On the other hand, mental retardation is a condition primarily characterised by substandard intellectual functioning.

The frequent confusion is partly attributable to the fact that the IH and the mentally ill may share some of the same characteristics. Like the mentally ill, some IH are angry, hostile and sometimes withdrawn. Many mentally ill people do poorly on activities involving the use of intellectual skills and problem-solving techniques. Moreover, a dual diagnosis of intellectual handicap

and mental illness is not uncommon, given the state of frustration in which the IH frequently find themselves.[20]

F. Current Trends in the Care, Training and Daily Living of the Intellectually Handicapped

Current trends in the care, training, working and daily living of the IH are characterised by three inter-related philosophies: normalisation, integration and the least restrictive alternative.[21] The implementation of these philosophies should be encouraged in all aspects of the IH person's life.

"Normalisation" means making available to IH people patterns and conditions of everyday life which are as close as possible to the norms and patterns of the rest of society. This does not mean that the IH will become "normal", nor that every IH person will "live out" in the community, be placed in regular schools or participate in competitive employment.

The main point of the doctrine of normalisation relates to the philosophy of the least restrictive alternative. As with any other person, limits on the IH person's right to self-determination should be imposed only in those areas and situations where there is no less restrictive alternative available. In other areas, the IH person should be free to make decisions on both major and minor matters to the same extent as other people.

"Integration" is the realisation of the philosophy of normalisation. It refers to integration into a non-handicapped community, in all spheres of the IH person's life.

The practical social significance of those philosophies currently being implemented is that the IH are now a much less segregated group than in the past. Wherever possible, they are educated, live, socialise and work within the community. As members of the community, they will have to conform to its norms and rules.

No doubt the implementation of these philosophies according to the IH person's needs, development and capabilities increases the likelihood of contact with the criminal justice system. More IH people are now growing up in a society that emphasises normality and achievement and not all will be able to conform, within their limitations, to these demands.

The fundamental inference to be drawn from the foregoing presentation of background information on intellectual handicap is that its relevance to offending behaviour and the criminal justice system will always be very subjective. The level of retardation, the different intellectual, social and emotional problems which the IH person has, his or her environment and the sorts of public attitudes which he or she will be up against will be the main factors in distinguishing one case from another.

PART III. THE INTELLECTUALLY HANDICAPPED AS OFFENDERS

A. The Relation of Intellectual Handicap to Criminality

In discussing the various ways in which society can deal with criminal offenders, one writer has commented that "how we view the offender affects what we do with him, and what, precisely, we hope to accomplish."[22]

How we view and deal with a particular offender or class of offenders must be based not only on the effects of their actions, but also on how we perceive the offender in the first place and how we perceive his or her actions as being produced. Are these considerations such that the normal stereotypes cannot be applied to the offending behaviour and the motivation behind it?

The role of intellectual handicap is clearly significant in this context, as are the conceptions held by the general public and criminal justice agencies of the physical and mental characteristics associated with intellectual handicap.

The problems commonly associated with intellectual handicap may account for anti-social or criminal behaviour in the IH. With lack of intelligence and understanding, lack of social and moral insight, lack of social experiences, low self-esteem and a low tolerance for frustration, some IH will be more prone to behaving anti-socially than is the average person. One must recognise, however, that "the average person" may also be deficient in any one or more of the above respects.

Several other explanations have been offered.

In discussing the substandard personality development of some IH, Gunzburg writes that much of an IH person's unsatisfactory behaviour can be said to derive "from the panic reaction of the child in him, and is not due to some evil, or a bad streak." He or she "reacts inappropriately for age because of his under-developed personality and he reacts excessively because he cannot cope with the environmental demands made upon him." Gunzburg further states that the combination of mature and immature aspects in the IH individual's personality can make his or her adjustment to the demands of society very precarious, and warns that it should not be assumed that his or her delinquencies are necessarily signs of badness or viciousness.[23]

Another writer comments that the criminal behaviour of an IH person may be attributed to his awareness of being different. This "may be responsible for feelings of inferiority, frustration and resentment. These feelings are especially strong in the mildly retarded for they have a clearer recognition of how they differ from others. The result is a tendency to break down more easily under pressure or stress. Such knowledge may lead them to commit violent, aggressive or destructive acts which are often an attempt to gain attention and prestige."[24]

Another writer, Smith, noted the fact that "retarded teenagers tend to be more responsive to affiliating with others who are trouble-makers, ruffians or agitators."[25] He explained this using a "reward-punishment behaviour modification model": for many IH teenagers, attempting to behave in a socially proper way has not been a rewarding experience at all. As a result, the person is literally 'turned off' from subsequently attempting to conform to the set standards.

Smith also attributed the fact that some IH become members of anti-social groups to the normal need for social attachments. Naturally, young IH adults will actively seek out persons who either overlook or are not critical of their handicap and social inadequacies. By carrying out "missions" for the group, by doing their dirty work or playing a part in the plotting of criminal acts, these IH may be rewarded for their success. For once they will feel valued.[26]

The incidence of violent and aggressive behaviour among the IH is obviously relevant to criminality. That the IH are more violent and aggressive than people of normal intelligence would seem to be an entrenched public perception. This may not be totally unfounded as a generalisation, especially in view of the apparent public confusion of mental retardation with mental illness. It does, however, need qualifying.

The fact of retardation itself does not mean that the IH person is naturally violent or aggressive. As has been pointed out, the IH react violently in the same situations in which others would be violent: when frustrated, angry, afraid or threatened. The point is that whereas the normal person will usually be able to exercise some control over such emotional impulses and will probably know that aggressiveness or violence are inappropriate or ineffective responses, many IH will not. They may be unable to curb the expression of their impulses and unable to grasp the significance of their actions. Thus when under pressure and with reduced control, the IH person may tend to act out directly.[27]

While the situations engendering violent behaviour may be the same as for normal people, the IH person is likely to find himself or herself in such situations more frequently.

The same sort of analysis can be applied to the public conception of the IH as having stronger criminal tendencies than other people. They are not inherently criminal because they are retarded. However, as has been seen, their intellectual, emotional and social deficiencies may lead them to criminal ways. Furthermore, these shortcomings mean that "once a subnormal has been started off on the wrong road the probability is that he will continue this way and the gap between his standards and those of society may become wider and wider."[28]

The importance of finding the most effective way of dealing with IH offenders is therefore obvious.

B. The Incidence of Criminality among the Intellectually Handicapped

Overseas research has been conducted on the incidence of criminality among the IH. In 1962 it was summarised thus:[29]

> Most studies indicate that the educable mentally retarded is represented by a higher delinquency and criminal rate than would be expected by their general prevalence in society. Here the problem is complicated by school failure, ... early drop-out, socio-economic status, difficulty in finding and retaining employment, inadequate societal planning for post-school life, etc. The borderline intellectual ability of the retardate is not seen as necessarily implying non-conforming or norm-violating behaviour. However, the involved lack of insight or comprehension in such a technical, complex and rapidly changing society creates situations which seem to penalise

this segment of our society.

In 1963 and 1964, Brown and Courtless in the United States undertook a survey entitled "The Mentally Retarded Offender", which sought to examine certain aspects of intelligence in prison populations.[30] Using an IQ cut-off point of seventy, they found that approximately 20,000 of the 190,000 prisoners in the entire system were mentally retarded. That is, 10% of the prison population were retarded.[31] This takes on its significance when compared to the statistically projected 3% mental retardation figure for the entire United States.

The figure of 10% was confirmed by Marsh, Friel and Eissler in 1975.[32] Ogg, however, has pointed out that the actual number of IH in prison will vary according to the geographic region of the country. Thus in the midwest of the United States, only 2% of the prison population were identified as IH, while as many as 27% were so identified in the south.[33]

Whether this 10% figure would accurately represent the New Zealand situation is unclear.

The only relevant New Zealand survey was one carried out in 1978 amongst the borstal population (fifteen to twenty year age group).[34] Not all inmates were tested for IQ.

The survey was based on two IQ tests: Ravens Progressive Matrices (a non-verbal IQ test) and the Otis Higher Examination (a test of verbal, or written, IQ). The results of the Otis test showed a high incidence of very low IQ. They were, however, said to be fairly unreliable since on a reading test, 24% of the inmates could read only up to the level of a ten year old.

The Ravens test was said to be a better indicator. It revealed that 4.4% of European inmates scored in the bottom 5% of the general population intellectually. Of the Maori inmates, 7.7% scored in this bottom 5%. The survey authors concluded that 6.4% of the prison population scored in the bottom 5% of the general population intellectually. However, the bottom 5% of the general population are not necessarily IH, so the 6.4% figure may in reality be too high.

In accepting the results of any of the above surveys, a note of warning must be sounded. Much will depend on how the penal or correctional institutions were selected, how IQ was tested and what level of IQ was selected as the cut-off point between retarded and non-retarded.

Furthermore, to take such findings as truly indicative of the incidence of criminality among the IH is to assume that the incarcerated population is a representative sample of the criminal population and that intellectual handicap is not a factor in the decision to incarcerate in itself. In fact, the IH offender is more likely to be apprehended, more likely to confess and more likely to be convicted than would be an offender of average intelligence.

It is, however, accepted that a disproportionate number of IH people, compared with the general population, commit crimes.[35]

C. Types of Offences Commonly Committed by Intellectually Handicapped Offenders

Brown and Courtless in their study also reported on the types of crimes committed by IH inmates. Of those identified as IH, a sample of 1000 inmates was selected with measured IQ's below fiftyfive. These amount, however, to only 1.6% of the 10% of the prison population identified as IH. Further, the survey did not cover jails and workhouses where misdemeanants and minor offenders were confined.

Of the 1000 inmates selected, it was found that 28% had been committed on conviction of breaking and entering and burglary. This corresponded closely to the figure cited by the United States Bureau of Prisons for the total prison population. However,, 57% of those inmates with an IQ below fiftyfive had been convicted of crimes against the person, including homicide, assault and sexual offences. Prison statistics indicated that of the total population confined to adult institutions, approximately 27% had been committed on the basis of these personal offences. The percentage of those convicted of homicide (15.4%) was three times as high as that of the total prison population.

In light of the qualifications which introduced these findings, the data should not be misconstrued as indicating positively that most IH offenders commit serious crimes against the person.

Most other sources indicate that offences of an impulsive or petty nature, which do not require careful planning or execution, preponderate among the IH anti-social population. Even amongst these sources, however, there is some disagreement.

Hayes and Hayes state that the offences most frequently committed by IH people are breaking and entering and burglary.[36]

According to Heaton- Ward, the offences committed by the moderately retarded person are usually minor, such as petty thieving, including the shoplifting of articles of little value. Some may commit acts of arson or be used by others of higher intelligence to commit more serious thefts on their behalf. He notes that crimes of violence are rare among the IH, but adds that there is some evidence that parents of battered babies are excessively likely to be of subnormal intelligence.[37]

Gunzburg, on the otherhand, sees the problem of sex delinquency as a real one.[38] This, he says, "does not originate in the subnormal's excessive sexual urges, but is the result of a faulty canalization of normal sex drives."[39] He distinguishes sex crimes from immorality. In the former category, involving offences which contain violence or a threat of violence, or are committed against people who cannot give legal consent, sexual assaults on children are common. He considers that such offences are not those of a sexual maniac, but rather, are a form of sexual exploration found frequently among adolescents. They are perhaps due to the IH person's poor judgment, lack of social and moral insight and lack of social experience.

As regards the IH person's immorality, Gunzburg further distinguishes between men and women. The offences most frequently committed by men are of a homosexual nature. Although he himself is not an active homosexual, the IH male will often be the victim of homosexual advances. He sees the case of "the immoral female subnormal swelling the ranks of the casual and professional

prostitutes [as] far more serious."[40] He ascribes this gliding into "the deceptively attractive life of immorality"to inadequate standards of the parental home and the powerful drive to snatch at a little love and affection.

D. Formulating the Appropriate Method of Dealing with Intellectually Handicapped Offenders

Without wishing to encroach excessively on the later examination of how the criminal justice system does and should deal with IH offenders, the points discussed in the foregoing sections anticipate the question of the extent to which intellectual handicap should be legally relevant to criminal responsibility. A distinction must be drawn here between those IH people who know what they are doing in committing an offence, and those who offend totally in a world of their own, unsuspecting of the consequences of their actions. To a certain extent, this distinction depends on the degree of retardation and also on the nature of the offence committed.

It is the firm view of the NZSIH that most IH people know when they are doing something wrong and that punishment should be meted out accordingly. Release from responsibility is not warranted by the mere fact of intellectual handicap. On the contrary, this could result in an expectation by some IH people that various types of anti-social or criminal behaviour are acceptable. It could also result in an expectation that they will not be punished for behaviour which they realise is unacceptable.

Whilst it will not always be possible to teach IH people appropriate behaviour and sense of responsibility prior to the commission of the act, they must be taught if possible to learn from their errors. The objectives in such cases will match some of those underlying the criminal justice system's treatment of the average offender: individual and perhaps general deterrence and making the offender understand and accept that the behaviour was wrong and that it entails personal liability.

