HOMICIDE AND INTELLECTUALLY DISABLED OFFENDERS

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THE ISSUES WHICH PERTAIN GENERALLY TO PERSONS ACCUSED OF MURDER but who may be suffering from a mental abnormality also pertain to the intellectually disabled accused. These issues include whether or not the person is entitled to a defence of insanity, or the defence of diminished responsibility—available in New South Wales, Queensland and the Northern Territory (Hayes 1991, pp. 145–57). The issues are complicated in the case of the intellectually disabled accused by the fact that the accused may be dually diagnosed, that is, in addition to the intellectual disability (which in itself may make a particular defence available) there may be a concomitant diagnosis of mental illness or behavioural disturbance.

Although the terminology 'insanity defence' or 'defence of mental illness' may be offensive to the person with the intellectual disability and his or her advocates, provided the disability affects the person in such a way that the elements of the *M'Naghten* Rules (1843 10 Clark and Fin.200:8 ER 718; per Lord Chief Justice Tindall at 722) are satisfied, this defence is available. The *M'Naghten* Rules state that:

> To establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, so as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.

In particular, the issues as identified by Ierace (1988) are whether intellectual disability could result in a defect of reason to the extent that the person did not know the nature and quality of the act he was doing or if he did know it, that he did not know he was doing what was wrong; and whether intellectual disability is a 'disease of the mind' for the purposes of the *M'Naghten* Rules. Ierace examines the cases which establish that this defence is open to the intellectually disabled accused, irrespective of the presence of psychiatric abnormality.

An example of the defence of diminished responsibility is that which is stated in Section 23A of the New South Wales *Crimes Act 1900* which states that:

> Where, on the trial of a person for murder, it appears that at the time of the acts or omissions causing the death charged the person was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for the acts or omissions, he shall not be convicted of murder.

In *R v. Byrne*, Lord Parker CJ, distinguished the term 'abnormality of mind' from the *M'Naghten* Rules thus:

> 'Abnormality of mind', which has to be contrasted with the time-honoured expression in the *M'Naghten* Rules 'defect of reason', means a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal. It appears to us to be wide enough to cover the mind's activities in all its aspects, not only the perception of physical acts and matters, and the ability to form a rational judgment whether an act is right or wrong; but also the ability to exercise will-power to control physical acts in accordance with that rational judgment. (*R v. Byrne* [1960] 2 QB 396, and approved in *R v. Purdy* [1982] 2 NSW LR 964)

Therefore, the expert evidence to be presented in relation to a defence of diminished responsibility for an intellectually disabled offender is:

- that the accused has an abnormality of mind;
- that the abnormality has arisen from the causes mentioned in the statutes including a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury; and
- that there is substantial impairment.

The defence of diminished responsibility is a controversial one, partly because in some jurisdictions there is the necessity to establish a link between the accused's mental responsibility and the act of killing. The controversy, and the role of expert witnesses is canvassed elsewhere (*see* Hayes 1991).

Patterns of Homicide by the Accused with an Intellectual Disability

It would appear from the limited data available, particularly in Australian jurisdictions, that offences against persons, including the offence of murder is disproportionately over-represented amongst prisoners with an intellectual disability. A study in New South Wales prisons (Hayes & McIlwain 1988) found that amongst the intellectually disabled population (an IQ score of less than seventy and deficits in social and adaptive functioning) 22 per cent were charged with murder. When the borderline category (those with an IQ of between seventy and eighty, and serious deficits in social and adaptive functioning) were included, the prevalence dropped to 7.4 per cent, compared with the census of Australian prisoners at 6 per cent. These findings tend to be confirmed by a Western Australian study (Jones & Coombes 1990) which found 16.7 per cent of the intellectually disabled prisoner population were charged with murder compared with 6.3 per cent of the general prisoner population.

Research world-wide (Hayes & Craddock 1984, chapter 2) indicates that intellectually disabled offenders tend to commit offences against property and persons, including murder, assault, arson, break and enter, and car theft. Offences for drugs, false pretences, robbery, or escape—that is, offences which require a more sophisticated degree of intellectual ability and planning—are infrequent (Hayes & McIlwain 1988; Jones & Coombes 1990).

