

Casebook of Forensic Psychiatric Practice in Capital Cases

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In association with:

ForensicPsychiatryChambers

Acknowledgements

The Death Penalty Project would like to thank Nigel Eastman, Sanya Krljes, Richard Latham and Marc Lyall for drafting the text of this compendium Casebook. It, together with the *Handbook of Forensic Psychiatric Practice in Capital Cases*, provides an indispensable, practical resource for mental health professionals and all those involved in the criminal justice process.

The authors are grateful to Oxford University Press for its permission to use some text, amended, from Eastman N, Adshead G, Fox S, Latham R, Whyte S, Williams H *Oxford Specialist Handbook of Forensic Psychiatry*, Second Edition, Oxford University Press (publication 2019) and Eastman N, Adshead G, Fox S, Latham R, Whyte S *Oxford Casebook of Forensic Psychiatry*, Oxford University Press (publication 2019).

This publication was made possible by a grant to The Death Penalty Project from the Magna Carta Fund of the United Kingdom Foreign and Commonwealth Office.

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Copies of this report may be obtained from:
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ISBN: 978-0-9576785-8-3

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Preface¹

There is a long accepted and strong tradition in medical education of using ‘problem-based’ approaches to learning, which is also represented in legal education. This most usually consists of presenting to the reader ‘a clinical case’ and then setting questions about it, as if in real clinical practice – thereby effectively simulating ‘on paper’ clinical investigation and decision-making. Usually, this is pursued by first describing a clinical presentation – perhaps with the results of some investigations already gained being given – and then inviting the reader to decide how they would, in real practice, proceed. The reader is then invited to ‘turn the page’ in order to read a suggested approach, or more than one approach, to addressing the case. Hence, whereas a textbook offers *information*, a ‘casebook’ teaches about the *use* of information.

We have adopted this method in the Casebook you are about to use. And in doing so, we have directly linked the book with the second edition of the *Handbook of Forensic Psychiatric Practice in Capital Cases*,² so that the two volumes are ‘companion books’, and should be read in conjunction with each other.

The Casebook is concerned with both clinical assessment *and* preparing and presenting expert evidence directed at one or more legal questions, so that the ‘case set’ usually addresses several inter-linking issues. However, it has not been possible to ‘set the case’ with a page break before presenting ‘approaches to the case’. And this is reinforced because there are nearly always ‘issues in several domains’ – legal, clinical, clinic-legal and ethical – pertinent to the case. Hence, the text of the suggested approaches to responding to the case is at times more discursive than one might find in a standard medical casebook. However, we hope the essence of the method is preserved – that is, ‘learning by doing’, albeit ‘doing on paper’.

We offer detailed information on the structure of the Casebook, and advice on ‘how to use it’, within the Introductory Chapter, which also addresses ‘theory and practice of decision-making in expert witness practice’. That chapter aims to present text about decision-making that will take the reader into ‘methods and cautions concerning decision-making’, going beyond information relevant to decision-making provided in the companion Handbook. We then go straight into Case 1. We hope you will both enjoy and benefit from dealing with the cases.

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¹ Some of the text, and also aspects of some of the cases, presented in this casebook reflect, albeit with amendment, text and cases in Eastman N, Adshead G, Fox S, Latham R, Whyte S *Oxford Casebook of Forensic Psychiatry*, Oxford University Press (in preparation); and we are grateful to Oxford University Press and to Gwen Adshead and Simone Fox for their permission to use some material in this way.

² Eastman N, Krjes S, Latham R and Lyall M, *Handbook of Forensic Psychiatric Practice in Capital Cases* (2017), Forensic Psychiatry Chambers and Death Penalty Project.



INTRODUCTORY CHAPTER:

Decision-making in clinico-legal practice³

³ Some of the information in this chapter repeats information or advice given in the Handbook. However, this will be somewhat expanded and also presented in a way that, it is hoped, will be directly helpful to the reader in utilising the cases in the book as a method of 'self education' and 'self training'. It is hoped also that, although each case is presented with cross-referencing into relevant parts of the Handbook, the Casebook may also be capable of 'standing alone' at some level, in terms of 'how decisions can properly be made in cases'.

Introduction

High quality technical and ethical decision-making in the assessment for court of a defendant or appellant, provision of a report, and giving oral evidence within a pre-trial, trial or sentencing hearing, is dependent upon having a clear understanding of the relationship between the highly differentiated disciplines of medicine and law (as described in Chapters 1 and 2 of the Handbook). If the interface between those two very different ‘terrains’ is not well understood, both in general and in regard to the specifics of an individual case, then it will be impossible to offer legally informed, reasoned and ethical opinions at the ‘frontier’ between the terrains. Hence, this chapter – which aims to offer some outline guidance on decision-making strategies and awareness, and on how the Casebook aims to assist practitioners in decision-making – should be read in conjunction with relevant pages of the Handbook. In broad terms, the Handbook offers *information* at the clinico-legal interface, whilst this Casebook deals with *use* of such information, be that information psychiatric or legal.

As will be evident from the Handbook, for the expert witness there are clinical and clinico-legal aspects of any expert opinion, with ethical aspects applicable to each of these two ‘stages’. First, there is clinical assessment – including often retrospective assessment – of the defendant’s diagnosis and mental state at a given time (either related to the time of commission of the alleged offence, or to some particular stage of the subsequent criminal justice process), and then there is the addressing of relevant legal test(s) in light of those clinical findings. And so, again, this chapter should be read in conjunction with pages of the Handbook relevant to those two stages.

More specifically as regards the relationship between the two primary ‘domains’ of decision-making, ‘clinical’ and ‘clinico-legal’, the latter is concerned with the way in which the clinical opinion arrived at can properly be ‘mapped onto’ any legal test to which it is relevant (see Chapter 2 of the Handbook) – in relation to either ‘responsibility’ concerning commission of the alleged offence, for example, or an aspect of some stage of the subsequent legal process. Choosing between ‘ways of mapping’ amounts to one particular – and ultimately crucial – aspect of decision-making, which may, in turn, reflect a particular ethical stance.

Contamination of medical assessment by legal process

There is the potential for ‘contamination’ of proper *investigative* clinical assessment of a defendant where it is conducted within an *adversarial* legal context, and where clinical conclusions will likely be challenged adversarially. However, such contamination is even more likely to arise in respect of clinico-legal decision-making than in clinical decision-making. That is, there may arise a distinction in practice between the methods of investigation and decision-making adopted in regard to the two domains or, at least, between the balance of methods applied between the domains. The former *should* quite clearly be reliant solely upon *investigative* medical method, whereas the latter is open to an obvious significant risk of contamination, because of ‘clinico-legal mapping’ being conducted solely within an *adversarial* legal process. And this danger is exemplified by some of the cases presented within this Casebook.

Given the very different models for seeking ‘truth’ of medicine and law in common law jurisdictions, it might be thought ‘natural’ that the clinician confronted with, firstly, the clinical assessment of a defendant and, secondly, mapping of that assessment onto a given legal test or definition, might *necessarily* vary his⁴ method according to the context. However, even in ultimately mapping medical diagnosis, or a mental

state description, onto a piece of law, the doctor should strive to maintain an investigative approach – even though any opinion is likely to be challenged adversarially.

For example, in determining what a defendant's likely mental state was at the time of an alleged offence, a doctor should use all available data, without any bias in his evaluation of that data – albeit his conclusions are likely to be challenged in cross examination based upon 'disaggregation' and 'selection', or 'selective emphasis', of pieces of data. As such, he will properly come to a clinical view based upon unbiased consideration of *all* the available clinical and legal data (or at least that data which is legally admissible, or made available to him), express it so in the report and in oral evidence, but then be challenged in an entirely different adversarial mode. And awareness of the latter can serve to encourage improper contamination of even clinical assessment.

Non-rational decision-making

There is, inherent in all decision-making, the risk of them being 'non-rational' – falling short of comprehensive analysis in rational terms of all the data, in the absence of either values or heuristic influence. This may be because of technical failure to integrate information; over-confidence; 'shooting from the hip'; and *ex post* decision review, with examination of consistency between cases. Each of these sources of 'error' has its origins in recognised patterns of human decision-making psychology, although there is insufficient space – either here or in the Handbook – to do other than note their existence and role, and to warn against lack of insight into their potential impact.

Bias

Lurking behind and within all of this is, of course, the issue of 'bias', since decision-making can clearly be – indeed, perhaps always is – subject to at least implicit (or unconscious) bias, based upon 'values blindness' or 'values bias', and expressed in 'heuristic' styles of decision-making. And perhaps the greatest danger in this context is to assume otherwise, or to assume, more generally, that all decision-making is inherently 'rational', and whether '*non-rationality*' reflects bias or whether it merely reflects 'inefficient' decision-making.

Finally, there is a distinction to be made properly between bias and *lack of independence*. Where the latter arises from improper influence upon the expert, and loss of agency, the former can arise without any such improper external influence.

Dealing with cases in stages

We turn in a moment to consider separately each of the two stages of assessment and opinion formation just described. And, in doing so, we would wish to emphasise that the two aspects must indeed be addressed sequentially and 'in turn' – although conducting the former stage will necessarily be influenced by knowledge, properly gained in advance, of the legal questions to which the clinical opinion formed will need to be applied. Without keeping to this approach, there is an *enhanced* likelihood of distortion of clinical method within the clinical assessment, through contamination of the investigative method caused by awareness of the legal context and questions at hand.

⁴ As in the Handbook, we adopt the masculine with the intention that the text be read to refer to both masculine and feminine.

Decision-making within clinical assessment and clinico-legal reporting

Instructions

The very first decision to make will be whether to take the case at all. Specifically, whether you are expert, or sufficiently expert, in both the clinical and likely clinico-legal aspects of the case; or whether another clinician would be better qualified to undertake the case. And this emphasises how important it is to engage in a detailed discussion with the instructing lawyers when you are first approached. Many lawyers will not understand some of the ‘sub-specialties’ within psychiatry or medicine or, indeed, even the difference between a psychiatrist and a clinical psychologist, and may in haste tend to say ‘we just want a psychiatric report on our client’. Responding to such an unconsidered approach is not acceptable, and must be resisted in favour of a detailed discussion, followed (if not provided at the outset) with a detailed ‘letter of instruction’.⁵

Decision-making within ‘clinical assessment for legal purposes’, and requisite knowledge for such decision-making, can be broken down into: *clinical*; *legal* (that is, knowing, or being informed by instructing lawyers of, the relevant legal tests to which your assessment will have to be directed); and *clinico-legal* (that is, mapping of relevant clinical data onto the legal tests or definitions at hand) directed at reporting to the court. And within each stage, there will very often be *ethical and professional* decisions to be taken. This separation of stages is reflected in how the cases in the Casebook are presented (see below under ‘how to use this Casebook’).

Clinical assessment

Basic principles

It might be thought that all that needs to be written here is ‘follow the rules of ordinary good clinical practice’. However, all fields of medical practice – and particularly some areas of psychiatric practice – are necessarily subject to varying degrees of ‘values incursion’, plus heuristic and other influences. This is especially so in a forensic context. Hence, for example, some diagnoses under consideration in clinical assessment inherently ‘contain’ less fact than others, and so leave more room for value judgement (and values disagreement). As the ‘fact to value’ ratios of diagnoses vary, this bears directly upon the potential for values incursion in their ‘use’.⁶ And consideration of the difference between diagnosing dementia and personality disorder immediately serves to make the point.

Therefore, even before getting to the point of mapping a defendant’s likely mental state, arising from a particular diagnosis, onto a given legal definition or test – which, perhaps, contains a more *obvious* potential for value judgement – the mere making of the diagnosis itself is potentially open to value judgment, especially so for some diagnoses. There can be widely varying degrees of ‘inter-rater agreement’ in the making of different types of clinical diagnosis (for example, schizophrenia versus personality disorder). Indeed, some psychiatrists may take a ‘values position’ per se on particular diagnostic categories in a forensic context such as, for example, refusing to acknowledge ‘personality disorder’ in the context of court process.

⁵ See Appendix 1 for an example of elements of a proper letter of instruction.

⁶ See generally Fulford KWM (2006) *Oxford Textbook of Philosophy and Psychiatry*, Oxford University Press

Even more so is the foregoing true where it is not solely ‘diagnosis’ or ‘mental state description’ that is offered to the court but ‘formulation’, since clearly formulation – which offers an ‘understanding’ of the defendant – is ‘looser’ and *even more* open to inter-rater unreliability (see Chapter 6 of the Handbook).