There are problems, however, in achieving these objectives in the case of an IH offender. To be effective, the punishment must be related, in the offender's mind, to the offending behaviour. Punishment received without being understood may further lead to fear, resentment and non-co-operation. In some IH people, it may strengthen an underlying belief that society is against them.

These considerations can apply to any offender, but they are especially relevant in respect of IH offenders given their substandard intellectual development and personal and social deficiencies.

That a sentence of imprisonment may achieve society's objectives in the case of some IH offenders is not disputed. But in many other cases, the prejudicial effects of a prison sentence will outweigh its presumed value to both society and the individual. Gunzburg, while acknowledging the value of strict discipline in some cases, states that "in the majority it is rather like using a sledge-hammer to crack a nut - and the scars left by this process may do irreparable damage to the subnormal's mental development."[41] In the same vein, it has been said that "giving a retarded person a criminal record is not necessarily the best way to teach him social responsibility."[42] The social responsiblity may be instilled and the punishment best administered in the context of the person's familiar surroundings by

family, friends or NZSIH staff.

So while the objectives to be achieved will generally remain constant, their implementation should depend on the individual IH offender concerned. It will also necessarily depend on the nature and seriousness of the offenee committed, a need for public protection and the need to satisfy the public's possible sense of outrage.

The other class of IH offenders, in terms of the distinction drawn at the beginning of this section, poses greater problems in the administration of the criminal law and criminal justice. These are people who really do not have much idea of what they are doing, let alone of the consequences of their actions. Can such people properly be held responsible for their actions and subjected to the criminal law in its present state? Should the tests of criminal responsibility be made more subjective to cater for the IH?

Perhaps the first questionis what society is hoping to achieve in rendering such offenders culpable. The first objective must be to show the offender and others that certain types of behaviour are not acceptable, that the offender has transgressed the limits of acceptable behaviour. Secondly, the offender is to be instilled with an improved sense of social responsibility such that he or she accepts accountability for the consequences of his or her actions which detrimentally affect others. Thirdly, society renders an offender culpable to enable punishment to take place.

The second question therefore is what society is hoping to achieve in punishing such offenders. Punishment should aim at reducing the likelihood of the offence being repeated by the offender or by others, inducing everybody to respect and abide by the law, protecting

other people and their property. Punishment should further the process of instilling social responsibility initiated by holding the offender responsible for his or her criminal behaviour.

The punishment imposed should be no greater than is necessary to achieve its objectives, and should be proportionate to the seriousness of the offence and the culpability of the offender. On occasions, however, a public need for protection and a need to satisfy the public's sense of outrage at the serious consequences of an offence may override these limitations.

Implementing the aims of society in attaching responsibility to certain acts and punishing the actors has special problems in the case of IH offenders who really know nothing of the nature and consequences of their behaviour. Indeed, where the offence committed by such an IH person is not serious or, even if serious, will not be repeated, it is difficult to see that punishment serves any purpose. There is no need for public protection. Other potential offenders are not likely to take as universally applicable the example set by non-punishment in such an extreme case. Nor will any benefits to the offender, in terms of understanding why the behaviour was wrong, accepting social responsibility, and future deterrence, flow from the punishment.

Where there is a need for public protection, or where some form of punishment would benefit the individual, then it should be imposed. As with the first class of IH offenders, the method of punishment should depend on the individual involved and on the nature and seriousness of the offence.

Relating the concept of punishment to that of culpability, it would seem unfair to apply a set of laws based on normality to people who have no conception of what is normal and that what they were doing is wrong. The criminal law reflects this to a certain extent. It allows the person, where appropriate, to set up defences of lack of mens rea, recklessness, insanity and so on, thereby negating responsibility for the criminal act.[43] But it is an either/or situation: the IH person who cannot satisfy the legal criteria for these defences is necessarily responsible for the crime.

The solution to this problem is not necessarily to modify the criminal law. Loosening up the current tests of criminal responsibility in respect of this group of offenders would make it difficult to disallow similar modifications in respect of other groups who could prove that the normal standards of responsibility are too high. A similar argument would discredit the setting up of a special defence of "intellectual handicap". Moreover, such a defence could be likely to be abused by those IH offenders who should properly be held responsible and punished in the same manner as other offenders.

The solution to the problems of responsibility and punishability must, where the normal standards of the criminal law are to be applied to such IH offenders, rest within the discretion of the sentencing judge. The discretion in sentencing is wide enough to enable a judge to weigh up all competing factors, including intellectual handicap, in determining the most just and effective way of dealing with the offender.

Leaving the matter in the hands of the judiciary rests, however, on one important presumption. This is that judges will recognise the offender as IH and will have sufficient knowledge of

intellectual handicap to be able to properly exercise their discretion. This in turn depends partly on whether lawyers and others involved in the court proceedings will be able to offer the necessary assistance in the matter. As shall be seen in Part V, the presumption is not irrebuttable.

PART IV. FIRST CONTACT WITH THE CRIMINAL JUSTICE SYSTEM: THE POLICE.

As the first and perhaps last point of contact between any offender and the criminal justice system, the police are in a position of enormous responsibility. In the case of the IH offender, given the prevalence of ignorant and prejudiced attitudes amongst the public to IH people, this responsibility is further increased by the fact that the police officer is "the front-line person who is first to mediate between the retarded person and the public."[44]

In assessing how well this responsibility is discharged and in looking at the legal and practical framework within which the New Zealand Police operate when dealing with an IH offender, the first point to note is that the police receive no formal education in intellectual handicap and its associated problems in the course of their training.[45] This may, and in fact does sometimes, impede them in dealing with IH offenders appropriately.

Initially, the problem is one of recognition. When asked whether IH people have been reported or have otherwise come to their attention because of alleged criminal or antisocial behaviour, many members of the police force assert that they have "never met one." In some cases this may well be true. In others, however, subsequent comments (such as references to IH people being 'round the twist') indicate that some members of the police do not know what to look for anyway, and highlight the fact that they share in general public attitudes towards the IH.[46] In the case of the police, unlike that of the public at large, this lack of knowledge and awareness of intellectual handicap amounts really to a professional inadequacy. To properly carry out their powers and duties where

an IH person is concerned, the police should be able to recognise intellectual handicap, make an informed judgment as to its relevance to the conduct in question and know how to deal with such a person.

A. Police Powers and Action in respect of Intellectually Handicapped Offenders - the Statutory Background and the General Instructions

In theory, the police's powers and duties in respect of IH offenders or suspected offenders are the same as their powers and duties in respect of other offenders. The legislation (with the exception of the Mental Health Act 1969) and the Police General Instructions pursuant to which the police are required to operate make no distinction between IH and non-IH people; the IH as a group rate no specific mention.[47]

But the fact that the distinction is not drawn is not of itself conclusive. More important is what the legislation and guidelines leave unmentioned, those areas left purposely nebulous. Thus the police are under no legal duty to investigate complaints from the public, nor to arrest a suspect (unless a warrant is in existence), nor even to prosecute for an offence. The decision in all these matters turns on the exercise of a wide discretion which, where not expressly conferred,[48] can be implied from the silence of the law.[49]

The General Instructions provide some guidelines at the policy level as to how the discretion in such matters is to be exercised. Whilst police action contrary to the General Instructions would not result in legal liability, it would in most cases be frowned upon and may lead to departmental sanctions.

The effect of the General Instructions on the manner in which the police decide to act can be seen by following through the alternatives available to them in dealing with an IH person suspected of or found offending.

Assume a police officer finds an IH person committing an offence punishable by imprisonment, for example, theft. A range of options as to what action to take is available to the officer, the extent of which will depend upon the seriousness of the offence, the wishes of the victim, the approach and attitude of the offender, the circumstances in which the offence was committed, and so on. Thus the IH person may be cautioned, spoken to, ordered to return the property, sent back to his or her family or IHC, summonsed or arrested. But essentially, in terms of the General Instructions, the options open to the officer are either to arrest or not to arrest.

On the question of arrest without warrant, the General Instructions merely state that the power to do so is at all times to be exercised with discretion, and that all arrests should be made for good and sufficient reasons in accordance with established policy. There is no need to arrest if the offence is a minor one committed by an otherwise respectable citizen who can be brought before the court on summons.[50]

An arrest may be effected pursuant to the authority conferred by s.315(2) of the Crimes Act 1961 and the IH person may be taken into police custody for questioning.

Section 316(1) of the Crimes Act imposes a duty on the arresting officer to inform the person being arrested, at the time of the arrest, of the act or omission for which he or she is being arrested. The duty need not be complied with if it would be impracticable to

do so or if the reason for the arrest is obvious in the circumstances. The act or omission may be stated in any words sufficient to give the arrested person notice of the true reason for his arrest.

Similarly, the General Instructions state that an arrested person should not be left in doubt as to the nature of the charge against him. There is a duty to tell the prisoner of the nature of the charge, unless the circumstances are such that the prisoner must know the general nature of the offence for which he is detained.[51]

Where IH people are arrested for an offence, it is arguable that the duty under s.316(1) may be breached in some cases.[52] Although the full import of the legal concept is not required, the wording of s.316(1) is such that the duty will not be satisfied merely by the arresting officer stating the reasons for the arrest; the words used have to be sufficient to give that person knowledge of the reasons. That any choice of words and any amount of explanation will get the message across to some IH people is not guaranteed.

The subjectivity of s.316(1) is supported by the fact that the duty need not be complied with if "the reason for the arrest is obvious in the circumstances." Obvious to whom? The IH person or the arresting officer? It is submitted that it is the former. Note that if the person is more severely retarded, it may be impracticable to inform him or her of the reasons for the arrest, in which case the duty need not be complied with. Much will depend on whether the arresting officer recognises the fact of retardation and on the degree of retardation.

The alternative view, that s.316(1) requires only a reasonable objective compliance, while facilitating the work of police officers, cannot be supported by the clear words of the subsection.

The fact that an IH person may not understand the reasons for the arrest may in some cases influence the officer in a decision to arrest. He or she may see this as the only possible course of action for the person's protection.

The General Instructions do not indicate what is to happen where an arrest is not made. Since in New Zealand there is no power of detention short of arrest,[53] the IH person is free to go as he or she wishes. However, the desire to please of many IH people and their respect for figures of authority may mean that they will not refuse a request by the officer to accompany him or her to the police station. In fact most "normal" people will be likely to accompany the officer in such cases, and many will believe that they are under arrest. At the station, the result of enquiries made may reveal the most suitable course of action - either an arrest at this later stage, a severe warning or cautioning, or release possibly to a community agency such as IHC.

Once the decision has been made to arrest the IH person and take him or her into police custody, how the person then remains to be dealt with will depend on the exercise of the police's prosecutorial discretion.

This discretion has no statutory basis but the General Instructions are clear on the question of its existence, at least in respect of minor offences.[54] They state that the question that should be uppermost in the mind of the police officer when deciding to prosecute

a minor offence is whether an arrest or prosecution is the best way of resolving a particular incident. There may be some alternative more suited to the occasion, for example, a warning, a caution, counselling or referral to a more appropriate agency. Consultation with National Headquarters on whether to exercise the discretion not to prosecute in unusual cases is encouraged.

Through the exercise of the discretion and through referral to other agencies not directly involved in law enforcement, some IH offenders may be dealt with in the most appropriate manner without being given a criminal record. For example, they can be taught where they went wrong and made to understand this and accept responsibility by IHC.

In the absence of a set policy in the realm of the discretion to prosecute, the decision will be based on a number of considerations. The General Instructions implicitly recognise the validity of any factor warranting an alternative resolution of the particular incident.

The more obvious factors are the nature and seriousness of the alleged offence, the culpability and circumstances of the prospective defendant, whether he or she has an unblemished record and whether the person has previously been let off with a warning in respect of similar incidents. Recognition of intellectual handicap could be an important factor. It could be relevant to the prosecution's chances of success and also to whether the police decide that a prosecution is the best way of resolving the case, given the availability of other more appropriate means. Where the arrest was made following a complaint from a member of the public, the police

may be more reluctant not to prosecute as the complainant would have to be advised of the reasons for the decision. How the complainant would receive such notification may thus be an additional factor relevant to the exercise of the discretion, for the police are also acting in such situations as mediators between the IH person and the public.

B. Police Powers and Action in Respect of Intellectually Handicapped Offenders - The Practice.[55]

The NZSIH, both at National Office and at branch level, report that police action in respect of IH offenders or suspected offenders is generally satisfactory. This means that although there is the initial problem of identification of intellectual handicap, once identified, the police are usually willing to take it into account in deciding how the IH person is best dealt with. So in practice, exercise of both the arrest and prosecutorial discretions may be based on the presence of intellectual handicap in the offender.

Police action where an offender is known to be or is suspected of being IH is usually to contact IHC and explain the situation to them.[56] The police and IHC then discuss the most preferable course of action, that is, whether IHC should take the matter into their hands or whether the police should proceed with an arrest or prosecution. The decision will be based on the nature and seriousness of the offence, whether there is a public need to see justice being done, whether the offender has previously been left in the hands of IHC following offences in the past, whether IHC can deal effectively with the offender, whether a prosecution would in fact achieve anything. IHC have reportedly persuaded the police to prosecute in some cases where they believed that this was the only way the IH person could be punished and taught responsibility. Ultimately

the decision rests with the police.