The offences committed by intellectually disabled forensic patients who are dually diagnosed as having a psychiatric abnormality in addition to their intellectual disability tend not to differ significantly from those who are not classified as forensic patients.

In terms of severity of crimes committed by intellectually disabled offenders, there tends to be a clustering of offenders who have committed repeated minor violations, and those who have committed a major offence such as murder, whereas the 'middle ground' of offences—particularly those involving planning ability and reasoning skills tends to be under-represented.

The profile of the intellectually disabled prisoner in Australia (Hayes & McIlwain 1988; Jones & Coombes 1990) is as follows: the average age tends to be in the twenties; unemployment is the norm, and those who are employed have low status jobs; very few have received schooling after the age of 16; most are single; Aboriginal people are over-represented; alcohol abuse is prevalent and is commonly related to the commission of the offence; severe deficits in social and adaptive skills are present, particularly in the areas of communication and social interaction skills; there is a high prevalence of multiple problems such as psychiatric abnormality, behaviour disorder, sensory deficit, or communication deficit in addition to the intellectual disability.

The pattern of the specific offence of homicide amongst intellectually disabled offenders has received scant attention, probably owing to the small numbers involved. Preliminary examination of client data assembled by the author indicates that there appears to be a tendency for the accused with an intellectual disability, when compared with the general offending population, to be more often involved in homicide against unknown persons, such as a

person encountered in the street, or the victim of a sexual assault by the accused. When the intellectually disabled accused murders a person known to him or her, it is likely to be a member of their family or a person resident in the same group home or institution. It is important to note that alcohol is implicated in the commission of the offence in many cases, whereas the abuse of other legal and illegal drugs appears to be rare. It also appears that homicides involving bizarre elements or mutilation of the victim tend to be rare. The pattern is more likely to be that of the individual lashing out aggressively, perhaps without even being fully aware that their actions could result in the death of another person. Some intellectually disabled offenders do not have a clear concept of death.

Prevention and Control

Ironically, attempts at prevention or control of homicidal behaviour by intellectually disabled persons usually only occurs after the commission of a violent and sometimes fatal offence. There is frequently a pattern of acts of violence against other people, such as the other residents of a group home or staff members or family members, against property perhaps involving arson or smashing possessions, or against the person him or herself, such as acts of self-mutilation. Typically, there have been ad hoc attempts at controlling the problem, usually with behaviour management techniques or tranquillising medication. The person may have been shifted to a number of different places of residence, owing to violent and unpredictable behaviour. This exacerbates the lack of continuity of any behavioural management programs and enhances the likelihood that new staff members will not be able to anticipate and deflect violent behaviour. The person may have been found to be unmanageable by their family. Their unmanageable and aggressive behaviour has often caused problems for years, in a number of situations, including at school and in the workplace. The work history may also be fragmented owing to violent and unpredictable behaviour causing termination of employment. Two case histories illustrate the irony of a situation where appropriate resources are allocated to the individual only after the commission of a violent offence.

Case 1 — Peter

At the age of sixteen, Peter resided in a group home in a country location. Despite a devoted and caring family he had been moved into a group home when his behaviour within the family context became unmanageable. As he grew in physical stature he posed a threat to other members of the family. After being resident in the group home for some period of time, he brutally murdered another resident, and mutilated the body. As far as could be determined, he did not suffer from any psychiatric abnormality. He was incarcerated in a series of juvenile institutions, following a finding of unfitness to be tried. He had received a limiting term at a special hearing, and was supervised by the Mental Health Review Tribunal. On the expiration of the limiting term, the supervision by the Tribunal also ceased. He was released from custody and sent back to the family. Within weeks, there was