It might be said, of course, that psychiatrists should therefore stick to ‘diagnosis and mental state description’, and eschew ‘formulation’. However, a crucial aspect of expert psychiatric evidence is commonly that of addressing ‘causation’. Hence, for example, a particular diagnosis and mental state description might be offered as likely to have been ‘present’ at the time of a killing; but the court will then understandably ask: ‘So what?’ or ‘What is the relevance of the mental condition to the killing?’. Now, clearly there is almost never a ‘scientific’ basis for offering an opinion on causation – even where, for example, the defendant suffers from substantial brain damage (since there may have been other additional ‘normal’ determinants of the offence than solely alteration of decision-making or behaviour directly attributable to a specific location of brain damage). Rather, all that can be offered is evidence as to ‘narrative’; that is, an answer to the question: ‘How does the condition fit into, or contribute to the overall narrative of the killing?’ (where there may, for example, be both ‘normal’ and ‘mentally abnormal’ contributors to the narrative; and also where there may be disputed narratives between the defence and prosecution). And this requires the offering of ‘formulation’, or an understanding, of both the mental condition and the offence.

Categories of clinical decision-making

This is not the place to rehearse comprehensively the literature on ‘clinical diagnostic decision-making’. However, particularly in the clinico-legal context, it is important first, at least, to distinguish between decisions concerning (1) *data collection* (what to collect, for example) and (2) *the method and extent of direct clinical assessment*, leaving aside, for the moment, *diagnostic decision-making*.

Specifically in regard to the first of these, the legal context necessarily (and ethically) bears upon what data should – or sometimes even can – be collected. For example, whereas in ordinary clinical assessment for a potential diagnosis of a degenerative brain condition it might be adequate – or even good practice – not to immediately request imaging or neuropsychometry, rather to ‘watch and wait’, where the diagnosis (or its absence) is legally relevant, the case will not wait for time to give the answer. And certainly in serious criminal cases, and especially in capital cases, the maxim ‘leave no stone unturned (now)’ applies.

What is crucial, however, is that there is as little contamination of clinical method as possible, in terms of contamination of investigative method by the legal context – even if diagnostic process is taken further than would be the case in ordinary clinical practice.

We say ‘as possible’ because some data collection may be ‘legally not allowed’. For example, in regard to either, or both, diagnosis and/or reconstruction of the defendant’s likely mental state at a relevant time, an important source of clinical data might be a witness in the case to whom you are told you do not have access and may not be granted access (for example, if you are instructed by the defence and the witness is a prosecution witness). In some circumstances, it may be possible to *gain* access to such a witness, for example by giving an assurance that you will not ask questions beyond such as are directly clinically relevant. However, on occasions, data may be *both* medically and directly legally relevant, so that the data remains unavailable to you beyond simply the witness statement (which may not be in an appropriate form, or comprehensive enough, to serve effectively as fully useful clinical data). Or there may be evidence

that is ‘legally privileged’ and that is not, therefore, available to you in any form or circumstance – even though you may be aware of its existence or even content.

That said, the maxim must be ‘function clinically as normally as is possible given, or despite, the legal context’, where the clinical decisions to be taken range across deciding what data to collect; how to assess the defendant clinically; what ‘tests’ to apply or request; and how to approach making a diagnosis or determining a relevant mental state description or formulation.

Methods of clinical decision-making

Turning to the process of clinical assessment per se, it may assist to rehearse what an ‘official’ website advises clinicians who are in ordinary clinical practice.

NHS Scotland opines: ‘Decision-making can range from fast, intuitive, or heuristic decisions through to well reasoned, analytical, evidence-based decisions ... there is a spectrum of decision-making; at one end of the spectrum, we use our intuition and experience to make decisions, where there is typically a high volume of simple decisions to be made. At the other end of the spectrum, there may be complex decisions to be made, where the level of uncertainty is high and an analytical and an evidence-based approach is needed to support the rules-based heuristics or experience we have gained over time in ‘similar’ situations.’ And, quite clearly, all assessments for legal purposes must be approached in detailed analytical terms – although the attempt to do so is very unlikely to be capable of avoiding all ‘heuristic’ influences.

The guidance adds: ‘Good, effective clinical decision-making requires a combination of experience and skills, including ... critical thinking; that is, removing emotion from our reasoning, being ‘skeptical’, with the ability to clarify goals, examine assumptions, be open-minded, recognise personal attitudes and bias, and the ability to evaluate evidence ... plus evidence-based approaches: using available evidence and best practice guidelines as part of the decision-making process ... and sharing your learning and getting feedback from colleagues on your decision-making.’

The latter aspect of the advice emphasises one obvious difference between decision-making in ordinary clinical and forensic contexts – assessment in a forensic context is usually clinically individual, although there can, and should, be *ex post* ‘peer review’ across cases of a clinician’s practice. Indeed, it is perhaps necessarily so in that the clinician gives ‘his’ expert opinion, not that of a team or committee. And herein lie ethical risks arising from being, or becoming over time, ‘a lone-wolf expert’.

The same NHS guidance advises: ‘(Use) feedback from others, and the outcomes of the decisions to reflect on the decisions that were taken in order to enhance practice delivery in the future. It is also important to reflect on (all) your ... decision-making strategies to ensure that you hone your decision-making skills and learn from experience.’ And here, although this may properly be applicable to forensic practice, reflection cannot operate in quite the same way that it can in ordinary clinical practice.

The advice then continues: ‘There are many factors involved in clinical decision-making, and each of the core skills has the potential to impact effective decision-making. In an ideal world, decisions would be made objectively, with a full set of evidence, an endless bank of resources, no time pressures, minimal interruptions, decision support tools to hand and plenty of energy to handle any decision-making situation

at any time of the day. However, this is not always the reality.' Yet, in a forensic context, especially in regard to serious criminal offences, the counsel must be, in terms of 'comprehensively leaving no stone unturned'.

Perhaps of crucial importance in a forensic setting is the advice: 'Reflect back on a recent decision you made – did you make the judgement and decision objectively, did you use all the data and evidence to hand? Did your personal attitudes or biases have a part to play in the decision? ... examine your own decision-making patterns.'

Clinical assessment in detail

There are clear 'aspects' of assessment, involving both direct clinical assessment and reviewing of other clinically relevant information, with decisions to make on the detail of each aspect.

Firstly, it is necessary to decide what *sources of information* can potentially be relevant to determination of diagnosis and also mental state(s) (related to whatever time is relevant to the legal question(s) at hand). As detailed in Chapter 4 of the Handbook, there will be a range of sources of information potentially capable of such relevance, and the first decision is to determine what sources should be considered. This may include, for example, past medical records, plus witness statements and police interviews, as well as the custody record. However, it is crucial to make the decision based upon 'bias' towards over-inclusion, since sources that prove irrelevant can be discarded, but sources not considered will remain unknown in terms of their relevance. The mere fact of 'selection' lays the foundation for an enhanced risk of bias in the assessment. Finally, great care should be taken to avoid 'selectivity' in seeking out – or using – the various potential sources of information, because of the risk of 'bias via selection'.

Secondly, when it comes to direct clinical assessment, *the manner and detail of questioning* is crucial. And the 'first rule' is to make the assessment with 'willful blindness' as to the legal relevance of any clinical findings to which you may come – again, in order to avoid an obvious source of potential bias, in terms of the impact your clinical findings may have upon the legal outcome. The expert should be 'willfully unconcerned about the legal outcome'.

Thirdly, as regards making decisions about *further investigations* (see Chapter 4 of the Handbook), again, the approach should err towards over-inclusion, which will likely enhance the reliability of the final clinical conclusions reached, whilst also offering a safeguard against frank – or inferred – bias, expressed within the manner of selection between various possible further investigations. And, notably, such further investigations may well require the expertise of other clinicians – for example, a clinical psychologist or neuroradiologist or, indeed, full clinical assessment by another psychiatrist with specialist expertise, such as a neuropsychiatrist.

All of the above will then lead to a decision as to what *diagnoses and mental states* are potentially 'in play' – that is, worthy of consideration in terms of 'differential diagnosis' (to use classical medical terminology), since only one 'certain' diagnosis or mental state is uncommon. And, where the evidence does not point to just one clinical conclusion, it will be necessary to lay out the points 'for' and 'against' the competing conclusions, as well as deciding upon how best to present to the court such competing conclusions (see below concerning report writing). Finally, the expert will need to address explicitly the likely 'validity' of their favoured clinical conclusion (or of competing conclusions).

If the expert cannot himself decide upon one favoured conclusion, then it is not at all unreasonable – indeed, it is right – to present the competing contenders, with the arguments in favour and against each, and then to leave the court to determine which should be alighted upon. Although the issue is a solely clinical one, if the expert cannot be fully confident in coming to a conclusion, the issue should be left to legal determination – even though this may feel ‘alien’ to you as a doctor.

The latter infers another topic, in that – especially but not solely – where there is a question concerning whether the defendant might be malingering or exaggerating mental symptoms, it will be important to address this directly within your clinical assessment (and then include a section of the clinical diagnosis aspect of your report on ‘*validation*’ – that is, setting out in detail what factors support, or tend to contradict, the clinical opinion to which you have come (see below)).

Related to the latter point is the question: ‘*When is a small or restricted quantity of data too little to be a basis for offering a clinical opinion?*’ This is not an uncommon question with which to be faced in the jurisdictions of less-developed countries that have fewer mental health resources and less access to other medical services, and where there’s often greater difficulty gaining access to both past medical – and other – records, and informants. There is no ‘simple answer’ to the question. However, in essence, the proper response is that the reliability of the clinical opinion expressed is dependent upon the data upon which it is based, and the nature of any gaps there may be. And, unless there is a gross lack of information, it should usually be possible to offer an opinion – but always with a caveat concerning its likely reliability. Indeed, the clinician – and also lawyer – should always be aware of the maxim ‘absence of evidence is not evidence of absence’. Ultimately, however, there may be a ‘floor’ of limited data below which ‘no reasonable clinical conclusion’ can be reached.

A variant of the latter issue concerns the bases upon which a mental state that occurred in a defendant at some earlier point than when they were being clinically examined can be *assessed in retrospect*. It is not unheard of for a forensically inexperienced psychiatrist to say: ‘I can’t say what the defendant’s mental state was when he killed because I wasn’t there’. This is a naïve, and unhelpful, response, since it is both possible for an expert to use all available data to reconstruct retrospectively, as best he can, what was the likely mental state – albeit with proper warnings about validity and reliability – *and* it is necessary for the courts that he does so.

It is good practice to express any diagnosis in terms of one of the two accepted international classifications of mental disorders – DSM5 and ICD10 (soon to be ICD11). This will exert personal diagnostic rigour upon the expert, in terms of: consistency across cases; laying a clear foundation for ‘diagnostic discussion’ with other experts; and also aiding the court in both understanding the basis upon which any diagnosis has been made and in determining proper routes to challenge that diagnosis. However, as the Handbook cautions, there are dangers of ‘misapplication’ of the two accepted classificatory systems to legal process (especially DSM5), or of deliberate adversarial ‘misunderstanding’.

Finally – although now we are veering very clearly towards clinico-legal reporting of findings (see below) – there will have to be decisions made about ‘*how best to explain*’ to a lay audience, which may ultimately include a jury, the clinical conclusions to which you have come. Here, the first rule is to avoid jargon as much as possible – or, at least, if you need to use it in order to facilitate communication with other experts in the case, go on afterwards to offer a simple lay description of what the term means. And, in laying out in your report your relevant clinical opinions, keep in mind that you will, almost certainly, need to ‘explain’

what these terms mean in lay terms in oral evidence, especially if there is a jury in the case. This could be through, for example, the use of ‘concrete analogy’ to get over abstract clinical notions (see Chapter 9 of the Handbook). Describe your clinical conclusions in a fashion that lays the ground for further and simpler explanation within oral evidence.

Decision-making within clinico-legal reporting

Law

It is clearly not the role of the expert to determine for himself the legal questions, definitions or tests to which his clinical findings should be applied. However, it *is* the responsibility of that expert to ensure that he has clear and comprehensive legal instructions, so far as he is – or can be – capable of determining this. This duty again emphasises the need to have a real understanding of law, both to be able to ‘understand’ what he is being told and to be aware that the instructions may sometimes not be adequate. Where the expert does not understand the instructions, or suspects that they are not comprehensive, he must ensure that there is sufficient dialogue with the instructing lawyer to rectify this (see also above).

In the cases presented in the Casebook, we lay out the law relevant to each case, and/or the reader will find it available in the Handbook. However, in practice of course, what the expert is told of the law within a case will often be dependent upon the instructing lawyers.

One – often ethically – difficult question arises where a particularly experienced expert becomes aware, when, for example, dealing with a clinico-legally inexperienced lawyer, that the lawyer is ‘missing out a question of importance’. Here, it may be sensible – and acceptable – to ‘ask legally intelligent questions’ of the lawyer about their instructions to you as a means of focusing them towards questions that you are aware are likely to be important. Therefore, within the cases we sometimes ‘set the case’ by way of giving ‘poor instructions’ – where part of the learning aspect of the case is to *recognise* that the instructions are inadequate, so that you need to decide to go back to the lawyers to ask for better or clearer instructions.