The police seem generally keen to keep IH people out of court and out of the criminal justice system.[57] An IHC Social Worker recalled several incidents which could have resulted in a court case, such as older IH males "annoying" young school children (which could be misinterpreted by society), setting off burglar alarms, trespassing, small thefts, - cases where the IH person does not realise that the behaviour is wrong or unacceptable, where the IH person is really the victim of his or her personal and social inadequacies rather than an active offender. In all these cases the police allegedly made an effort to talk to the offending person and to make him or her understand and accept the wrongfulness of the behaviour.

Evidence gathered from police at senior level and from officers on the street would seem to support the NZSIH views. The friendly "community relations" approach advocated and implemented by many officers in their dealings with the public would no doubt achieve a great deal in the case of an IH person suspected of or found offending. Many IH people respond badly to harsh expressions, cues and treatment, while at the same time looking up to figures of authority. They will be much more co-operative with and receptive to police who adopt a friendly approach.

Senior police staff, however, adverted to the fact that the police force consists largely of young officers many of whom do not exercise sufficient discretion in deciding whether to arrest. Either they do not always know when to use the discretion or they do not know how much discretion to use when faced with a situation which could justify an arrest. So whether they recognise a person as IH or not, officers

may not take intellectual handicap into account. If a part of the police training programme were devoted to the IH as a special group, this may result in a greater use of discretion by younger officers when dealing with the IH.

While appearing to be wide in theory, in practice the prosecutorial discretion is more limited. Many of the factors relevant to the exercise of the discretion will already have been considered in deciding whether or not to arrest the person. It is rare for the police to decide against prosecution once an arrest has been made. Where the decision is made not to prosecute an IH offender, this may be partly due to the fact that he or she was not recognised as IH until after an arrest was made.

Apart from the nature and seriousness of the offence, two other main factors appear to be important in the exercise of the prosecutorial discretion. The first is recognition of intellectual handicap. This goes largely to whether the police believe that a prosecution would be successful. Because the IH person may not have known what he or she was doing, the 'guilty mind' required by most offences will have been absent. But - and perhaps somewhat surprisingly - the primary significance that the police would seem to attach to intellectual handicap is that the person will not be fit to stand trial. He or she will be found to be 'under disability' in terms of s.39C of the Criminal Justice Act 1954.

The second factor is that IHC exists as an alternative and possibly more appropriate agency to deal with the incident.

The exercise of this discretion is a difficult matter for the police and in a sense IHC are to blame for this by placing the police in a position of uncertainty. Whereas at times they are asking the police to show understanding or leniency by taking the fact of intellectual handicap into account, at others, in accordance with the principle of normalisation, IHC are asking the police to treat the offender as they would any other offender and to take action accordingly. This results in a perpetuation of the consultative process referred to above.

A decision not to prosecute is in practice always accompanied by a warning to the IH offender. This is seen as important, since although the wrongfulness of the person's actions will be fully brought home to him or her, if possible, by IHC (if referral to IHC is a part of the decision not to prosecute), a police warning is likely to have a greater and more lasting effect in most cases as coming from an outsider in a position of authority.

C. Police Questioning of Intellectually Handicapped Suspects

Police questioning of persons in custody in relation to an alleged offence is governed in New Zealand by the 1930 English Judges Rules[58] and Administrative Directions to the Police, first formulated and approved by the Judges of the King's Bench Division in 1912 and 1918.

The Rules do not have the force of law, but are applicable in New Zealand as guidelines to the police on the proper course of action to be taken in the various stages of an investigation.[59] The Rules are not to be construed strictly, but rather their spirit is to be observed. The spirit of the Rules is such that any evidence obtained unfairly or improperly from the person questioned may be excluded from subsequent court proceedings at the judge's discretion.

Thus persons in custody whom the police have decided to charge with an offence must first be cautioned as to their right to silence, before questioning proceeds. The caution is couched in these terms: "Do you wish to say anything in answer to the charge? You are not obliged to say anything unless you wish to do so, but whatever you say may be taken down in writing and given in evidence." The same caution should be administered where the prisoner wishes to volunteer any statement.

The police are not entitled to cross examine the prisoner improperly in respect of a voluntary statement; they may question only for the purpose of removing ambiguity.

Any statement made in accordance with the Rules should be taken down in writing and signed by the person making it after it has been read to him and he has been invited to make any corrections to it.

There is a clear possibility that the police may be acting improperly or unfairly, in breach of the Rules, when questioning an IH person. The breaches may be inadvertent, but may also be deliberate given that the Rules are often inconsistent with good police practice. For example, the police may have to cross-examine an IH prisoner "improperly" in respect of his or her voluntary statement simply in order to obtain a clear and logical picture of the facts. Such questioning may, however, be justified in some cases on the basis that it was directed to removing ambiguity.

Many IH prisoners will be unlikely to understand the caution administered before questioning or before the taking of a voluntary statement, especially if the formal terms of the caution are not elaborated on. The fairness of evidence having been obtained from

an IH person who is unaware of the right to silence, unaware of the effect of his or her statements and likely to make admissions he or she neither intends nor understands may well be in issue in subsequent court proceedings. Although a technical breach of the Rules will probably not be established, a disregard of their spirit usually will be, with the consequence that the trial judge may in his discretion refuse to admit the statement thus obtained.

In 1978, the Home Office issued Administrative Direction 4A to the English police.[60] It directed them to take particular care in putting questions to and accepting the reliability of answers from a person who appears to be mentally handicapped and possibly unable to understand questions and open to suggestion. As far as practicable, and where recognised as such by the police, a mentally handicapped adult should be interviewed only in the presence of a parent or person in whose custody, care and control he is, or any other person with a professional interest in the mentally handicapped.

This direction is not in force in New Zealand. However, in practice it seems that a person in custody identified as IH is seldom refused a request to have a relative, friend of IHC staff member present during questioning. This of course depends on the timing of the request, the nature of the offence and whether the police identify the person as IH. The question of recognition is obviously crucial. Where the person is so identified, it appears that the initiative to have another person present during questioning is taken by the police.

The Judges' Rules do not affect the principle that any statement made or answer given to a question put by a police officer must have been voluntary if it is to be admitted in evidence.

In the New Zealand case of Naniseni v. The Queen,[61] the voluntariness of the accused's confession was challenged. Turner J. in the Court of Appeal reviewed the New Zealand and overseas authorities to settle the meaning of 'voluntary'. Relying heavily on the wording of s.20 of the Evidence Act 1908, he concluded that 'voluntary'[62]

> ... must be taken to signify that the will of the person making the confession has not been overborne. If the factor which is set up as rendering the confession not voluntary is something in the nature of threats, violence, force or other form of compulsion ... or ... "duress, intimidation, persistent importunity, or sustained or undue influence or pressure", whatever is alleged as an inducement must have been brought to bear on the prisoner by some other person, and to have influenced him to make the confession. If what is set up is the more special ground of "some fear of prejudice or hope or advantage exercised or held out to or upon him", not only must the inducement be held out by some other person but that other person must be shown to be a person in authority over him.

The voluntariness of an IH person's statements may well be impeachable in subsequent proceedings. The prosecution will bear the burden of affirmatively proving their voluntary nature.[63]

Any of the factors mentioned by Turner J. in the passage cited may have been present to overbear the IH person's will, in particular, intimidation, or some fear of prejudice or hope of advantage. However, the prosecution may successfully argue that the person's will was not in fact overborne by that of the police officer. As Turner J. stated, "the will of some other person is essential;

the involuntariness cannot be produced from within."[64] The argument would be that the intimidation, duress, fear of prejudice or hope of advantage, etc. are the product solely of the IH person's particular mental and emotional processes, rather than having been 'held out' by the police officer.

Although the Naniseni Court was not directly concerned with s.20 of the Evidence Act, that section must clearly be applied wherever applicable. It provides that:

> A confession tendered in evidence in any criminal proceeding shall not be rejected on the ground that a promise or threat or any other inducement (not being the exercise of violence or force or other form of compulsion) has been held out to or exercised upon the person confessing, if the Judge or other presiding officer is satisfied that the means by which the confession was obtained were not in fact likely to cause an untrue admission of guilt to be made.

It has been shown in the United States that IH suspects are more likely to confess than others.[65] The reasons for this may be the IH person's poor judgment, impressionability, desire to please, confusion, fear and, of course, low intelligence.

One problem in applying s.20 to confessions obtained from IH suspects is that in the majority of cases, the admission of guilt will, as has been said, result not from direct or indirect means actively employed by the police officer, but rather from the person's own reactions to the entire situation.

Even if 'means' were employed, were these in fact likely to cause an untrue admission of guilt to be made?

The test to be applied in determining the likelihood of untruth under s.20 was enunciated by the Supreme Court in R. v. Hammond:[66]

> ... the test ... is whether or not an innocent person in the position of the accused and in the circumstances in which he was placed would be likely to confess to a crime which he had not committed ...[F]or this purpose, the Judge is not entitled to have regard to any view which he may have formed as to whether the admission actually made was true but must restrict himself to the consideration of the tendency or otherwise of the accused, assuming him to be innocent, to admit guilt.

The test must be applied subjectively, such that one must consider the likelihood of an innocent IH person, of the same degree of retardation as the accused, confessing to the crime which he had not committed. Many IH may respond to an inducement by admitting guilt, whether they are innocent or guilty. The tendency to admit guilt is likely to increase with the severity of the retardation such that the more retarded the accused is, the more likely he or she will be to respond even to the most trivial inducement. Hence the reliability of the statement will be closely related to the degree of retardation.

Finally, if an IH person's confession is admitted in evidence, his or her counsel may still place in issue its probative value. In R. v. Santinon[67] the British Columbian Court of Appeal held that while not of itself rendering a statement involuntary and inadmissible, a person's mental condition is relevant to the weight to be attached

to the evidence. The case involved an insane person, but the ruling must necessarily apply also to evidence obtained from an IH person the reliability of whose statements is doubted. Indeed in R. v. Stewart[68] it was found that the probative value of admissions made by a severely retarded defendant was far outweighed by their prejudicial effect. In that case, the evidence was not admitted at all.

The probative value to be attached to the statement of an IH person will be a question of fact and degree in each case. The level of retardation will be the predominating factor. Other factors will go to the general reliability of the statement in light of all the circumstances in which it was made, including impropriety or unfairness.

It must be remembered that in practice, a relative, friend or IHC staff member will be present during questioning and the taking of a statement. Allegations of unfairness, involuntariness and, perhaps, lack of probative value will therefore be difficult to sustain.

D. Police Powers under the Mental Health Act 1969

The only statutory provisions which confer and impose on the police specific powers and duties in respect of the IH are s.35 and s.36 of the Mental Health Act 1969.[69] These provisions extend the role of the police as law enforcement agents to that of agents of the mental health system.

Section 35 empowers a police officer to make or cause to be made an application for a reception order for the detention of a person in a psychiatric hospital if he or she has reasonable cause to believe that the person

a) is mentally disordered, and

b) is neglected or cruelly treated by any person having the care or charge of him or her, or is suicidal or dangerous, or is not under proper oversight, care or control.

The power is exercisable if an application for a reception order appears to be for the person's good or in the public interest. If necessary, the officer may apprehend any such person found wandering at large and bring him or her before a District Court Judge.

Under s.36, any District Court Judge to whom an application has been made for a reception order in respect of any mentally disordered person may issue a warrant for the arrest of that person and require any member of the police to apprehend the person and bring him or her before a District Court Judge.

A full discussion of these provisions is not proposed.[70] The duty that may arise by virtue of s.36 entails only the carrying out of a judicial order. While the power conferred by s.35 raises certain issues, such as the inherent unsuitability of the police to act in respect of mentally disordered persons and the breadth of the grounds for exercise of the power, it is rarely invoked in respect of IH people. The usual course of action where a police officer comes across an IH person in circumstances that would warrant exercise of the power is to contact the person's family or IHC.[71]

PART V. INTELLECTUAL HANDICAP AS A FACTOR IN CRIMINAL PROCEEDINGS AND THE COURT DISPOSITION OF INTELLECTUALLY HANDICAPPED DEFENDANTS

An affirmative exercise of the police's prosecutorial discretion necessarily results in the initiation of court proceedings. At this stage, the presence of intellectual handicap in a defendant and the recognition accorded such by key criminal justice personnel - police prosecutors, lawyers and judges - can play an important part in the determination of his or her fate. This may be so without guilt or innocence of the alleged crime even becoming an issue.

A lack of awareness of intellectual handicap is often reflected throughout the court process by the criminal justice personnel involved. If and once recognised as IH, attitudes to the defendant may vary from insensitivity through to patronisation and assumptions of incapacity on the one hand, to assumptions of inherent criminality on the other. Informed and understanding attitudes may, of course, figure in between these extremes.