turmoil within the family owing to his aggressive behaviour towards his mother in particular (he threatened her with a knife) and the strong suspicion that he had sexually molested his three year old sister. The family were assisted in their attempts to manage his behaviour and keep him at home by teams of intellectual disability professionals, but there were limitations on the time and availability of the professionals. Following the intervention of several agencies (the agencies will not be identified here, in order to preserve their confidentiality and the confidentiality of this case) the relevant government department was ordered to find an appropriate placement and to institute management procedures as a matter of urgency. Since being removed from his family, Peter has had a number of placements including a secure ward for very violent and seriously intellectually disabled people. This was felt to be inappropriate for Peter whose level of intellectual disability is mild to borderline. He was then placed in a ward environment which included patients with psychiatric illnesses and behavioural disturbances, most of whom required short-term intervention and supervision. During all of this time, the relevant government department allocated a special nurse to him on a one-to-one basis, twenty-four hours a day, seven days a week. With intense professional involvement, and the application of appropriate behaviour management techniques by extremely skilled professionals, as well as the one-to-one supervision, Peter's behaviour has improved to the point where there have been no violent outbursts for at least nine months. He is being considered for a work placement. He is not in a secure contained environment, but whenever he leaves the ward he is accompanied by his caregiver. When he goes on work placement, the caregiver will go also. There is no doubt that the financial and professional resource input into this case has been warranted in terms of the prevention of harm to others in the community and the improvement in Peter's behavioural disturbances. Nevertheless, had this level of resource application been available to Peter and his family a decade ago when his behaviour first began to be a problem, it is highly likely that the death of his co-resident in the group home could have been prevented. There is as yet no clear indication of how long Peter will require the intense one-to-one supervision.

Case 2 — Allen

Allen is a 31-year-old man who is functioning in the mild range of intellectual disability, on a percentile rank of three. He has serious social and adaptive skills deficits, his functional age equivalents being between five years and seven years. His intellectual disability was detected soon after birth. From the age of eleven he resided in a series of institutions for intellectually disabled young men, including being a boarder at a special school, and at one stage being moved to a group home in a remote country location. He has on occasions been admitted to psychiatric hospitals, and has lived on the streets, as well as having been resident in inner-city boarding houses. His mother died when he was twelve. His sister died when he was in his mid-twenties. His father cannot care for him owing to the father's psychiatric illness. Allen suffers from epilepsy. He has been described as manipulative and

unpredictable. It was not uncommon for Allen to be banned from or kicked out of places where he resided either because he did not pay his rent or because he used aggressive and intimidating behaviour towards others and caused damage to property. Despite maintaining contact with his community resource person, he lived a life characterised by dislocation, and the use of violent and aggressive behaviour in order to get his own way. He was unable to find and maintain employment, nor to become involved in educational opportunities. He was placed under the guardianship of the relevant Minister in November 1979. In 1989 Allen was charged with murder, following a night of violence during which he and two co-accused violently assaulted and robbed a number of people, mostly street dwellers. One of these assaults resulted in the death of the victim. Allen was found unfit to be tried and following a special hearing of the facts, he was given a limiting term of seven years. For some time he was in the protection wing of a maximum security gaol, and was also admitted to the prison hospital on several occasions. Eighteen months ago (approximately January 1991), Allen was transferred to a special unit for intellectually disabled offenders where he has received consistent behaviour management programs which have addressed his social and adaptive skills deficits, as well as his violent and aggressive behaviour. He has been gradually taken off all tranquillising medication except that which is necessary for the management of his epilepsy. During his fitness hearing, one expert witness expressed the opinion that Allen would be incapable of learning any new skills and that his behaviour in the future could only be managed by massive doses of tranquillising medication. This appears not to be the case. Allen engages in a number of activities in the special unit. He works at assembling the earphones used on aircraft. He cleans his cell, plays sport and participates in games of cards, assembles jig-saw puzzles, participates in literacy and numeracy programs, unit meetings, and personal relationships programs. His behaviour is stabilised and he has had no major outbursts of violence for some months. He is now able to articulate his problems and frustrations more clearly and has achieved the ability to empathise with other people. He shows insight into his own behaviour and is able to predict consequences, for example, that losing his temper is not worthwhile because he is moved out of the special unit to a segregation unit for a period of time. He has been reclassified from a maximum security prisoner to a medium security prisoner, and will shortly be transferred to a medium security special unit. It is unfortunate that, in order to obtain appropriate and consistent programs from motivated and professional staff in a secure residential environment, it was necessary for Allen's living conditions and social interactions to deteriorate to the point where he was virtually living on the streets and committing random violent assaults. Had he received appropriate resources when he was first institutionalised at the age of eleven, it is unlikely that he would currently be in prison.