Finally, in serious criminal cases, very experienced counsel should be appointed, and so you should ensure that you receive, directly from him and at an early stage, detailed ‘advice’ that includes the relevant legal questions. However, even in capital cases, counsel are not always at this level.

Clinico-legal *per se*

Having determined the likely diagnosis and mental state at some relevant time(s), and being informed of both the relevant law and the legal questions within the case, the expert must apply his mind to ‘mapping’ his clinical conclusions onto the legal questions that he has been asked to address (a process we have termed ‘psycholegal mapping’ in Chapter 2 of the Handbook).

Here, it might be thought that the process is ‘automatic’ and requiring of no ‘decision-making’. However, in practice, first, there must be a decision taken concerning which of your clinical conclusions (diagnosis, mental state description or formulation) are *relevant* to the legal questions at hand; and then what *the manner of presentation* should be of those clinical conclusions in relation to the relevant definitions or tests – that is, the manner of the psycholegal mapping.

Deciding about how to address the clinico-legal issue(s) may go beyond deciding merely about 'presentation', however. Although the law of expert evidence requires, almost ubiquitously, that an expert should not offer opinion on 'the ultimate issue' (for example, guilt or innocence), sometimes this requirement may not be entirely unambiguous in its observation, the court itself may bend the rule, or the legal test may be 'so simple' that the boundary between 'clinical' and 'legal' seems almost to vanish.

In order to illustrate these alternative situations, consider first '*insanity*', in relation to which the expert is almost always allowed/required to give an opinion on, for example, whether the defendant did not 'know' that he was doing was 'wrong' (see Handbook for the legal definition). Yet what does 'know' mean? What about the defendant who was so psychotically driven at the time of the *actus* that he was unable effectively to pay attention to knowledge that he would otherwise have that what he was doing was wrong? Does such 'lack of appreciation' amount to 'not knowing'? Surely that is a legal question, yet it is not uncommon – almost, apparently, required – for an expert to give an opinion on 'insanity' in a way that leaves him to adopt his own understanding of the law, and even sometimes not to notice that he is doing so.

Similarly, in many jurisdictions it has become almost accepted practice that, in consideration of the partial defence of '*diminished responsibility*', rather than solely describing the defendant's likely mental state concurrent with the killing and leaving the court to 'translate' that into addressing the moral question, the expert may – almost should – offer an opinion not only on whether there was an 'abnormality of mind', but also on whether that abnormality of mind was such as to 'substantially impair the defendant's mental responsibility'. Indeed, before reform of the defence in English law, the Court of Appeal explicitly approved the practice. Yet, in doing so, the expert both seems to take on the role of the jury and also opens himself up to cross examination on all of the evidence in the case that the jury will have to 'decide upon'. So, in addressing that defence, an expert must often draw his own boundaries; that is, decide how, clinico-legally, to express his opinion in regard to 'the second limb' of the defence.

The latter example raises a more general question: 'If the legal definition at hand is loose, how do you deal with such latitude in the expression of your opinion?' By contrast, a tight legal definition offers greater 'certainty' in clinico-legal mapping – although the lack of room for the exercise of 'discretion' by the court may, if the definition is highly incongruous with clinical constructs, infer the potential for infringing natural justice.

Likewise, in addressing whether a defendant had been '*capable of understanding the police caution*', the expert will have to decide whether solely to describe the defendant's likely mental state concurrent with the administering of the caution, or whether to answer the ultimate question. And here, the court will very likely require him to do the latter. Yet, without knowledge of what 'level' of understanding is required in law, or whether the law requires 'continuing' understanding and the ability to keep the caution in mind throughout the interviews, how can he properly do so?

In almost entirely similar terms, will you, as an appointed expert, express an opinion upon whether a defendant is *fit to plead*, when to do so may require a detailed understanding upon your part of – and, more crucially, judgement upon – the complexity of the evidence in the trial? Or whether, having assessed a defendant to be abnormally '*suggestible*' and/or '*compliant*', you are prepared, when asked, to opine upon whether his/her confessions to the police are 'reliable'. Where the first two constructs are 'quasi-clinical', the latter is solely legal, and open to jury determination beyond taking a view about expert evidence offered to them.

Where other experts – for example, a clinical psychologist – is instructed by the same side as you and is reporting direct to the court, you will need to decide how much of their report, if any part, to repeat in your own report. Here, usually, summarising their findings will be sufficient; and also necessary, so as to be able to ‘relate’ them to your own clinical findings and psycholegal mapping.

Ethical and professional

The latter types of issues naturally infer ‘ethical decision-making’. Indeed, such decision-making will be necessary, potentially, across all three of the stages already discussed – even the stage dealing with ‘law’ since, as will already be apparent, there may be ethical decisions to be taken in regard to your actions in respect of your communication with the instructing lawyers concerning what legal questions, tests or definitions are in play (see above).

In this respect, we refer the reader to Chapter 15 of the Handbook, concerning identifying myriad potential ethical pitfalls when assessing and presenting clinical information to be used in legal process – often reflecting the profoundly different methods and constructs of medicine and law (as again described in Chapters 1 and 2 of the Handbook). As such, within the cases, as well as explicitly raising particular ethical questions, we sometimes offer information intended to be suggestive of particular ethical issues that require identification and decision-making. However, rather than repeating here examples of ethical issues that it may be important to address, and ways of deciding upon them, again, we refer the reader towards detailed reading of Chapter 15 of the Handbook.

How to use the Casebook

The overall method of the Casebook

As already described, whereas the Handbook offers ‘*information*’, this Casebook offers assistance towards ‘*using information*’ in practice. This is expressed through a variation of the method commonly used in postgraduate medical education of setting *problem cases*, plus *questions to address*, with ‘turn over’ *suggestions* of how the case might be approached. Hence, in each of the 22 cases described, we offer a *case description*, comprising medical and legal information – sometimes also with explicit ethical aspects – and pose *questions to address*; this is then followed by suggested approaches to deciding upon answers to the questions posed. It is not suggested ever that the questions ‘set’ are the only possible questions arising from the case as described. However, they are the ones that we, the authors, have alighted upon to offer for your consideration – you may wish to add in others of your own to address. Similarly, we do not suggest the approaches to responding to the questions we outline are the only ones that are justifiable. Indeed, the reader may profit from – and enjoy – pointing out to himself obvious approaches that we might seem, to him, to have missed.

It is important to *emphasise* that we do not offer a ‘correct answer’ to each case, clinically, clinico-legally and/or ethically; indeed, we often offer alternative answers to decide between. Rather, we try to show the *justification* for each possible answer that might be arrived at, clinically, legally or ethically. Put simply, this is in terms of ‘show your workings’, given that the quality of an opinion lies not in the opinion expressed per se but in the process by which it was reached, and in its underpinnings.

There are, within expert witness practice, recognisable ‘psycholegal case types’ that represent a particular combination of diagnosis, or mental state abnormality *and* a particular legal question. That is, each is a particular exemplar of a piece of psycholegal mapping. And we have tried, in choosing cases, to capture particularly common, or particularly problematic, psycholegal case types – that is, case types that give rise to common or particularly problematic issues at the interface of psychiatry and criminal law, and/or ethical conundra.

As will be observed, we therefore ‘categorise’ each case in terms of the specific *clinical*, *legal*, and *clinico-legal* issues that are in play within it. So, for example, Case 1 is headed ‘dementia; understanding a police caution; cultural validity of tests’ (reflecting the *clinical*, *legal* and *clinico-legal* issues, respectively, that are dealt with in the case). And rehearsal of these specific issues – both in the ‘header’ to each case and in the contents page early in the book – will serve, we hope, to allow the reader to look through the ‘menu’ of cases in order to select fields and topics from which he believes he would benefit from experiential education and training. Alternatively, the reader may wish to look at some case that appears to have aspects in common with a real case with which he is – or has been – faced within his practice; that is, a case that looks to be of a similar ‘psycholegal case type’.

Throughout the book we therefore separate out information and questions posed to the reader within each ‘case’ in terms of *case description*; followed by information that is *legal*; and then the *clinico-legal* stage (concerned with mapping the clinical findings onto the legal questions, definitions or test). We then add some text on ‘*professional and ethical issues*’. And finally, in most cases, we include ‘*additional information*’ which we consider may assist the reader in reflecting upon how they dealt with any of the preceding stages. In just one case – Case 5 – the nature of the case, and the issues it presents, are such that it is more convenient to merge the three stages just described.

There are cases in which it appears clear, or at least likely, that data and opinion from ‘other experts’ is required – for example, clinical psychologists or radiologists. And, where this is so, we address what are reasonable ways of ‘incorporating’ such data and opinion that are beyond the expertise of the instructed psychiatrist, but which are relevant to the opinion they express within their own discipline.

Finally, as we write in the *Postface*, we should welcome responses from readers to the cases presented, and to the approaches we suggest to addressing them, including of course constructive criticism.

How to use each case

At the top of each case we give some cross-referencing into the Handbook, as sources of information and advice that are relevant to it. This is not comprehensive, but aims to point you towards ‘main aspects’. However, you would be best advised to attempt the case *before* reading relevant pages or sections of the Handbook, and then check whether you were well informed, or might have dealt with the case better if you had known the information contained within the Handbook.

Hence, as we have already explained, we first describe, within the *case description*, a clinical and legal scenario and then, at the end of the description, we give an ‘instruction’, usually ‘You are asked to ...’, or we pose a question or two – either of these amounting to your ‘instructions’ from the lawyers in the case.

Usually, we do not specify ‘which side’ is approaching you, as your responses to it should be uninfluenced by this. You are then invited to address the case, based upon the data you have been given, in terms of clinical investigation. Next, under *‘legal’* we outline the relevant law. And then, under *‘clinico-legal’*, you are required to carry out the psycholegal mapping stage of the exercise. We then add some text concerning the *‘professional and ethical issues’* that the case raises, across all of its stages – and we would hope that some of these (perhaps others too) will have been noted, and ‘responded to’ by the reader as he went through the case (see below). Finally, where appropriate to the case at hand, we add in, at the end of the case, some relevant *further information* – often further and more detailed clinical psychology information than had been ‘given’ to the reader within the body of the case (in fact, these sections have been written by the author of the Casebook, who is a clinical psychologist).

Clearly, for ‘maximum learning by doing’ we would advise that, once you have read the initial case description and the ‘instructions’, you then attempt – ideally on paper (there is nothing so challenging as to have to ‘write down’ what one thinks) – to respond comprehensively to the case, under the headings *‘clinical’*, *‘legal’* (to see whether you, in fact, know the relevant law, or can glean it by referring to the Handbook) and *‘clinico-legal’*. As regards the *‘ethical and professional’* issues dealt with after this, we do not pose any questions but suggest that you ask yourself whether you can detect any such issues in the case, and which ones. Where you are not aware of the relevant law, or are not confident of being so, and cannot find it described in the Handbook, then obviously it will be sensible to read that text before going on to the clinico-legal section.

Sometimes, beyond posing a single instruction or question to consider immediately after the case description, under one or more of the ‘main headings’ we pose further specific questions relevant to that domain. And it is suggested, again, that you attempt to respond to these before reading the text that we then offer as ‘the authors’ response’ to the question.

Since some of the questions are posed ‘as you go through the case’ (see above), we have not made a physical page break at the end of the case description and posing of ‘the main instruction or question’. However, you are advised that, for maximum ‘learning by doing’, you address any question posed *as you go through* the case for yourself, before reading the text ‘under’ that question, rather than simply reading all of the questions and answers as you might within a textbook.

We hope that the above guidance will assist the reader to ‘get going’ quickly, easily and productively. We also hope you enjoy the cases.

