FITNESS TO PLEAD: UNDER DISABILITY IN THE 90’s

Papers presented at a seminar held by the Legal Research Foundation at the University of Auckland on 31 March 1995
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PREFACE

These papers were presented at the Legal Research Foundation Seminar on “Fitness to Plead: Under Disability in the 90’s” held at Auckland on 31 March 1995. The aim of the seminar was to outline the issues arising out of the mental incapacity of defendants and their fitness to stand trial. These difficult issues have been compounded by recent changes to mental health legislation in New Zealand. The speakers at the seminar were asked to provide guidance on the issues of identification and disposition of mentally disabled defendants. The keynote speaker at the seminar, Ian Freckleton, an Australian expert on medical evidence, addresses the unique evidential issues which arise in this area.

The Legal Research Foundation and the authors hope that the papers in this volume will provide a practical resource for medical and legal practitioners working in the field as well as indicating areas of the law and policy in need of reform.

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Identification of Accused who are under a Disability
—a Lawyer’s View

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Introduction
I have been asked to speak about the identification of accused who are under a disability, and of course I can only address this topic as a lawyer. There are two obvious aspects to the issue of “identification”: (1) how to do it, and (2) when to announce it. Each of those aspects of identification raises the consequential question of what to do next. Therefore I will need to mention the steps that should be taken by a lawyer who thinks that his or her client may be under disability to obtain medical assessments, and also what the lawyer needs to do by way of preparation for the disability hearing. That hearing is the means by which the state identifies and announces its identification of a person under disability.

How a lawyer is alerted to disability
Needless to say, the signs of disability are easier to spot than they are to describe. However the law does provide a description of the symptoms which a lawyer should be alert for. They are set out in s 108 of the Criminal Justice Act 1985, in the three paragraphs to subs (1). At the earliest stage the lawyer need not be concerned with the initial part of the subsection, because the first thing to do is to recognize the alarm signals.

Where there is a risk that difficulties in communication with counsel will not be apparent to the medical practitioners who will eventually be giving evidence at the disability hearing, it may be necessary to arrange for a lawyer to give evidence on this point. Rule 8.07 of the Rules of Professional Conduct should be borne in mind: “A practitioner must not act as both counsel and witness in the same matter.” This problem is considered in the article by Brookbanks cited in para 2.1 below, but it is useful to remember that the court will be sensitive to the existence of communication difficulties, and an indication by counsel from the bar should normally be sufficient to raise the issue.

1 An important guideline: ability to participate
A trial gives the accused an opportunity to answer the allegation, so the accused must be capable of exercising that right. The accused is liable to being held responsible for the crime, so he must be able to respond to the accusation (see Duff, “Fitness to plead and fair trials: (1) a challenge” [1994] Crim LR 419). As far as disability is concerned, the relevant time is now, at court, rather than before, at the time of the offence. This is one of the points on which disability differs from the insanity defence (see Brookbanks, “Judicial determination of fitness to plead—the fitness hearing” (1992) 7 Otago Law Review 520).
2 Interpreting the criteria

The sorts of things to look out for when considering paragraphs (a), (b) and (c) of s 108(1) are as follows:

- does the client appreciate his presence in relation to time and place, apprehend that he is charged with an offence and is going to appear in a court, understand that there is a judge, a prosecutor who will try to convict him, defence counsel to help him avoid conviction, a jury to decide guilt or innocence? (from Wieter v Settle 193 F Supp 318(WD Mo 1961), cited in Hitchen, “Fitness to stand trial and mentally challenged defendants: a view from Canada” (1993) International Bulletin of Law and Mental Health 5.

- is the client capable of some level of abstract reasoning so as to be able to understand the possible consequences of the proceedings? Can he interpret the implications of testimony and the judge’s decision? (see Mickenberg, “Competency to stand trial and the mentally retarded defendant” (1981) 17 (3) California Western Law Review 65, cited in Hitchen, loc cit)

- is the defendant able to recall and state the relevant events and able to explain the facts to counsel? Is this done rationally, and does it include the making of critical decisions based on counsel’s advice? Would he be able to give evidence? Is the defendant capable of making reasonable decisions (even if the decisions he actually makes do not seem reasonable)?

- should a second legal opinion be sought? Just as it may be in a patient’s best interests to seek a second medical opinion before agreeing to serious surgery, so too a lawyer’s client may best be protected by a second legal opinion.

Should the difficulty be disclosed?

Once a lawyer decides that one or more of the alarm signals set out in the three paragraphs to s 108(1) have been triggered, a decision has to be made about what to do. A client who is under disability will not necessarily be totally unable to make legally effective decisions. For example, a mentally ill patient may be able to give effective consent to treatment. So, what is the lawyer’s duty when the client who may (note, at this stage, only may) be under disability doesn’t want a medical assessment and doesn’t want the question of disability raised in court? See R v Carrel (1992) 8 CRNZ 220 for an illustration of such a case, where the inquiry was initiated by “a responsible and very experienced counsel” against the client’s wishes.

The problem of whether to raise the matter of disability against the client’s wishes may seem especially difficult where the offence is not particularly serious. Of course no question of a disability hearing arises where the offence does not carry imprisonment (s 109 CJA), but for many imprisonable offences the offender can expect a non-custodial sentence. The lawyer may wonder whether it is really worth raising the issue of disability in those circumstances.

The problem seems more acute where the case is such that the defence can properly be put to the court without the client giving evidence. There may be other defence witnesses.
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who are available and whose evidence seems plausible and likely to raise at least a reasonable doubt about the client’s guilt. Circumstances such as these may suggest to the lawyer that, even in a serious case, the issue of disability need not be raised.

Also, at the other extreme, there is the client who is clearly guilty but because of the relatively minor nature of the offence and the client’s previous good record, diversion may be available. Again the lawyer may wonder whether raising the issue of disability is an unnecessary complication in those circumstances.

Put in terms of the client’s right to participate in the hearing of the allegation, and the need for him or her to be able to do so as central to the notion of fairness, the problem can be expressed as follows: should a lawyer take a case to trial in the face of the alarm signal, taking the risk that unfairness will be avoided by keeping the client silent while his or her case is put through other witnesses?

This risk is potentially great, although it is a subject which has not yet been explored by the courts here. If a lawyer leads the client into a trial which is unfair there will be a breach of certain rights affirmed in the New Zealand Bill of Rights Act 1990: s 25(a) (the right to a fair trial), s 25(e) (the right to present a defence). Breach of such rights could lead to an action for damages against the lawyer whose task it was to represent the client. Rule 1.12 of the Rules of Professional Conduct states that a practitioner must accept legal responsibility for his or her actions. Liability for such breaches of the client’s rights would not depend on a contractual relationship and there seems to be no reason why in principle a barrister should not be liable where negligence or even deliberate (albeit well-intentioned) breach of the client’s rights is proved.

1 When there is a problem: the Rules of Professional Conduct

As would be expected, a guide to the way to approach difficult ethical issues is provided by the Rules of Professional Conduct for Barristers and Solicitors. These have the force of law by virtue of s 17 of the Law Practitioners Act 1982 which gives rule making powers to the Council of the New Zealand Law Society. The current edition of the Rules is the 2nd Edition, published on 1 February 1993.

There are no rules specifically referring to the dilemmas created by the possibility of the client being under a disability, and it is difficult to find assistance in the technical literature dealing with legal and medical ethics. It seems to me that the best existing guide is provided by the following Rule:

Rule 8.01: “In the interests of the administration of justice, the overriding duty of a practitioner acting in litigation is to the court or the tribunal concerned. Subject to this, the practitioner has a duty to act in the best interests of the client.”

2 The interests of the administration of justice

This expression is one of those comfortable legal cliches which is used to give the appearance of substance in the law. However in the context of this Rule and the problems mentioned above the proposition emerges that from counsel’s perspective, the overriding duty to the court is discharged by bringing the issue of disability to the attention of the court (even where client denies any disability). Once the issue is raised, counsel’s duty
is to the client. The continuing duty not to deceive or mislead the court (Commentary (1) to Rule 8.01) is consistent with the need to avoid representing that there is no unfairness issue arising from the continuation of trial procedure.

Another consequence of this rule is relevant to a later stage, but I mention it here so it can be borne in mind. It is that, where a disability hearing is held, it would be wrong to attack medical evidence which counsel knows is accurate except insofar as it is in the client’s interests to properly test the soundness of that medical evidence.

3 The best interests of the client

Opinions will vary as to what is in the client’s best interests. There will be the client’s opinion, counsel’s personal opinion, counsel’s professional opinion, the medical practitioners’ opinions (personal and professional), not to mention the opinions of persons supportive of the client who may or may not be potential witnesses.

How should a lawyer decide what is in the best interests of the client? It is important to remember that at this stage a decision has been made, as a consequence of the Rule of Practice mentioned above, to ask the court to obtain an assessment of the client with a view to a disability hearing. It seems to me that the appropriate approach for the lawyer to take from then on is to assume that the best interests of the client are achieved by minimum (ie no) interference with his or her liberty. It is for the court to decide otherwise and the issue of interference will fall as a matter to be decided in the course of the administration of justice.

An essential qualification on this is where the client has made a decision to accept that he or she is under disability and to consent to whatever the court may decide by way of disposition. If counsel accepts that the client has made those decisions responsibly, then they form part of the client’s instructions and must be followed.

Preparing for a disability hearing

Once the lawyer recognizes any of the alarm signals set out in the paragraphs to s 108(1) of the CJA, the aim becomes the holding of a disability hearing where the court can make findings of fact. These may lead to the conclusion that the client is under disability, or they may lead to a finding of no disability. Even in the latter case there may be findings of fact which can form the basis of an application for a stay of proceedings, or of some other form of judicial intervention in the interests of fairness (exclusion of evidence, discharge under s 19 CJA or s 347 Crimes Act 1961).

The onus and standard of proof will have to be borne in mind. In Carrel (above) it was held that when the prosecution raises the issue of disability, the standard of proof is beyond reasonable doubt; but when the issue is raised by the defence, the standard of proof is on the balance of probabilities; and when the issue is raised by the defence against the wishes of the client, the standard of proof is again on the balance of probabilities.

A frequently used method of bringing the attention of the court to the issue of disability, although not an essential procedural step, is to invite the court to invoke its powers to require psychiatric examination of the client under s 121 of the CJA. This is not an essential step because a disability hearing can be initiated, pursuant to s 111, "on the
evidence of two medical practitioners that the defendant is mentally disordered”, and such evidence can be obtained other than by a court-ordered report. However, where s 121 is to be used, the current practice is to have the client who is presently appearing in court stood down for an assessment by the forensic psychiatric staff; such an assessment may provide the judge with the material necessary to “satisfy” the court (s 121(1)) “that a psychiatric report would assist the court in determining (a) if the defendant is under disability ...”. Strictly this only applies where the client is in custody, but that limitation seems to be overlooked in the interests of efficiently obtaining reports on legally aided clients. Of course the judge may release the client on bail with a condition that he or she attends as directed for psychiatric examination (s 121(2)(a)).

The result of a request for a psychiatric report under s 121 will normally be only one such report, and indeed the words of the section are in the singular. To obtain the necessary evidence that the client is mentally disordered so as to initiate a disability hearing pursuant to s 111, another medical examination will be necessary. It should be noted that there is a difference in terminology: s 121 refers to “psychiatric examination”, while s 111 refers to the evidence of two “medical practitioners”; in an appropriate case (for example where the client denies being under disability) it may be necessary to consider whether a report under s 121 is properly that of a psychiatrist as distinct from that of a non-specialist medical practitioner.

1 The legal issues: interpretation of the statutes

As with preparation for any judicial hearing, counsel will need to bear in mind the court’s approach to interpretation of the legislation governing the matter in issue. It is important to remember that “under disability”, and the ingredients, including “mentally disordered” are legal, not medical, expressions. “Under disability” is a legal status not a medical diagnosis. The statutory definitions of “under disability” in s 108(1) CJA and of “mental disorder” in s 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 are therefore of paramount importance.

Having said that, and it was a point made by Brookbanks in the introduction to his article mentioned in para 2.1 above, it may nevertheless fairly be asked whether this distinction between medical diagnosis and legal status is really that marked. Certainly courts endeavour to apply the ordinary and natural meaning of the words of any statute that has to be interpreted judicially, but here the words are rarely—if ever—ordinarily used in the phrases and in the combinations of phrases in which they appear in the two sections just cited. It can therefore hardly be said that there is an ordinary and natural meaning of those words in those contexts which differs from a technical medical meaning.

Unfortunately things are not that simple in practice. What is often noticeable in disability hearings is that the medical practitioners giving evidence seem to be under various forms of misapprehension about what the legal issues are that the judge has to determine. I suspect that sometimes there is genuine ignorance about that, but there are also occasions where difficulties in communicating with courts arise from issues which are not settled in psychiatry. Medical jargon can differ from the ordinary and natural meaning of words as understood by courts, as the issue of whether intellectual handicap is a mental disorder illustrates. Apparently medical opinion tends to favour distinguishing between intellec-
tual handicap and mental disorder (of course a person may suffer from both)—see NZLC R30, paras 125–127—whereas judicial decisions have interpreted the words “an abnormal state of mind ... characterized by ... disorders of ... cognition” in the definition of “mental disorder” as including intellectual handicap: *R v T* [1993] DCR 600, where Judge McElrea applied a purposive approach to interpreting the statute, stressing the avoidance of unfairness. See also *Police v M* [1993] DCR 1119.

Another illustration of the overriding importance of judicial interpretation of the statutory definitions in the face of medical controversy concerns differences in medical opinion as to whether personality disorder (or psychopathic disorder) is a mental disorder or not. This will be resolved in court by application of the statutory definition of mental disorder so that sometimes mental disorder can include personality disorder, but not necessarily and not even usually: NZLC R30, para 211. The point here is that, at the end of the day, the decision as to whether the client is under disability is a legal decision, not a medical decision.

As was noted in para 2.1 above, the relevant time for assessing the question of disability is the present, rather than the time stated in the allegation of the offence. This is one of the respects in which the status of “under disability” differs from the defence of insanity. Counsel must be wary of medical practitioners putting too much emphasis on the alleged offence when forming their opinions on disability.

2 Alerting the experts to the problem

Where there are communication difficulties which concern the lawyer, yet the client denies being under disability and is apparently capable of giving responsible instructions on some matters (perhaps peripheral or unrelated to the charge) the problem of disclosure arises: how much should counsel reveal to medical practitioners? This problem is minimized because the medical practitioners can be expected to have reasonably full discussions with the client which overlap matters the lawyer has discussed and found of concern.

It would be appropriate to indicate to the medical practitioners whether the client is able to communicate adequately with counsel for the purposes of conducting a defence, and to tell them that this is a point on which they will be asked to give evidence.

3 Other possible witnesses

Central to the definition of “mental disorder” is the serious danger to the safety of the client or of others, and as an alternative, the seriously diminished capacity of the client to take care of himself or herself. If the client is opposed to being found to be under disability the lawyer will need to consider whether there are any witnesses who can assist the client on these points.

4 Pre-hearing disclosure of medical opinions

This has been considered by the Law Commission, which has advanced the following propositions:

where the prosecution has called for the evidence, there should be a duty to disclose
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... (iv) on humanitarian grounds, the practitioner should exercise a discretion not to disclose the information.

A parallel provision applies in respect of psychiatric reports to the court. Where the court has obtained a report pursuant to s 121 of the CJA, disclosure is governed by s 122 which empowers the court to order that there be no disclosure of any part of the report to the client where the court is of the view that such disclosure "would be likely to prejudice his or her physical or mental health or endanger the safety of any person".

5 Preparing questioning of witnesses

Analysis of the legal issues will reveal the questions that need to be asked. Brevity is always desirable, and especially so where technical evidence is being given.