Education in this area would greatly facilitate the task of defence counsel[72] and judge. A general knowledge of intellectual handicap and specific knowledge of the possible related legal issues and the approaches to dealing with the IH in court could appropriately be incorporated into undergraduate law study or be made the subject of seminars, perhaps of the "continuing education" type sometimes organised by the New Zealand Law Society. The point of such education would be not only to enable recognition of intellectual handicap, but also to assist counsel in preparing the client's case (deciding which factors to emphasise and which, if any, defences would be viable) and the court in disposing of the defendant appropriately

(for example,it may find the defendant's handicap to have negated any intention to commit the crime or it may consider it an important factor in deciding which sentence to impose). It is to be hoped that it would result in counsel and judges being more reluctant to invoke the provisions of Part VA of the Criminal Justice Act 1954 concerning mentally disordered persons.

Credit must be given to IHC and their efforts to counter the effects of this current lack of education. Where a defendant is known to IHC, it is not infrequent for them to play an active part before and during the court proceedings. Thus an IHC staff member (usually a social worker) may brief defence counsel on the particular circumstances of the IH defendant, the relevance of his or her handicap to the alleged offence and may suggest to counsel the most appropriate disposition to be presented to the court. In court, he or she may act as a mouthpiece for the IH defendant with particularly poor communication skills. In his or her capacity as a person with experience or expert knowledge in intellectual handicap, the IHC staff member may be called upon by the judge to give evidence on any matters relating to intellectual handicap in general or to the particular defendant. Finally, he or she will be there to give the IH defendant the possibly needed moral support in unfamiliar court surroundings.[73]

While, with respect to IHC, there may be possible dangers of abuse in its apparent power to influence the course of prosecution (such as legally innocent IH people being pressured into guilty pleas), its role in court proceedings must be seen as a necessary consequence of the uncertainties which IH defendants would appear to cause to criminal justice personnel at present.

A. Possible Court Dispositions of the Intellectually Handicapped Defendant

The range of options which may be available to the judge in criminal proceedings involving an IH defendant is considerably wider than that available to the judge in respect of a non-IH defendant . Not only may the IH accused be found guilty or not guilty of the alleged crime, but also the provisions of Part VA of the Criminal Justice Act 1954 may be invoked such that the accused be diverted, either temporarily or permanently, from the criminal justice system to the mental health system.

1. Not guilty or guilty

The IH defendant may be able to plead guilty or not guilty, raise defences and be acquitted or convicted of the offence charged in the same way as any other defendant.

This section examines briefly the relevance of intellectual handicap to the issue of responsibility for the crime and the defences which the IH accused may raise in criminal proceedings.[74]

(a) Intention

In Cunliffe v. Goodman[75], "intention" was defined as a state of affairs which the party intending decides to bring about, and which he or she has a reasonable prospect of being able to bring about, by his or her own act of volition. Whether the intent required by a particular offence can be satisfied by proof that the accused foresaw or knew of the highly probable consequences of his or her actions,[76] or by proof that the accused desired the results of his or her actions,[77] the main issue in the case of the IH accused is whether he or she has the mental capacity to form an intention. Specifically, could the IH person make a decision to bring about the state of affairs? Was it brought about by the person's own acts of volition ?

Most IH people are only mildly or moderately retarded and would probably be capable of forming the required intent.

Where an argument of lack of intention to commit the crime does succeed, the IH person will be acquitted. The evidence may, however, justify a finding of insanity and acquittal on the grounds of insanity, if this defence is raised.

(b) Recklessness

The mens rea required for certain crimes can be satisfied by proof of recklessness on the part of the accused. Recklessness means adverting to the consequences of one's acts. It is not clear in New Zealand whether recklessness is to be judged subjectively or objectively. If the former, as was held in DPP v Morgan,[78] the IH person will have been reckless if he or she adverted to the consequences of his or her act, but committed it nevertheless, thereby causing injury or damage. If the latter, as was held by a majority of the House of Lords in R. v. Caldwell,[79] the IH person will have been reckless if he or she did an act which in fact created an obvious risk, and in doing that act gave no thought to the possibility of there being a risk, or decided to ignore the consequences and run the risk. Obviously, many more IH offenders will be found to have had the mens rea to commit the crime when judged on the "reasonable person" standard of the Caldwell test.

(c) Negligence

The IH accused may be held to have been negligent and therefore criminally responsible for his or her act if, in committing it, he or she felt below the standard of skill and care which would have been observed by a reasonable person.[80] Where negligence is in issue, the likelihood of an IH person being acquitted is slender.

(d) Mistake

The IH person may have a defence to the crime charged if he or she can prove that the act in question was committed because of a mistake of fact. If the offence requires proof of a mere intent to commit the act, it seems that any honest mistake will suffice. However, if the offence requires proof of some further state of mind, such as knowledge, then the mistake will have to have been both honest and reasonable.[81] For the defence to succeed, the mistake will have to have been such that had the facts been as the accused believed them to be, no offence would have been committed.

Thus in the case of a charge of rape under s.128 of the Crimes Act 1961, the IH person's honest and genuine belief that the woman consented to the act of intercourse will not afford grounds for the defence unless a person of normal intelligence would also have believed the woman to be consenting. The reasonableness of an IH person's belief, when judged on "normal" standards, will often be difficult to maintain.

(e) Intoxication

The intoxication of an IH accused may be relied on to negative any element of the mens rea required for the particular crime. It may also be relied on to prove that the actus reus was not voluntary.

In R. v Kamipeli,[82] the New Zealand Court of Appeal held that evidence of intoxication can be used to negative the mens rea required for any crime and that the Crown bears the burden of proving the required intent. This approach was supported in the Australian case of R. v O'Connor,[83] in which the High Court of Australia declined to follow the House of Lords decision in DPP v Majewski .[84] In the latter case, considerations of public policy prevailed over logicality and led to the ruling that intoxication could only be

used to negative mens rea in crimes of specific intent; in crimes of basic intent the intoxication itself constitutes the mens rea.

The question has been expressly left open in New Zealand.[85]

Intoxication may be an important concept in the context of intellectual handicap, where excessive or incorrectly prescribed medication may result in violent or aggressive behaviour. It may be argued that intoxication had a greater effect on the IH defendant, but otherwise the IH are in the same position as the non-IH in relation to this defence.

(f) Automatism

The defence of automatism may be established by proving that the act in question was committed involuntarily by the muscles independently of the mind, thereby negating criminal responsibility.

The defence could be viably raised by the IH offender if, for example, he or she suffered from epilepsy[86] or cerebral palsy, or was so severely retarded that the mind could not be said to control the body.

It is not clear in New Zealand whether the defence would be available to a person who was at fault in bringing about his or her state of automatism. Much will depend on the outcome of the intoxication dispute. If fault is relevant, this would mean, for example, that the IH person who embarks on a course of conduct knowing that he or she suffers from epileptic fits, may be reckless or negligent if the conduct results in injury or damage to another.

If the intellectual handicap of the defendant has not been considered relevant in determining guilt, it may yet become relevant in sentencing the guilty IH person. Its relevance in each particular case will depend upon a variety of factors: the nature and seriousness of the offence, the conduct of the IH person in court, the degree of handicap, the views of the particular judge and the sentencing alternatives available.

2. Diversion to the mental health system

The term 'diversion to the mental health system' refers here to any psychiatric intervention in the course of criminal proceedings which results in either the temporary or permanent transfer of the accused from the criminal justice system to the mental health system.

Under the provisions of Part VA of the Criminal Justice Act 1954, there exist various types of psychiatric diversion: committal to a psychiatric hospital following a finding of disability, committal following a finding of insanity or the process of what is essentially a civil committal after conviction. Strictly speaking, "psychiatric diversion" implies either an attempt at a permanent solution or at least an attempt to manage the problem temporarily, and does not therefore include a remand for psychiatric observation and reporting. However, there are three reasons for considering the remand procedures to be a form of diversion to the mental health system. First, they constitute a psychiatric intervention in the course of criminal proceedings. Secondly, although the person is deemed to remain in the legal custody of penal or police authorities, in reality he or she is under the control of the psychiatric hospital authorities. Thirdly, the remand may provide the starting point for a civil or a voluntary committal to a psychiatric hospital.

This section examines the different means by which an IH accused may be diverted to the mental health system. A discussion of the desirability and potential problems of such diversion is contained in the following section.

(a) Diversion by means of psychiatric remand procedures

An important diversionary tactic from both the psychiatric and practical points of view is the court's power to order that the person be temporarily detained in a psychiatric hospital for the purpose of observation of his or her mental condition. Thus s.39B (1) of the Criminal Justice Act provides that:

> ... where any person charged with any offence punishable by imprisonment is in custody pending a hearing or trial before any Court, and it appears to that Court that he may be under disability, or that at the time of the commission of the alleged offence he may have been insane within the meaning of s.23 of the Crimes Act 1961, the Court may, subject to subsection (3) of this section, make an order that he be removed to a hospital and be detained there under observation pending the hearing or trial.

Subsection (2) provides that the same power applies in respect of a person convicted of an offence who is in custody pending the determination of his or her appeal.

Subsection (3) requires the court to be satisfied, before making the order, that it is necessary or expedient that the person's mental condition be under observation in a hospital.

Subsections (4) and (5) provide that the total period of detention under the initial order and extensions thereof shall not exceed two months.

The court may at any time order that the person be removed from the hospital and returned to custody for the purposes of the hearing or trial or determination of his appeal. Such order must be made upon receipt of the hospital Superintendent's report on the person's mental condition.

Very few persons are remanded under s.39B: fourtyfour in 1979, sixty in 1980 and sixtytwo in 1981. Only a minimal proportion of these are IH: two in 1979, one in 1980, one in 1981 and none in 1982.[87]

The primary purpose of remand under s.39B is to determine whether the person is under a disability, that is, unfit to stand trial, or whether he or she was insane at the time of committing the alleged offence.

Remand for the purpose of obtaining a psychiatric report may also be ordered by the Court under s.47A of the Criminal Justice Act, in a wider variety of situations than under s.39B. The power is extended in respect of persons already convicted of an offence punishable by imprisonment. It is exercisable before or during the course of the trial, before sentencing or pending the determination of an appeal. The court must consider it expedient that a psychiatric report on the person's mental condition be made available to it.

The court may make one of three orders. Under subsection (2)(a), the court may make it a condition of a grant of bail that the person attend for psychiatric out-patient treatment. It may, under subsection (2)(b), order that the person be committed to a penal institution for up to two weeks and be psychiatrically examined there. Under subsection (2)(c), where the court considers impracticable that the examination be carried out in a penal institution or where a report recommending further detention for observation is available, the court may order that the person be detained and examined in a psychiatric hospital for up to one month. Where the latter order is made, the court must order that the person be returned to custody for the purposes of the hearing or trial, sentencing or determination of the appeal once it receives the hospital Superintendent's report.

Obviously many more people are remanded under s.47 A (2)(c) than under s.39B: 283 (9 IH) in 1979, 236 (6 IH) in 1980, 268 (8IH) in 1981.[88] Three IH persons were remanded under s.47A(2)(c) in 1982.

The use of s.47A(2)(c) is not restricted to determining the accused's fitness to stand trial or sanity. It may also be used to assist the court in imposing an appropriate sentence in light of the person's mental condition. Thus the psychiatric report could indicate intellectual handicap as a factor relevant to sentencing.

The majority of persons remanded, whether pursuant to s.39B or s.47A, are not subsequently found to be under disability or insane.[89] This stems from the disparity between the statutory test for determining remandability (the court simply has to be satisfied that the person's

mental condition warrants observation) and the statutory tests for determining disability or insanity, and surely reflects an excessive use of these procedures.

It is sometimes said that the courts' power to remand is no more than a speedy method of committal.[90] Strictly speaking, this cannot be so in view of the statutory time limit of two months. However, use of the remand procedures may provide the starting point for a civil or voluntary committal to a psychiatric hospital. Indeed, under s.42(4) of the Mental Health Act 1969 there is a procedure whereby any person detained in a penal institution on remand pending trial may be the subject of an application for a temporary reception order. Only one IH person has been detained as a special patient pursuant to s.42(4) since 1979. An average of twenty patients in total were detained under the subsection each year from 1979 to 1980. Further, a recent New Zealand study has indicated that where the psychiatric report does indicate a disability, such that the person is unfit to plead, there would seem to be an expectation that the prosecution will be withdrawn or the case dismissed and the matter settled informally out of court, perhaps by a civil or a voluntary committal.[91]

In 1983 the Donaldson Commission of Inquiry stated in its Report that it considered s.39B and in fact most of the provisions of Part VA of the Criminal Justice Act to be generally adequate.[92] However, both the 1981 Working Party on Psychiatrically Disturbed Prisoners and Remandees and the members of the 1983 Committee of Inquiry into Procedures at Oakley Hospital and Related Matters[93] criticised the Act's remand provisions and especially those enabling the detention of remandees in psychiatric hospitals. The Working Party in fact recommended that s.39B be repealed and that all assessments take place under s.47A.[94]

Their criticisms were based largely on the fact that most of the persons remanded by the courts have not been found guilty and that for a considerable number of those remanded for sentence there is no certainty that they will receive a custodial sentence. They condemned the deprivation of liberty by detention in either a prison or a psychiatric hospital without a careful consideration of the necessity for such a move.