THE CASES:



List of Cases

Case 1: Dementia; understanding the police caution; cultural validity of tests

Case 2: Acquired brain injury; fitness to be interviewed; malingering (of memory deficit)

Case 3: Intellectual disability with personality disorder, suggestibility and compliance; rebutted confession; expert opinion on ‘unreliability’

Case 4: Intellectual disability; fitness to plead and stand trial; disagreement between psychiatrist and psychologist

Case 5: Intoxication, dependence, withdrawal, secondary brain damage; witness statements, professional versus expert witness; fitness to have been interviewed, fitness to plead and stand trial

Case 6: Intoxication without dependence, substance-induced psychosis; capacity to form specific intent; retrospective reconstruction of mental state

Case 7: Delusional disorder, drug-induced psychosis or intoxication; insanity; retrospective reconstruction of mental state

Case 8: Depression with psychosis, diagnosis of children and adolescents; insanity; detailed ‘mapping’ of mental state onto components of insanity

Case 9: Schizophrenia; diminished responsibility; substantial impairment of mental responsibility, denial of the *actus*; refusal to discuss the *actus*

Case 10: Psychopathy and paraphilia, including their diagnostic status; diminished responsibility, conditions accepted as ‘abnormality of mind’; types of mental pathology and abnormality of mind

Case 11: Depressive illness, psychological consequences of abuse, malingering (of mental illness); provocation, relevant mental characteristics; expressing psychiatric factors within provocation

Case 12: Withdrawal from substances, intoxication; provocation, capacity to form specific intent, insanity, diminished responsibility; ‘woundability’ within provocation, withdrawal or intoxication in relation to capacity to form specific intent, insanity, diminished responsibility

Case 13: Battered woman syndrome; battered woman syndrome and provocation; battered woman syndrome in provocation and diminished responsibility

Case 14: Acquired brain injury, cognitive impairment, epilepsy; automatism; frontal lobe syndrome, epilepsy in automatism, and sentencing

Case 15: Intoxication and dependence, drug-induced psychosis; automatism, insanity, incapacity to form specific intent; intoxication, drug-induced psychosis, automatism, insanity

Case 16: Personality disorder, vulnerability; duress; inadequate instructions, expert witness boundary

Case 17: Battered woman syndrome (BWS), PTSD, anxiety and depressive disorders; duress; mental disorder and reasonable fortitude

Case 18: Autism and intellectual disability; joint enterprise, diminished responsibility, rebutted confession; developmental disorder, joint enterprise, diminished responsibility, rebutted confession

Case 19: Mania; self-defence; relevance of mental disorder to self-defence, insanity

Case 20: High-functioning autism spectrum disorder; discretionary death penalty, capacity for reformation, and corrigibility; clinical correlates of 'capacity for reformation'

Case 21: Post-traumatic stress disorder, classificatory systems, rating scales; sentencing, mitigation, risk assessment towards risk-based sentencing; clinical data and mitigation, clinical risk assessment for penal purposes, going beyond instructions

Case 22: Treating doctor as expert, neurotic depression, adjustment disorder; new evidence, appeal for unsafe conviction; assessing for diminished responsibility on appeal

Case 1

Key themes

- *Clinical* – dementia
- *Legal* – understanding the police caution
- *Clinico-legal* – cultural validity of tests

Handbook references

- Use of psychometric tests (p46)
- Neuropsychological assessment (p49)
- Diagnostic groups (p56)
- Competence to understand a police caution (p94)

Case history

Uriah is a 75-year-old man. He has been charged with indecently assaulting a 14-year-old girl two years ago.

Uriah is unable to recall the name of his secondary school. However, he says that he went on to study at university. He then served as an officer in the Army. Thereafter, for 30 years, he worked in a bank, latterly as a bank manager for 22 years. He has been married for 35 years and has two children. There is no family history of mental or neurological disorder of note. Uriah has always been a light drinker.

He has suffered two head injuries. When in the Army, a hatch struck him on the head and fractured his skull. He believes that he probably lost consciousness. He was hospitalised for two or three days. Three years ago, he believes, he ‘tripped’, hit his head and damaged his cheek and shoulder. He believes that he may have lost consciousness for two or three minutes. He was helped by workers at a nearby ‘medical college’. He was not admitted to hospital.

Uriah has not been affected by mental health problems historically. However, he has headaches, which he feels at the front of his head, most days.

Over the last 12 months, he believes that his memory has worsened significantly. He has said: ‘*I don’t remember what I had for breakfast the day before. I forget what I did last week. My wife has started to put things on the calendar, as it’s the only way I can remember things. The only way I know what day and date it is when I look at the paper in the morning.*’ He went on, ‘*I can remember a lot but not things recently. I can remember faces but not names, but then I’ve never been that good at names.*’

He is far less active than he was a year ago. And his wife has started to look after the family finances. He can also no longer do crosswords. He has commented: ‘*My wife thinks I’m getting Alzheimer’s...I can’t do things in my mind anymore.*’

His wife first noticed changes in his behaviour around a year ago, and his difficulties have worsened over time. Hence, Uriah sometimes repeats himself several times in a conversation; cannot recall the events of the previous day; and two or three times a week he leaves the shower running, forgetting to turn the taps off. He has also started to fall asleep at the dinner table. Finally, Uriah has lost weight during the last six months.

He was interviewed by the police six months ago about the current allegation. He tells you that he has no memory of this, and continues to maintain this stance.

When charged, he denied the allegation, reporting that he had no memory of ever meeting the alleged victim.

Within the witness statements you read that, at the time of his arrest six months ago, Uriah commented to police: 'Oh no! I knew I shouldn't have done it, but I thought she liked me.' You then read in the prosecution bundle that he was subsequently interviewed by the police, within three hours of his arrest, at which interview he essentially repeated the same attitude that he had expressed on arrest.

You are asked to consider two questions:

- 1. What, if any, is his medical diagnosis?**
- 2. What was his likely ability to have 'understood the police caution' at the time of being interviewed?**

Clinical

How might you approach establishing a diagnosis?

There are several diagnostic possibilities that might explain Uriah's memory difficulties. And it is important to rule out a cause other than dementia, given his history of having previously suffered two serious head injuries; his report of a persistent headaches; and the recent weight loss.

Taking a more detailed collateral history from a close relative is essential. This will include questions about personality and behavioural change, the duration of any memory decline, the impact this has had upon his functioning, and how varied has been that impact. Questioning about any disinhibition in behaviour may be relevant to his legal situation beyond the questions currently posed to you legally.

Dementia assessment includes taking a thorough psychiatric history, as well as conducting a physical examination, including a detailed neurological examination. Consider starting with a screening test to assess the defendant's cognitive performance – for example, the Addenbrooke's Cognitive Examination-III (ACE-III). This is a 100-point test that may not be valid in all cultural groups but otherwise provides an estimate of cognitive functioning in different domains. Detailed neuropsychological testing, by a clinical neuropsychologist, might then be needed, dependent upon the results of the screening you have administered.

Also, arrange blood tests, including thyroid function tests, vitamin B12 and folate, plus renal and liver function tests, an HIV test and syphilis serology; it is important to exclude any treatable form of dementia

Dementia subtypes

The following list represents a basic system of categorising dementia:

- Alzheimer's disease
- Vascular dementia
- Frontotemporal dementia
- Lewy body disease
- Parkinson's disease dementia
- Huntington's disease
- Prion disease

(should that prove to be the diagnosis), or some other cause of his mental disability. Also, if all these are negative, consider a diagnosis of 'reversible' dementia, in terms of 'normal pressure hydrocephalus', diagnosed ultimately by CT or MRI brain scanning (if such imaging is unavailable, then large-volume lumbar puncture, and prolonged lumbar drainage, may assist, but no one test has been validated to rule out potential response to surgery).

Structural imaging, especially MRI scanning, will not only help to determine the nature of any dementia, but will also help to exclude other cerebral pathologies.

If a diagnosis of dementia is confirmed try, as far as possible, to clarify the time course and pattern of Uriah's cognitive decline, since this may assist towards establishing the type of dementia he may likely have (most obviously in distinguishing between Alzheimer's and arterio-sclerotic dementia – the former characteristically being 'smooth' in onset, and the latter 'stepwise').

People with mental disorder – including dementia or other cerebral pathology – commonly experience high levels of anxiety and mood symptoms, and so it is important to consider whether Uriah has any other mental disorders, either that exist co-morbidly or that may be causing, or worsening, his apparent cognitive problems. Most commonly in the elderly, 'depressive pseudo-dementia' can occur.

Legal

Understanding the police caution

In almost all jurisdictions, when arrested, a suspect is given a 'police caution'. The wording of this varies across jurisdictions. However, typically it includes an explanation that the suspect has 'the right to remain silent' but that 'what they say may be recorded and may be used in evidence against them'. In England and Wales, the courts can make adverse inferences from a suspect's silence, unless he had some mental disorder that determines otherwise, and so this will form part of the caution. Notably, it does not include or infer any element concerning how a normal person might properly be capable of responding to the caution – for example, in exercising 'judgment' about how to deal with the interviews. Rather, the test merely requires that the defendant 'understood' the caution. So that it is a very 'low level' legal test. There is, therefore, potentially a 'gap' between 'understanding the caution' and 'fitness to be interviewed', whilst

‘unreliability’ arising from mental characteristics represents yet another distinct ‘test’ relevant to police interviews being used within a prosecution case.

Instructions – police caution

1. Explain the impact of any condition you have diagnosed on:
 - a) The defendant’s concentration and attention
 - b) The defendant’s ability to have understood words, including the words in the police caution
 - c) The level of distress the defendant was likely to have been in at the police station
2. Explain which symptoms of that condition caused any difficulties, and how they caused those difficulties.
3. Explain whether the defendant’s response could be relied upon as indicating his understanding of the caution.

Clinico-legal

How could you retrospectively assess his ‘ability to have understood the caution’?

There are two aspects to this question: (1) what was his likely mental state at the time of administration of the caution; and (2) what were the likely implications of this for his ability to understand the caution? And it would be wise to keep these two questions distinct in your mind – albeit, the opinion you have to offer amounts to ‘melding’ the two in a case where the defendant was likely not in a ‘constant’ mental state (for example, should Uriah have had an ‘additional’ acute confusional state, or have had high anxiety worsening his cognitive functioning, separation of the two will be particularly important, and important in terms of whether – although he initially may have understood the caution – he continued to keep it in mind during the interview).

Also, the terms of the legal definition are ‘loose’, and so you will need to decide: ‘do I simply describe his likely mental state, in as much detail as possible, without interpreting it in terms of the test per se (for example, in regard to the *degree* understanding required)?’; *or* ‘do I assume that the interviewee has to be capable of “keeping in mind” the caution throughout the course of the interview, and report upon that?’; *or* – perhaps bearing in mind that on its face it seems to be a very ‘simple’ test – ‘do I give an opinion on what amounts to “an ultimate legal issue”?’⁷

Bearing in mind these ‘alternative approaches’ to answering the legal question posed, it seems unlikely that Uriah’s own account of his state at police interview, given in retrospect, will be helpful, because of his apparent memory problems. However, his wife or children might be able to describe his mental state at the time, as might any lawyer that attended the interview with him. It may also be helpful

⁷ See the Introductory Chapter for examples of clinico-legal decisions that may have to be made concerning offering an opinion on ‘understanding the police caution’.

to explore his understanding of the caution given to him now, and to test his recollection at intervals throughout your assessment. It is not necessary that he recalls the original caution but rather that, at that time, he understood it and was capable of retaining that understanding for the duration of his interview. Demonstration of his ability to do this now will suggest he had such ability on the earlier occasion, unless you have determined that his clinical state has likely worsened during the interval between the interview and current clinical assessment. However, testing understanding requires more than just asking: 'Do/did you understand what I just told you?', since people with dementia will often 'mask' their impairment – for example, through feeling embarrassed or humiliated when their memory impairments are exposed – so it will be necessary to ask for him to explain back to you the meaning of the caution you have just given.

Listening to a recording – or viewing a video recording – of the police interview is likely to assist in forming a view on Uriah's mental state at the time of his arrest, which may, by inference, suggest a proper view of his likely understanding of the caution that was administered earlier. If these are not available, then the transcript of the interview should be viewed. Police custody records might also show evidence that Uriah was either confused or distracted, or not – from which, with other information, inferences might be drawn again in regard to the legal question posed.

If he was assessed by a forensic medical examiner (FME) around the time of the interview, then his/her witness statement should be viewed – although assessments by FMEs are commonly brief and not definitive on either this issue or 'fitness to be interviewed' (see Case 2).

If, as is likely, this is a case of dementia, then Uriah's cognitive function will likely decline further over time. His fitness to plead and stand trial is therefore also likely to be an issue, especially if there has been a substantial delay since the police interview was conducted (see Cases 4 and 5).

Ethical and professional issues

How should you interpret and incorporate clinical tests into your opinion?

The assessment for dementia can be complex, and the correct diagnosis can perhaps only be confirmed with absolute certainty at post mortem. However, comprehensive clinical assessment in a case such as this includes, in basic terms, describing both cognitive decline and functional impairment. The cognitive decline is assessed on the clinical history and by neuropsychological assessment.

The neuropsychological assessments that are used might have been developed with populations different from that of the defendant, and so if they are used in different cultural groups, the results would have to be interpreted with caution (see also below). At no stage should a 'score' on a test lead to a diagnosis. Equally, it makes no sense to refuse to diagnose dementia simply because the recommended tests are not validated on the population from which the person you are assessing comes. And, as in all clinical psychiatry, your diagnosis will ultimately be based upon information from a number of sources, including neurological findings, collateral information, clinical interview and neuropsychological results.

In a case where the issue of understanding the police caution is likely to be finely balanced, and to depend upon detail that can only reliably be assessed neuropsychometrically, you may need to emphasise that your opinion relies a good deal on such tests.

If a clinical psychologist is not available, should I still address the diagnosis, and test?

This is a common problem in forensic practice in less-developed countries, with more limited mental health services. The answer to the question may depend upon how ‘marginal’ the diagnosis is clinically. But, if there is any concern that assessment may not be diagnostically reliable in the absence of such testing, then the court should be advised of this and the justice implications emphasised.