Questions should be prepared following the wording of the statutory definitions. They can be kept quite simple. They should follow the sequence of the definitions, so prepare them in that order. For example (to a medical practitioner):

"does the client have an abnormal state of mind?"
(if so) "is it characterized by delusions?"
(and) "is it characterized by disorders of mood?"
(and) "is it characterized by disorders of perception?"
[similarly re volition and cognition]
(and) "is it of such a degree that it ... [etc, following s 2 of the 1992 Act]

Where an answer to any of these questions is to be challenged, explore the reasons for that opinion being given, including the materials available to the doctor and the time spent with the client and the conditions under which any examination occurred. Is this an area where experts may disagree in their diagnosis? How experienced in this area is the witness?

If you get the answers you want, there is no need to explore the basis for them. In the unlikely event that the expert simply answers "yes", that will be sufficient if you do not
have to challenge it. If the court wants to hear more, the court will ask. If the expert embarks on a lengthy answer the lawyer should ask if the answer, in summary, is essentially "yes", if that is the answer the lawyer wants. Remember that the lawyer asks the questions in English (ordinary and natural meaning), the expert may be answering in jargon, and the judge must make a decision in English. Bear in mind the matters discussed in para 4.1 above, which stress the overriding importance of the ingredients of the statutory definitions as interpreted judicially.

6 Representing the client: counsel's role

The lawyer must not be distracted by the wider interests of justice which concern the judge to the extent that the client's interests are neglected. Of course the lawyer must bear in mind how the judge will come to a decision, but the point here is that the lawyer's own opinion of what is in the interests of justice should not be advanced at the expense of the client's rights.

Remember the client's rights: BORA, s 11 (the right to refuse to undergo medical treatment); s 17 (right to freedom of association); s 18 (right to freedom of movement); s 22 (right not to be arbitrarily detained). A disability hearing is, from the client's perspective, often about whether these rights survive official scrutiny of his or her mental state.

7 Possible results of disability hearing

These should be borne in mind at the preparation stage because there might be evidence which could assist the court in deciding between the alternatives. The possible results are:

(i) where disability is found: s 115 CJA
   - immediate release (subs (2)(b))
   - detention in hospital under compulsory treatment order (subs (2)(a))
   - detention as special patient (subs (1)(a))
   - no order if person is liable to immediate imprisonment (subs (2)(c))

(ii) where no disability is found:
   - *Police v XYZ* [1994] DCR 401, inability to adequately instruct counsel arising from something less than mental disability will give rise to issues of fairness and the possibility of a stay of proceedings.
   - defended hearing (trial) proceeds with possible defence of insanity; issue of disability may be raised again (s 109 CJA), including at sentencing—see Hall, *Sentencing in New Zealand*, p 268.
Police Exercise of the Charging Discretion

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Introduction

In New Zealand all state prosecutors, including the New Zealand Police, operate under the Solicitor-General’s Prosecution Guidelines (Crown Law Office, 1992). These guidelines are formulated to ensure that decisions to commence and to continue prosecutions are made on a consistent, principled, and publicly known basis. The Attorney-General is the senior Law Officer of the Crown in New Zealand, and as such has ultimate responsibility for the Crown’s prosecution process. Successive Attorneys-General however have taken the view that it is inappropriate for them, as Ministers holding political office in the Government of the day, to become involved in decision-making about the prosecution of individuals. In practice therefore the Solicitor-General exercises all of the senior Law Officer’s functions relating to the prosecution process. Almost all prosecutions in this country for offences under the general criminal law are brought by the Police. A few exceptions are those prosecutions brought by other Government Departments, local authorities, or special authorities such as the RSPCA. Prosecutions by individuals, although permitted in most cases, are rare. The Solicitor-General’s Prosecution Guidelines are therefore a prime source of guidance for the Police in deciding whether to prosecute any individual for any offence. They indicate the basis on which the Law Officers of the Crown expect those decisions to be made.

The general discretion to prosecute

The initial decision to prosecute a person rests in most cases with the Police. Although the Police may often seek legal advice from its own in-house legal advisers, local Crown Solicitors, or from the Crown Law Office (Solicitor-General), it is never for the Solicitor-General or other legal adviser to make the initial decision to prosecute; it is their function to advise.

The two major considerations in deciding whether to prosecute are:

- Evidential sufficiency, and
- The public interest

1 Evidential sufficiency

The first question always to be considered is whether the person making the decision (“the prosecutor”) believes that there is sufficient admissible and reliable evidence that an offence has been committed by an identifiable person, to establish a prima facie case against that person. A prima facie case is one where, if the evidence is accepted as credible by a court or properly directed jury the court or jury could find guilt proved beyond reasonable doubt.
2 The public interest

The second major consideration is whether, assuming a proper evidential basis for the prosecution, the public interest requires a prosecution to proceed. Generally, the more serious the charge, and the stronger the evidence to support it, the less likely it will be that a matter can properly be disposed of other than by prosecution. On the other hand, the public interest may require that a prosecution should almost invariably follow for some classes of offences if the necessary evidence is available, eg, driving with an excess breath or blood alcohol level. Factors that may assist in determining whether the public interest requires a prosecution include:

- The seriousness (or conversely the triviality) of the offence: eg, does the conduct really warrant the intervention of the criminal law?
- The prevalence of the alleged offence and the need for deterrence.
- The effect of a decision not to prosecute on public opinion.
- The attitude of the victim of the alleged offence to a prosecution.
- All mitigating or aggravating circumstances.
- The youth, old age, physical or mental health of the alleged offender.*
- The degree of culpability of the alleged offence.*
- Whether the consequences of any resulting conviction would be unduly harsh or oppressive.
- The likely sentence imposed in the event of conviction having regard to the sentencing options available to the court.
- The availability of any proper alternatives to prosecution.
- The staleness of the alleged offence.
- The obsolescence or obscurity of the law.
- Whether the prosecution might be counter-productive, for example by enabling the accused to be seen as a martyr.
- The entitlement of the Crown or any other person to compensation, reparation or forfeiture as a consequence of conviction.
- The likely length and expense of a trial.
- Whether the accused is willing to co-operate in the investigation or prosecution of others or the extent to which the accused has already done so.

None of these factors, or indeed any others which may arise in particular cases, will necessarily be determinative in themselves. All relevant factors must be considered and weighed according to their importance.

Factors of particular significance in cases of persons who may be "under a disability" or mentally impaired are marked with an asterisk.

A weighing of all the above factors in any given case usually overwhelmingly favours
prosecution in the vast majority of cases. In general, persons having a mental impairment are treated no differently to anyone else.

**Police General Instructions concerning prosecuting mentally disordered persons**

Police General Instructions in this area are sparse, and have not been updated for some time, referring still to the previous Mental Health Act 1969 and the Criminal Justice Act 1954. General Instruction M 104 reads as follows:

**Offences Committed by Mentally Disordered Persons.**

1. Where an offence is committed by a mentally disordered person whether "committed" or an informal patient within the meaning of the Act that person shall be dealt with before the Court in the usual manner.

2. It does not necessarily follow that a "committed" or informal patient was under disability or insane at the time of the offence and this is an issue for the court to determine.

3. Where such a patient is found by the Court to be "under disability" (eg, unable to plead) and the Court orders detention in a hospital pursuant to s 39G of the Criminal Justice Act 1954 the information should not be withdrawn.

According to Police General Instructions, therefore, outdated as they are, the view is that the Police consider that issues of the mental capacity of a suspect are not within their proper province or sphere of competence. The Police, perhaps not unnaturally, shy away from making judgments in this area, preferring to leave such matters for the Court to determine. Offenders are prosecuted without a weighing of the mental state of the suspect as a major factor in the actual initial decision to prosecute. Of course, any indicators of a person’s mental state, or status or capacity known to the Police will be advised to the Court so that appropriate enquiries may be made or reports obtained.

**Alternatives to prosecution for mentally impaired persons**

Alternatives to prosecution, such as warnings or diversion are not often appropriate for mentally impaired persons. A warning, as will be obvious, may not be comprehended or acted upon, and diversion schemes usually require an admission of guilt, a conscious choice between diversion and prosecution, and some measure of community service or reparation. An understanding of these options and processes may be ruled out if a person is likely to be found to be “under disability”.

**Prosecution will only be avoided in rare cases**

Given the unsuitability of alternatives to prosecution, and the weight of Police policy in

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1 The purpose of this instruction is to ensure that the information and the prosecution remains “live” in case the Attorney-General directs that a defendant originally detained as a special patient, but no longer considered to be “under disability”, be brought again before the appropriate court under subs (4) or (6) of s 116 of the Criminal Justice Act 1985. If the Attorney-General directs instead that such a defendant shall thereafter be held as a patient, any prosecution is then permanently stayed by virtue of s 116(7) of the Act. Similarly, if orders are originally made under s 115(2) of the Act detaining the defendant merely as a patient, the original proceedings are thereupon permanently stayed by virtue of s 115(5) of the Act. The proceedings will either be revived in the event that the defendant again comes before the court on the direction of the Attorney-General, or will be stayed by virtue of either s 115(5) or s 116(7) of the Act.
favour of prosecution in all but the rarest of cases, it is difficult to imagine cases that might escape the prosecution process. An example might be a person with a known intellectual impairment who assaults a care-giver or fellow resident in a minor way. If the assault is minor, and the victim agrees, and there is a reasonable prospect that the perpetrator is or is likely to be found to be “under a disability”, then a prosecution may be considered unwarranted and inappropriate. If such offending persisted, however, a prosecution might well be warranted to see whether a formal finding of “under disability” and the exercise of some appropriate disposition option might be of some benefit to the offender or victim of the offences. As offending becomes more serious, such as assault with a weapon, or assault with intent to injure, injuring with intent, indecent assault, etc, it is likely that the Police (and society) would consider a prosecution as the only appropriate response under our present system.

Conclusion
The Police in New Zealand have a discretion to prosecute offenders for offences against the general criminal law. The discretion is very wide and is to be exercised in accordance with guidelines laid down from time to time by the Solicitor-General, who exercises a supervisory role over the criminal process under a delegation from the Attorney-General. Whilst the mental health or capacity of a suspected offender may be a factor in the exercise of a discretion to prosecute that person, it would not be a major factor in the vast majority of cases. The Police do not consider it appropriate that they make definitive judgments about a suspect’s mental state, preferring to leave such matters to medical authorities and the Courts. Current policy and guidelines require that generally mentally impaired persons are not treated differently to other persons as far as the initial decision to prosecute is concerned. Only in extremely rare cases would a prosecution for an offence be foregone by the Police because of a person’s mental state or capacity, either at the time of the offence or the investigation.
Assessment of Fitness to Stand Trial

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The determination of fitness to plead, or competency to stand trial as it is known in the United States, has long been a vexed issue for the law. The interpretation to be given to legislative provisions on the subject and common law decisions remains unclear and troubled in New Zealand, Australia, England, Canada and the United States. However, the fitness of a person to stand trial is of its nature a threshold issue, determining whether or not they properly belong within the criminal justice system or whether they should be detained in a non-penal institution without a determination of their legal culpability.

Although issues in relation to fitness have come before the courts on many occasions, a substantial portion of the case-law that has arisen has focussed not on the indicia of fitness or unfitness but on the adjectival law—the procedures to be employed in fitness hearings. Similarly the legal literature on fitness to stand trial has been largely devoted to these "applied" issues, while for its part most psychiatric and psychological literature on the subject has been descriptive, reciting characteristics of particular accused found unfit to stand trial, factors typical of such findings and the custodial consequences of being found unfit.

Thus both the decided cases and most of the literature have begged the fundamental question requiring answer by mental health assessors and courts alike: what actually constitutes unfitness to stand trial?

Inevitably, decision-makers in relation to fitness to stand trial must depend significantly upon expert assessments provided on the issue by psychiatrists and psychologists. Rates of agreement between mental health professionals and court determinations have been found to exceed 90%. To facilitate the provision of probative material, the ultimate issue

1 The author acknowledges the helpful comments of John Dawson on an earlier draft but takes full responsibility for all errors and omissions.
3 See Brookbanks, "Judicial Determination of Fitness to Plead—the Fitness Hearing" (1992) 7 Otago Law Review 520, 537. However, of course, the decision is ultimately for the court "and not for medical men of whatever eminence": R v Rivett (1950) 34 Cr App R 87, 94.
rule in relation to such matters is routinely ignored. The burden of such reliance was described by a Scottish psychiatrist as placing “an awesome responsibility on the examining psychiatrist calling for extra caution on his part”. However, the mental health assessor can only assess in terms of the criteria provided by the law. The uncertainty in those criteria has been described as leading to “a lack of uniformity in the evaluation and decision-making process and the real possibility that the final decisions are unreliable and invalid”.

This paper analyses what it asserts should be regarded as the key features of unfitness to stand trial, and assesses the extent to which legislation and decided cases have taken them into account. In addition, the paper argues both that an assessment of fitness must be functional in nature, context-dependent and pragmatic, and that it must focus in an informed way upon the capacity of the accused for rational evaluation and communication.

**Fitness to stand trial**

The insistence that an accused be fit to stand trial arose out of a concern in the common law that criminal trials be fairly conducted. The justifications for the requirement that the accused be fit to stand trial may be divided into four:

- a recognition that it is fundamentally unfair to try an unfit accused;
- a recognition that it is inhumane to subject an unfit accused to trial and punishment;
- a perception that a trial of an unfit accused is comparable to trial of an accused in absentia, a procedure which our legal system repudiates; and
- a concern to avoid diminution of the public’s respect for the dignity of the criminal justice process if unfit accused are subjected to trial and punishment.

A variety of different procedures are employed in different jurisdictions, ranging from allowing a judge or magistrate to decide the issue, empanelling a separate jury for the purpose and deferring to a specialist body constituted for the task.

The precise criteria for fitness to plead vary significantly from country to country but all have at their core a determination of whether an accused person at the time assessed is able

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meaningfully to participate in the criminal trial process.

1 England

The English common law\textsuperscript{12} criteria for fitness to stand trial were formulated by Baron Alderson in \textit{R v Pritchard}\textsuperscript{13} (emphasis added):\textsuperscript{14}

There are three points to be inquired into: firstly whether the prisoner is mute of malice or not, secondly whether \textit{he can plead to the indictment} or not, and thirdly whether \textit{he is of sufficient intellect to comprehend the course of proceedings on the trial} so as to make a proper defence to know that he might challenge any of you to whom he may object and to comprehend the details of the evidence.

The word “comprehend” has been held to mean no more than “understand”.\textsuperscript{15} The emphasis, therefore, is upon understanding of the proceedings, while the scope of the requirement that he be able to “plead to the indictment” remains somewhat unclear. There is little emphasis upon capacity for communication or decision-making, and no distinction is drawn between intellectually disabled, physically or mentally ill accused.

Chiswick has commented that in practice:\textsuperscript{16}

the concept has been narrowed to the capacity of the accused to understand the charge, distinguish between a plea of guilty and one of not guilty, follow the evidence in court, and give instructions to his defending solicitor. These are tests of comprehension and communication, functions that may be compromised by mental dysfunction.

There has been little by way of judicial analysis of the forms of mental illness which should be accounted sufficient to render an accused unfit to plead\textsuperscript{17} although the decision of Devlin J (as he then was) in \textit{R v Roberts}\textsuperscript{18} accepted that “defects of the senses”, whether or not combined with a “defect of the mind” may render a person unfit to plead.\textsuperscript{19}

The Committee on Mentally Abnormal Offenders chaired by Lord Butler of Saffron Walden\textsuperscript{20} recommended the replacement of the expression “unfit to plead” by the expression “under disability” and proposed that the reference to challenging a juror should be omitted from the \textit{Pritchard} criteria. The Committee suggested that two further criteria be added: namely, whether the defendant could give adequate instructions to his

\begin{itemize}
  \item \textsuperscript{13} (1836) 7 C & P 103.
  \item \textsuperscript{14} See also \textit{R v Governor of Stafford Prison} [1909] 2 KB 81; \textit{R v Robertson} (1968) 62 Cr App R 690; \textit{R v Berry} (1977) 6 Cr App R 156.
  \item \textsuperscript{17} See Brookbanks, “A Contemporary Analysis of the Doctrine of Fitness to Plead” (1982) Recent Law 84, p 91ff.
  \item \textsuperscript{18} [1954] 2 QB 329, 331.
  \item \textsuperscript{19} See also \textit{R v Berry} (1978) 66 Cr App R 156.
\end{itemize}
or her legal advisers and also plead with understanding to the indictment.