The members of the Oakley Inquiry also remarked that the conditions in which the remandees were detained and examined were such as to accentuate some psychiatric problems and mental disturbances and to deprive any observation carried out of at least some of its validity. They further stated that "to keep [persons on remand] under circumstances such as these where they are expected to associate with persons of the kind described is, in our opinion, a practice which cannot be sustained and should not continue."[95]

These criticisms bear special force in the case of IH remandees, who may be particularly susceptible to harsh treatment and abnormal surroundings, and are likely to be greatly affected by other people with whom they associate.

The Working Party recommended that persons should not be remanded to psychiatric hospitals for observation unless there is no alternative or there are very special circumstances which require this. The members of the Oakley Inquiry recommended similarly, adding that a separate remand unit be made available where remand to a psychiatric hospital is necessary.

While the Working Party, the Donaldson and Oakley Inquiry members and the Task Force on Revision of Mental Health Legislation made a number of other worthwhile recommendations in respect of the remand provisions of the Criminal Justice Act, a discussion of these is outside the scope of the present study. Attention has been briefly focused only on those seen as bearing particular relevance to the IH.

(b) Diversion by means of a finding of disability

A dissenting judge in an American case where the accused was found unfit to stand trial was reported as saying that "the decision licenses every illiterate moron to violate the law with impunity."[96] Not only is the statement an example of the lack of agreement in legal and judicial circles in respect of the handling of IH offenders, but also it fails to catch the full import of a finding of disability, namely, indefinite psychiatric detention, with all the serious potential problems attaching to it.

Because it is considered important in our system of justice that an accused be able to participate in his or her own trial, the law requires that the person be mentally fit to stand trial. To borrow the wording of the Law Reform Commission of Canada, "the purpose of the fitness rule is to promote fairness to the accused by protecting his right to defend himself and by ensuring that he is an appropriate subject for criminal proceedings."[97]

The rule is embodied in s.39A(1A) and s.39C of the Criminal Justice Act, with the traditional phrase "unfit to stand trial" replaced by "under disability." In defining when a person is under disability, s.39A(1A) largely reproduces the Common Law fitness criteria. Thus a

person is under disability if, because of the extent to which he is mentally disordered, he is unable to plead, or to understand the nature or purpose of the proceedings, or to communicate adequately with a solicitor for the purpose of conducting a defence.

Section 39C of the Act provides that if, before the hearing or preliminary hearing of the information alleging the offence, the Judge is satisfied on medical evidence that the person is mentally disordered, he has to determine whether the person is under disability. If so, a finding of disability must be recorded.

It is clear that mental disorder, of itself, does not amount to unfitness. What is less clear is the degree of disability required. For example, is it necessary that the defendant be able to arrive at a thoroughly rational decision as to his or her plea, be able to understand the legal issues and procedural intricacies of the case and be able to give impeccable instructions to his or her counsel?

In a classic mid-nineteenth century case, the trial judge stressed that "it is not enough that the accused may have a general capacity of communicating on ordinary matters."[98] Jurors in that case were told that the accused must understand the details of the trial.

However, the case law has evolved considerably since then and indicates that today, the requirements are on a much lower level. The view that the accused must be able to instruct counsel "properly", must be "properly able" to defend himself and able to give "proper" evidence and make "proper" decisions was rejected in R. v. Robertson.[99]

Perhaps the most carefully formulated expression of the "understanding" test is that of Devlin J. in R. v. Roberts:[100]

> ... if there are no certain means of communicating with the defendant so that there are no certain means of making sure that he will follow as much as it is necessary that he should follow of the proceedings at his trial, then he should be found unfit to plead.

Thus to be fit, the accused will need to understand that he or she is being charged with an offence, what it means to plead "guilty" or "not guilty", that there is a right to be defended, to call evidence in defence, to testify on his or her own behalf and to challenge jurors.

The Common Law requirement that the accused be able to instruct counsel has been superseded in the statutory disability criteria by the lesser requirement that he or she be able to communicate adequately with a solicitor. A part of this may be that the accused recollect the events leading up to and surrounding the commission of the alleged crime. In the leading case of R. v. Podola,[101] it was held that temporary loss of memory at the time of commission of the crime did not render an accused unfit to stand trial. But the implication is that where the amnesia is symptomatic of an organic or functional disorder affecting the accused's fitness, then he or she may well be so unfit. Indeed, Parker C.J. in delivering the Court's decision, stated:[102]

> We cannot see that it is in accordance either with reason or common sense to extend the meaning of the word to include persons who are mentally normal at the time of the hearing of the proceedings against them, and are perfectly capable of instructing their solicitors as to what submissions

their counsel is to put forward with regard to commission of the crime.

The gradations of severity of retardation mean that while some IH defendants will be within the statutory disability criteria, others will be quite capable of standing trial. The criteria relate specifically to intelligence, memory and the ability to concentrate, communicate and take part in decisions. Of the common problems associated with intellectual handicap, poor memory, short attention span, difficulties in abstract thinking and speech impairments will be relevant in determining disability.

Clearly either party to the proceedings, or the court itself, can raise the issue of fitness. Defence counsel may be in a difficult position where he or she has doubts as to the client's mental abilities. Although the client may object to the issue being raised (whether counsel will respect this wish in turn depends on whether the client is able to adequately communicate), there is also a duty to the court to help it arrive at the truth.

At Common Law, where the issue of fitness arose at the instance of the prosecution, the burden of proving the fact had to be discharged beyond a reasonable doubt. Where the defence raised the issue, the burden was discharged simply by proof on the balance of probabilities.[103] There is no reason to suppose that this has not been carried through to s.39C.

Subsections (4) and (5) of s.39C enable the court to postpone consideration of the disability question if, in its opinion, it would be to the accused's advantage to do so. At any trial or hearing, consideration of the issue may be postponed until any time up to the

opening of the case for the defence. At any preliminary hearing, it may be postponed until any time before the court determines whether the person is to be committed to the High Court. Thus where the prosecution has not established a prima facie case, the information may be dismissed or the accused acquitted without the question of disability being considered.

The Law Reform Commission of Canada has proposed a reform of the procedure in respect of the Canadian equivalent of s.39C, which would allow the judge to postpone determination of the disability issue to the end of the trial.[104] There would thus be full adjudication on the substantive issues of the case before the accused risks indefinite detention on the ground of unfitness. The Commission made the following specific proposals.

The trial judge may order a hearing on the accused's fitness immediately once the issue is raised. Upon request by either party, or where the trial judge considers that it would be in the interests of justice to do so, the determination may be postponed until the end of the case for the prosecution.

After presentation of the case for the prosecution, the trial judge would have three possibilities: on motion by the defence he may either acquit the accused or postpone the issue to the end of the trial, or he may order a hearing of the accused's fitness to stand trial. Determination of the disability issue would only be postponed to the end of the trial where defence counsel has demonstrated that he or she has a case to present and that it would be in the interests of justice to proceed on the merits of the charge.

Where the trial is by a judge sitting alone, consideration of the issue is simply postponed to the end of the trial, whereupon the judge has two alternatives: either to acquit the accused or direct that the issue of fitness be determined. If the accused is found not to be under disability, then a conviction is entered.

Where the trial is by jury, the procedure would be somewhat different. The judge would postpone consideration of the issue until all the evidence at the trial had been heard. The jury would then be directed to consider the guilt or innocence of the accused. A verdict of "not guilty" would mean that the accused is acquitted and there would be no fitness hearing. Where the jury considers the accused to be guilty of the charge, it would deliver a conditional verdict of "guilty if fit". The issue of fitness would then be determined by the judge. If the accused is unfit, the judge would set aside the jury's conditional verdict and make an order for the disposition of the unfit accused.

Subject to provision being made for the trial judge to direct that the jury deliver either an acquittal or a conditional verdict, the Commission's proposals should be adopted in New Zealand. They remove the risk of indefinite detention of an innocent person and reduce the risk of the defence's case being jeopardised by the further passage of time involved in the hearing of the issue. They secure the very purpose of the fitness rule, namely, to protect the defendant's right to a fair trial. The only problem foreseen with implementation of the proposals is that in the case of a trial by jury, it may introduce difficulties into the delimitation of the functions of judge and jury such that a jury, uncertain of the significance of

its conditional verdict, may instead return a verdict of 'not guilty'. This problem need not, however, arise if the legislation that would have to be enacted properly sets out the procedures and the jury is given proper directions by the judge.

A finding of disability by no means "licenses every illiterate moron to violate the law with impunity". On the contrary, it is followed by an order under s.39G(1)(a) of the Criminal Justice Act that the person be detained in a hospital as a special patient. The effect of the order is to adjourn the proceedings until the person ceases to be under disability. If the person is subsequently transferred to committed patient status, the proceedings are stayed.

Very few persons are detained as special patients in psychiatric hospitals pursuant to s.39G(1)(a). There were only seven in 1979, seven in 1980 and six in 1981. In both 1979 and 1980, only one such patient was IH. No IH person was detained pursuant to s.39G(1)(a) in either 1981 or 1982. This reflects the fact that in practice, where a psychiatric report indicates a disability such that the person is unfit to plead, the prosecution will be withdrawn and no finding of disability will be made.[105]

(c) Diversion by means of a finding of insanity

The criminal law assumes an accused to be sane at the time of commission of an alleged offence. The presumption may be rebutted by the judge or the accused raising the question of insanity and the successful pleading of the defence of insanity under s.23 of the Crimes Act 1961. The accused will be acquitted on the grounds of insanity.

Section 23(2) provides that:

> No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable -
> (a) of understanding the nature and quality of the act or omission; or
> (b) of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

The insanity defence will not often be raised where an IH person has been charged with a crime. The main reason for this is that any case in which the defence could have been viable by reason of the person's natural imbecility or disease of the mind will usually have been siphoned off at an earlier stage with an informal out of court settlement or a finding of disability.

If raised, the defence is unlikely to succeed in respect of an IH offender. Although there will usually be no difficulty in establishing that at the time of commission of the offence the IH person was labouring under natural imbecility or disease of the mind,[106] it will be more difficult to prove that the person did not understand the nature and quality of the act or omission, or did not know that it was morally wrong.

Whether the IH person understands the nature and quality of the act of omission depends on the degree of retardation as well as on the nature of the offence. Most IH offenders are only mildly or moderately retarded and will have a fair idea of what they are doing. This applies especially in respect of offences involving liability

for consequences. For example, an IH person who picks up a gun, aims it at someone and pulls the trigger is likely to realise the consequences of his or her actions. Similarly, it has been suggested that most IH offenders will know that their act or omission was morally wrong.[107]

Under s.39E of the Criminal Justice Act, if on the trial on indictment of a person charged with an offence it appears in evidence that the person was insane at the time of commission of the alleged offence, and he is acquitted, the jury are required to find specifically whether he was insane at that time, and to declare whether he was acquitted on account of his sanity.

The expected consequence of an acquittal on account of insanity is that the court will order the person's detention as a special patient pursuant to s.39G(1)(b) of the Criminal Justice Act.

Section 39G(2) provides for three alternative courses which the court may adopt. Thus, where the court considers that it would be safe in the public interest to do so, it may order that the person be detained as a committed patient in a psychiatric hospital, or that the person be immediately released, or it may decide not to make any order under the section if the person is subject to a sentence of imprisonment or detention that has not expired.

The matters to be considered by a court in exercising its discretion under s.39G(1) and (2) following an acquittal on account of insanity were canvassed by Roper J. in R. v. GH:[108]

> The fact that the individual poses no threat to the public is not conclusive of the matter. What might be in the best interests of the individual is not conclusive of the matter. All the circumstances must be considered quite apart from the individual's mental state ... While no element of retribution or deterrence is involved, ... there still remains some wider element of public interest, quite apart from its safety, and quite apart from what might be in the best interests of the individual involved where that interest and the public's coincide ... The gravity of the charge is of considerable importance in considering an application such as this.

The accused in that case was acquitted, on grounds of insanity, of a triple murder. It was accepted that he no longer posed any threat to the public interest. Roper J. rejected the contention that his mental condition justified a regular committal order and made an order that the accused be detained as a special patient under s.39G(1)(b).

The implications of this decision are not necessarily unfavourable to the IH offender. Depending on the nature and seriousness of the offence committed, the court will have regard to his or her well-being in deciding which order to make. It will have regard to all the circumstances of the case. In appropriate cases, counsel for the IH accused may stress the unsuitability and ineffectiveness of psychiatric detention[109] and the availability of community alternatives for the care and treatment of the IH person.

The statistics indicate that the courts would seem to exercise equally their discretion to order the detention of any accused acquitted on account of insanity as either a special or a committed patient. In 1979, five persons were detained as special patients pursuant to s.39G(1)(b), two of whom were IH; four were thus detained in 1980, none of whom were IH, two in 1981 (neither were IH). One IH patient was detained under s.39G(1)(b) in 1982. As committed patients pursuant to s.39G(2), five persons were detained in 1979, none of whom were IH; four persons were thus detained in 1980, one of whom was IH; three persons were thus detained in 1981, none of whom were IH. Two IH persons were detained as committed patients pursuant to s.39G(2) in 1982. It is not known in how many cases the courts, following an acquittal on account of insanity, made an order for the person's immediate release or made no order at all under s.39G.