Additional information

Psychometric testing for dementia in detail

Dementia is defined as a decline in memory and other cognitive abilities severe enough to interfere with daily life. Neuropsychological testing plays a crucial role in the diagnosis of dementia by specifying the extent and nature of cognitive deficits, which is the key criterion for the diagnosis. It usually involves the following neuropsychological investigations:

Premorbid level of functioning

Premorbid functioning tests are designed to estimate the individual’s cognitive abilities prior to the onset of dementia. The Test of Premorbid Functioning (TOPF) is the most commonly used test in the English-speaking world. It is a reading task that contains irregular words, and the individual’s performance is compared with a normative sample. The results are compared with the individual’s current cognitive functioning to investigate a possible decline.

General intellectual functioning

Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV) is the most widely used battery for assessing the individual’s current cognitive functioning.

Attention

Working memory tests, such as Digit Span subtest in WAIS-IV, are useful in assessing the individual’s ability to sustain attention.

Processing speed

Processing speed is assessed by timed tasks, such as WAIS-IV Symbol Search and Coding subtests. These tests are sensitive to non-specific organic changes in the brain.

Memory

Memory assessment is an essential component in suspected dementia. The Wechsler Memory Scale – Fourth Edition (WMS-IV) is one of the most popular and widely used memory assessment instruments.

Memory is a complex process that can be separated into long-term and short-term. Long-term memory is often categorised as: (a) non-declarative (implicit) – memory for learned skills and procedures, such as

riding a bike or skiing; and (b) declarative (explicit) – memory for everyday knowledge and facts. Explicit memory is further divided into semantic and episodic memory. Semantic memory is the memory for everyday facts and concepts, and episodic memory involves memory for personal events.

The WMS-IV consists of seven subtests, and it provides five indices: Auditory Memory; Visual Memory; Visual Working Memory; Immediate Memory; and Delayed Memory. Additionally, the WMS-IV provides an additional cognitive test, the Brief Cognitive Status Exam (BCSE), which evaluates global cognitive functioning in patients with suspected memory deficits including dementia or suspected Alzheimer's disease.

Visuospatial abilities

Visuospatial tasks examine visual perception and interpretation of simple and complex visual stimuli. The individual is requested to copy geometric figures or assemble blocks (for example, Rey Osterrieth Figure, WAIS-IV Block Design subtests).

Language

In addition to clinical observations of the individual's language abilities, a number of tests evaluating various abilities, such as semantic knowledge (for example, WAIS-IV Vocabulary subtest) and confrontation naming (for example, Boston Naming Test) are available.

Executive functioning

Executive functioning is an umbrella term that encompasses a wide range of abilities that are sub-served by the frontal lobes. Assessment of executive functioning includes assessment of planning (BADS; inhibition (Stroop and Hayling Tests); rule detection (Brixton test); and mental flexibility (Trail Making Test).

If the defendant has previously been very high-functioning, then decline may be more difficult to identify (since there is a risk of looking just at their current functioning, rather than at any decline there may have been). Similarly, if somebody has been highly dependent upon others before any cognitive decline, then their functional decline may be difficult to measure. The diagnosis is therefore dependent upon high quality clinical practice, utilising multiple methods and sources of information.

Variation of assessment of dementia across different cultures

As with all mental disorders, there are cultural variations in the way dementia may present. The essence of dementia is cognitive (and functional) decline, and so the emphasis should be upon assessing whether there has been decline. However, the optimal level of functioning differs across cultures and may not be comparable to the 'western norms'.

Studies of understanding the police caution

In one study in the UK,⁸ comprehension of the caution was investigated among two groups, police station suspects (N = 30) and individuals (N = 24) attending a job centre in the same area, matched for intellectual ability. In both groups, understanding was very limited and did not relate either to their situation at the time of testing or to self-reported experience of the criminal justice system. Even under optimal experimental conditions, only 11% (six) of the participants were able to demonstrate full understanding of its meaning. Worryingly, though, more than 96% (52) claimed to have understood the caution fully after it had been presented to them as it would be by the police, yet none of them did so. The authors therefore suggest practical measures to ameliorate the difficulties, but the importance of devising a new, simplified, version of the current caution is emphasised.

⁸ Fenner S, Gudjonsson G, Clare I, 'Understanding the Police Caution', *Journal of Applied and Social Psychology*, February 2002

Case 2

Key themes

- *Clinical* – acquired brain injury
- *Legal* – fitness to be interviewed
- *Clinico-legal* – malingering (of memory deficit)

Handbook references

- Acquired brain injury (p24)
- Neuropsychological assessment (p49)
- Malingering, feigning and deception (p51)
- Fitness to have been interviewed (p95)
- Amnesia (p115)

Case history

Mark is a 24-year-old man with an established diagnosis of acquired brain injury who is charged with murder.

Mark's parents are teachers. He had a stable childhood and no difficulties at primary school. Unfortunately, when aged 12 years, he fell three metres from a tree, landing on his head. He lost consciousness for 10 minutes. He was quickly placed in the recovery position and the emergency services were called, and he was taken to hospital. On arrival, his Glasgow Coma Score was 11 (motor 4, eye 3, verbal 4). On CT scanning, it was found that he had sustained a skull fracture in the temporal region and had an extradural haematoma, which was evacuated during an emergency surgical procedure.

Mark spent two days in intensive care, and was in hospital for a total of seven days before being discharged home. He later reported post-traumatic amnesia lasting 24 hours after the fall, with no significant pre-traumatic amnesia. Mark returned to mainstream school but had difficulties with attention. His academic performance was poor and he failed the exams that he sat at the age of 16 years. He had particular difficulties with his short-term memory.

After leaving school, he gained employment as a security guard, working in nightclubs and pubs. He has been able to live independently as an adult, but his parents have supported him financially.

Mark is now charged with the murder of a customer, who died during a violent altercation outside of a nightclub where Mark was working. It is alleged that Mark struck the man several times with his fists.

When Mark was interviewed by the police, he claimed to have no memory of the incident.

Mark's lack of memory of the alleged offence has led to concerns that he might be fabricating amnesia. He has therefore been assessed by a clinical psychologist, who administered a number of screening tests for malingering, reported as follows:

Excerpt from psychological report

'The M-FAST structured interview was administered. This is a brief 25-item screening interview designed to provide an initial indication as to whether an individual might be feigning psychiatric illness. Mark obtained a score of 17, above the cut-off score of six for malingering.'

'It was also noted that Mark's self-report was inconsistent with his observed behaviour. Further, he endorsed suffering from very extreme and uncommon symptoms, and symptom combinations that were both unlikely and inconsistent with common mood and psychotic disorders – for example, he reported experiencing a large number of visual hallucinations.'

'The Structured Inventory of Malingered Symptomatology (SIMS) was also administered. This is a 75-item, multi-axial, self-administered screening measure to detect malingering. Mark obtained a score of 40, above the cut-off score of 14. He had a markedly elevated score on the amnesic subscale, endorsing symptoms of memory impairment that were inconsistent with patterns of impairment seen in brain dysfunction or injury.'

'The Test of Memory Malingering (TOMM), a 50-item recognition test for adults that includes two learning trials and a retention trial, was also administered. The TOMM is sensitive to malingering but not to neurological impairments – all individuals, even those with neurological impairments, have a high capacity for storing and retrieving pictures of common everyday objects, which is the test used in the TOMM. Most individuals achieve close to the maximum score on the TOMM. However, Mark scored poorly on all aspects, strongly suggesting malingering.'

You are asked to offer an opinion concerning whether or not Mark's memory loss is genuine, and whether he has any psychiatric disorder.

You are also asked whether he was fit to have been interviewed, or is now fit to be interviewed.

You have not, at present, been asked to address whether, if he does have a mental disorder, it is relevant to the offence with which he is charged.

Clinical

How should you approach this case?

This case is complex, and there is a tendency in cases of this nature (multiple possible explanations of symptoms) for experts to become polarised. It is, of course, possible – if not likely – that in a case with different relevant factors, each will have some part to play in the overall picture. Mark had a significant head injury, which in itself does not mean there is mental disorder; but there needs to be careful consideration of the neuropsychological and psychiatric impact of the injury. However, consideration of the impact of his head injury should not distract attention from the possibility that Mark might (also) have another

mental disorder. As regards whether he is deliberately exaggerating or feigning cognitive problems, it is possible for there to be a combination of cognitive impairment plus genuine mental disorder *and* exaggeration of the degree of impairment. There are clinical methods to try to understand the overlap but, ultimately, no opinion can wholly remove any uncertainty.

What is malingering?

Malingering is the deliberate fabrication of symptoms or deficits where there is a strong incentive to deceive. This needs to be contrasted with, for example, 'lack of effort', where a defendant simply does not engage fully with an assessment – wherein poor attention, fatigue, depression and anxiety, for example, can all contribute to a 'lack of effort'. It is also to be distinguished from presentation of symptoms that arise from mental pathology and do not amount to 'deliberate (and fully conscious) fabrication or exaggeration – for example, 'factitious disorder' (a mental disorder in which a patient assumes 'a sick role' in order to gain attention or care, in the absence of any apparent external incentive).

Any forensic assessment should include a section dealing with the 'validity' basis of the clinical opinion expressed – both because this is good practice and because of the false perception that malingered mental disorder is common in criminal proceedings, so that failure to address malingering is likely to be perceived as naïve. Typically, malingering relates to cognitive deficits, commonly memory, or symptoms of mental illness. However, the clear distinction should be drawn between 'likely validity' and 'malingering'.

Assessment for amnesia per se

In the absence of concern about possible malingering, the following should be noted concerning assessment of amnesia (albeit one should *always* be wary as to the possibility of claimed amnesia being malingered or exaggerated).

Amnesia for violent offences can be fabricated (see below), but it is also common as a valid symptom, especially in relation to severe violent offences, in that between 25% and 70% of violent offenders claim amnesia for the offence in circumstances post-conviction, wherein they have no incentive to do so.

In summary, there is an increased rate of likely valid amnesia in those:

- Exhibiting some psychiatric disorders
- Who have used alcohol or substances at the time of offence
- With history of alcohol dependency/misuse
- Who are not habitually violent, and have been involved in a severely violent episode

Clinical assessment of claimed amnesia, including where it is suspected to be malingered, requires a full medical history to be taken, including assessing for evidence of:

- Sleepwalking
- Epilepsy
- Head injury (past or recent)
- Diabetes
- Current medication that can interfere with consciousness and memory

- History of trauma and abuse (which might cause mental dissociation)

There should then be taken a detailed history of the exact narrative of the episode of claimed amnesia (last thing remembered, islets of memory, length of amnesic gap); and of the pattern of any previous, or subsequent, episodes.

Look also for (in)consistency between the defendant's current account and any account they gave previously – for example, as recorded in the depositions or police interviews.

How could you attempt to assess Mark specifically for malingered amnesia?

Arguably, malingering is not a psychiatric disorder (but see below in regard to DSM5), and so there should always be caution in assessing for it. Rather, as already suggested, it should be addressed in terms of 'what are the factors supportive of validity, or of invalidity, of the symptoms presented?'

Memory is a complex process, with fallibility at different levels. And it is important to consider, first, what are the *likely reasons* in the subject for a false claim of either a period of amnesia, or of ongoing memory disability, and then look for:

- Any internal inconsistency in the defendant's account
- Any inconsistency between the defendant's self-report and other information
- Any inconsistency between symptoms claimed and observed behaviour
- Whether the nature of the description of memory deficits fails to come out at interview in a way that is common and clinically coherent in someone with a valid memory disability
- Absence of a usual response to valid memory difficulty, in that genuine amnesia, or memory difficulties, commonly give rise to anxiety and concern, unless the claimed memory disability is accompanied by some other disorder – either organic or functional – that would tend to modify this natural response (for example, he is suffering with fronto-temporal dementia, which is characterised by lack of insight and emotional blunting)
- The degree to which the defendant's account fails to accord with the usual natural history of the likely pathological cause of his memory disability

Similar requirements apply to determining the likely validity, or not, of other mental symptoms complained of by a defendant – for example, psychotic experiences.

The assessment of Mark should also include scrutiny of his responses to questions put to him. People who are malingering may inadvertently lapse in their pretence of memory problems. It is not, however, an assessment intended to catch the subject out. Normal memory is fallible and many factors can cause memory problems – for example, stress, sleep deprivation, anxiety, mood disorders, and drug or alcohol use.

Individuals who have previously suffered from a given mental condition typically find it easier to fabricate symptoms on a further occasion than those who have not and, in such cases, psychological testing can particularly assist (see below). Mark's testing strongly suggests at least an element of malingering, and it will be important for this to be addressed by other, clinical, means.

Psychological assessment of malingering

As with Mark, if there is concern about possible malingering, a specialist psychological assessment – using tests containing elements directly or indirectly relevant to malingering – can help to determine the issue, usually by way of ‘triangulation’ of clinical *and* a range of clinical psychological approaches (that is, clinical *and* metric-based).