2 Canada

In Canada s 2 of the Canadian Criminal Code provides that a person is “unfit to stand trial” if they are “unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings; (b) understand the possible consequences of the proceedings; or (c) communicate with counsel” (my emphasis). The focus of the section, therefore, is again upon understanding and capacity for communication. There is a requirement of a “mental disorder” but no criterion of rationality or any comparable concept.

A key decision to have interpreted the Canadian provisions is that of \( \text{R v Taylor} \). The accused (a lawyer) was found to be suffering chronic paranoid schizophrenia. Expert evidence suggested him to be articulate and conscious of the nature and possible consequences of the proceedings but expressed the view that he was unfit to stand trial because due to his paranoia he would not be able to trust counsel and instruct them in his best interests. At first instance he was found unfit to stand trial because his mental illness deprived him of the capacity to instruct counsel rationally or to communicate with counsel or to conduct his case. He appealed and the Court of Appeal rejected the “analytic capacity test” and adopted what they classified as the “limited cognitive capacity test”, under which the presence of delusions does not vitiate the accused’s fitness to stand trial unless the delusions distort the accused’s rudimentary understanding of the criminal justice process. They held that the accused’s ability to conduct a defence and to communicate and instruct counsel is limited to: an inquiry into whether an accused can recount to his/her counsel the necessary facts relating to the offence in such a way that counsel can then properly present a defence. It is not relevant to the fitness determination to consider whether the accused and counsel have an amicable and trusting relationship, whether the accused has been cooperating with counsel, or whether the accused ultimately makes decisions that are in his/her best interests.

It is not easy to gauge the breadth of the decision. It appears to repudiate the contention that the impact of a paranoid illness would necessarily render an accused unfit to stand trial, but it does require that the quality of the accused’s instructions be such that counsel can “properly” conduct a defence on their behalf. It may be that irrationality in instructions, contradictory versions of events or uncooperativeness would all preclude a

22 (1992) 11 OR (3d) 323.
23 See also Lafferty v Cook 949 F 2d 1546, 1554 (10th Cir 1991).
24 Page 338.
25 Page 336.
Fitness to Plead

“proper” defence. The court gave no indication.

3  United States

In the United States two cases are authoritative on the nature of unfitness to stand trial: *Dusky v United States*26 and *Drope v Missouri*.27 In the vital but cryptically short decision of *Dusky*, the Supreme Court agreed with the submission from the Solicitor-General that it is “not enough for the district court judge to find that ‘the defendant [is] oriented to time and place and [has] some recollection of events’.” The Court held that (emphasis added):28

> The test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as a factual understanding of the proceedings against him.

Thus, the inquiry of the court is not upon whether the accused is mentally ill per se or intellectually disabled but upon whether his or her experience of hallucinations, delusions or other abnormalities will adversely impact upon his or her functioning in court.29 The attempt is to ensure that each accused is a conscious, rational participant in their trial;30 otherwise it has been suggested that a criminal trial “loses its character as a reasoned interaction between an individual and his community and becomes an invective against an insensible object”.31 The key concept in the decision is capacity for rational understanding.

In *Drope v Missouri* the Supreme Court was more expansive, noting that it had long been accepted that a person whose mental condition is such “that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defence may not be subjected to trial”.32 They agreed too that “Even when a defendant is competent at the commencement of his trial, a trial court must always be alert to circumstances suggesting a change that would render the accused unable to meet the standards of competence to stand trial”.33 The decision is often regarded as a gloss upon *Dusky* but does not exhibit the same concern with the need for rational understanding in the competent defendant. It probably takes the law no further.

4  Australia

In Australia the common law remains as set out in 1958 in *R v Presser*34 where Smith J held that the test to be applied was one of “common sense”: “whether the accused, because of mental defect, fails to come up to certain minimum standards which he needs to equal

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26  362 US 402, 4 L Ed 2d 824, 80 S Ct 788 (1960).
29  See Winick, “Presumptions and Burdens of Proof in Determining Competency to Stand Trial: An Analysis of Medina v California and the Supreme Court’s new Due Process Methodology in Criminal Cases” (1993), 47 University of Miami Law Review 817, 897.
32  43 L Ed 103, 113 (1975).
33  43 L Ed 2d 103, 119.
before he can be tried without unfairness or injustice to him”.35 His Honour gave what is one of the most substantial lists of indicia that exists in reported case-law (emphasis added):36

He needs, I think, to be able to understand what it is that he is charged with. He needs to be able to plead to the charge and to exercise his right of challenge. He needs to understand generally the nature of the proceeding, namely, that it is an inquiry as to whether he did what he is charged with. He needs to be able to follow the course of proceedings so as to understand what is going on in court in a general sense, though he need not, of course, understand the purpose of all the various court formalities. He needs to be able to understand, I think, the substantial effect of any evidence that may be given against him; and he needs to be able to make his defence or answer to the charge. Where he has counsel he needs to be able to do this by giving any necessary instructions and by letting his counsel know what his version of the facts is and, if necessary, telling the court what it is. He need not, of course, be conversant with court procedure and he need not have the mental capacity to make an able defence; but he must, I think, have sufficient capacity to be able to decide what defence he will rely upon and to make his defence and his version of the facts known to the court and to his counsel, if any.

The High Court has made it plain that the Presser rules are the “minimum standards with which an accused person must comply before he or she can be tried without unfairness or injustice.”37 The requirements centre upon capacity for understanding and ability to make forensic decisions, as well as to communicate both to the court and his or her legal representatives.38 It is not necessary that a represented accused understand the law “if that lack of capacity does not render him unable to make a proper defence”.39 Nor is a requirement of rationality articulated, but it would be open to argument that such a requirement is inherent in Smith J’s ratio. However, the High Court has held that “in some cases, complete understanding [of proceedings] may require intelligence of quite a high order”.40

The Presser criteria have attracted a measure of controversy. They were endorsed by the Victorian Law Reform Commission41 but criticized by the Victorian Intellectual Disability Review Panel which referred to:42

The possible danger of too readily dismissing the person’s capacity to comprehend, and ... the subjective nature of determining the extent to which the person may satisfy the Presser criteria. It also fails to consider that the person may benefit from

35 Page 48.
38 Section 631 of the Western Australian Criminal Code and s 613 of the Queensland Criminal Code similarly focus upon whether the accused is capable of understanding the proceedings so as to be able to make a “proper” defence. The High Court in Ngatayi v R (1980) 30 ALR 27, 32 applied the approach of Smith J in R v Presser [1958] VR 45, 48 in interpreting the Western Australian Criminal Code provision.
assistance or tutoring, in order to better understand the proceedings.

Late in 1994 the Model Criminal Code Officers Committee promulgated a draft Mental Impairment Bill 1994. In its terms it is very similar to the Presser criteria:

3. A person is mentally unfit to stand trial for an offence if the person’s mental processes are so disordered or impaired that the person is:
   (a) unable to understand the nature of the charge; or
   (b) unable to plead to the charge and to exercise the right of challenge; or
   (c) unable to understand the nature of the proceedings (namely, that it is an inquiry as to whether the person committed the offence); or
   (d) unable to follow the course of the proceedings; or
   (e) unable to understand the substantial effect of any evidence that may be given in support of the prosecution; or
   (f) unable to make a defence or answer the charge.

The proposed legislation does not measure the fitness of a person by evaluation of the extent to which they are prejudiced in their capacity to take part in the trial process save by reference to a variety of open-ended cognitive criteria. With the limited exception of (e), they are not qualified in terms of adequacy or sufficiency for any purpose, but starkly stated. They are similar to the rudimentary understanding criterion articulated in Ontario in R v Taylor.43

5  New Zealand

The key fitness to plead provision in New Zealand is s 108 of the Criminal Justice Act 1985 (NZ) where it is prescribed that a person is “under a disability” if because of the extent to which a person is mentally disordered, they are unable (a) to plead; (b) to understand the nature or purpose of the proceedings; or (c) to communicate adequately with counsel for the purpose of conducting a defence (my emphasis). To this extent, therefore, the concentration is upon the unclear notion of ability to plead, presumably to express a wish to plead guilty or not guilty, to understand what the trial is about in principle and to communicate “adequately” with their legal representative. Again much lies within the word “adequately”. Adequately for what, one would like to know. The legislation gives no indication but Heron J in R v Carrel44 has accepted that it requires consideration of the quality of the accused’s communication as well as the physical possibility of communication.

In that case his Honour held that the delusional system entertained by the defendant was preventing him giving adequate instructions to his counsel:45

[he] will not discuss the critical aspects of the case. I consider all that amounts to a communication but an inadequate one. It is not just a matter of being unwise, although it is that as well, but a failure to communicate sufficiently and suitably. There exists a form of communication which in dictionary terms and giving the

43 (1992) 11 OR (3d) 323.
45 Page 766.
word its etymological origins is not equal because part of the defence is not addressed by one of the parties to the communication.

The effect of this focus upon the quality of the defendant’s communication was to all intents and purposes an assessment of the defendant’s rationality and the adverse impact of his state of mind upon his best interests in the criminal justice process.46 This decision builds upon the earlier decision of Wilson J in R Owen (No 2)47 where his Honour inquired into whether the accused was able to “reach a proper decision whether to plead guilty or not guilty” and did so explicitly in terms of assessing whether he was “able to reach a rational judgment” on the issue.48

In the recent unreported case of R v M49 the High Court was called upon to rule upon the fitness of a 39 year old accused who had been a patient in a psychiatric facility since his teenage years. However, it was his intellectual disability that was the problematic aspect of his capacity to stand trial. Neazor J found that the accused’s suffered from a disorder of cognition and found that his understanding of what is involved in pleading to a charge was deficient and unlikely to be susceptible of improvement. He also found that the accused could not be brought to understand the nature or purpose of the proceedings. However, importantly, his Honour found that the accused’s capacity to convey his version of events was not so impaired as “to prevent counsel becoming informed” after a good deal of hard and careful work. He accepted that the accused might well be unable to make an informed decision on whether to give evidence but found that as a matter of law he was not satisfied that that was a factor coming within s 108(1)(c) and its reference to communication with counsel. In my respectful view, this highlights a significant deficiency in the legislation as presently framed.

No definition of “mentally disordered” is found in the Act so recourse must be had to the definition in the Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ) where mental disorder is defined as:

an abnormal state of mind (whether of a continuous or intermittent nature) characterized by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it

(a) Poses a serious danger to the health or safety of that person or others; or

(b) Seriously diminishes the capacity of that person to take care of himself or herself.

In relation to an intellectually disabled person this focuses the court’s inquiry upon their disorders of cognition, or potentially of their disorders of mood, perception or volition. This is appropriate if the quest is for assessment of the person’s ability to understand

46 Compare R v Berry (1978) 66 Cr App R 156.
48 Page 831. A difference exists, however, between His Honour’s finding that an accused must be able to have a rational recollection of the events and circumstances in which he was a participant at the time of the alleged offence (p 832) and the decision of the English Court of Criminal Appeal in R v Podola [1959] 3 All ER 418 where it was held that hysterical amnesia does not render an accused unfit to stand trial.
49 HC Wellington, T66/94, 8 November 1994, per Neazor J.
proceedings and to participate meaningfully in them through their counsel. The problem comes in the qualifying aspects of the definition, namely whether the person poses a serious danger to their own or others’ health or safety or their impairment seriously diminishes their capacity to take care of themselves. Such criteria, in my respectful view, are simply not pertinent to the inquiry to be undertaken. These matters are neither germane nor useful for the purpose of assessing an individual’s fitness to engage in a forensic process.

**Expert assessment**

Forensic clinicians generally concede that the meaning of fitness to stand trial is highly contextualized and that the standard that they apply is “open-textured”, depending upon the seriousness and complexity of the charges, on the challenges facing the accused in the given case, the relationship between the accused and his or her lawyers, those lawyers’ communication skills and a number of other criteria.

The United States Supreme Court has recognized that there are “no fixed or immutable signs which invariably indicate the need for further inquiry to determine fitness to proceed” and has conceded that the question is often a difficult one “in which a wide range of manifestations and subtle nuances are implicated. That they are difficult to evaluate is suggested by the varying opinions trained psychiatrists can entertain on the same facts”. Once again, this does not advance understanding very far.

Aside from the difficulty of the process, in light of the unclear requirements of the courts for their assessments, a little is known about expert assessments of fitness to stand trial. The context in which an accused is referred for a fitness to plead assessment is important. It may be at the aegis of the accused, the Crown or the judge. Studies by Aubrey in 1987 and 1988 have indicated that certain characteristics are particularly prominent among those who are assessed for fitness to plead, namely that 55% had a history of inpatient treatment, while 48% had a previous conviction for a serious offence. He also found that such assessments are more common where violence of some kind has been displayed in the offence with which they are currently charged.

Rogers and Mitchell maintain in the Canadian context that there is “a notable absence of specific guidelines for assessing fitness to stand trial” and that no doubt for this reason “forensic psychiatrists and psychologists often adopt rather idiosyncratic interpretations of fitness to stand trial”.

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50 This issue was resolved by Neazor J in *R v M*, above n 49, by something of a sleight of hand holding that the accused’s disorder of cognition seriously diminished his capacity to take care of himself (p 7).
51 Curiously, there is a history of confused criteria in this context with *R v Dyson* (1831) 7 C & P 305, subsuming intellectual disability under the rubric of insanity. This was continued in *R v Pritchard* (1836) 7 C & P 303: see D Grubin, “What Constitutes Fitness to Plead?” [1993] Criminal Law Review 748.
52 *Drope v Missouri* 43 L Ed 2d 103, 118.
53 Ibid.
The problem is exacerbated where a request from either court or legal representative is in terms that do not enable the expert to be clear about the purpose of the report or where the report is apparently commissioned for more than one purpose. Such a practice is both dangerous and unsatisfactory.

Larkin and Collins\textsuperscript{56} found in assessing 77 pre-trial psychiatric reports that in 27\% the criteria for assessment of fitness to plead were not explicitly mentioned by the authors,\textsuperscript{57} leading them\textsuperscript{58} to agree with the proposition advanced earlier by Chiswick\textsuperscript{59} that "some psychiatrists ... seem uncertain of the criteria for fitness to plead and confused the issue with responsibility". Given the mixed messages sent by the legislature and the courts in many jurisdictions, such confusion is hardly surprising.

**Relevant factors for expert assessment**

One of the most difficult factors posed for experts endeavouring to assist the courts in supplying assessments of accused persons' fitness to stand trial is the inherent vagueness of most legal formulations of fitness. That given extra-curially by Nicholson \textsuperscript{60} of the Western Australian Supreme Court (as he then was), is not unusual where he argued that the essence of a fitness to plead finding should focus upon the capacity of the accused to understand proceedings. He qualified this by stipulating simply that:

\begin{quote}
this does not require an accused to have a complete understanding or an ability to conduct a defence. It is a test to be applied in a reasonable and commonsense fashion. It is enough that the accused can understand the evidence and instruct his or her counsel as to the facts of a case.
\end{quote}

While this formulation may have considerable merit, it assists the expert little in knowing what criteria should occupy his or her mind in undertaking a fitness assessment. What quality of understanding is necessary? What if the accused is quite irrational? What if the accused is apparently self-harming in his or her attitude toward the trial? What if the accused's perception of the trial process or his or her representation is dominated by paranoid ideation? What if he or she cannot make choices as to strategies or if the instructions as to forensic tactics are perverse?