(d) Diversion by means of a committal upon conviction

Instead of passing sentence on a person convicted of an offence, the court may make an order under s.39J of the Criminal Justice Act that the person be detained as a committed patient in a psychiatric hospital. It may do so if satisfied on medical evidence that the person is mentally disordered and that his mental condition requires that he be detained in a psychiatric hospital either in his own interest or for the safety of the public.

Many more offenders are diverted to the mental health system pursuant to this section than pursuant to any other section in the Criminal Justice Act. In 1979, ninetytwo persons were committed under s.39J, twelve of whom were IH; one hundred and two persons were thus committed in 1980, nineteen of whom were IH; twentythree

persons were thus committed in 1981, twentyone of whom were IH. Eighteen IH persons were committed under s.39J in 1982.

In the absence of data as to the number of IH and other possibly mentally disordered offenders convicted by the courts, it is not possible to know the true extent to which the power under s.39J is invoked.

However, the appropriate use of the procedure was recently considered by the New Zealand Court of Appeal in R. v. Elliot.[110] The Court stated:[111]

> It is not sufficient that the medical practitioners consider that the treatment and rehabilitation of the offender is desirable in the public interest. It is not sufficient that they consider it desirable that he should be involuntarily committed to a mental hospital. They must consider his detention to be necessary in his own interest or for the safety of the public ... Under ... s.39J the medical certificate must establish that so long as he is at large in the community the offender is a danger to other persons.

The Court further recognised that the principle of proportionality must be given proper weight. Thus if an order under s.39J would be disproportionate to the gravity of the offence of which the person was convicted, yet committal is thought necessary, then the ordinary civil committal procedures under the Mental Health Act should be used.

In 1983, the Legal Information Service - Mental Health Foundation Task Force on Revision of Mental Health Legislation stated in its Report that in light of the Elliott decision, it considered the procedures under s.39J to be generally satisfactory.

It did, however, make some recommendations in respect of s.39J. The first was that the Elliott holding relating to proportionality be incorporated into the section. The second was that the Court should have upon conviction of a person, the power to place that person under personal guardianship or a community-care order if in-patient treatment is not required.

(e) Diversion by means of a civil or a voluntary committal

The involvement of an IH person in criminal proceedings may, as has been indicated, lead to a civil or a voluntary committal of that person to a psychiatric hospital pursuant to the procedures contained in s.19 to s.24 or s.15 of the Mental Health Act 1969. A consideration of committal and admission procedures under the Mental Health Act is beyond the scope of this study; the possibility is therefore no more than adverted to. Furthermore, the civil or voluntary committal of an IH person who has been involved in criminal proceedings need not necessarily result only from his or her criminal behaviour but may be the culmination of a variety of other factors as well, for example, a lack of persons willing or able to care for him or her, a recognised psychiatric disturbance in addition to the retardation, or general social misconduct.

B. Criminal Justice or Mental Health System? - The Relative Merits

As was seen in the preceding sections, the IH accused may be processed through the court system in the normal way and be either acquitted or convicted of the offence charged, or may be diverted to the mental health system pursuant to various provisions in the Criminal Justice Act and Mental Health Act. This section examines the desirability of and problems involved in each of these courses.

1. The IH in penal and correctional institutions

The IH person convicted of a crime may be sentenced in the same manner as any other convicted offender. Depending on the nature and seriousness of the crime committed, the degree of handicap and any other factors the court may consider relevant, this may be a sentence of preventive detention (specifically in respect of sexual offences committed by a person over twenty five years of age), periodic detention, community service or any other sentence of imprisonment with the possibility of a release on probation. Or the person may simply be ordered to pay a fine.

Leaving aside the general shortcomings of the New Zealand penal system and general theories as to the validity of imprisonment as a means of punishment, rehabilitation, deterrence or otherwise, whether a sentence of imprisonment will be appropriate in respect of an IH offender will depend very much on the individual circumstances of each case.

Punishment and detention of any kind cannot be justified where the person is so retarded as to be unable to understand it, where the offence committed was not serious and where the person is not dangerous.

In many other cases, however, there is no real reason to distinguish IH offenders from "normal" offenders in terms of the validity of penal detention. The overall purposes allegedly served by a sentence of imprisonment - punishment, incapacitation, deterrence, retribution - will generally apply equally to IH and other offenders. But the rehabilitation of the IH offender is another matter. In fact the main question is whether a term of imprisonment is likely to be more destructive of the IH prisoner than of another.

Many IH fit in quite well to the prison environment. The routine, the imposed discipline and the lack of responsibility are in fact likely to be more easily accepted by an IH prisoner than by other prisoners. The problem is that the deprivations and restrictions involved in the imprisonment will not necessarily be related in the mind of the IH offender to the criminal conduct for which he or she was sentenced. In some, the prison regime may only strengthen anti-social attitudes and feelings of frustration, as it may in the case of many other "normal" prisoners. The main problem for an IH inmate will be peer acceptance. He or she will be a prime target for abuse, exploitation and degradation, and is likely to rank lowly in the prisoner hierarchy.

Given the small number of IH inmates,[112] it is not surprising that New Zealand penal institutions provide no special programmes or training for them. This is also due to a general lack of staff and financial resources, which even if available in greater abundance would probably be directed to special programmes for other

larger and equally deserving groups, such as sex offenders or alcohol and drug addicts. The IH will be incorporated into existing training programmes and assigned tasks according to their abilities.[113,114]

As a generalisation, a sentence of imprisonment cannot be said to harm the IH more than it may other offenders. Much will depend on the degree of handicap, the type of person and the length of the term of imprisonment.

2. The suitability of psychiatric diversion of the IH

Diversion to the mental health system is an option which must remain open to the courts in those circumstances where mental disorder is considered to negate criminality or where it is considered to take priority over criminality in terms of what is to be done with a particular offender. Thus social control can still be exercised but in a setting geared to treating the disorder rather than punishing for "criminal" behaviour.

T.S. Szasz has pointed to the dangers of psychiatric diversion.[115] He argues that psychiatric diversion undermines both our criminal justice system and the social fabric of our society, partly because the diversion itself subverts the rule of law, partly because the rhetoric of diagnosis and therapy diverts attention from the fact of wrongdoing and the moral legitimacy of punishment. He explains this by stating that the rule of law requires that the innocent be left at liberty and that the guilty be punished. The former requirement often makes people feel guilty at not being able to

control others who annoy or offend them, while the latter often makes people feel guilty for having to punish those guilty of lawbreaking. Psychiatric diversion comes into play to subvert the rule of law by providing a mechanism that simultaneously allays citizens' guilt for punishing certain acts and actors and satisfies their need for security by depriving certain acts of their legitimacy and certain actors of their liberty. It does so by treating certain actors as mentally disordered and their acts as symptoms of their disorder, for which they are not responsible, but for which society may justly impose compulsory "therapeutic" measures on them.

This challenge to the theory underlying psychiatric diversion does contain an element of truth, but proceeds on a narrow view of the meaning of "rule of law". Surely the real argument must be that the rule of law is subverted by an informal process which condemns someone to a period of custody without the benefit of legal trial. This is not the case with psychiatric diversion. When diversion occurs, it is a formal process regulated by law, not an arbitrary exercise of power in the face of which the individual is helpless.

The challenge further proceeds on the questionable assumption that focusing on the fact of wrongdoing and the legitimacy of punishment is the basis of our criminal justice system and is the only way of preserving the social fabric of our society. Criminal justice in New Zealand - and this is supported by the whole tenor of the Criminal Justice Act - treats neither the fact of wrongdoing nor the legitimacy of punishment as the paramount considerations in achieving justice in all cases. The individual circumstances and

needs of the offender may be considered to be equally important.

Psychiatric diversion must be seen not as an undermining of the criminal justice system, but rather as a recognition of its limitations in respect of certain acts and actors. Where a mentally disordered offender is not legally responsible for his or her actions and cannot therefore be punished for them, the criminal justice system has nothing to offer either that person or society. But where the person requires psychiatric treatment, or where the public need for protection warrants his or her detention, then the mental health system can provide the necessary service. Hence the value of psychiatric diversion, where appropriately used.

Nevertheless, psychiatric diversion is totally inappropriate in the case of IH offenders.

Its first goal, namely, the offer of psychiatric care and treatment, cannot apply to the IH. Unless suffering additionally from a mental illness, psychiatric care and treatment can do nothing for the IH person. No measure of drugs, individual or group therapy, electro-convulsive therapy or indeed any other form of psychiatric treatment can increase the IH person's intelligence and decrease his or her difficulties in learning or social adaptation. Further, the abnormal environment of the psychiatric hospital, with its dismal population of psycopaths, manic depressants and schizophrenics, is an enormous obstacle to any intellectual, emotion or personality development in most IH people. As the members of the Oakley Inquiry stated, in response to submissions of the NZSIH focusing on the needs of IH persons: "We believe that Oakley Hospital is a quite inappropriate place for intellectually handicapped persons to be cared for. Such people should be looked after in quite separate institutions..."[116]

Nor can the second possible goal of psychiatric diversion, namely, to protect the community, apply entirely to IH persons. Normally, psychiatric detention satisfies this need for two reasons. First, it guarantees the removal of the offending person from society. Second, it enables treatment of the person such that he or she be returned "safe" to society. Only the first consideration can apply to the IH offender.

The complete inappropriateness of psychiatric detention in respect of the IH forms the basis of the NZSIH's main submission to the Department of Health on current proposals for Reform of the Mental Health Act. The submission is that "mental subnormality" be excluded fromthe Act's definition of "mental disorder"; thus both that Act and the provisions of Part VA of the Criminal Justice Act would no longer apply to IH persons. Instead, a shift to responsibility with the Department of Social Welfare and community-based care is envisaged. This position is also adopted by the Health Department in its Position Paper on reform of the Mental Health Act.

In discussing the problems of psychiatric diversion of IH offenders, the distinction must, however, be drawn between remand patients and special or committed patients.

Although it may be necessary to determine whether an IH person is fit to stand trial or falls within the statutory definition of insane, or the relevance of his or her handicaps to the question of sentencing, there is no need for the person to be detained in a psychiatric hospital for the purpose of the examination. Clause 116 of the Criminal Justice Bill in fact emphasises that psychiatric detention of remandees should be ordered only where strictly necessary.

In their present form, the remand provisions may, however, be beneficially used in the case of an IH person remanded in order to determine his or her fitness to stand trial. The utility of the procedures under both s.39B and s.47A is apparent when one considers that the actual examination time need only comprise a small part of the remand period. Under s.39B, the person may be remanded to a psychiatric hospital for up to two months. While subsection (8) only authorises the administration of medical treatment or procedures necessary to prevent deterioration of the person's health, it does not preclude the remand period being used to "coach" the IH patient on what the trial is all about in order that he or she be found fit to stand trial. Such coaching would not entail the administration of medical treatment or procedures.

Although the period of a remand under s.47A(2)(c) is limited to one month, that section envisages the possibility that the psychiatric report obtained after a remand pursuant to s.39B recommend further detention for examination, despite the two month time limit under s.39B. Thus under s.47A(2)(c), the person may be detained for a further period of one month, extending the time theoretically available for coaching to three months.

The possibility of the remand provisions being used in this manner was referred to by the Canadian author, Schiffer, on the basis of communication with forensic psychiatrists.[117] Its feasibility in certain cases has also the support of NZSIH staff consulted.

The success of such coaching would depend on the degree of retardation (specifically, intelligence and powers of concentration) as well as on the patient's incentive to learn and become fit. It is quite possible for a more mildly retarded person to gain the necessary understanding within the two month or three month time

limit.[118] It would also depend on the availability of staff to do the coaching. There is a widespread lack of qualified psychiatric staff in NewZealand hospitals. However, NZSIH staff or other persons may be allowed to visit the IH patient for coaching purposes by the hospital superintendent.[119]

There is no evidence that the remand provisions are in fact used in this manner, but the possibility nevertheless exists and could be put to good use to prevent further diversion of the IH person to the mental health system and to enable the processing of the case through the courts in the normal way.[120]

The detention of IH persons as special or committed patients is unjust and unnecessary in itself for the reasons explained above. The injustice is capped when one considers that in theory, the order for detention as a special or committed patient may last indefinitely. As the Task Force on Revision of Mental Health Legislation stated:[121]

> At present, the fate of special patients is almost entirely within the discretion of the Minister of Health and the Minister of Justice. One or other may order the transfer of a special patient back to prison;[122] direct that a special patient's status be changed to that of committed patient;[123] direct the discharge of a special patient;[124] or advise the Governor-General as to change of status or discharge decisions if the patient was charged with an offence punishable by life imprisonment or for a term of fourteen years.[125]

In respect of persons detained as special patients following a finding of disability, the same power to review the order is conferred on a High Court Judge.[126]

The criteria upon which the change of status or discharge decisions are based relate essentially to whether the person's mental condition requires his or her continued detention as a special patient.