Hence, a psychologist will properly look for:

- Floor effect – a defendant performing very poorly on the majority of tests
- Below-chance responding on ‘forced choice’ symptom validity tests, such as the TOMM and the Word Memory Test (WMT)
- Performance suggesting malingering on a forced choice test – for example the ‘coin in hand’ test; such tests are, in reality, easy but they are set up with the defendant as if they are difficult, who, if malingering, then performs intentionally poorly
- Better performance on harder tasks than on easier ones
- Large errors in answers to questions (for example, stating that it is 1908 when asked to identify the current year)

Legal

What factors should be considered when assessing whether a defendant is/was fit to be interviewed?

Claimed amnesia for an alleged offence, be it valid or malingered, is not a potential basis for a finding – either concurrent or retrospective – of unfitness to be/have been interviewed, since many questions can be asked about other matters not directly applicable to the event of the alleged offence per se. Hence, only if you were to find that – aside from Mark’s claimed amnesia for events relating directly to the alleged offence – he was also claiming, validly or otherwise, ‘current’ memory disabilities could that be relevant to his fitness to be interviewed (for example, a chronic alcoholic with amnesic syndrome might not be able to hold information, or earlier posed questions, in his mind for long enough to participate effectively in a police interview).

There is no formal legal test, in English law, of ‘fitness to be interviewed’; but if asked to comment upon such fitness, an expert needs to conduct a functional assessment of essentially the suspect’s capacity to offer effective participation, or to have effectively participated, in a police interview. Also, ‘fitness to be interviewed’ is distinct from consideration of the likely ‘reliability of interviews’. There are relatively few situations where a psychiatrist will assess someone for fitness to be interviewed at the time they are arrested, so it is more likely to be a retrospective opinion that is offered.

As regards Mark’s claimed memory disability, asking him about his recollection of his arrest and the interview, as well as how he answered questions, will be important. If he does not remember these (that is, not only does he not recall events related to the alleged offence but also the police interviews), then consider whether Mark can now, albeit in retrospect:

- Understand the nature and purpose of such interviews

- Comprehend the questions that were put to him
- Appreciate the significance of the answers given
- Show evidence of being able to make rational decisions about what he would wish to say

Sample questions to assess fitness to be/have been interviewed include:

- Do you understand why you have been/were arrested?
- What did the police want to find out in the interview?
- Who could you turn to/have turned to for help during the interview?
- What would/did you do if you did not want/had not wanted to answer a question?

Further, it is important to set any demonstrated ‘disabilities’ in regard to being interviewed in the context of the defendant’s specific mental disorder(s), so that the court can see ‘from what’ any possible unfitness arises. And, if the assessment occurs before interview, evaluate how any disability can be ameliorated – for example, by waiting for a suspect to come out of ‘drug or alcohol withdrawal’, or be treated for symptoms of severe mental illness. Hence, in Mark’s case, any failure to answer questions, or possibility of confabulation, should be explained in terms of his brain abnormality – albeit it may not be valid.

Finally, a police interview should not go ahead, or have gone ahead, if it is/was likely to cause significant harm to the suspect’s physical or mental state – although frequently police interviews do proceed without this having been considered.

Instructions – fitness to have been interviewed

1. Explain the impact of any condition you have diagnosed on:
 - a) The defendant’s concentration and attention
 - b) The defendant’s ability to have understood the questions asked during his interview
 - c) The defendant’s capacity to have decided whether to answer questions
 - d) The defendant’s ability to have understood the significance of the answers that they gave
2. Explain which symptoms of the condition caused any difficulties you have highlighted in 1. above.
3. Explain whether the defendant had the capacity to decide on whether to instruct a legal representative at the time of his interview. If you find that he lacked capacity, please explain – with reference to symptoms of any mental disorder you have diagnosed – why you have reached this conclusion.

Ethical and professional issues

Should psychiatrists comment upon possible malingering?

There is very real question as to whether a psychiatric expert should ever address whether someone is malingering in the context of legal proceedings, in that this can come very close to – or even be equivalent

to – expressing an expert opinion in terms of ‘he is lying’ (or not). However, although it is usually assumed that your patient is telling you the truth in clinical practice, it is still normal practice to take a view as to whether symptoms described are clinically coherent and, if not, then whether any apparent incoherence, and/or apparent unreliability, is causally linked to the possibility – or already known fact – of some type of mental disorder.

Beyond this, in criminal proceedings, defendants may have reasons not to tell the truth, including about mental symptoms, and so it is naïve – or will be challenged as naïve – to address a defendant ‘as an ordinary patient’. Hence, it is reasonable to take a ‘clinical view’ as to the likely validity of symptoms described by a defendant – this being a clinically grounded process, as described above, to be distinguished from assessment of ‘whether the defendant is lying’ about ordinary matters (albeit ordinary evidence of lying – say, in the case papers – will be of some background relevance to clinical assessment of likely symptom validity).

In summary, psychiatrists specialise in the diagnosis and treatment of mental disorders, albeit within which lies ‘assessment of likely symptom validity’. Arguably, they do not specialise in detecting malingering *per se*. Psychologists, perhaps, have more claim than do psychiatrists to be able to identify people as seeking to exaggerate, or portray themselves in a positive way, or as making little effort when tested, but none of these is specifically directed towards addressing whether someone is consciously fabricating psychopathology.

What if you just don’t know the answer to the question you have been asked?

It is very rare in expert witness practice for a witness to say ‘I don’t know.’ Aside from ‘arrogance’, the legal process itself often encourages an opinion to be expressed – usually in terms of ‘on balance’, or ‘more likely than not’ – so that it is usual for an expert to express their opinion in one direction, even if with some reservation. However, there is of course a duty to be honest in expressing your opinions, including in regard to the degree of confidence with which you hold a view. If an expert genuinely *cannot* answer the question that has been posed, then they should make this clear, and quite clearly so where the question requires expertise beyond their knowledge and experience.

If you are asked ‘Is Mark malingering?’, then you might respond by giving opinions about the nature of any mental disorder you decide that he exhibits, and the significance of any psychological assessments in the context of your assessment – but avoid expressing an opinion on the question as asked. This might mean that you infer what you believe the ‘truth’ to be, but you allow room for the court to exercise its own proper function.

Additional information

Psychological assessment for malingering of mental symptoms

Malingering is defined as the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives.

Feigning is the deliberate fabrication or gross exaggeration of psychological or physical symptoms without any assumptions about its goals.

Appropriate adults – Dominica

Criminal Law and Procedure Act, Schedule 2, as would be amended by the Criminal Law and Procedure (Amendment) Bill

6. Vulnerable persons

- 6.1 An electronically recorded Custodial Interview of a vulnerable person must take place in the presence of an appropriate adult.
- 6.2 If the only obstacle to an electronically recorded custodial interview is that a juvenile's parent or guardian is unavailable and all reasonable efforts to contact them have failed, an authorizing officer may authorize the Law Enforcement Officer to proceed with the electronically recorded Custodial Interview. In all such cases the authorizing officer shall make a note in specific terms of the reasons for proceeding with electronically recording the Custodial Interview in the absence of an appropriate adult.
- 6.3 If a person is blind, seriously visually impaired or unable to read, an authorizing officer shall make sure his legal adviser, relative, appropriate adult or some other person likely to take an interest in him, and who is not involved in the investigation, is available to help check any documentation. When this Guidance requires signing, the person assisting may be asked to sign instead, if the suspect prefers. This paragraph does not require an appropriate adult to be called solely to assist in checking and signing documentation for a person who is not a juvenile, or mentally disordered or otherwise mentally vulnerable.
- 6.4 If any procedure in this Guidance requires information to be given to or sought from a suspect, it must be given or sought in the presence of the appropriate adult if the suspect is mentally disordered, otherwise mentally vulnerable or a juvenile. If the appropriate adult is not present when the information is first given or sought, the procedure must be repeated in the presence of the appropriate adult when he arrives, so that the appropriate adult is fully informed before the procedure takes place.

The usual assessment protocol is to establish the presence of feigning first, and motivation for feigning and the probability of malingering second.

Tests such as *Structured Interview of Reported Symptoms-2 (SIRS-2)*, *Structured Inventory of Malingered Symptomatology (SIMS)*, and *Miller Forensic Assessment of Symptoms Test (M-FAST)* are designed to detect identify malingered psychopathology.

Miller Forensic Assessment of Symptoms Test (M-FAST) is a 25-item structured screening interview. It consists of seven items: Unusual Hallucinations; Reported versus Observed; Rare Combinations; Extreme Symptomatology; Negative Image; Unusual Symptom Course; and Suggestibility. A positive score indicates the need for further assessment.

Structured Inventory of Malingered Symptomatology (SIMS) is a 75-item screening self-report test that consists of five subscales: Low Intelligence; Amnesic Disorders; Neurological Impairment; Affective

Disorders; and Psychosis – hence, it can be particularly useful when assessing individuals who present with cognitive deficits and neurological complaints.

Structured Interview of Reported Symptoms – 2nd Edition (SIRS-2) is the most widely used and comprehensive assessment for detecting feigned psychopathology. It is a 172-item structured interview assessing a wide range of psychiatric symptoms. It consists of eight primary scales: Rare Symptoms (RS); Symptom Combinations (SC); Improbable and Absurd Symptoms (IA); Blatant Symptoms (BL); Subtle Symptoms (SU); Selectivity of Symptoms (SEL); Severity of Symptoms (SEV); and Reported Versus Observed Symptoms (RO).

The Paulhus Deception Scale (PDS) assesses forms of socially desirable responding, namely Self-Deceptive Enhancement (SDE) and Impression Management (IM), which are associated with malingering.

Symptom validity ‘forced-choice’ tests, such as the *Test of Memory Malingering (TOMM)*, are used to assess malingering of cognitive deficits. These tests investigate whether the individual is putting in ‘optimal effort’, and whether the observed result is a true representation of their abilities. If the individual performs below the chance level (worse than you would obtain by flipping a coin), it is likely that he knew the correct answers and purposely provided incorrect answers.

Once the presence of feigning is established, the assessor should consider applying the DSM5 criteria to establish the presence of malingering. The DSM5 states that malingering should be strongly suspected if any combination of the following factors is noted to be present: (1) medico-legal context of presentation; (2) marked discrepancy between the person’s claimed stress or disability and the objective findings; (3) lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen; and (4) the presence in the patient of antisocial personality disorder (ASPD).

Case 3

Key themes

- *Clinical* – intellectual disability with personality disorder; suggestibility and compliance
- *Legal* – rebutted confession
- *Psycholegal* – expert opinion on ‘unreliability’

Handbook references

- Personality disorder (p21)
- Learning disability (p23)
- Interrogative suggestibility and compliance (p53)
- Reliability of confessions (p96)

Case history

After a killing in his local area, Lee went to a nearby police station and asked to speak to the detective in charge of the investigation. He was interviewed and subsequently charged with two murders. Lee had previously been assessed by his local psychiatrist, and the following is an excerpt from a letter by the psychiatrist he saw to his family doctor:

Lee said that his mother told him that he could have died in utero. He does not know what difficulties there were during his mother's pregnancy. He was unable to tell me any details of his early development.

'Generally, his memory of childhood events was poor. He was not able to tell me of any specifically good or bad childhood memories. He told me that he had been physically disciplined by his mother, sometimes with a belt. He feared her on occasions. He was not able to tell me the dates that he attended school. He made friends at school and was close to his teachers. He found it "hard" to read and write. He explained that he did not attend secondary school but went to a "church school" for a time, where he learnt "trades, like woodwork".

'He worked as a security guard in his mother's firm for a short time. However, as he could not read and found it "hard" to write, he was unable to sustain this employment.

'He then worked as a "building contractor" for a time. He was "in charge of five men". He would "agree a price" with people who wanted simple building work carried out – for example, the erection of a retaining wall. His wife would assist him with "reading and writing", and a friend would eventually collect the money that was owed. He, himself, would help carry out the building work. He used the money to buy clothes for a market stall that he ran. Again, his wife would "do the paperwork" for this. He would also sell "pants and hats", and regularly made a profit from trading – he described himself as "a good salesman".

'He has lived with his wife for nine years. She had children from a previous relationship. His wife would cook meals for the family. Both would look after the family finances. He had his own bank account. Both would carry out shopping, and both would look after the children.'

'Six years ago, he suffered a head injury after falling 15 feet. He bled through the nose and was in hospital for around a year.'

A psychological report has already been obtained. The clinical psychologist carried out a number of objective tests of Lee's cognitive state and, in his report, Lee is described as having 'a reading age of between six and seven years. Lee's performance on testing suggested an intellectual level within the least-able 1% of the population'.

You are asked to assess Lee and prepare an expert report concerning his confession and whether it is reliable.