Bonnie\textsuperscript{61} sets out the following sophisticated criteria for assessing fitness to stand trial:

- ability to communicate a preference;
- ability to understand relevant information about a particular forensic decision to be made by the accused;

\begin{itemize}
  \item Larkin & Collins, "Fitness to Plead and Psychiatric Reports" (1989) 29 Medicine, Science and the Law 26.
  \item See also Chiswick, "Fitness to Stand Trial and Plead, Mutism and Deafness" in R Bluglass and P Bowden (ed), *Principles and Practice of Forensic Psychiatry*, Churchill Livingstone, London, 1990.
  \item Page 31.
  \item Chiswick, "Insanity in Bar of Trial in Scotland: A State Hospital Study" (1978) 132 British Journal of Psychiatry 598.
  \item Above, n 2, p 576ff.
\end{itemize}
Fitness to Plead

- ability to appreciate at a basic level, or at a substantial level, the significance of information in relation to his or her situation;\textsuperscript{62} and
- the ability to make reasoned choices during the forensic process.

Within the criterion of ability to communicate preferences, of course, is the assumption that an accused has the ability to make decisions. Even under these criteria, though, the possibility exists that the reasoning processes of the accused will be perverse and contrary to his or her best interests by reason of the presence of mental disorder.\textsuperscript{63}

Arguably the capacity to understand the import of proceedings and the capacity to provide lucid instructions to counsel will vary on the basis of the Crown case and the nature of the case. A complex case involving obtaining property by deception or fraud, for instance, is likely to require considerably more application of cognitive faculties than a simple assault case.

A series of requirements may be plotted, depending upon the nature of the case and the defence strategy:

- ability to understand the nature of the charges;
- ability to understand the possible consequences of the proceedings;
- ability to understand forensic options;
- ability to make choices;
- ability to maintain appropriate courtroom demeanour;
- ability to understand evidence;
- ability to give evidence;
- ability to instruct as to lines of cross-examination;
- ability to make decisions on the calling of witnesses.

One might qualify each one of these capacities for understanding, decision-making and communication by the adjective such as "rational" or one might impose a limit upon the level of understanding such as "to a basic degree". It depends upon how substantially as a matter of principle one is concerned to ensure that the accused be able to function within the trial setting.

The setting out of such requirements illustrates the fluidity of fitness to plead as a measure of what can be changing functional abilities.\textsuperscript{64} For the most part those prejudiced from effective functioning in the trial process by reason of intellectual disability will be disadvantaged on a continuing basis but those disadvantaged by psychiatric illness will frequently only be impaired during an acute or florid phase of their illness. For this latter

\textsuperscript{62} This is of particular application in relation to accused suffering limitations in cognitive capacity, disturbances of thought or affective disorders.

\textsuperscript{63} See, eg, \textit{R v Carrel} [1992] 1 NZLR 760. Ironically it will generally be the accused's instructing solicitor and barrister who are most privy to such problems but \textit{R v Carrel} and \textit{R v M}, above, n 49, have confirmed the difficulties in legal representatives giving evidence of such matters.

\textsuperscript{64} See Rogers & Mitchell, above, n 55, p 98.
group, the passage of time or the use of medication may well facilitate the return to sufficient mental health to enable their being tried without disadvantage.

Assessment of fitness to plead ought to be coterminal with the demands likely to be made of the accused in the particular proceedings in which he or she is charged. It is inappropriate to apply low level criteria to an accused who is charged in complex proceedings in which he or she will need to play a major role, just as it is inappropriate to apply elaborate criteria to a simple trial in which the defence will primarily be oriented toward assessing sufficiency in law of the Crown’s evidence.

Some matters, however, should be regarded as fundamental. For instance, in any proceedings, the accused must be able to understand the charge brought against him or her, as well as the nature of their plea. For any form of proceeding to take place against an uncomprehending or significantly impaired accused strikes at the integrity of the criminal prosecution system and can only detract from the respect in which the criminal justice system generally is held. The solution to the adverse effects upon accused charged with minor offences, and yet found unfit to stand trial, lies within increased flexibility being given to the courts to deal proportionately with all accused found unfit to stand trial.65

As a practical matter it can be profoundly difficult to be confident, as counsel, expert assessor or judge, that a person suffering from intellectual disability66 or a person with a variety of mental disorders, ranging from paranoias to manias, truly understands the nature of charges, as well as the consequences that could flow from different forms of plea or strategy within a plea decision.

It might be argued that it is sufficient if the accused can understand the overall objectives of the defence strategy so as to provide sufficient instructions to their lawyers. Even this, though, is problematic. It is clear that a degree of autonomy in relation to the conduct of a person’s defence is properly possessed by counsel and instructing solicitors but they must have sufficient guidance to make decisions that are consistent with the wishes of their client. Tactical decisions can involve the taking of significant risks with potentially detrimental consequences for the accused. As the Australian High Court pointed out in Keseverajah v R,67 even late in the trial the accused may need to participate actively “to protect his own interests” to instruct upon the taking of exceptions to the charge, the responses should the jury ask question or make requests, or the approach to be adopted should the jury be unable to reach a verdict or if the judge needed to take action following submissions from the parties.

In the medical context a patient must be acquainted with the potential for significant risks prior to engaging in medical treatment.68 In addition, the patient must be able to

65 For instance, some such accused could be released into the community with conditions directed toward reducing the likelihood of their reoffending. The stringency of such conditions could vary according to the seriousness of the offence with which they have been charged (but not found guilty) and the strength of the evidence against them.

66 See Bonnie, “The Competence of Criminal Defendants with Mental Retardation to Participate in their Own Defense” (1990) 81 Journal of Criminal Law and Criminology 419.

67 (1994) 68 ALJR 670, 678.

68 See Rogers v Whitaker (1992) 175 CLR 479.
communicate their choice as to treatment, to understand the information sufficiently to make an informed choice, appreciating the significance of information provided to them for their own context and would need to be able to engage in a process of rational evaluation, or reasoning, about the information before they could be said to have given informed consent. Buchanan and Brock make the useful point that competence is adequate decision-making capacity, not “perfect rationality” and divide its components as follows:

- the ability to understand the relevant options;
- the ability to understand the relevant consequences for the patient’s life of each of the relevant options; and
- the ability to evaluate the consequences of the various options by relating them to his or her own values.

Surely, comparable principles should apply in the context of an accused participating in the trial process. If adequate instructions cannot be procured from the accused during the trial process, it must surely be counsel’s responsibility to inform the court of that fact with the potential that the accused is found unfit to stand trial or to continue to stand trial. If adequate decision-making capacity is clouded by inadequate intellect or mental illness, a person should not be accounted fit to stand trial. This standard does not demand a high level of rationality but does contemplate the ability in an accused to apply reasoned contemplation to the subject matter of the charges against him or her and the ability to communicate instructions accordingly.

The capacity of an accused to participate in the decision-making process in relation to the calling of witnesses can also be problematical at a practical level if the accused experiences irrational prejudices or, for reason of intellectual impairment or psychiatric disorder, is unable to make a reasoned decision on the subject. Now that accused in almost all jurisdictions no longer have the right to make an unsworn statement, it is also a reality that thought-disordered or impaired accused persons are often in a very poor position to give sworn evidence and be cross-examined. By reason of this, they are in a worse position than other defendant in the criminal process. When their impairment reaches a point where they are unable to give a rational or comprehensible account of relevant matters in evidence, in my view they should be accounted unfit to stand trial.

The United States Court of Appeals for the Ninth Circuit in Moran v Godinez made an interesting distinction. It held that the capacity of accused to waive constitutionally guaranteed rights in the trial process should be differentiated from the accused’s

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69 See Appelbaum and Grisso, “Assessing Patients’ Capacities to Consent to Treatment” (1988) 319 New England Journal of Medicine 1635 who also make the point that ideally the patient be able to manipulate the information given to them rationally, using their logical processes to compare the risks and benefits of the options made known to them. Whereas appreciating a situation entails assigning values to information provided, rational manipulation is the process of weighing information to reach a decision, an option precluded by psychoses, deliria, dementias, extreme phobias or panics, euphorias, depressions or angers.


71 972 F 2d 263, 266 (9th Cir, 1992).
competency to stand trial. It explicitly adopted the "reasoned choice" test in relation to
the waiver of constitutional rights:

A defendant is competent to waive counsel or plead guilty only if he has the
capacity for "reasoned choice" among the alternatives available to him. By
contrast, a defendant is competent to stand trial if he merely has a rational and
factual understanding of the proceedings and is capable of assisting his counsel.
Competency to waive constitutional rights requires a higher level of mental
functioning than that required to stand trial.

The difficult issue posed in this regard for countries without constitutionally entrenched
rights is whether "reasoned choice" should be the major criterion or whether "rational
understanding" is sufficient.

It is vital too that the accused be able to communicate rationally and effectively with his
or her legal representatives. The psychiatric state of akinesia can result in apathy, apparent
disinterest on the part of an accused to his or her fate and unpreparedness to communicate
with legal representatives. Tomashesfky72 points out that such a condition strikes at the
root of the ability of an accused to participate in the trial process:

An apathetic defendant who is disinclined to speak up during the give-and-take of
cross examination cannot be of much help in his own cause, especially if he does
not recognize his own disinclination.

Thus, it becomes apparent that mere capacity to communicate an instruction is not
sufficient. The instruction may be in the form of little more than a grunt. It may be
monosyllabic or nonsensical in the context of other aspects of the communication. There
must be a qualification upon the communication, such that the communication is
sufficient to enable counsel to represent the accused effectively.

It needs to be acknowledged too that intangible factors such as the rapport, or lack of it,
subsisting between the accused's lawyers and him or her play a major role in the feasibility
of the accused adequately comprehending proceedings. If a substantial alienation has
evolved between counsel and the accused, with the accused suspecting his barrister of
being part of a conspiracy against him, his ability to comprehend the trial process is likely
to be substantially impaired. This is not all that unusual a situation where an accused
person with a combination of despair and paranoia becomes convinced that the system
will not give him or her a fair go. The situation is further complicated if the accused
chooses to represent him or herself.73

72 Tomashesfky, "Antipsychotic Drugs and Fitness to Stand Trial: the Right of the Unfit Accused to
Refuse Treatment" (1985) 52 University of Chicago Law Review 773, 785.
73 As Americans put it, waiving the right to counsel, exercising their Faretta right (Faretta v California
422 US 806 (1975) which requires a judge to warn an accused of the dangers and disadvantages of self-
representation so that the record will establish that the accused has made the decision about waiver,
aware of what he or she is doing and eyes open. This in itself brings problems in competency
assessment: see Note, "Competence to Plead Guilty and to Stand Trial: A New Standard When a
However, as Nicholson J\textsuperscript{74} indicated, pragmatism too must enter into the judicial assessment process. An absolute standard which requires full comprehension of forensic subtleties would result in excessive rates of declaration of unfitness to stand trial. However, if the threshold is set too low for assessment of fitness to stand trial, the potential exists for false convictions because of the impairment of the accused to participate in the trial process. The balance is not easy.

**Expert tests for fitness to stand trial**

The task of assessment is an unwanted one for many mental health professionals as their primary orientation is frequently toward assessment and treatment of psychiatric impairment, rather than assessment of a patient's competency to function within a legal environment. An irony is that, of necessity, the demands of the legal forum and the problems experienced in the client's communicating instructions required for his or her defence are likely to be better appreciated by the client's lawyers than by mental health professionals.

However, given that determinations have to be made about accused persons' fitness to stand trial, and given that those decisions are significantly influenced by expert evidence from psychiatrists and psychologists, it is important to reduce subjectivity and arbitrariness in the assessment process. These aspects of the process have been the subject of critique by the Victorian Intellectual Disability Review Panel:\textsuperscript{75}

Recommendations by experts as to whether a person meets the Presser rule are often made too simplistically and quickly judged in a single interview. A person may satisfy some criteria but not others and subjective judgments are made by expert witnesses as to the degree to which a person satisfies each of the criteria.

Clearly, general criteria which would enable falsifiable and reliable assessment of fitness to stand trial, thereby reducing the role of subjectivity of clinical judgement, would be of considerable utility to those responsible for conducting the assessments.

A variety of attempts have been engineered to develop standardized fitness to plead assessments, dating back to 1973 and a scale developed by Dr A Louis McGarry and his associates at the Harvard Laboratory of Community Psychiatry.\textsuperscript{76} This first test contained 13 items directed toward assessing an accused's ability to cope with the trial process, such as appraisal of available legal defences, quality of relating to lawyer and capacity to engage in planning legal strategy.


\textsuperscript{75} Submission, 17 December 1992, p 8.

However, such standardized assessments are themselves subject to criticism and may be culturally limited by reason of their North American background. They continue to labour under the difficulty that the requirements for participation in the legal process remain to be clearly articulated by the courts.

Most assessments in both Australia and New Zealand are non-standardized and in the case of persons potentially disabled by intellectual disability are clinical in orientation but supported by psychometric testing. Assessment based upon clinical experience is the norm and at a practical level forensically problematical given the reliance customarily placed upon such forms of expert evidence by courts.

Jones in Australia acknowledged that when called upon to assess the fitness to plead of an intellectually disabled person a variety of options are open to him—interviewing (structured or semi-structured), a general intelligence approach, an abilities approach, a specific test of fitness to plead and an experimental approach. He said that from a psychologist’s point of view, there was no standard set of procedures and that for the most part a combination of methods tended to be employed. He advocated the development of a specific screening test and argued that it could be developed in conjunction with lawyers and validated against actual court outcomes and the opinions of relevant people.

When the task required of the mental health practitioner lacks normative texture and is highly discretionary, depending upon clinical impressions, it is both difficult for counsel to cross-examine and unlikely to be the subject of appellate court intervention. This is a recipe for experts to usurp the role of the court. Indeed, Hart and Hare found in a study of males remanded for competency to stand trial that the courts accepted 77 out of 80 clinician assessments. This may have been because the assessments were so compelling, but it is more likely to be a combination of preparedness to defer to the expertise offered and because the opinions expressed by the assessors were so dominated by clinical impression as to defy ready evaluation.

The need for reform
Fitness to stand trial is a threshold issue whose importance cannot be overemphasized. It is unconscionable that persons who are unable adequately to comprehend what is transpiring in their own trial, or to participate in the trial process or to communicate their rationally formed instructions to their lawyers, be subjected to trial. A criterion for assessment should be upon whether the impact of their intellectual disability or psychiatric impairment means that they are significantly prejudiced as criminal defendants, as compared with persons not suffering such disabilities.

78 See Hart & Hare, "Predicting Fitness to Stand Trial: the Relative Power of Demographic, Criminal and Clinical Variables" (1992) 5 Forensic Reports 53; see also Reich & Tookey, "Disagreements Between Court and Psychiatrist on Competency to Stand Trial" (1986) 47 Journal of Clinical Psychiatry 29; Golding et al, “Assessment and Conceptualization of Competency to Stand Trial” (1984) 8 Law and Human Behavior 321.
79 The only exception to this might be asserted to be a “trial of the facts” which can lead to an acquittal only, as under the Criminal Procedure (Insanity and Fitness to Plead) Act 1991 (UK).
However, in most jurisdictions, New Zealand among them, the law has not prescribed with sufficient detail what its standards are for those who are to be tried in its courts. Until it does so with precision, it cannot expect sophisticated and pertinent expert evidence on the subject of fitness. Standardized tests for fitness to stand trial have the potential to be of great assistance to the courts. However, they cannot realistically be developed until legislation or courts prescribe whether or not rationality in understanding, decision-making and communication, or the capacity for exercise of a reasoned choice, is required before an accused can be brought to trial. This is an area which the legislature or the judiciary needs to give the lead and then the other disciplines, psychiatry and psychology, will be able to contribute to the criminal justice process. It is important that the cryptic and inadequately expressed criteria for participation in the trial process be abandoned and substituted by a clear provision, taking into account the approach of the United Supreme Court in *Dusky v United States*\(^{80}\) and consolidating on the humane analyses articulated by Wilson J in *R v Owen (No 2)*\(^{81}\) Heron J in *R v Carre*\(^{82}\) and Neazor J in *R v M*\(^{83}\) such as the following:

An accused shall be found unfit to stand trial if

(a) he or she cannot substantially understand the charges preferred; or

(b) he or she cannot rationally make a decision on whether to plead guilty or not guilty to the charges; or

(c) he or she cannot substantially understand and follow, with assistance from his or her legal representatives, if they exist, the evidence against him or her; or

(d) he or she cannot rationally give adequate instructions to his or her legal representatives, if he or she is legally represented, in relation to the conduct of his or her defence, or if he or she is not legally represented, make such decisions him or herself rationally; or

(e) he or she cannot rationally make the decision on whether to give evidence and, if he or she wishes to give evidence, do so rationally and without being substantially prejudiced by psychiatric or intellectual impairment.