Similarly, an order for detention as a committed patient lasts until the hospital superintendent or the Minister of Health considers the patient "fit to be discharged."[127]

Because the condition warranting the IH person's committal to a psychiatric hospital is not one from which he or she can ever recover, the order for detention may therefore last indefinitely.

The arguments most frequently put forward in favour of indeterminate detention of the mentally disordered are largely inapplicable in respect of the IH. The flexibility of the sentence, usually perceived as an incentive to be cured, is unlikely to have any significance for an IH patient. He or she cannot be cured of the handicap. Nor is the IH person likely to understand that discharge depends on him or her. If the IH person does understand that the duration of the detention depends on his or her improvement, this very flexibility may only lead to a narrow view of the hospital staff as judges rather than therapists. This will impede any improvement in the condition.

The argument that the indefinite detention is justified in the interests of public safety can only apply to those IH persons who are considered dangerous.

Although in theory detention as a special or committed patient is indefinite, in practice, the leave of absence provisions of the Mental Health Act may be invoked so as to curtail the period of detention. Under s.66 of the Act, any committed patient may be granted leave of absence from the hospital for up to twelve months by the Superintendent or the Director of the Division of Mental Health of the Department of Health. The leave is extendable more or less permanently, provided each extension does not exceed twelve months. In other words, the patient may be ordered to return to the hospital for a notional time in order that the leave be re-extended for a further period. A large number of committed patients are in fact absent on leave.[128]

Leave of special patients is governed by s.47 of the Mental Health Act. A person acquitted on account of insanity who is detained as a special patient may be granted indefinite leave by the Minister of Health (or by the Governor-General in Council in certain cases) if two medical practitioners certify that the patient is fit to be absent from the hospital. Special patients detained following a finding of disability may only be granted leave for up to seven days.

IH patients, provided they are not considered dangerous, may be prime candidates for leave of absence. A psychiatric hospital cannot offer them care and treatment of the kind required and their continued detention is therefore unnecessary. Any condition may be attached to the granting of leave to committed patients or special patients detained following an acquittal on account of insanity. A condition that the IH person reside at an IHC facility or attend an IHC centre in order that appropriately qualified staff be able to care for the person in view of his or her criminal behaviour could be both beneficial to the individual concerned as well as socially valuable.

Despite the practical possibility of the leave provisions being invoked, the indefinite detention of an IH person in a psychiatric hospital cannot be justified.

Where an IH person is found to be under disability, it is suggested that the court be able to make one of the following orders:

1) An order releasing the accused immediately. This would be appropriate for the more severly retarded accused who poses no threat to either himself or society and who will never cease to be "under disability".

2) An order that the accused reside at or attend an IHC facility or receive some other appropriate form of treatment. This would be appropriate for the more mildly or moderately retarded accused who poses no threat to himself or to society. The order would be subject to reindictment and trial if the person can be trained to develop sufficient understanding to stand trial.

The main problem with this order would be that IHC or the community agency chosen may be reluctant to receive the accused. In the case of an IHC facility, the person may be seen as an undesired "criminal" element amongst an otherwise normal IH population.

3) An order for mandatory detention where the IH accused does pose a threat to himself or to society. It is recognised that at present this would have to be within the confines of a psychiatric hospital.

Detention in a psychiatric hospital following an acquittal on account of insanity cannot, as has been seen, be justified on the basis of the IH person's need for treatment.

Where the person is not dangerous, the court may, at present, make an order for his or her immediate release. Where some form of detention is required, it is proposed that the court be able to make a personal guardianship order of the kind envisaged by the Dependent Persons Bill 1983, or make an order that the person be placed under the care and control of a community agency such as IHC or of a psychopaedic hospital (which would be more geared to treating the needs of an IH person than a psychiatric hospital).

Where the IH person is convicted of an offence but the court considers that some form of care and treatment is necessary and that a sentence of imprisonment would be inappropriate, it is suggested that the court have the power to place the person under a personal guardianship or community care order as suggested by the Task Force on Revision of Mental Health Legislation.[129]

PART VI. CONCLUSION

About one hundred years ago, Justice Oliver Wendell Holmes wrote : "An individual may be morally without stain because he has less than ordinary intelligence or prudence, but he is required to have those qualities at his peril." [130]

Harsh as this may sound, the foregoing examination of the fate of the IH person who becomes enmeshed in the criminal justice system would indicate that in the majority of cases, this is still true today. The retardation which may itself account for the criminal behaviour of an IH person has been seen to be capable of creating unusual pressures for criminal justice personnel. While the police generally respond adequately to these pressures, the frequent inability of the judiciary to accord due and proper recognition to the fact of retardation means that in many cases, justice cannot at present be guaranteed for the IH offender.

While only a small percentage of the 10,000 or so persons who make up New Zealand's IH population will ever become involved in the criminal justice system, this does not warrant a maintenance of the status quo. Not only are greater public awareness of and legal education in intellectual handicap required, but clearly legislative reform is imperative if all IH offenders are to receive the kind of treatment that a truly enlightened society would give them.

APPENDIX 1

In this Appendix, the following abbreviations are used:

MHA - Mental Health Act 1969

CJA - Criminal Justice Act 1954

TABLE 1

ADMISSIONS BY LEGAL STATUS OF INTELLECTUALLY HANDICAPPED PATIENTS TO PSYCHIATRIC HOSPITALS, 1979-1982. *

STATUS		1979	1980	1981	1982
INFORMAL		763	777	760	697
COMMITTED	s.19 MHA	74	97	96	114
	s.21 MHA	101	119	130	114
	s.23 MHA	1	2	1	2
	s.24 MHA	-	4	2	-
	s.39I CJA	-	-	1	-
	s.39G(2) CJA	-	1	-	2
	s.39J CJA	12	19	21	18
	Other Sections	6	-	-	4
SPECIAL	s.39G(1)(a) CJA	1	1	-	-
	s.39G(1)(b) CJA	2	-	-	1
	s.42 MHA	1	3	-	-
	s.42(4) MHA	1	-	-	-
	s.43 MHA	1	-	-	-
	Other Sections	-	-	2	-
REMAND	s.39B(1) CJA	2	1	1	-
	s.39B(2) CJA	1	-	-	-
	s.47A(2)(c)CJA	9	6	8	3
TOTAL ALL IH PATIENTS		975	1030	1022	955

* Data prepared for this study by the National Health Statistics Centre of the Department of Health. For administrative reasons, figures were not available for the years preceding 1979. The latest available figures are those for 1982.

The diagnosis of mental retardation for these purposes is based on the International Classification of Diseases, introduced for mental health coding. "Mental retardation" is defined in the ninth revision of the ICD as "a condition of arrested or incomplete development of mind which is especially characterised by subnormality of intelligence." The coding is made on the individual's current level of functioning without regard to its nature or causation. The assessment of intellectual level is based on whatever information is available, including clinical evidence of adaptive behaviour and psychometric findings. IQ levels are used only as a guide.

TABLE 2

TOTAL ADMISSIONS BY LEGAL GROUPING TO PSYCHIATRIC HOSPITALS, 1979-1982. *

STATUS	1979	1980	1981	1982
INFORMAL	10705	10855	10820	10799
COMMITTED	3115	3568	3722	3921
SPECIAL	109	116	111	119
REMAND	330	298	331	306
TOTAL	14259	14837	14985	15145

* Source: National Health Statistics Centre, 1984.

TABLE 3

TOTAL ADMISSIONS BY LEGAL STATUS TO PSYCHIATRIC HOSPITALS, 1979-1981. *

STATUS		1979	1980	1981
INFORMAL		10705	10855	10820
COMMITTED	s.19 MHA	1616	1929	2009
	s.21 MHA	914	1028	1051
	s.23 MHA	26	26	28
	s.24 MHA	5	6	16
	s.39I CJA	1	6	7
	s.39G(2) CJA	5	4	3
	s.39J CJA	92	102	23
	Other Sections	20	7	6
	No Section	436	460	479
SPECIAL	s.39G(1)(a) CJA	7	7	6
	s.39G(1)(b) CJA	5	4	2
	s.42 MHA	53	70	64
	s.42(4) MHA	19	19	21
	s.43 MHA	15	11	9
	Other Sections	10	5	9
REMAND	s.39B(1) CJA	42	57	61
	s.39B(2) CJA	2	3	1
	s.47A(2)(c) CJA	283	236	268
	Other Sections	3	2	1
TOTAL ALL PATIENTS		14259	14837	14985

* Source: Towards Mental Health Health Law Reform - Report of the Legal Information Service - Mental Health Foundation Task Force on Revision of Mental Health Legislation (Mental Health Foundation of New Zealand, December 1983) pp. 420-421.

FOOTNOTES

1 Hereinafter abbreviated to "IH".

2 Hereinafter referred to as NZSIH, or IHC, according to the context.

3 R.M. Smith An Introduction to Mental Retardation (McGraw-Hill Book Co., New York, 1971) p.5.

4 Ibid, pp.5-6.

5 A.A. Morrison, Dr D.G.M. Beasley, K.I. Williamson The Intellectually Handicapped and their Families (Research Foundation of the New Zealand Society for the Intellectually Handicapped, Wellington, 1970) p.10. Persons in the group described as borderline are frequently not considered to be IH at all.

6 Quoted in S.C. Hayes and R. Hayes Mental Retardation - Law, Policy and Administration (The Law Book Co. Ltd., Sydney, 1982) pp. 3-4.

7 R.M. Smith, op.cit. pp.218-220.

8 R.M. Smith, op.cit. p.220.

9 R.M. Smith, op.cit. p.177.

10 W.A. Heaton-Ward Left Behind - A Study of Mental Handicap (MacDonald and Evans Ltd, Plymouth, 1977) p.35.

11 Morrison, Beasley and Williamson, op.cit.

12 The authors of the survey identified and located 2396 IH people. They acknowledge the fact that there may have been some IH who met the survey criteria but were untraceable. According to 1971 census figures, the total population of the regions surveyed was 728, 896.

13 The precise rate was found to be 3.29 per thousand, but account had to be taken of the low prevalence for the Wellington region, which had the largest total population for any region of the sample. In their forecast for the future, the authors estimated little change in the prevalence of intellectual handicap in New Zealand.

14 See, for example, Hayes and Hayes, op.cit. p.3; Law Enforcement and Handicapped Persons: An Instructor's Training and Reference Manual (National Institute on Mental Retardation, Toronto, 1975) p.18.

15 This factor may be particularly relevant to the significance of intellectual handicap in police questioning and court proceedings.

15a Of approximately 10,000 IH persons in New Zealand, 1414 were in IHC residential facilities in 1981 to 1982 and 1545 in 1983.

16 Law Enforcement and Handicapped Persons: An Instructor's Training Manual, op.cit. p.19.

17 Hayes and Hayes, op.cit. p.278.

18 R.M. Smith, op.cit. p.22.

19 Law Enforcement and Handicapped Persons: An Instructor's Training Manual. op.cit. p.20.

20 R.M. Smith, op.cit. pp 2-3.

21 Hayes and Hayes, op.cit. pp 5-6.

22 H. Toch "Perspectives on the Offender" in H. Toch (ed.) Psychology of Crime and Criminal Justice (Holt, Rhinehart and Winston, New York, 1979) p.147.

23 H.C. Gunzburg Social Rehabilitation of the Subnormal (Baillière, Tindall and Cox Ltd, London, 1960) pp 37-39. Gunzburg defines personality as the interrelationship of all the qualities of an individual, whether acquired or inherited, negative or positive.

24 S.E.K. Hewitt "The Mentally Handicapped and the Police" 52 Police Journal (1979) 243 at 246.

25 R.M. Smith, op.cit. p.279.

26 Ibid, p.180.

27 This is illustrated by a recent case reported in The Evening Post (Wellington, New Zealand, 11 June 1983, p.6) A 25-year old man was banned from entering the IHC hostel which he looked upon as his home. Having been refused entry, he put his fist and boot through a door. With the way still barred, he shouldered the door and broke the frame. In court, he pleaded guilty to intentional damage and was ordered to pay a fine.

Most people would no doubt have overcome the initial impulse caused by the anger, frustration and feeling of rejection, realising the violent and destructive behaviour could only worsen their situation. This seems to have been beyond the intellectual and emotional capacities of this IH person.

28 H.C. Gunzburg, op.cit p.175.

29 J.O. Smith "Criminality and Mental Retardation" Training School Bulletin 59 (3) 1962 74-80; cited in Hayes and Hayes, op.cit. p.395.

30 Reported in B.S. Brown and T.F. Courtless "The Mentally Retarded in Penal and Correctional Institutions" American Journal of Psychiatry 124:9, March 1968, 1164-1170.

31 It is not clear what percentage of these inmates had been identified by the community as retarded prior to incarceration.

32 R.L. Marsh, C.M. Friel and V. Eissler "The Adult MR in the Criminal Justice System" Mental Retardation 13(2) 1975 21-25.

33 E. Ogg Securing the Legal Rights of Retarded Persons (Public Affairs Pamphlet No. 492, New York: Public Affairs Committee 1973); cited in J. Schilit "The Mentally Retarded Offender and Criminal Justice Personnel" Exceptional Children 1979, 13, 16-22.