The ultimate issue and usurping the court

From Pora v The Queen [2015] UKPC 9 (NZ)

In this case, a clinical and forensic psychologist was instructed in relation to the mental state of the defendant and the reliability of confession evidence.

It is the duty of an expert witness to provide material on which a court can form its own conclusions on relevant issues. On occasions that may involve the witness expressing an opinion about whether, for instance, an individual suffered from a particular condition or vulnerability. The expert witness should be careful to recognise, however, the need to avoid supplanting the court's role as the ultimate decision-maker on matters that are central to the outcome of the case. Professor Gudjonsson trenchantly asserts that Pora's confessions are unreliable and he advances a theory as to why the appellant confessed. In the Board's view this goes beyond his role. It is for the court to decide if the confessions are reliable and to reach conclusions on any reasons for their possible falsity. It would be open to Professor Gudjonsson to give evidence of his opinion as to why, by reason of his psychological assessment of the appellant, Pora might be disposed to make an unreliable confession but, in the Board's view, it is not open to him to assert that the confession is in fact unreliable.

Clinical

The instructing lawyers may not know that some accused persons and defendants can be vulnerable, specifically in terms of being 'suggestible' and/or 'compliant', which are essentially clinical, or quasi-clinical constructs, and which certainly are known to be associated with some types of mental disorder. You may have to inform them in broad outline of the relevant scientific literature, and essentially pose for yourself the question: 'Is the defendant either or both abnormally suggestible or compliant?'. If so, is there evidence to suggest that such suggestibility and/or compliance operated during the relevant police interview? Alternatively, the lawyers may be psycholegally 'canny' and ask you specifically to address 'suggestibility' and 'compliance'.

Suggestibility (properly known as ‘interrogative suggestibility’) represents the extent to which, within a closed social interaction, an individual comes to accept – that is, believe – messages or information communicated to them during formal questioning within a police interview, or potentially during cross-examination (wherein the ‘communication’ will likely not be ‘subtle’, as it might be within an ‘investigative’ police interview, but adversarially more ‘obvious’).

Suggestibility is associated with – that is, more likely in the context of:

- Poor memory recall
- Low intelligence
- High emotionality and anxiety
- High social desirability
- Fear of negative evaluation
- Low assertiveness and self-esteem

Compliance is the tendency to go along with propositions, requests or instructions for some immediate instrumental gain. Usually, within a police interview, this is to escape the immediate pressure being faced, and with the intention ‘I can sort it all out later’. In contrast to those who are suggestible, the individual is fully aware that they are giving false information.

It is associated with:

- Eagerness to please
- Poor self-esteem
- Desire to avoid conflict

How could you carry out an assessment?

A full psychiatric assessment is needed in order to identify any mental disorder that might render Lee more than usually vulnerable to either suggestibility or compliance, and to ‘explain’ any identified abnormal suggestibility or compliance (see below regarding direct assessment of these). It should particularly include focused consideration of any:

- Learning disability (which seems likely)
- Mood disorder
- Psychosis
- Personality disorder (especially with ‘dependent’ and ‘avoidant’ features)

This is a case where there are clues but no certainty concerning a variety of potential, different mental disorders that may be present. This emphasises the need to follow an established, and detailed, method of comprehensive psychiatric assessment and investigation; there is a danger that ‘clues’ towards a particular diagnosis or state may bias the psychiatrist in a particular direction during the assessment.

A detailed psychological assessment is also essential, usually including cognitive assessment. However, additionally specific psychological tools should be applied, notably the *Gudjonsson Suggestibility Scale (GSS)* and the *Gudjonsson Compliance Scale (GCS)*. These latter assessments will augment the psychiatric

assessment, and focus specifically upon suggestibility and compliance. The former is based upon an ‘experiment’ of telling the subject a story and then seeing whether they give in to ‘leading questions’; and then shift their responses further in the same direction after they are provided with negative feedback. The latter is a self-report questionnaire.

If the defendant is shown to be highly suggestible or compliant on testing, then scrutiny of interview transcripts or recordings is required to examine whether there were interactions indicating that Lee was suggestible and/or compliant within the interview. If the results are ‘positive’, then this will both serve further to demonstrate his suggestibility or compliance per se, and also may identify pieces of ‘evidence’ that he gave that are likely to be ‘unreliable’ (see below), though not necessarily ‘false’ (again, see below) – albeit, giving an expert opinion concerning such an inference of ‘unreliability’ can lead the expert towards the proper limits of the psychiatrist’s (or psychologist’s) expertise (again, see below).

Legal

Any rebutted confession, or other aspects of a police interview, deemed by the judge, within a *voir dire*, to be ‘unreliable’ will be excluded from the trial. In your instructions, you have been asked to advise on the reliability of Lee’s confession. If such contested material remains as evidence, then expert evidence can be called (on a second occasion) in order to assist the jury in determining whether they should attach other than normal ‘weight’ to the evidence. In either situation, the expert cannot express an opinion as to whether the confessions are ‘false’.

Clinico-legal

The request to offer an expert opinion on whether Lee’s confession is reliable can infer some psycholegal controversy, since a psychiatrist should avoid commenting on whether or not a defendant is telling the truth, which may erroneously be identified with whether his confession is reliable. It will be important to be clear, including with yourself, that you are addressing only whether there are psychiatric or psychological aspects of Lee that would infer unreliability.

The assessment will, of necessity, require the transcripts or recordings of the interviews to be read by the expert – and, again, there is a risk, in examination in chief or under cross examination, of the boundary between ‘unreliability’ and ‘falsehood’ becoming blurred. It is crucially important, therefore, to keep to description of clinical constructs – such as diagnosis, mental state, suggestibility and compliance – and to any inference for ‘reliability’, and not for ‘truth/falsehood’. So, beyond description of any mental disorder there may be – and its potential in very general terms to give rise to unreliability of account – you might comment upon the defendant’s:

- Ability to understand the process of having been interviewed and of the significance of making a statement (always with reference to their mental disorder, or characteristics)
- Vulnerability to fear or influence (as a result of their mental disorder or characteristics)
- Demonstrated ‘suggestibility’ and/or ‘compliance’
- Accounts, or interactions, within the police interviews indicative of suggestibility and/or compliance having operated

There is much research evidence that rebutted (distinguished as false) confessions are more common in younger defendants, those with learning disabilities and those under the influence of drugs and/or alcohol.

Given that the police interviews may likely be of obvious evidential importance to the court, in terms of whether the defendant was truthful in them or not, there is a risk of the expert being drawn away from opining solely on ‘reliability’ towards ‘truth or falsehood’. But this must be resisted. The psychiatrist should not become a thirteenth juror.

Ethical and professional issues

Should an expert declare a confession unreliable?

Beyond keeping to the boundary of not opining on the ‘truth/falsehood’ of Lee’s confession, there is a further question of whether the expert should even go so far as to express an opinion upon the ‘reliability’ of the confessions. In doing so, of necessity he will take a view of the nature of the exchanges within the interview per se, in order to determine whether Lee’s abnormal suggestibility or compliance ‘operated’; yet the jury must also take an ordinary view on the nature and implications of the exchanges, in terms of whether they appear to be reliable. Hence, in opining on ‘reliability’ the expert is, indeed, becoming a ‘thirteenth jury person’ – that is, going beyond simply giving an opinion that the defendant is abnormally suggestible or compliant.

Clearly, the question of whether someone’s confession can be relied upon is ultimately for the court to determine. There is a clear distinction to be drawn between ‘expert evidence inferring unreliability’ and ‘ordinary evidence inferring either unreliability or reliability’, so the expert should properly keep within the bounds of ‘expert evidence inferring (un)reliability’ – and, as in other legal situations, not offer an ‘ultimate’ opinion on whether the interviews, or aspects thereof, are reliable or not. Describing Lee’s mental disorder and its impact on his likely behaviour during a police interview will, for example, fall one side of the line; but giving a clear opinion that what he said should (therefore) be viewed as unreliable is likely to be on the wrong side of that line. Although there is inevitably variability in what courts will ‘allow’ the psychiatrist to address, he should take great care to maintain the proper boundary for himself.

Additional information

Psychological assessment of suggestibility and compliance

Psychological assessment for suggestibility and compliance involves a full psychological assessment, including obtaining a full developmental and social history, assessing the defendant’s personality style and their ability to function under stress, and applying formal tests of suggestibility and compliance.

The Gudjonsson Suggestibility Scale (GSS) was developed to identify people who are susceptible to erroneous testimony during interrogative questioning by the police. It measures ‘interrogative suggestibility’, which is defined as ‘the extent to which, within a closed social interaction, people come to accept messages communicated during formal questioning, as the result of which their subsequent behavioural response is affected’. The GSS assesses the individual’s suggestibility to ‘yield’ to leading questions and then ‘shift’ even further in the same direction after receiving negative feedback. Individuals with learning disabilities

and children tend to perform worse on the GSS, as they are more susceptible to altering their answers under influence or pressure.

The Gudjonsson Compliance Scale (GCS) is a self-report measure of compliance that assesses the individual's eagerness to please and avoid conflict and confrontation.

Instructions – confessions, suggestibility and compliance

1. With reference to psychological testing, please describe whether the defendant is suggestible and to what degree. Explain the way in which any suggestibility might impact on his function.
2. With reference to psychological testing, please describe whether the defendant is compliant and to what degree. Explain the way in which any suggestibility might impact on his function.
3. Describe whether any condition you have diagnosed and the results of psychological testing indicate that the defendant's confession might be unreliable. Please explain your response, with reference to specific symptoms or characteristics found in the defendant.

Case 4

Key themes

- *Clinical* – intellectual disability
- *Legal* – fitness to plead and stand trial
- *Psycholegal* – disagreement between psychologist and psychiatrist

Handbook references

- Learning disability (p23)
- Neuropsychological assessment (p49)
- Changing and adding to reports (p82)
- Fitness to plead and stand trial (p98)

Case history

Kirani has been charged with the murder of Mr Jones, an elderly man.

Mrs Jones had been seated in a part of the house known as the gallery at around 8.30am. She heard her husband cry out: 'Boy! boy!'. She made her way to the corridor from where the cry had come and there she saw a man holding a knife to the head of her husband. Blood was streaming from Mr Jones. Mrs Jones ran to her husband's aid and pulled the attacker, trying to get him away from Mr Jones. The man then stabbed her in the forehead. She continued to struggle with him and he struck her with a bench, whereupon Mrs Jones fell to the ground, landing in a seated position. The attacker stood over her and in front of her. She began to scream for help.

Her screams were heard by neighbours. One climbed over the fence and approached the house. He looked through a window and saw Mrs Jones on the floor covered in blood. He attempted to gain access to the house but found all the doors that he tried were locked. He returned to the front of the house and heard an unidentified neighbour shout that someone was running from the house. The neighbour then observed a man running from the house, wearing a white T-shirt. The man jumped over a fence and fled.

The neighbour entered the house, and she saw prints of sneakers in the blood leading through the kitchen and bedroom, and blood on the steps outside the house. The prosecution contend that these prints must have been made by the attacker. The attacker, according to Mrs Jones, was dressed in a dark overall and was carrying a backpack.

At 9am, police officers were summoned to a place not far from the Jones' home. There they found a crowd of people. Some of the crowd were holding Kirani, a 25-year-old man. He had been apprehended by some of those present. He appeared to be exhausted, was breathing heavily and was carrying a backpack.

The prosecution's case is that Kirani had gone to the Jones' home with clothes in his backpack and that he changed into these after killing Mr Jones, disposing of the dark overall which Mrs Jones had seen him wearing at the time of the attack. When Kirani was subsequently detained, he was found to be wearing a white T-shirt under a dark outer garment. A minuscule amount of blood was found on the white T-shirt and the dark outer garment worn by the appellant.

Two days after the killing, an identity parade was conducted during which Mrs Jones positively identified Kirani.

His lawyer has concerns about his intellectual functioning.

You are asked to give an opinion on Kirani's fitness to plead and stand trial.

Clinical

A full psychiatric assessment would need to be augmented by consideration of the separate components of the fitness to plead and stand trial test (see below). An assessment of cognitive function by a psychologist is necessary where the concern is intellectual function and a requirement, potentially, to make a diagnosis of intellectual disability. If your psychiatric evaluation of Kirani concludes that he was suffering from a mild learning disability, the diagnosis does not answer the question of fitness to plead and stand trial (again see below); and it is necessary to consider the nature and degree of the cognitive impairment, including in the specific context of the fitness to plead criteria, in order to provide an opinion as to whether, how, and to what extent Kirani's intellectual disability impacts upon each of the abilities required for fitness. Clearly, the complexity of the evidence and 'narrative' of the prosecution case – and of any defence evidence that may be available to counter this – will be relevant to the defendant's fitness, and so the 'boundary' between clinical assessment per se and fitness may become somewhat blurred.