Such a provision has the advantage of concentrating upon functional impairments potentially unfairly suffered by psychiatrically and intellectually disadvantaged accused persons in the trial process. It avoids the problems inherent in labelling them with mental illnesses or disorders, or employing irrelevant criteria borrowed from the civil commitment context. Such a provision focuses upon the key aspects of reasoning, understanding, capacity to make choices and communication which are potentially such as to prejudice certain accused persons from participating in the trial process to the level open to other persons accused of criminal offences. It enables flexibility, focussing upon the particular proceedings, and pragmatism in light of the demands posed in different contingencies.

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80 362 US 402, 4 L Ed 2d 824, 80 S Ct 788 (1960).
83 Above, n 49.
Disability Hearings Under The Criminal Justice Act—a Judge’s View

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Introduction
Disability hearings are rare and somewhat tricky. I commend the Legal Research Foundation for hosting this seminar which may do much to dislodge some of the mystique that surrounds this aspect of Mental Health/Criminal Justice Law.

The right to have a disability hearing is doubtless a most important one. Not only that, but defendants who may be eligible are often the most vulnerable in terms of the criminal justice system. I apprehend that there may be many defendants who come into the criminal justice system but who, for a variety of reasons, are never directed for psychiatric assessment or have the benefit of the consequences that may flow from that.

The comments and observations I now set out are done so in an effort to bring a practical and clinical outline of the procedure from a judge’s point of view.

Spotting the candidate
When defendants first appear in Court it is invariably a busy list court of the District Court. It is not unusual for well in excess of a hundred defendants to be processed in the course of a day. The task of the judge is to attend to each case as quickly, efficiently but humanely as time permits.

If a defendant appears dishevelled and/or disorientated, this may be the first cue to having that defendant’s personal situation assessed before a plea is taken.

In the Auckland District Court there exists the all important Court Liaison Nursing Service. This is a community mental health nursing service provided to and operating from within the Justice Department. It is staffed by community mental health nurses and in Auckland the service extends to most courts. It is funded by Waitemata Health. The stated aims of the Service are:

The primary aim of the Service is to provide and act as a focus for the interface between Justice and Mental Health services, in order to facilitate efficient and responsive systems when dealing with issues concerning Mental Health.

It is important that court officers, ie, defence counsel, duty solicitors, prosecutors and judges are aware that the service exists and that defendants are able to be referred for on the spot assessment within the Court building.

As a matter of practice, a defendant may be assessed by a forensic nurse before appearing
in the dock or may first appear in the dock and be stood down for assessment at the
suggestion of a court officer.

The important point to stress is that considerable care must be taken to ensure that a
defendant who may be a candidate for assessment is spotted and assessed.

**Initial report**

In the greater Auckland area where the forensic service is in place, an initial and brief
report will ask the Court to do one of a number of things. The report could for instance
indicate that the defendant is already subject to the Mental Health system but that he or
she should be processed by the criminal justice system in the normal way. However, if
upon initial assessment it appears that the defendant’s mental state is likely to be directly
relevant to the charge faced or will otherwise impact on the judicial process, a remand to
enable further investigation should be requested. This invariably occurs by requesting a
psychiatric report pursuant to s 121 of the Criminal Justice Act.

This section is something of a trap for young players. It is a complex section and it is most
important to prescribe exactly which statutory provision is in issue. *Do not leave it up to
the judge, study the section and make your request carefully.*

In courts where no forensic service operates I think it best that a short remand is obtained
so that an initial assessment can be carried out. If that seems to warrant a full psychiatric
report, then the request under s 121 can be made.

**The question of plea**

A psychiatric report may suggest that a defendant is under a disability or is otherwise
mentally challenged. Before the defendant is called on the date to which he has been
remanded, an amount of work is required in preparing the way for what should happen
next. In a busy list court a judge appreciates counsel who has thought through the issues
and can succinctly summarize the position and what is sought.

If the psychiatric report suggests that the defendant is mentally disordered and could not
or should not participate in a court hearing within the meaning of s 108 of the Criminal
Justice Act, a request should be made at that time for a disability hearing. My suggestion
is that having made the request, a further adjournment is sought to set up the hearing
properly. We found in *Police v M* [1993] DCR 1119 that successive dates for hearing were
required because insufficient court time had been allocated initially for proper disposition
of the case. It became a protracted and stressful affair. Once the report is available, I would
be inclined to:

1) Discuss the position with the prosecutor and obtain a Police or Crown view;
2) Assess what witnesses might need to be called having regard to the issues raised;
3) Liaise with the Fixtures Clerk as to what time will be required and when that time
can be allocated.

Some priority should be given to disability hearings. I would tend to insist that court
administration ensures that that occurs.
The hearing

Section 111 of the Criminal Justice Act suggests that disability hearings are largely inquisitorial. There is no "proof" required to a requisite standard. Section 111(1) provides that a judge must be satisfied on the evidence of two medical practitioners and after hearing from prosecution and defence that a defendant may be under a disability.

Who should provide the evidence at disability hearings is a moot point.

I have found it useful in disability hearings to conduct a judicial conference with counsel beforehand to discuss the format of the hearing and the evidence to be provided.

It could be argued that it is for the defendant to provide the further medical opinion required by s 111 but equally it may be the Court's responsibility to organize that. I favour a procedure which sees counsel for the defendant assembling the evidence in support of the notion of disability, calling it and allowing that to be tested by the prosecution. The prosecution, of course, has the right to call its own evidence. The Court has no right to call evidence but by appointing counsel to assist, a canvassing of the important issues is often facilitated.

The important issues

When the Mental Health (Compulsory Assessment and Treatment) Act 1992 was passed, the new definition of "mentally disordered" was transported into the Criminal Justice Act.

A reading of R v T [1993] DCR 600, Police v M [1993] DCR 1119, Police v M (No 2) [1994] DCR 388 and finally Police v M (No 3) (DC Auckland, 30 November 1994) convey clearly the uneasy relationship between the Mental Health Act and the Criminal Justice Act. I illustrate the problem in this way. Section 108 of the Criminal Justice Act provides that a person is under a disability if that person is unable:

(a) To plead; or
(b) To understand the nature or purpose of the proceedings; or
(c) To communicate adequately with counsel for the purpose of conducting a defence.

But before getting to that stage the person must first be defined as mentally disordered.

Section 2 of the Mental Health Act sets out the definition of persons who are mentally disordered. Medical health professionals have tended to approach s 2 restrictively and exclude from the definition persons with a hint of intellectual disability. They have often tended to focus on whether or not a person can be assisted therapeutically by the Mental Health model and if they cannot, to exclude them from the definition. This is understandable from a Mental Health point of view but is quite inconsistent with the spirit of s 108. I do not wish to repeat all that was said in the decisions to which I have just referred. But I think it is important that counsel stand their ground, notwithstanding what medical opinion may opine.

I would accordingly suggest that evidence focuses on:
1) Whether a defendant has “an abnormal state of mind” in the pure not populist psychiatric sense;

2) That broadly that person’s abnormal state of mind poses a serious danger or otherwise restricts that person’s ability to care for himself. In this respect note the way in which authority is developing. In Re JK (1994) NZFLR 678 a quite restrictive view was taken to this requirement. However, in Re D (1995) NZFLR 28 and in Re KLD (DC Auckland, No 113/94, 13 February 1995) the Court has interpreted this second leg of the definition to “mentally disordered” much more liberally.

Disposition

If the evidence supports a finding of disability, the Court must make an order pursuant to s 115 of the Criminal Justice Act. Once again, this is not an easy section to interpret.

Police v M (No 2) was in large part concerned with disposition. It was contended by the Police in that case that the Court was required to make an inpatient compulsory treatment order. This submission was rejected and it has important consequences for the defendant.

You will see from s 115 that a defendant:

1) May be released;
2) Be detained as a special patient;
3) Be subjected to either a community or inpatient compulsory treatment order;
4) No order may be made if the person is otherwise subject to a full-time custodial sentence.

It is very much in the defendant’s interests if a community treatment order can be made or failing that, an inpatient compulsory treatment order is made. Detention as a special patient is much more restrictive and it may be important to ensure that evidence is placed before the Court which could justify detention other than as a special patient.

Conclusions

The undertaking of a disability hearing will be very much assisted if we are clear from the outset what the objectives are and what points need to be covered. The procedure is sufficiently difficult as to probably warrant a check list being drawn up.

Judges are not highly experienced in this field, simply because the procedure does not often arise. It may be, however, that many more defendants are candidates for orders than is recognized.
The Disability Hearing: Evidential Issues
—a Psychiatrist’s View

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The aim of this paper is to summarize my clinical experience in the field of (acute/remand inpatient) forensic psychiatry in Auckland over the last 13 years as it relates to disability hearings. I will concentrate on the events leading up to the hearing, and the hearing itself. All will be from a very practical and clinical angle as it relates to pertinent medico-legal questions. It will also be a modified version of my multimedia presentation at the seminar itself, but it will not be a formal research treatise on the question of disability as such.

Introduction
The interested reader will want to consult the wording of the relevant Acts and sections mentioned at other places in this booklet. This includes the current legal definition of “mental disorder” within the meaning of the Mental Health Act (MHA) 1992, ie, s 2, p 4, and the “General rules relating to liability to assessment or treatment”, as per s 4 of the same Act, p 6. Many other sections are indirectly relevant, and a working knowledge of the MHA would help to understand some of the intricacies of the Act in relation to the question of disability.

Part VII of the current Criminal Justice Act 1985 applies in relation to matters surrounding disability, with ss 108 to 116 being of particular relevance. Sections 121 to 123 CJA deal with matters related to the psychiatric report to the court, and is discussed in some detail in other parts of this booklet.

In relation to psychiatric matters, the currently most widely accepted classification in use in New Zealand and in most other parts of the world, is the Diagnostic and Statistical Manual of Mental Disorders, DSM IV, by the American Psychiatric Association (as editor and publisher), Washington DC. This book is readily available in medical bookstores in Auckland, and elsewhere.

There are other books and journals available which deal specifically with the question of disability within the meaning of the Act. It might help to contact your library, or bookshop. If you think we could be of help, please feel free to also ring us, phone 09-815 5150, (Mason Clinic), or 09-8497 789 (administration, management).

Pre-disability hearing
It is probably in the best interests of all parties concerned if any form of concern by anyone re the mental health of the alleged offender is (in the appropriate form) brought to the notice of someone who is deemed to be able to assist. This is a somewhat long-winded sentence, but it tries to wind its way through a number of important issues including confidentiality, freedom of information, and civil rights, just to name a few. It also takes
into account policies, and procedures (of the police, and others) of how to deal with alleged offenders. These matters frequently become clinically very relevant, especially if early statements and video-interviews done at the time, retrospectively raise the question of disability. At this stage, i.e., right after the material time of the alleged events, the distinction between "insanity" and "disability" becomes quite foggy: "insanity" relates to the mental state at the time of the alleged offence, while "disability" relates to the mental state at the time of the hearing.

In my experience the police in Auckland have, in many if not most cases I later became involved with, been very interested to address the mental health of the alleged offender very early by contacting our court liaison staff in the various courts in Auckland, as well as other psychiatric services during and after hours, and weekends. Dropping charges, considering compulsory treatment orders, or other strategies appear sometimes appropriate to save the particular alleged and mentally unwell offender from going through the usual court procedure.

On other occasions, our court liaison service, both prior to and during the procedure itself will be in the position of trying to assist the alleged offender, as well as counsel and prosecution. The emphasis is on liaison, facilitating assessments, contacts, and preliminary opinions of how best to proceed from a court liaison/forensic psychiatry point of view. The important point is that court liaison is contacted, be that in person, by phone, fax or locator in the various courts. This includes occasions like court cases on Saturday mornings, and on selected days during statutory holidays (etc).

In my current role as psychiatrist in charge of the acute admission and remand unit called Kauri of the Mason Clinic, I screen, in discussion with court liaison, certifying medical practitioner, and often counsel, virtually all remand referrals for inpatient assessment pursuant to s 121(2)(b)(ii) CJA prior to actually coming in to the Mason Clinic. This is basically a daily exercise, and demand on our beds for seven male, and four female remandees virtually always outstrips supply. It often then becomes a clinical and medico-legal, and often political judgement between the competing demands of the general mental health system, the prisons and the courts. Be that as it may, sometimes you might find that not everyone to be assessed re disability needs to be in a hospital setting at least in the first instance. Nevertheless, I do recommend in the context of this seminar, that anybody to be considered re disability should ideally be assessed in hospital to exclude possible underlying psychiatric, neurological and other medical conditions which could conceivably contribute to a disturbed mental state. I am particularly worried about some of the effects of non prescribed and illicit drug abuse which can mimic a range of psychiatric and other conditions, and in fact can cause potentially dangerous medical emergencies. I also note that the potential for suicide during confusional states is often difficult to assess.

The above implies that disability can be a temporary state, can be fluctuating depending on the alleged offender's mental state, and does not necessarily require treatment in hospital. Language problems, cultural and ethical difficulties, a "poor fit" between counsel and the alleged offender is often equally important when it comes to assess matters like muteness, amnesia, "confusion", and malingering, to name a few of the more
common difficulties counsel will sometimes face. This is where inpatient assessment pursuant to s 121(2)(b)(ii) CJA becomes relevant.

I will deliberately bypass the legal requirements pursuant to s 121 CJA and concentrate on clinical matters relating to the inpatient assessment. Our extensive investigations concentrate on all of the requirements of s 121(2)(b)(ii) CJA, disability being one of them. You will thus in our inpatient court reports find comments which address the “wider picture”, including comments on mental disorder (MHA), psychiatric disorder/illness (DSM IV), disability (CJA), insanity (Crimes Act), prognosis, dangerousness, and disposition (in the form of recommendation). I mention this here because a later legal finding of disability in my opinion also needs to be seen in the context of its possible consequences, and in relation to other options regarding s 115(1)(a) CJA, s 115(2) CJA, or the compulsory treatment orders. If, for example, an order pursuant to s 115(1)(a) CJA (as “special patient”) is made, then the charges can be resurrected by the prosecution at a later time. At that time issues re insanity (or imprisonment) might become relevant, which the patient might not necessarily see as a reward for getting well, and then getting tried again. Some of our patients have over the years acquired their own “expert” knowledge through their own experience, and often prefer to malinger “not mentally disordered”, in order to gain a finite prison sentence rather than a possibly extended or maybe infinite time of attention by various mental health services. The “soft option” of a “psych ticket” as sometimes in the past, is not necessarily the preferred option any more. This is one more reason why good liaison between counsel, police/prosecution and staff of forensic psychiatry services will go a long way towards evaluating the most appropriate way to assist individuals before the courts, who are deemed to suffer from a mental disorder to such an extent that they are judged to be under disability within the meaning of the Act.

The hearing

The legal requirements for the actual procedure are as per s 111 CJA. Two medical practitioners are required to provide an opinion in regard to disability, and the judge makes the final decision. This is where many psychiatrists see some irony in the fact that legal representatives are required to make findings concerning mental disorder or not, or being insane ie, the law-makers seemingly want the law to decide on medical matters, for example, who is mentally disordered. In contrast, most psychiatrists in my experience would probably think that their many years of training had something to do with assessing and deciding who might be mentally disordered or not.

Many questions remain to be decided prior to the actual hearing. Much has been discussed during the seminar March 31, 1995, and by others in this booklet. I refer to various interpretations of the criteria of being mentally disordered as per MHA, and the poor fit of this with current psychiatric classifications of mental disorders (DSM IV). Nevertheless, psychiatrists are required to offer an opinion on the extent of the mental disorder. This will hopefully be an occasion to clarify that not every mentally/psychiatrically disturbed individual/patient is necessarily under disability when seen in court.