Predicting and Preventing Violent Behaviour

The prediction of violent behaviour is an area which is notoriously unreliable (Litwack & Schlesinger 1987). Nevertheless, under certain circumstances it may be possible to predict violent behaviour accurately enough to justify certain types of intervention and preventative actions. More specifically:

1. There is no research that contradicts the common sense notion that when an individual has clearly exhibited a recent history of repeated violence, it is reasonable to assume that that individual is likely to act violently again in the foreseeable future unless there has been a significant change in the attitudes or circumstances that have repeatedly led to the violence in the recent past.

2. There is no research that contradicts the notion that even when an individual's 'history' of violence is a somewhat distant history of a single act of (serious) violence—which has led to a continuing confinement—it can reasonably be assumed that that individual will act violently again, if released from confinement, if it can be shown that he or she maintains the same complex of attitudes and personality traits (and physical abilities) that led to violence in the past and that, if released, the individual would confront the same circumstances that led to violence in the past.

3. There is no evidence regarding the validity of predictions of violence that are based upon threats, or statements of intention, to commit violence.

4. Even in the absence of a history or threats of violence, there may be occasions (for example, when an individual is clearly on the brink of violence) when preventative action is justified based on a prediction of violence.

5. Although mental health professionals have yet to demonstrate any special ability, not shared equally by lay persons, to predict violence, they may well yet demonstrate such an ability—at least in certain circumstances, or, at least they may well possess special techniques or understandings that can improve the accuracy of predictions of violence (Litwack & Schlesinger 1987, pp. 236–47).

When these principles are applied to the intellectually disabled person accused of homicide, a number of specific principles of preventative action emerge. The first is that if a person has committed a violent act, they are likely to do so again unless there has been a change in their attitudes or circumstances. Such a change seldom occurs with the intellectually disabled accused persons who commit homicide. The early acts of violence, as can be seen from the case histories described above, usually result in less rather than more supervision and intervention, and less likelihood of placement in an appropriate residential situation and involvement in appropriate programs to

change behaviour. Ultimately, when all community resources have been exhausted, including placement with a long-suffering family, the person usually ends up in some form of confinement in a psychiatric institution, an institution for intellectually disabled people, or prison. Unless the person receives appropriate programs within the institutional environment, they are likely to reoffend either whilst in the institution or upon release.

One research study (Cocozza & Steadman 1978) has found that 42 per cent of patients evaluated as dangerous committed an assaultive act immediately following hospitalisation. These findings have been confirmed by other studies (Rofman, Askinazi & Fant 1980). The situation emerges, therefore, of a person who, having been placed in an institution as a result of violent behaviour, has a nearly one-in-two chance of committing further violence once in the institution. The likely consequence of such an act within the institution is removal from programs which would be of benefit in learning to control behaviour and placement in an even more deprived environment. A cynical and iconoclastic definition of insanity states that insanity is repeating the same act over again but expecting a different result. Under this definition, systems which seek to prevent further violent behaviour by incarcerating offenders in institutional environments—wherein they receive no resources or appropriate programs—and expecting their violent behaviour to somehow cure itself are certainly insane.

A further principle which emerges from the points outlined above is that, in relation to the accused with an intellectual disability, it is highly likely that mental health professionals possess special techniques which *can* improve the accuracy of predictions of violence. The fact that the mental abnormality is long-standing in nature—unlike some acute psychiatric illnesses, for example—and that social and adaptive skills deficits—including deficits in coping behaviours and the abilities to control inappropriate aggressive outbursts—can be identified using standard adaptive behaviour scales means that experts in this area are probably in a better position to predict and, therefore, with appropriate resources, prevent further violent behaviour.

In many instances of homicide by an accused with an intellectual disability, the expert evaluation, the trial, and the subsequent imprisonment are a situation of 'shutting the stable door after the horse has bolted'. It appears that the government departments allocating resources are exhibiting an unwillingness to learn from past experience which they would consider decidedly abnormal if it were paralleled by the learning behaviour of the intellectually disabled accused.

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