34 This information was provided informally by the Director of Training and Education of the Justice Department, May 1984.

35 See further, for example, R.C. Allen "The Retarded Offender: Unrecognised in Court and Untreated in Prison" Federal Probation 32(3), 1968, 22 at 23.

36 Hayes and Hayes. op.cit. p.395.

37 W.A. Heaton-Ward, op.cit. p.37.

38 H.C. Gunzburg, op.cit. pp 234-236.

39 Ibid, p.235.

40 Ibid, p.234.

41 Ibid, p.39.

42 Law Enforcement and Handicapped Persons: An Instructor's Training and Reference Manual, op.cit p.24.

43 The relevance of intellectual handicap to the success of such defences is discussed in Part V A (1).

44 Law Enforcement and Handicapped Persons: An Instructor's Training and Reference Manual op.cit. p.23.

45 Training in intellectual handicap and dealing with IH people may sometimes be received on an informal irregular basis. For example, as part of their community-oriented training in 1982, cadets from the Police College at Papakowhai participated in a sports day with IH people from an IHC centre. This took place at the initiative of one of the cadets, who had previously been involved with IHC work. Upon request by IHC, the event was successfully repeated in 1983.

It has to be recognised, of course, that the IH are only one amongst other minority groups in society deserving of special attention in police training (for example, alcohol or drug addicts, perhaps certain ethnic or cultural groups). With limited police resources, such other groups may justifiably take priority over the IH.

46 A confusion with mental illness may, in the case of the police, be partly attributable to the fact that the powers conferred on the police by s.35 and s.36 of the Mental Health Act 1969 are exercisable in respect of mentally disordered persons generally, regardless of whether the person is mentally ill, mentally infirm or mentally subnormal.

47 Nor, however, do the legislation and General Instructions distinguish between the insane and the normal.

48 As in the case of the power to arrest conferred by s.315 of the Crimes Act 1961.

49 As in the case of the prosecutorial discretion.

50 New Zealand Police Department, N.Z. Police Act Regulations and General Instructions, vol.1, para A106 (1), (2) and (3). There may be some speculation as to whether a police officer would consider an IH offender to be an "otherwise respectable citizen."

51 Ibid, para A 108 (1) and (2).

52 The implication of s.316(4), which provides that a failure to fulfil the duty shall not deprive the person arresting of protection from criminal responsibility, is that a breach of the duty may still result in civil liability of the arresting officer.

53 Blundell v. Attorney-General [1968] NZLR 341.

54 General Instructions, para A 111 (5) and (6).

55 The material presented in this section is largely based on interviews with staff at Police National Headquarters Legal Section, Constables and Sergeants at the Wellington Central Police Station, and IHC staff, in particular a Social Worker from the Wellington IHC branch who has had frequent contact with the police on behalf of IH people involved with the law.

56 However, not all IH people are known to IHC or, even if known, have contact with IHC. Where this is the case, police usually contact the person's family or those under whose care and control he or she is.

57 This approach may be partly attributable to the fact that the police's more frequent contact with IH people is in their role as helpers and protectors (for example, taking lost IH people home).

58 The Judges' Rules are set out in Home Office Circular 536053/23, 24 June 1930, issued with the approval of the judges for the purpose of removing difficulties or divergences of opinion as to the meaning of the Rules.

59 R. v. Convery [1968] NZLR 426.

60 Home Office Circular No. 89/1978. The unwillingness of British detectives to obey the direction resulted in signed confessions from two murder suspects identified as IH. In one case the suspect was released when another person was charged with the murder, but in the other, the suspect was subjected to eight months' detention and a murder trial before being found not guilty. Cited in Hayes and Hayes, op.cit. p.397.

61 [1971] N.Z.L.R. 269.

62 [1971] N.Z.L.R. 269, 274.

63 R. v. Ibrahim [1914] AC 599, 609; cited and approved in Naniseni v. The Queen [1971] N.Z.L.R. 269, 270.

64 [1971] N.Z.L.R. 269, 274.

65 M. Kindred, J. Cohen, D. Penrod and T. Schaffer (eds.) The Mentally Retarded Citizen and the Law (Free Press, New York, 1976) p.622; cited in Hayes and Hayes, op.cit. p.397

66 [1965] N.Z.L.R. 257, 258.

67 [1973] W.W.R. 113.

68 (1972) 56 Cr.App.Rep. 272.

69 The Act applies to IH persons by virtue of the definition of "mentally disordered" in s.2, whereby a person is mentally disordered if he or she suffers from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person is either mentally ill, mentally infirm or mentally subnormal. The "mentally subnormal" are those suffering from subnormality of intelligence as a result of arrested or incomplete development of the mind.

70 Several overseas empirical studies have reported on the police's discretion in the emergency apprehension of mentally disordered persons. See, for example, E. Bittner "Police Discretion in Emergency Apprehension of Mentally Ill Persons" (1966-1967) 14 Social Problems 278; A.R. Matthews "Observations on Police Policy and Procedures for Emergency Detention of the Mentally Ill" (1970) 61 J. Crim.Law, Crimin. and Police Sci 283; R.G. Fox and P.G. Erickson Apparently Suffering from Mental Disorder (Centre of Criminology, University of Toronto, Toronto, 1972).

71 From personal communications with IHC staff.

72 As recipients of the invalids benefit, most IH defendants are eligible for Offenders Legal Aid. This is usually availed of in practice, as is the Duty Solicitor scheme. The quality of both these services is reputed to be variable, with frequent allegations specifically of lack of experience, commitment and time. See the Report of the Working Party on Access to Law, Justice Department, Wellington, 1983. The NZSIH, in conjunction with the New Zealand Law Society, is currently investigating the viability of establishing a register of practitioners who have a special interest in intellectual handicap and to whom the IH or their families could refer for legal aid or representation. The concept is not dissimilar to that of the bars for the mentally retarded which exist in certain areas of the United States.

73 The role that IHC may play in court proceedings is illustrated by the following case which took place in Wellington in 1983. The defendant, a 27-year old borderline IH male, had been charged with five separate offences of burglary, theft and being unlawfully on the property of another person. He was represented in court by several duty solicitors, all of whom were extensively briefed by the IHC Social Worker involved with the case. The hearing was interrupted by a remand to Porirua Hospital for psychiatric examination

pursuant to s.47A(2)(c) of the Criminal Justice Act. The two separate court appearances were before different judges; the first was allegedly quite understanding, the second much less so, probably in light of the fact that the psychiatric report indicated that the defendant was under no disability. The IHC Social Worker was present during both court appearances. When called upon by one of the judges to speak for himself, the defendant made a very poor impression. He was in fact so incoherent that people left the court room laughing. Thereupon, the Social Worker was called upon to speak for him. The defendant was sentenced to four months imprisonment on the burglary charges and to three months on the other charges, to be served concurrently at Mt. Crawford Prison. From communication with the IHC Social Worker involved.

74 Attention is being focused here on offences requiring some fault on the part of the offender.

75 [1950] 2 K.B. 237, 253.

76 The test accepted by the majority in Hyam v. DPP [1975] A.C.55.

77 The test accepted in R. v. Steane [1947] 1 K.B. 997.

78 [1975] 2 All E.R. 347.

79 [1981] 1 All E.R. 961.

80 R. v. Storey [1931] N.Z.L.R. 417.

81 In The Queen v. Tolson (1889) 23 Q.B.D. 168, it was held that the mistake has to be honest and reasonable if it is to afford a defence; the case was distinguished by the House of Lords in DPP v. Morgan which held that the mistake need only be honest.

82 [1975] 2 N.Z.L.R. 610.

83 (1980) 29 A.L.R. 449.

84 [1976] 2 All E.R. 142.

85 R. v. Roulston [1976] 2 N.Z.L.R. 644.

86 Some courts have, however, treated epilepsy as insanity. See R. v. Foy [1960] Qd.R. 255.

87 **All figures cited in this section are reproduced in table form in Appendix 1.**

88 The excessive invoking of this procedure by police prosecutors was criticised by Sinclair J. in the case of Stretch and Others v. Police (1980) 3 T.C.L. 12/6.

89 Finding of both the Commission of Inquiry into Psychiatric Services at Oakley Hospital (Hutchinson Report, 1971) and the Working Party on Psychiatrically Disturbed Prisoners and Remandees (1981).

90 See, for example, M.E. Schiffer Mental Disorder and the Criminal Trial Process (Canadian Legal Text Series, Butterworths, Toronto, 1978) p.58.

91 R. Barrington Study of Psychiatric Remands (Victoria University of Wellington Institute of Criminology, 1984, forthcoming). The study focused on 93 cases in which the defendants were remanded under s.39B or s.47A. In 31 of these, the remand was ordered for the purpose of determining the defendant's fitness to stand trial. In only 2 of the cases, both involving an IH person, did the report indicate unfitness. Both of these resulted in the charges being withdrawn; a civil committal followed in one case and it is believed that a referral to IHC care followed in the other.

92 Report of the Commission of Inquiry into the Circumstances of the Release of Ian David Donaldson from a Psychiatric Hospital and his Subsequent Arrest and Release on Bail Government Printer, Wellington, 1983, p.78.

93 Henceforth "the Working Party" and "the Oakley Inquiry".

94 The recommendation was substantially endorsed in the Report of the Legal Information Service - Mental Health Foundation Task Force on Revision of Mental Health Legislation, entitled Towards Mental Health Law Reform (Mental Health Foundationof New Zealand, 1983) p.149.

Clause 116 of the Criminal Justice Bill 1983 embodies substantially modified remand provisions. Essentially, the clause narrows the range of purposes for which courts may currently order remands and limits the situations in which a court may order the detention of a person in a penal institution or psychiatric hospital for the purpose of psychiatric reporting.

95 Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, Government Printer, Wellington, 1983, para 13.11.

96 Friedman v. Escalona No. 75 C4414 (N.D. 471, filed 30 December 1975); cited in S.K. Miller The Criminal Justice and Mental Health Systems: Conflict and Collusion (Oelgeschlager, Gunn and Hain Publishers Inc., Cambridge, Massachussetts, 1980) p.52.

97 Law Reform Commission of Canada Mental Disorder in The Criminal Process (Ottawa, 1976, Report No. 5).

98 R. v. Pritchard (1836) 7 Car.&P. 303.

99 [1968] 1 W.L.R. 1767.

100 [1953] 2 All E.R. 340, 341.

101 [1960] 1 Q.B. 325.

102 [1960] 1 Q.B. 325, 356 (underlining mine).

103 R. v. Robertson [1968] 1 W.L.R. 1767; R. v. Podola [1960] 1 Q.B. 325, 329-330.

104 Supra n.97.

105 cf. Part VA(2) (a).

106 See the definition of 'disease of the mind' laid down by Devlin J. in R. v. Kemp [1957] 1 Q.B. 399, 408.

107 Personal communication from IHC.

108 [1977] 1 N.Z.L.R. 50, 52.

109 cf. Part V A (3).

110 [1981] 1 N.Z.L.R. 295.

111 [1981] 1 N.Z.L.R. 295, 300.

112 cf. Part III (2).

113 Personal communication from the Director of Training and Education of the Justice Department, May 1984.

114 The IH offender referred to in n.73 is currently serving sentence at Mt. Crawford Prison. The IHC Social Worker involved with his case reported that he is adapting quite well to prison life, accepting the "easiness" of the routine and lack of responsibility. Because he was exploited and used by other prisoners (for example, they would incite him to do such things as trying to climb over the wall), he was placed in a different wing with greater supervision. The fact that he has been given a job in prison (a very menial task) was said to be attributable to IHC's representations to the prison authorities on his behalf.

115 T.S. Szasz "Insanity and Irresponsibility - Psychiatric Diversion in the Criminal Justice System" in H. Toch (ed.) op.cit. p.136.

116 Oakley Inquiry Report, op.cit. para 17-19.

117 M.E. Schiffer, op.cit. p.57.

118 Personal communication from NZSIH staff.

119 Section 61(1) of the Mental Health Act. Subsection (2) confers a similar power on the Director of the Division of Mental Health of the Department of Health.

120 Clause 116 of the Criminal Justice Bill 1983 largely removes the possibility of the remand provisions being used in this way, as the total period of detention in a psychiatric hospital may not exceed one month. This period of time would only suffice for coaching of very mildly retarded persons.

121 Towards Mental Health Law Reform, op.cit. p.144 .

122 Section 44(1) Mental Health Act .

123 Section 44(8) Mental Health Act; s.39H (2) and (3); s.39I (2) Criminal Justice Act .

124 Section 39I (2) Criminal Justice Act .

125 Section 39H (4), s.39I (3) Criminal Justice Act .

126 Section 74(4) and (5) Mental Health Act .

127 Section 73 Mental Health Act .

128 Personal communication from IHC. See also Towards Mental Health Law Reform, op.cit. p.422 .

129 cf. Part V A (2)(d) .

130 Cited in Haggarty, Kane and Udall " An Essay on the Legal Rights of the Mentally Retarded " (1972) 6 Family Law Quarterly 59 at 66.