It might also clarify the fact that psychiatrists often find it difficult to comment on whether the alleged offender is in a position to adequately communicate with counsel -
psychiatrists usually will want to comment if the defendant is in their opinion able to adequately communicate with them, ie, the interviewing and assessing psychiatrist.

Differences in outcome concerning s 115(1)(a) CJA, and s 115(2) CJA have been discussed by others before. Other options are also available, and will be discussed later in this booklet.

During all of the hearing, clinicians are well aware that the often adversarial nature of the hearing can destroy the frequently already tenuous therapeutic alliance between the assessing, and supposedly soon treating doctor giving evidence, and the remandee, soon presumably to be his/her patient. It is not necessarily a forte of paranoid patient, for example, to forget their doctor’s comment about their abnormal state of mind, their bizarre delusions and behaviour, and their real/perceived danger to others. Counsel might also remember that what counsel says is not necessarily what their client hears. The discussion of dangerousness in court in front of the often angry remandee/patient sometimes later develops into many new aspects for the life of medical and legal (as well as other) individuals involved with a certain group of litigious remandees/patients in court. Again, good liaison with all parties involved can address many potential difficulties cognizant of legal considerations protecting the rights of the individual/accused. This also applies to the actual handing over to the remandee, of the actual report pursuant to s 122 CJA. Our service deals with more than 12 (male and female) stalkers with a history of a minimum of at least five years potentially dangerous compulsive following of others. Some have, and some will, in the future, most likely resort to serious violent acts towards others. Please liaise with us when your client’s jealousy has propelled him/her to paranoid beliefs/behaviour. He/she might be somewhat irrational in his/her discussion with counsel, and disability might look at first sight to be the only issue. Nevertheless, often more is at stake, including the safety and well-being of medical and legal staff professionally involved with the remandee.

It is also advisable that comprehensive notes are kept by all parties involved. This is not thought to be a wise comment, but in view of the right of appeal pursuant to s 112 CJA against the finding of being mentally disordered, and disability, the question of bail could arise. Responsible handling of frequently complicated matters is often only possible if one can fall back on detailed notes, which have the potential to be acceptable to the court.

Post-script

Trying to assist many mentally disordered/psychiatrically ill alleged offenders during their way through the various remand stages can be like dancing on a moving carpet in the dark. During the hearing, medical terminology is often out of step with legal jargon. During the sentencing stage (or equivalent), the court is sometimes forced by the reality of the current non-availability of services for specific sub-groups of offenders, to think creatively. Individuals with an intellectual disability (or handicap or mental retardation) are one group of individuals who have caused some considerable concern to psychiatric services and the law. Nevertheless, the moving carpet is seemingly turning magic, and special facilities, and legislation might be available soon. This augurs well for the future, as does the ongoing dialogue (despite all philosophical, political and other differences) between the various levels and individuals of law and health providers.
Disability and Dispositional Issues: a Legal Perspective

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Introduction

The question of the appropriate disposition for offenders found to be under disability in terms of s 108 Criminal Justice Act 1985 is currently one of the most difficult medico-legal issues facing professionals in the criminal justice system. The importance of the under disability (fitness to plead) doctrine has been well rehearsed in other contexts. While the fitness rules themselves have a long history in New Zealand criminal law, the issue of fitness to plead has, until relatively recently, seldom been the subject of litigation in this country. The present "crisis" in this area of practice arises directly from the recasting of the definition of "mentally disordered" in the Mental Health (Compulsory Assessment and Treatment) Act 1992. It is also compounded by a lack of suitable facilities for the containment and management of certain classes of "under disability" offenders with special needs. Notable amongst these are offenders with an intellectual disability.

The purpose of this paper will be to focus on the dispositional options which are currently available to the courts under the Criminal Justice Act 1985 and to consider their appropriateness in relation to persons found to be under disability. I will attempt to demonstrate that the rapidly changing landscape in the area of disabilities and human rights law also impacts on practical questions of disposition, and adds to the complexity of the issues that must be addressed in particular cases. It is an area, I would suggest, where urgent reforms are needed.

Meaning of disposition

The word "disposition" is not used in relevant legislation in New Zealand. While in its generic sense it may be taken to include sentencing, it has acquired a more specialized meaning, signifying the manner in which an offender is dealt with by a court following a specific finding that the offender is mentally disordered, legally insane or otherwise unfit to be tried or sentenced. It follows that an offender may be subject to disposition who has not been convicted of an offence or has been found to be not criminally responsible on account of insanity. Equally the question of disposition may be relevant to an offender who has been tried and convicted but who, because of the supervening presence of mental disorder, is not fit to be sentenced according to conventional principles. Disposition in New Zealand generally signifies the activation of a specific therapeutic process aimed at the treatment and/or containment of the offender. It is unconcerned with formal sentenc-
Fitness to Plead

...ing aims in that its concerns are not with the punishment but rather the treatment and detention of mentally disordered offenders. We might say that disposition represents a distinctive “specialist” response to specific challenges presented by mental disorder in the course of the trial process. Its concerns are, as such, much narrower than those of sentencing.

Disposition and human rights

An aspect of the changing landscape in this area of practice concerns the impact of human rights upon mental health law generally. The significance of such international human rights documents as the International Covenant on Civil and Political Rights and the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care cannot be ignored in their application to the practice of forensic psychiatry. Increasingly relevant local legislation is being subjected to the scrutiny of international standards which articulate the optimum standards of treatment and management for persons with mental illness. Furthermore, the implications of the New Zealand Bill of Rights Act 1990 are increasingly being worked out in this area, particularly as regards the right to a fair trial, and minimum standards of due process. Although the connection has been slow in developing, it is now clear that these external standards are as relevant to the practice of forensic psychiatry as to other areas of mental health. The New Zealand Law Commission has recently confirmed the relevance of international standards in the context of disability in its recent report on Community Safety. The consequences of these developments have only begun to be felt and have yet to be fully explored. However, it is clear from recent decisions like Police v XYZ, R v T, In Re S, and In Re M that judges are aware of the importance of giving expression to relevant human rights where mentally disordered and intellectually disabled offenders are concerned and have expressed concern that effective remedies ought to be provided when those rights are breached. Relevant human rights are by no means exclusively concerned with the need to achieve procedural fairness, which is at the heart of the doctrine of fitness to plead. Other relevant rights include the right to refuse medical treatment and the right to freedom from cruel and unusual treatment or punishment. The latter right might be a relevant consideration where, for example, a severely intellectually disabled offender is sentenced to imprisonment in a penal environment that makes no particular provision for inmates with special needs.

Other areas in which human rights concerns might be expected to have an impact in future

3 The processes for the implementation of international standards into domestic law are usefully considered in Mulgan, “Implementing International Human Rights norms in the Domestic Context: The Role of a National Institution” (1993) 5 Canterbury L R 235.
6 [1993] DCR 600.
“fitness” litigation include pre-hearing psychiatric and psychological evaluations in association with the right to refuse treatment, and “dangerousness” assessments in the determination of whether or not to make a special patient order. There is, above all, a need for vigilance to ensure that offenders are afforded the full range of relevant human rights to which they are entitled and that relevant procedures are apt to secure such rights.

Relevant legislation

The principal statutory provisions governing disposition in New Zealand are contained in s 115 of the Criminal Justice Act 1985. Disposition is also, arguably, a relevant concept in relation to hospital orders provided for in s 118 Criminal Justice Act 1985. However, hospital orders are distinguished from other forms of disposition in that they require the conviction of the offender as a precondition and represent a “benevolent alternative” to a custodial sentence.9 In this context the issue is not procedural protection as such, rather the need to ensure that convicted offenders who are mentally disordered are dealt with humanely. By contrast the disposition options in s 115 Criminal Justice Act 1985 require neither conviction nor eligibility for imprisonment as preconditions for their utilization. The terms of s 115 have recently been modified by statutory amendment effected by the Mental Health (Compulsory Assessment and Treatment) Act 1992.10 These amendments ensure that normal mental health law principles apply once a change in status to “patient” has occurred. Because the provisions in s 115 are part of a statutory code11 a judge does not have the freedom to consider any disposition possibility not expressly provided for in the statute. However, there may be nothing to prevent a judge from ordering a stay of proceedings in an appropriate case. This was the course undertaken in Police v XYZ12 for the purpose of ensuring that an offender who was functionally unfit to stand trial though not legally under disability was not forced to undergo a trial which he would have been unable to meaningfully participate in. While the powers that are given, including the power to discharge, are sufficiently broad to cover most cases, recent experience has shown that some categories of offender patients present very special difficulties which the present legislation has been unable to adequately address. To the extent that the statutory dispositions give rise to duties under the Mental Health Act, high degree of care must always be exercised to ensure that the facts of individual cases are within the strict boundaries which the statute defines.13 This interpretative approach is necessary to ensure that there is no peremptory or indiscriminate interference with personal freedom arising from the exercise of the statutory options.14

Section 115 provides four disposition options:

1) An order that the person be detained as a special patient (s 115(1)(a)).

2) An order that the person be detained as a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (s 115(2)(a)).

10  The relevant amendments are contained in the Fourth Schedule to the Act.
11  R v Mason [1987] 2 NZLR 249.
14  Ibid.
3) An order that the person be immediately released (s 115(2)(b)).

4) Make no order at all where the person is liable to be detained under a custodial sentence (s 115(2)(c)).

While detention as a special patient is mandated as the normative disposition for any person found under disability or acquitted on account of insanity, the statute permits the discretionary use of the options of immediate release or detention as a patient where it would be safe in the interests of the public to do so (s 115(2)). In general, judges are reluctant to impose special patient status because of its indeterminate character and the difficulties for an offender in securing reclassification. However, in cases involving very grave offences it has been held to be irresponsible to suggest that any option other than special patient status is an appropriate disposition.\(^\text{15}\) In any case where the court considers an option other than special patient status, psychiatric evaluation of dangerousness is an essential precondition. While this is a formal statutory requirement, there is currently no requirement that the psychiatric evaluation be presented as evidence at a formal hearing to assess dangerousness. However, considering the grave consequences for a defendant of a special patient order and the relative unreliability of dangerousness assessments, it may now be timely for the legislature to consider recasting the dangerousness assessment as a formal adversarial hearing, analogous to a disability hearing. This would enable defendants to challenge the assessments of clinicians through cross-examination and to adduce their own evidence on the issue of danger to the public.

The fourth option will not be further considered in this context.

**Special patient status (s 115(1))**

In New Zealand the phrase “special patient” is statutorily defined (see Mental Health (Compulsory Assessment and Treatment) Act 1992 s 2). It is not a diagnostic category. It describes a range of offenders who have been made subject to therapeutic intervention at different stages of the prosecution process. It may include persons who have been found to be under disability or legally insane but also includes offenders who have been transferred to a hospital while serving a custodial sentence pursuant to the provisions of Part IV Mental Health (Compulsory Assessment and Treatment) Act 1992. In the present context special patient signifies that the offender is under disability but not conclusively ineligible for trial. Section 116 of the Criminal Justice Act 1985 prescribes the maximum period that an offender may be detained as a special patient before either being brought back to court for trial or reclassified to “patient” status. Detention under s 116(1) should be for as short a period as is necessary to determine the offender’s ability to stand trial.\(^\text{16}\) Furthermore, there is nothing to prevent a Court ordering a defendant’s return to court after a stated period in order to assess his current mental status and to order, if necessary, his return for trial.\(^\text{17}\)

\(^\text{15}\) *R v GH* [1977] 1 NZLR 50. The case involved a multiple homicide. The patient was said to have fully recovered from his illness at the time of disposition and was not thought to represent a danger to the public.

\(^\text{16}\) *R v Carrel* [1992] 1 NZLR 760.

\(^\text{17}\) Ibid, 768.
In the statute it seems reasonably clear that special patient status is separate and distinct from detention as a patient under s 115(2). However, there does appear to be some judicial uncertainty or confusion on this point. In R v S (No 1)\textsuperscript{18} where the court had to consider the disposition options in s 115 in relation to an offender who had suffered a stroke subsequent to the offence being committed, Heron J appears to conflate the "special patient" and "patient" options into a single category or, alternatively, to overlook the possibility of detention as a patient under s 115(2)(a). In any event the court proceeded on the basis that there is only one hospital-based option pertinent to s 115, in respect of which the descriptions "special patient" and "patient" appear to be used interchangeably. The same analysis is repeated in a later decision involving the same defendant.\textsuperscript{19} This would seem to be a misreading of the statute, but should not be taken to imply that there is only one category of patient status for dispositional purposes.

As a matter of law it is not clear when the making of a special patient order is appropriate. However, it has been held that in making any order under s 115 the starting point is detention as a special patient and that this is only to be departed from in certain circumstances.\textsuperscript{20} Nevertheless, special patient status may be inappropriate for certain classes of offenders, notably the intellectually disabled who may not be assisted by conventional psychiatric treatment and whose psycho-social needs are more apposite to a 24 hour supervised setting.\textsuperscript{21} It must be remembered that special patient status is an indeterminate disposition and subject to political control. In my submission it should never be used unless it is clearly established, by evidence if necessary, that it is the \textit{least restrictive} means of intervention available to achieve the ends of public protection.

**Detention as a patient under the Mental Health Act**

In reality a "committal" order under s 115(2)(a) opens up two quite distinct disposition options. A person may be detained pursuant to an inpatient order or as an outpatient. As regards the prior decision whether to order the person’s detention as a "patient" or to immediately release him or her, there are at present no statutory guidelines. The matter is entirely in the discretion of the sentencing judge. However, if it is conceded that the principal justification for committal will normally be to ensure that the person receives treatment for an extant mental disorder, it could be argued that committal will be inappropriate where, at the time the order is made, the offender is not suffering from a psychiatric illness or disorder within the meaning of the generally accepted psychiatric classifications. This rationale may be of great significance when considering how to deal with an intellectually disabled offender who has been found unfit to plead or legally insane. There is some authority for the view that if the form of disability suffered by the offender is not of a type that would justify detention in a mental hospital and the person does not represent a danger to the public in the wider sense, then it may be appropriate

\textsuperscript{18} (1991) 7 CRNZ 186, 187.
\textsuperscript{19} See R v S (No 2) (1991) 7 CRNZ 576, 579.
\textsuperscript{20} R v T [1993] DCR 600, 10 FRNZ 195.
\textsuperscript{21} Police v M (No 2) [1994] DCR 388. An offender "under disability" detained as a special patient would normally be detained in a Regional Secure Unit. A widely held perception is that such environments pose serious risks for intellectually disabled offenders and that such placements are generally against the interests of the patient.
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to order the person's immediate release.22 In any event it may be doubted whether inpatient detention can be justified in order to put in place "safeguards" or for the purposes of achieving supervision, as has been held in two recent cases.23 The principal difficulty with such an approach is that the Mental Health (Compulsory Assessment and Treatment) Act 1992 is an Act concerned with compulsory assessment and treatment. Any detention under that Act for purposes other than treatment would, arguably, be unrelated to the purpose of the legislation and could be impugned as being arbitrary and in breach of s 22 of the New Zealand Bill of Rights Act 1990. Again, the principle of the least restrictive alternative is relevant here. No person should be detained ostensibly for treatment under compulsory procedures where there is no prospect of treatment being given. The court must endeavour to achieve a dispositional solution consistent with the offender's actual needs which involves the least intrusion upon individual liberties necessary to achieve any relevant public interest goals. While public safety will often be a relevant consideration in such cases, it is not an exclusive concern. Other considerations including enhancing patient autonomy and self-determination are also relevant and may need to be weighed with other competing policy interests.

Outpatient detention

In the first instance where an order is made pursuant to s 115(2)(a) it is deemed to be a compulsory treatment order. On the making of the order the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 "apply accordingly" (Criminal Justice Act 1985 s 115(4A)). It has been held that the fact that s 115(2)(a) specifies that the offender be "detained in a hospital" does not necessarily mean that in every case where that disposition option is employed a person must be received and held in a hospital. In Police v M (No 2)24 Judge Boshier held that there is nothing in the statute to suggest that any such order must be treated as an inpatient order and that the omission of the word inpatient from subs 4A must be interpreted as deliberate.25

The Mental Health Act specifies that in making a compulsory treatment order the Court shall make a community treatment (outpatient) order unless it considers the patient cannot be treated adequately as an outpatient (s 28(2)). However, while the thrust of the legislation is in favour of treatment in the community, it would seem that a court cannot make a community treatment order unless it is sufficiently satisfied that services for care and treatment on an outpatient basis appropriate to the needs of the patient are available and that the social circumstances of the patient are adequate for his or her care in the community (s 28(4) Mental Health (Compulsory Assessment and Treatment) Act 1992). It will not be enough that the Court is satisfied in general terms that the patient is well enough to manage in the community.26 It has been held that the words used in s 28(4)(a) cannot be read as implying an obligation upon service providers to ensure that such services are in existence and available. Rather, they require the court to investigate the resources which are available to support a patient in the community, and to investigate the ability of the service to provide those resources.

Immediate discharge

This disposition option will be appropriate where the court is satisfied that the release of the offender will not pose a danger to the public and the offender is unlikely to benefit from any form of treatment or detention. Immediate release would be appropriate where, for example, a finding of disability has been made in relation to a relatively minor charge, since there is no presumption that persons under disability who are an occasional nuisance must be dealt with under either the Criminal Justice or Mental Health regimes.  

A difficulty with this option as it presently stands is that the legislation does not specifically authorize that any such release may be subject to conditions imposed by the court. It is doubtful whether a judge exercising his or her discretion pursuant to the section would be lawfully authorized to impose conditions in the absence of clear statutory authority. However, such a power could make discharge a more attractive option in cases where the offending is minor, there are no clear advantages in committal, but the court is reluctant to authorize the offender’s release into the community without some official oversight. This aspect could well benefit from consideration as a possible area of law reform.

Appeal against a disposition order

Current New Zealand law makes provision for appeals against a finding of disability and against acquittal on account of insanity (Criminal Justice Act 1985, ss 112, 114). An appeal against a finding of disability gives the same right of appeal to the defendant as if the finding were a conviction and is conducted as a rehearing of the issue. An appeal against acquittal on account of insanity is also conducted as if it were an appeal against conviction and will enable any ground of defence to be reconsidered which would have given an outright acquittal. However, while these general rights of appeal exist in respect of specific findings of disability and insanity, there is no jurisdiction for a court to reconsider a disposition order under s 115 by way of general appeal. In Howard v Police the appellant sought to appeal the decision of the District Court Judge whereby he was made subject to an order for detention as a special patient under s 115(2) following a finding of disability, seeking to argue instead that his committal should have been pursuant to s 115(2)(a) as a committed patient. He proposed to argue that the District Court Judge erred in law in making an order under s 115(1)(a) in that he did not apply the correct legal test and took into account irrelevant matters.

In resolving the issue of jurisdiction, Williams J first noted that s 115(1) of the Summary Proceedings Act 1957 requires as a precondition to any general appeal that there must have been a “determination ... of [an] information.” His Honour noted the Crown’s objection that because there had been no such determination there could be no appeal, a proposition which, in the event, derived support from the observations of Tipping J in I v Police where his Honour said:

29 Above.
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... [I]f a person is ordered to be detained as a special patient there is capacity for the proceedings against him to revive in certain circumstances. That presupposes that the information is still alive and it can hardly be regarded as determined... Also to be noted is s 112 of the Criminal Justice Act which gives a right of appeal against a finding of disability, equating that with a conviction. But there is no right of appeal against an order for disposition, as opposed to an order making a finding of under disability, and it may well be that Parliament has deliberately omitted a right of appeal in the latter context, not equating it with a sentence.

Williams J agreed with the observations of Tipping J but was concerned, as was Tipping J, with what appeared to be a gap in the legislation whereby a general appeal can lie against a finding of disability but not against a subsequent order for disposition. This, the Court held, was anomalous and required a defendant seeking to challenge the basis of a disposition order to go through the "cumbersome" (and costly) procedure of judicial review. Williams J concluded that there was no reason in principle why there should not be a right of general appeal against a disposition decision, given the liberty interests of individuals in such cases, and recommended that the issue be considered as a matter of possible law reform.

Reform

I intimated at the outset of this paper that this is an area of the criminal law that is ripe for reform. In another context I have argued that the time may have come to give consideration to the desirability of establishing a separate code dealing with issues of disposition and sentencing for mentally disordered and intellectually disabled offenders. My view is that such a code would be helpful in defining areas of current uncertainty and would provide guidance for professionals dealing with the relative complexities of this area of law and practice. However, this is not the only area where reform is desirable. The existing disposition options are inadequate to deal with the special problems presented by certain offender groups, in particular, the intellectually disabled. The present options hail from a time when orthodox practice made no distinction between the intellectually disabled and the mentally disordered for the purposes of management and treatment. The intellectually disabled were dealt with for practical purposes as though they were mentally ill.

This thinking is no longer acceptable and fails to appreciate the fundamental changes in approach as regards the characterization and management of intellectual disability that has occurred in the last 20 years. For these reasons facilities for the containment of those with intellectual disability need to be tailored to their specific and distinctive needs and be better able to reflect changes in professional thinking.

Finally, the present incongruity between relevant criminal justice and mental health legislation needs to be resolved as a matter of urgency. It is unsatisfactory that the courts should be forced into strained interpretations of relevant legislative provisions in order to achieve procedural fairness. In this area, where defendants are especially vulnerable.

to being misunderstood and the possibility of arbitrary loss of liberty, it is especially important that the law should be clear and certain. For this reason I favour the Law Commission recommendation that the standard for disability in s 108 Criminal Justice Act 1985 should be redrawn to exclude mental disorder as a necessary pre-condition of a finding of disability. Such a minor legislative change would ensure that persons who were functionally under disability would not be excluded from the protection offered by fitness to plead procedures simply because their mental or intellectual condition failed to conform to the statutory definition of mental disorder. The fitness to plead rules should aim to maximize the procedural protections available to disabled persons and should not be seen to be working against that fundamental goal.
Institutional Concerns: a Psychiatrist’s Perspective

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“Fitness” is an important pre-trial issue. In spite of the importance of medical input it remains a legal concept and has several principal underpinnings:

1) That conviction or punishment of a mentally disordered person would not deter future criminal offending, and

2) That it is fundamentally unfair to try a mentally incompetent defendant.

The Court in *R v Dashwood* [1943] 1 K B 1 held that it is a cardinal principle of our law that no man can be tried for a crime unless he is in a position to defend himself, and that that includes his being in a mental condition to defend himself.

Terms such as mental condition, mental state, mental illness, mental disease, syndrome, are medical terms. Mental disorder is a legal term used in the Mental Health Act and in the Criminal Justice Act to define disability.

Legal disability is defined in s 108 CJA:

... a person is under disability if, because of the extent to which that person is mentally disordered, that person is unable

a) to plead,

b) to understand the nature or purpose of the proceedings, or

c) to communicate adequately with counsel for the purposes of conducting a defence.

From the above it is apparent that having a mental disorder is a necessary but not sufficient basis for a finding of “disability”. That is; many people have mental illness but only a small percentage of these will be found to be under (legal) disability.

A finding of disability can be made at any stage of the trial process (s 109). Generally, a disability hearing is only held after a person has been remanded for thorough assessment of his/her mental status and after advice is given to the court that that status will continue for an appreciable length of time. In the case of severe mental illness, which might respond to medicine, a further remand to a hospital may well see the remandee/patient improve and able to make a plea. So in general, those presenting for disability hearings are those with chronic, severe mental illness, and those who have intellectual disability, from birth or from other causes, such as head injury.

If a finding of disability is made (after a properly constituted hearing), several disposition options can be taken by the judge. These have been dealt with in detail by previous
speakers but I again raise the matter because of the problems sometimes associated with the disposition. Briefly:

In the matter of charges to minor offences, the judge may:

a) (s 115(2)(a)) “make an order that the person be detained in a hospital as a committed patient; or

b) (2)(b) make an order for that persons immediate release; or

c) (3)(c) decide not to make any order....”

The judge in making the order must be satisfied that it would “be safe in the interests of the public”. Public safety is important but in this context seems to be placed above the patient’s interests, and quite different to what clinicians are used to in the MHA when the primary motivation for committal is “assessment and treatment” with a threshold of dangerousness and ability for self-care stated in reference to the patient’s illness/disorder. Section 115(2)(a) CJA committals are in every respect treated as s 30 MHA committals.

Any order made pursuant to s 115(2) will be deemed to be the finish of the case (s115(5)), ie, the defendant cannot be brought back to court on the same charges. The ultimate disposition is now within the jurisdiction of the “responsible clinician” in charge of that individual’s assessment, care and treatment who now regards the patient to be committed under the equivalent of a Compulsory Treatment Order (ie, s 30 MHA) and who can exercise his/her discretion accordingly, including the discretion to discharge the patient from the Act. This can constitute a dilemma. Persons have been committed to a hospital, only to be discharged the following day by a clinician who may not have been familiar with the case and from a hospital institution which may have a different threshold of admission criteria from that held by the court as well as resource contraints necessitating priority admissions. You will also remember that the bias in the MHA is toward community committals. As stated above, many hospitals see their function as providing assessment and treatment for the mentally ill (as apposed to the mentally disordered). In the rush to dismantle the evils of the institutions, gaps have been left in the care of the chronically mentally disordered, who may be so, not because of illnesses but because of injuries, substance abuse or other causes.

In the case of serious charges, the court, upon the finding of disability, will make an order that the person be detained in a hospital as a “special patient” under the Mental Health Act 1992. Any order made pursuant to s 115(1) makes that person a special patient (ref part IV MHA 1992).

Special patients under s 115(1)(a) of the CJA Act are under strict control. They can only be permitted leave by the Director of Mental Health.

If they remain under disability then the “special patient” status continues for

a) “... seven years (from the date of making the order) in a case where any offence charged was punishable by imprisonment for life or preventative detention....”, or
b) A period, "... equal to half the maximum term of imprisonment to which the defendant was liable on conviction..." (s 116).

If the patient's mental status changes and they are deemed to be no longer under (legal) disability, notification is made to the Attorney-General who has the option (after consultation with the police) of:

1) bringing the defendant back to court for trial (s 116 2(a)) or
2) directing that the former special patient be held as a committed patient. (In this option, all charges are deemed to have been dealt with) (s 116(4)).

Disability is a legal issue determined by a judge.

As the definition suggests, there are legal criteria which must be met before a judge can make a determination.

In practical terms, a medical practitioner assesses the defendant who is remanded as an inpatient (usually) for the purpose of "determining a) if the defendant is under disability..." (s 121 CJA). Practically, the expertise of the medical practitioner is focused on whether or not the defendant has a mental disorder. Whether or not they can plead, or communicate is perhaps best determined by counsel. Often, those of us writing reports, raise a query about whether or not the defendant can communicate for the purposes of making a defence, and refer the ultimate decision to counsel as to whether or not they can take instructions.

The definition of legal disability given in s 108 is not helpful to the medical practitioner who has been requested to assist the court in the determination of the matter.

Smith J in R v Presser [1958] V R 45 outlined six criteria necessary for a person to have "ability":

1) He needs to be able to understand what it is that he is charged with.
2) He needs to be able to plead to the charge and exercise his right of challenge.
3) He needs to understand, generally, the nature of the proceedings, namely, that it is an inquiry as to whether he did what he is charged with.
4) He needs to be able to follow the course of the proceedings so as to understand what is going on in court in a general sense...
5) He needs to able to understand ... the substantial effect of any evidence that may be given against him and he need to be able to make his defence or answer to the charge.
6) Where he has counsel, he needs to able to do this through his counsel by giving any necessary instructions....

I would add one more to the list. That the defendant needs to know or understand the consequences of his plea.
The first and essential component in the assessment of disability is the determination of whether the defendant is "mentally disordered".

Definition:

Mental Disorder, in relation to any person, means an abnormal state of mind (whether of continuous or intermittent nature) characterized by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it;

a) poses a serious danger to the health or safety of that person or of others; or
b) seriously diminishes the capacity of that person to take care of himself or herself

Several problems arise in respect of this definition: It leaves some doubt about the disposition of those solely with intellectual disability, (who do not have additional mental illness) and who may not meet the definition of "mental disorder" but nevertheless cannot plead, understand or communicate. Not only is it highly contentious that an intellectually disabled person has a disorder of cognition (on the grounds that for them it is part of their normal state), but also because of the exclusion clause given in s 4 of the MHA which states;

The procedures by Part I and II of this Act shall not be invoked in respect of any person by reason only of;

...e) Intellectual Handicap.

This clearly means to a clinician that intellectual handicap of itself cannot be a mental disorder. That is, committal procedures under Part I and Part II of the Act cannot be enacted to commit such a person if all they present with is intellectual disability. However, those with sole intellectual disability, who offend and present to the court are dealt with under the CJA and Part IV of the MHA (titled "Special Patients and Restricted Patients"). Thus they can be committed, as these defendants fall outside the exclusion criterion of s 4 MHA 1992. While it is quite understandable for a judge, in the absence of any other option (in respect to an intellectually disabled individual who may exhibit dangerous behaviours), to commit the intellectually disabled person under the provisions of Parts II and IV of the Act, this only increases the dilemma for the clinician. Once the order is made, the committed person comes under the provisions of the MHA 1992, and, in the case of a 115(2)(a) committal, is treated like any other ordinary committed person and is subject to the definition of ss 2 and 4 and the review mechanism. As you have heard, the definition expressly excludes those with sole intellectual disability from the definition of mental disorder. Is it any wonder that the responsible clinician or the members of the Mental Health Review Tribunal, feel compelled to discharge the solely intellectually disabled from the Act? The temptation for judges to prevent this by committing the intellectually disabled, pursuant to s 115 (1)(a) thereby making them a "special patient" and immune to the interference of the Mental Health Review Tribunals, must be great and to date has not occurred, to my knowledge. Even in this scenario, a problem remains. After three months, the responsible clinician must review the special patient (s 77) and certify whether or not the patient remains under disability, or conversely whether the patient in his/her opinion is no longer under disability. This section (s 77) makes it explicit that the provisions of ss 2 and 4 (and others) "shall apply". This means that at review the clinician
is again faced with the dilemma: whether to strictly interpret the Act and state that the patient is no longer under disability, or whether to ignore the matter. In the former scenario, the certificates will go before the Attorney-General who will either redirect the case to court (when the same problems will arise) or who will order the patient committed pursuant to s 116(4) which brings the matter within the jurisdiction of the Responsible Clinician, who may well feel obliged to discharge the patient, on the grounds that continued committal is illegal, even though this may have disastrous consequences for the individual and for the community.

How did this problem arise? There are two dimensions, clinical and legislative:

The clinical notion that “intellectual disability” is subsumed under mental disorder is an old one. The MHA 1969 defined Mental Disorder in term of “Mental Illness, Mental Infirmity and Mental Handicap”. In the days of the mental “asylum”, all categories of disabled people were incarcerated together. Modern convention now regards the mentally ill, who need doctors and nurses for their assessment and treatment, quite differently from the intellectually disabled, who require psychologists, teachers and care-givers for their well being. It is well appreciated that the intellectually disabled can have co-existent mental illness. Hospitals in fact can be quite hostile environments for the intellectually disabled, particularly the forensic hospitals, which contain the angry, the predatory, the personality disordered, the very (mentally) ill, the drug addicted and others. The intellectually disabled learn maladaptive behaviours; they become double victims. In addition, their inappropriate presence in a hospital prevents the hospital being available for mentally ill persons, for which it was designed, and forces the hospital into providing a custodial role for a society which understandably is reluctant to see the intellectually disabled go to prison.

The legislative component to this dilemma is partly a lack of synchronicity between the MHA and the CJA, and partly an absence of legislation for those who may need it on occasions, namely the intellectually disabled. In regard to the former problem, the reference to “mental disorder” in s 108 CJA, could be deleted so that if a person is unable to plead, understand and/or communicate, whatever the reason (mental illness, intellectual disability, head injury), then the courts could deem that person to be under disability and make an appropriate disposition. Alternatively the words, “or intellectually disabled” could be added, in the s 108 definition. The individual would first be remanded, as at present, be assessed as to disability, and the cause of it. At the disability hearing, the most appropriate person to speak to the issue (viz, a doctor in the case of the mentally ill, and a psychologist in the case of the intellectually disabled), would do so, and additionally advise the court as to the most appropriate disposition.

The lack of legislation governing the intellectually disabled is contentious but has concerned the Mental Health Services and the Services for the Provision of the Intellectually Disabled since the introduction of the MHA 1992, when these service gaps and anomalies first became apparent. One of the issues in managing the intellectually disabled is their varying degree of incapacity. Generally speaking, the greater the incapacity (ie, the greater the disability), the less likely that individual is to be in a position to offend (because they are so dependent upon care-givers). Most of the intellectual
disabled who come before the courts are in the "borderline, mild and moderate" range of intellectual ability. The absurdity is that there is no adequate legislation for the few intellectually disabled persons whose predilection to fire setting, sexually inappropriate and maladaptive behaviours are well-known and who could be protected from offending behaviour by the application of legislation similar to the MHA. The provisions of the Protection of Personal and Property Rights Act 1988 do not appear to suffice but perhaps could be "beefed up". The current problem due to the absence of suitable legislation, is that those intellectually disabled persons who are "uncontrollable" remove themselves from care, sometimes offend, and come before the courts to enter the medical arena, solely due to the legislative muddle (the preserve of the law) and the lack of disposition options (the preserve of the health purchasers).

Are there any answers?

Yes. In regard to a suitable disposition for the intellectually disabled, the Spectrum Trust of SPIDS (a CHE provider service to the intellectually disabled) and the Regional Forensic Services, Auckland, have persuaded the purchasers of health (North Health), to fund a unique, community based, adequately resourced, 24 hourly staffed, secured home for this client group. For the first time, they will be managed in a IH specific environment by specialist care givers. Those with additional disorders including mental illness, will access the appropriate Mental Health Services. The safety issues will be addressed in consultation with the Regional Forensic Service. The service as of March 1995 is not yet up and running and there is much work to be done to ensure quality services to this client group and safety to the community at large.

In regard to the legislative issues, the above matters need tidying up and serious consideration given to legislation for the committal of the intellectually disabled before they offend and to enable their maintenance in an appropriate domicile, not necessarily in a hospital.

I have not addressed the Mental Health Amendment Act 1994, but comment that we as a nation came perilously close to having draconian law introduced, due in the main to pressure politics, lack of understanding of the effects that political and fiscal changes have on the Mental Health sector and because of lack of consultation.

I am grateful to be part of this seminar, and on behalf of Mental Health Service Providers, plead to be heard by the legal profession and the law-makers in these matters affecting the disposition and jurisdiction of the intellectually disabled.
Fitness to Plead: Prospects for Reform

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Introduction

Previous papers in this seminar have described in detail the problems of the current definition of unfit to plead, and have noted the problems of disposal for those individuals who are found under disability but who do not fit the Mental Health Act definition of "Mentally Disordered".

There is, quite naturally, an expectation that, having been identified, these problems will be rapidly "fixed" by government, and particularly by the Ministry of Health, which has responsibility for mental health legislation. In practice, a "quick fix" is not easy to make.

In this paper, I wish to outline and underline some of the problems which currently arise in this area, to raise some of the possible avenues of reform, and to outline the process of development of changes and what we are currently doing about it.

Four issues will be addressed:

1) The definition of unfit to plead.
2) Options for disposal, and in particular the development of appropriate legislation.
3) Interim options.
4) Development of appropriate services, particularly for those who are intellectually disabled.

Definition of unfit to plead/under disability

Previous speakers have described in detail, the problems arising from the current definition. Some of the difficulties related to the lack of detailed criteria, as outlined by Ian Freckleton. The most pressing problem currently before us is the difficulty caused by the inclusion of "mentally disordered" as a necessary criterion, and it is this problem which I intend to address.

It is clear that linking the definition of unfitness to plead to the current definition of mental disorder in the Mental Health (Compulsory Assessment and Treatment) Act 1992 is not appropriate.

One question which arises is—was it intended to make this link to exclude intellectually disabled individuals? The answer is probably not. It is significant that the exclusion of intellectual handicap as a reason for invoking the Mental Health Act, is linked to Part I and II of the Act, suggesting that it was intended that individuals with intellectual handicap could be included in the rest of the Act, including Part IV which refers to special patients.
The phrase "disorder of cognition" may be interpreted as including intellectual disability. This is disputed by many clinicians, but as we have already heard, the courts are quite clear that this covers the situation of an individual with intellectual disability so far as the definition of unfitness to plead is concerned.

There is a clear need to resolve this difficulty by broadening the criteria and removing the link to the definition of "mental disorder" in the Mental Health Act.

The Mental Health Act Amendment Bill, introduced in 1994, attempts to address this problem. In this Bill, the term "mentally disordered", in s 108 of the Criminal Justice Act, is replaced with "mentally impaired".

"Mental impairment" does not require the elements of dangerousness or diminished capacity for self care, and includes severe intellectual disability:

"Mentally impaired", in relation to any person, means suffering from:

a) an abnormal state of mind (whether of a continuous or intermittent nature), characterized by delusions, or by disorders of mood or perception or volition or cognition; or

b) a state of arrested or incomplete development of mind involving severe impairment of intelligence and social functioning.

This is certainly an improvement, but still leaves some gaps. The Law Commission\(^1\) have suggested that a better approach is to replace "mental disorder" in s 108 by "mental impairment", but to leave this latter term undefined. In the light of what has already been outlined in this seminar, this would seem to be a very reasonable suggestion as an interim measure to remove the more pressing current difficulties.

Whether any further amendment to s 108 is considered, will in part depend upon the fate of the Mental Health Act Amendment Bill, which is yet to be reported by to the House by Select Committee. It appears at this stage that the Bill, as it stands, is unlikely to proceed, so development of other alternatives should continue.

The Department of Justice have indicated their intention to review the provisions of Part VII of the Criminal Justice Act, which includes s 108. They, quite correctly, would like to consider any changes to Part VII of this Act as a coherent whole, rather than changes occurring piecemeal, but in view of the current difficulties of s 108, they would support an interim amendment to this section.

A comprehensive review of the whole of Part VII of the Criminal Justice Act will be complex. It will take considerable time to complete the necessary research and consultation involved to do the job properly. We look forward to working with our colleagues in the Justice Department on this.

**Disposition options**

There is little point in amending legislation to enable persons to be found under disability

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who are not “mentally disordered” if the options available for their disposal are only those for “mentally disordered” persons. It is clear that there is a need to provide an avenue, or avenues, of disposition for the intellectually disabled and others who may fall outside the definition of “mentally disordered”.

I am assuming, as touched on by previous speakers, that disability will be a finding only in those cases where the charge is a serious one—we are not talking of options for those who may be charged with trivial offences only.

There are essentially three options for disposition of those found under disability:

- An order under s 115(1) (a) of the Criminal Justice Act requiring detention as a special patient in a hospital.
- An order under s 115(2) making a compulsory treatment order under the Mental Health Act.
- Discharge.

Detention as a special patient is a very restrictive option, and should be ideally reserved for those individuals for whom any less restrictive option cannot be safely considered.

Discharge may be inappropriate—there is no ability to impose supervision, monitoring, education or any rehabilitation. It is of course entirely possible that an alternative mechanism, such as a personal order under the Protection of Personal and Property Rights Act 1988 could be used concurrently with the discharge, providing some degree of control. The PPPR Act 1988, however, does not appear to be able to supply the degree of control necessary to ensure safety in the case of some individuals who exhibit more dangerous behaviours.

A compulsory treatment order under the Mental Health Act has the advantage of being a potentially more flexible instrument, allowing for “treatment” to be provided in any setting which is appropriate for the individual. The problem is that this can only be used for those individuals who meet the criteria for “mental disorder”.

As has already been noted by previous speakers, problems have arisen in those cases where the court has found an individual with intellectual disability to be mentally disordered for the purpose of the disability hearing, only for the individual to be (quite properly) discharged from the compulsory treatment order by the Responsible Clinician, when the case is reviewed using the criteria set out in the Mental Health Act. Quite understandably, this causes frustration for both the Court and for the clinician involved, and runs the risk for the individual concerned that they may either be placed in a situation where they will offend again or that there may be no option but to impose an overly restrictive special patient order.

It appears, then, that there is a need for a fourth disposal option designed to meet the needs of those who are under disability but not mentally disordered, particularly those who are intellectually disabled. This option should be flexible in terms of placement of the individual, and must be focussed on the needs of the individual: education, rehabilitation, monitoring and safe management rather than detention.
This avenue is currently being looked at by the Ministry. We are calling the option a "compulsory care order", though it is important to note that this is not the same type of order as that proposed in the Mental Health Act Amendment Bill.

1 Possible compulsory care legislation

Any legislation in this area needs to fit coherently with other legislation covering the needs of those who are disabled or incompetent to make decisions about their own welfare. It seems inappropriate to develop specific legislation for the needs of a very small group—those under disability—without linking this to legislation to cover a wider group of people who may need some degree of restrictive care to safely manage risky or frankly dangerous behaviours.

This may be conceptualized as "layers of an onion":

The core group, those particularly the focus of our attention today, are those individuals who are charged with a serious offence, but who because of their disability are found unfit to plead.

The next layer out consists of those individuals who as a result of their disability, exhibit behaviour which is clearly and demonstrably dangerous, but who have not necessarily been charged with an offence. This may be a small group, but a group which causes considerable problems. The next layer are those who, because of their disability, are not able to make decisions about their own care, but who need some degree of restriction because of risk, usually to themselves.
The outer layer consists of individuals who lack competence as a result of their disability, but who do not pose a risk or require any restriction.

The needs of the outer 2 layers are largely met by the provisions of the PPPR Act.

The core group clearly need some new provision. The inner layer, those who exhibit dangerous behaviours, are the most difficult group, both to define, and to provide for. It seems most logical that compulsory care legislation should be aimed primarily at the core group and the inner layer, but should be developed in a way which interfaces with the PPPR Act as well as the Criminal Justice Act. It is important that the legislation umbrella is coherent, consistent and comprehensive.

This proposal raises a number of questions:

• How wide should the scope for this legislation be?
• How can we define the “dangerous” few so that the provision remains focussed on those who require such care and not broadened to impose unnecessary labels or restrictions on those who do not?
• How can we dovetail the legislation with existing legislation, especially the PPPR Act?
• What range of conditions should be included? Intellectual disability and head injury should be included but what about the elderly, the medically frail or the profoundly deaf?—all conditions which may lead to any individual being unfit to face charges in a court of law?
• Some commentators have suggested that development of new legislation is unnecessary—that the provisions of the PPPR Act can be applied and are sufficient. While this Act as it stands lacks the power to deal with the more difficult individuals who may be in our two inner groups, there may well be merit in considering whether expanded powers of the PPPR Act may be an alternative to new legislation.

Whatever the final format, it is clear that legislation for this group should be firmly focussed on rehabilitation, education and therapeutic needs, and should allow the least restrictive alternative compatible with safe management.

The Ministry of Health is currently in the process of examining the options for compulsory care, though it does appear that meetings to date have produced more questions than answers.

2 Possible format

One possible format for compulsory care is to follow a similar pattern to compulsory treatment under the Mental Health Act, including a similar system of rights and reviews.

Input to a compulsory care order could be via a finding of disability under s 115 of the Criminal Justice Act, following a conviction (similar to s 118 of the Mental Health Act) or possibly via a direct application to the court on the grounds of a high probability of dangerous behaviour likely to result in a serious offence.
The aim would be to enable safe, therapeutic management to be given to a disabled person to avoid the over-restrictive option of hospitalization as a special patient, or inappropriate placement in a penal institution.

**Temporary options**

1) **Definition of under disability**

   Amendments to the Mental Health Act, which are expected to include an amendment to s 108 of the Criminal Justice Act as outlined earlier in this paper, are expected to be introduced to Parliament later in this year, and may be enacted and operational by early next year at the soonest.

2) **Disposition options**

   Development of Compulsory Care legislation will take longer to develop, because of the difficulty of firstly determining the scope, and secondly of drawing up a framework which is workable and comprehensive—a time frame of two years would be an optimistic estimate.

   In the interim, what do we do about the small but important group who do not fit into the existing framework?

   One option may be to introduce a “quick and dirty”, time-limited provision to “plug” the current gap. One possibility that has been suggested is to amend the exclusion criteria in s 4(e) of the Mental Health Act so that those individuals found under disability as a result of intellectual handicap are removed from the exclusion. This would allow such individuals to be placed on a compulsory treatment order, allowing a more flexible set of management options.

   The problems with this are self evident:

   - The definition could be seen as “arbitrary”.
   - The distinction between intellectual disability and mental illness is blurred, a backward step both clinically and philosophically.
   - There is a risk that a “time limited” interim provision could become a more permanent provision.

   The advantage would be to allow a less restrictive option than the detention in hospital as a special patient, which may be the only option at present available for safe containment of an individual whose behaviour poses a significant risk to the community.

   It is difficult to see other workable interim solutions. Suggestions would be most welcome! In the meantime, we must struggle on with the law as it stands.

**Service provision**

The traditional option for the detention of the person found unfit to plead, was the psychiatric hospital. While detention and treatment in hospital may well be appropriate for someone who is clearly mentally disordered, long term incarceration in a mental hospital for an intellectually disabled individual is inappropriate and potentially damaging.
Previous speakers have referred to the change in attitude and service provision for intellectually disabled people, separating the needs of this group from those who are mentally ill.

For those intellectually disabled individuals who are charged with, or convicted of a serious offence, or certain individuals who pose a danger as a result of their behaviour, a more flexible range of services is required.

Such services range from community supervision, through specialized education and habilitation programmes, special living and residential services, to secure facilities with intensive skilled staffing.

Emphasis in all services should be on the programme provided, including skilled staff input for monitoring and oversight, education, habilitation, behavioural and other therapeutic management, rather than detention per se.

It is necessary for services and legislation to develop in parallel. There is little point, for example, in developing a programme in the community for intellectually disabled individuals who are found unfit to plead if the only disposition option available is a special patient order.

In the interim, hospital based services should develop programmes and facilities to meet the needs of this group, and should ensure that intellectually disabled and brain-injured patients are managed and treated in specialized programmes, rather than in units provided for treatment of those with mental illness, including secure forensic psychiatric units.

Such services will require the expertise of both disability services and forensic psychiatry. Whether they are operated as a specialized area of forensic services with disability service input, or as a disability service with forensic input is debateable. It would seem most appropriate for the latter, though the most essential feature is to ensure both sides of the needs are met.

As Dr Chaplow has noted, there are already innovative local initiatives occurring to address these matters.

The Ministry of Health will be working with RHAs to ensure that appropriate services are defined and purchased to meet the needs of this group.

Further research is needed to define the extent of need for services.

Conclusions

In this paper, I have tried to outline the problems arising from the present provisions, to discuss some of the possible solutions, and outline the processes being taken to develop options for legislation and services.

The problems, some of which were created by the change in mental health legislation in the 1992 Act, and some of which are of longer standing, need to be tackled in a coordinated, coherent manner, rather than by piecemeal changes in legislation.

This is a process that will take a long time to develop.
In the meantime, we need to consider carefully whether the problems we face are so severe, and so urgent, that some “dirty” short term changes are needed, or whether we can afford to utilize the present legislation unchanged while the process of development proceeds.

In the meantime, consultation will be undertaken, and helpful suggestions are more than welcome.