Legal

Defendants are assumed fit to plead, unless they come within the terms of 'unfitness' as described in *R v Pritchard* and *R v M (John)* (see Handbook). That is:

Whether the defendant is of sufficient intellect to comprehend the course of the proceedings of the trial, so as to make a proper defence; to challenge a juror to whom he might wish to object; and to understand the details of the evidence

This is usually interpreted as relating to separate criteria of:

- Understanding the charges
- Deciding on whether to enter a guilty or not guilty plea
- Being able to challenge a juror
- Being able to instruct legal representatives before and during any trial
- Following and understanding the details of the evidence
- Giving evidence in their own defence

Clinico-legal

Beyond clinical assessment of any mental disorders or disabilities that you may have determined to be present now in Kirani (it is his state now, and not at the time of the offence that matters), and any access you may have to psychometric assessment of him (see below), it will be necessary within your interview with Kirani therefore to ask questions of him that go directly to each of the legal criteria. You must interpret his answers in light of your clinical assessment of his disabilities and their severity. So you might ask the following questions, under each legal criterion:

Understanding the charges

- What are you charged with?
- What does that mean?
- Can you explain what they say you did?

[You find, for example, that Kirani appears to have a basic understanding of the nature of the charge against him, and that he understood that ‘murder’ involves killing someone.]

Deciding whether to plead guilty or not

- Can you explain the difference between pleading guilty and not guilty?
- Do you know why they say you did it?

[Kirani seems to understand that ‘guilty’ means that he accepts that he committed the act. However, his understanding is relatively superficial, and his cognitive impairment determines that he might struggle to understand more complex matters, such as the standard of proof ‘beyond reasonable doubt’.]

Exercise his right to challenge jurors

- Do you know what the jury does?
- What would you do if you saw someone you knew on the jury?

[There is no reason on examination to suspect that Kirani could not recognise someone and identify them in court if they were on a jury.]

Instruct solicitors and counsel

This matter is likely to be assessed by considering the way in which Kirani is able to follow your questions and respond to them. Kirani’s ability to assimilate information and respond to new information can also be assessed. Kirani’s legal representative might also describe any difficulties they are having – and it is good practice to interview defence lawyers in these terms.

[Kirani can give you a basic account of the allegation against him. He can understand basic questions, but you have concerns that he might not understand more complex ones. There seemed a risk that his answers would be over-simplified and limited by his intellectual capacity. When you introduce additional complexity, he seems to struggle to incorporate this into his understanding and fails to use this information.]

Follow the course of proceedings

Again, the way in which Kirani is able to follow your questions, including his responses to more complex questions, will inform your overall opinion in relation to this.

[You conclude that Kirani likely could only follow complex matters in a limited way. He could probably understand direct questions, but once multiple themes are introduced it is unlikely that he would be able to follow matters to an extent that would allow his participation in the trial process.]

Procedure when accused does not understand proceedings – Botswana

Criminal Procedure and Evidence Act

If the accused, though not insane, cannot be made to understand the proceedings, the judicial officer may proceed with the preparatory examination or trial, and, if the examination results in a committal for trial, or where the trial is before a magistrate's court and results in a conviction, the proceedings shall be forwarded to the High Court with a report of the circumstances, and the High Court shall make thereon such order as it thinks fit.

Give evidence in his own defence

[Kirani seems likely to be able to give oral evidence, but his ability to weigh up how he may wish to answer questions would probably be limited, in your opinion.]

Based upon your findings that Kirani is lacking in any of the criteria, you will need to describe both his apparent inability and its pathological bases. You are likely, then, to be asked the 'ultimate' legal question: 'Is he fit to plead?' Most psychiatrists will answer this question, based upon the fact that, although it is a 'legal' question, (in most jurisdictions) it will be a judge who determines the outcome – and because the tests are tests of 'capacity', which are 'close cousins' of clinical constructs.

In some fitness hearings, it may be necessary also to give an opinion on whether, under the pressure of trial, a defendant who is currently fit to plead will likely *remain* fit. This infers a more difficult expert task, since any opinion relies upon prognostication about both the nature of the proceedings as they will likely unfold and the defendant's reaction to them.

In a case where unfitness is caused by a 'reversible', or treatable, condition, it will usually be sensible to advise that a 'fitness hearing' be put off until attempts at treatment have been pursued (this will not likely apply to Kirani, given the likely permanent nature of his disabilities).

Finally, where a defendant is 'just fit', it may be sensible to advise the court on what 'special measures' might be put in place that would 'enhance' his functioning – although, commonly, this is best proposed by a clinical psychologist (see below).

Psychologists and fitness to plead

Some jurisdictions specify that fitness to plead is a matter for only medical practitioners to address as an expert. Assuming you have assessed Kirani, and having concluded that he is not fit to plead and stand trial, a psychologist subsequently carries out an assessment.

On the basis of the history that Kirani gives, the psychologist forms the view that his level of functioning is that of someone who has an intellectual disability – that opinion being supported by psychometric testing. The *Wechsler Adult Intelligence Scale IV (WAIS-IV)* test was administered to Kirani. His verbal IQ was found to be 75, his performance IQ 65, giving a full-scale IQ of 68. On this basis, the psychologist concluded that Kirani's performance fell in the 'extremely low' category of intellectual functioning, whereby fewer than 2% of the population would be expected to achieve a result lower than that of Kirani.

The psychologist concluded, however, that even given this level of intellectual impairment, Kirani was likely to be fit to plead and stand trial, providing that the lawyers do not use language that is too complex, or link several ideas or issues within one question, and he is allowed breaks to check his level of understanding.

Instructions – fitness to plead and stand trial

1. With reference to any condition that you have diagnosed, explain whether the defendant is able now to:
 - a) Understand the nature of the charges
 - b) Decide on the whether to plead guilty or not
 - c) Exercise his right to challenge jurors
 - d) Instruct his legal representatives
 - i) Can he understand the relevant information, apply his mind to the information and communicate intelligibly his instructions?
 - e) Follow the course of proceedings
 - i) Will he understand the evidence, apply his mind to it and be able to respond intelligibly to it?
 - f) Give evidence in his own defence
 - i) Will he understand questions, apply his mind to answering them and communicate his answers intelligibly?
2. Indicate clearly if the defendant is unable to satisfy any of the requirements above. If you describe impairment in any of the above abilities, indicate whether, in your opinion, the impairment amounts to him being unable to complete that requirement.
3. If you conclude that the defendant is unfit to plead and stand trial, please indicate whether the proceedings might be modified in any way so that he can participate.
4. Indicate whether the defendant is likely to recover from any condition you have diagnosed and what the duration to recovery is likely to be.
5. Indicate whether recovery may be accompanied by them becoming fit to plead and stand trial.

Variations in the statutory terminology for mental disorder relating to fitness to plead

Long term	Jurisdiction
Insane and unfit	Antigua and Barbuda The Bahamas Belize Grenada Guyana St Kitts and Nevis Trinidad and Tobago
Fitness to stand trial (including fitness to plead)	Jamaica
Of unsound mind and incapable of making his defence	Bangladesh Botswana Ghana Kenya Malawi Malaysia Nigeria Pakistan Sierra Leone Singapore Sri Lanka Tanzania St Vincent and the Grenadines
Of unsoundness of mind or of any other disability and incapable of making a proper defence	Zambia
Mentally ill and unfit	St Lucia
No statutory term	Barbados Cameroon Dominica India Lesotho Swaziland Uganda

Ethical and professional issues

Managing disagreement between psychologists and psychiatrists

The expert evidence of psychiatrists and psychologists can often work synergistically; for example, the diagnosis of a personality disorder may be strengthened if supported conjointly by the clinical examination of a psychiatrist and the results of personality assessments administered by a psychologist.

However, conflict between the evidence of psychiatrists and psychologists can sometimes arise, especially when psychometric tests have been administered. Not uncommonly, there can be dispute as to the meaning of a test score – for example, whether it indicates pathology or – as in the case of Kirani – concerning the functional significance of the test results.

If conflict does arise, it is important for all those involved to keep within their own field and methodology of expertise, in terms of whether those instructed are qualified to administer tests; interpret tests; make a diagnosis; or offer advice on treatment. And much will depend upon both the details of the individual case and the individual clinician.

In this case, it will be important to understand the basis of the difference of opinion, with explicit reference to the *Pritchard* criteria and which of these criteria is in dispute. For the court, it is likely to be helpful if a ‘joint statement’ of areas of agreement and disagreement can be produced, so that the areas of conflict can be made explicit – and, if necessary, explored by the court by way of both experts giving oral evidence.

Additional information

Neuropsychological assessment of intellectual function

Clinical psychologists and neuropsychologists apply psychometric tests to obtain a measure of individuals’ general intellectual functioning (intelligence quotient (IQ)). These tests utilise normal distribution statistical models, and the individual’s scores are then compared with the known ‘norms’. Hence, the test has to be relevant to the person’s age, culture and language background. Adaptations of the tests have been published worldwide with the relevant norms included.

The *Wechsler Adult Intelligence Scale-IV (WAIS-IV)* is the most widely used clinical instrument to assess intellectual functioning. It is an individually administered psychometric assessment that is designed to assess intellectual functioning of adolescents and adults aged 16 years to 90 years. The test provides general intellectual functioning (full-scale IQ) and four index scores: verbal comprehension; perceptual reasoning; working memory; and processing speed. The mean IQ is 100, and an IQ of 69 – which is more than two standard deviations below the mean – is considered to indicate the presence of ‘intellectual impairment’.

Importantly, factors such as poor effort, intoxication, fatigue and low mood can negatively influence the individual’s performance on the test – hence the need for any of these factors to be taken into consideration before forming an opinion about the individual’s global level of intellectual functioning.

Case 5

Key themes

- *Clinical* – intoxication; dependence; withdrawal; secondary brain damage
- *Legal* – witness statements; professional versus expert witness
- *Clinico-legal* – fitness to have been interviewed; fitness to plead and stand trial

Handbook references

- Alcohol and drug misuse and dependence (p21)
- Acquired brain injury (p24)
- Before accepting instructions (p31)
- Neuropsychological assessment (p49)
- Fitness to have been interviewed (p95)
- Fitness to plead and stand trial (p98)

Case history

Nigel is brought by the police to the emergency room (ER) when you are on duty. You are told that he had been arrested in the street 72 hours earlier, after being found next to the body of a man in an alleyway. The two men were believed to have been acquaintances. The victim had died from head injuries. Several bottles of alcohol were close by, and Nigel smelt strongly of alcohol when arrested.

Nigel was interviewed by the police and replied 'No comment' to all the questions that were put to him. He claimed not to be able to remember how he came to be next to the victim. You are the psychiatrist on call in the ER.

Nigel's previous medical records show that he is 50 years old and has a long history of very heavy alcohol use, having reported previously that he had drunk two litres of spirits a day for 15 years. He has attended the ER previously, with minor injuries after falling or having been involved in fights.

Nigel received no medical treatment while in police custody. However, the police officers accompanying Nigel say that he was confused. In the ER, he is sweating, shaking and agitated. On examination, he is hypertensive and tachycardic, and blood tests show poor liver function.

Nigel lives in a nearby hostel. The manager told police that he had noticed that, in recent weeks, Nigel had often appeared 'lost', and sometimes seemed 'out of it'. He had also gone missing for a few days at a time recently. The manager also reported that Nigel also generally has poor short- and long-term memory, and is often poorly kempt.

Subsequent to assessing and treating Nigel, you are asked by the police to provide various statements and reports, as described below.

Clinical, legal and clinico-legal

You are asked to provide a statement to the police describing your contact with Nigel and medical opinion on him at the time

In doing so you need to determine what information you should include, and what not.

Ordinary witnesses (for example, ‘eyewitnesses’) give evidence of what they saw/heard/observed. Medical witnesses may also describe factual matters. Hence, they can be asked to describe medical facts that they observed, such as a patient’s presentation and likely condition. In this role, they are acting as a *professional* (not *expert*) witness, similar to acting like an eyewitness, but giving factual evidence that requires professional knowledge in order to interpret and explain it. This might include, for example, describing the typical symptoms of an illness occurring in an individual, or the usual effects of a particular medication. However, to be able to provide such evidence the doctor will necessarily have had some professional involvement with the patient, and will likely have been, at some relevant point, their treating clinician.

A *professional witness* cannot give evidence of opinion, other than in terms of ‘the fact of clinical opinion formed in the course of assessing and treating a patient’. In contrast, an *expert witness* gives ‘opinion evidence’ per se – that is, beyond the foregoing. And an expert witness is qualified as such by virtue of his knowledge, expertise or experience, so that he is able to assist the court in matters outside its own knowledge and experience. Hence, an expert witness:

- Will be independently instructed by a party (or sometimes jointly instructed), or by the court
- Will provide an opinion on an issue within the spheres of their expertise
- Is a ‘secondary’ witness, providing an opinion on established facts (or alternative disputed facts)

All types of witness can be required to attend court and be both examined and cross-examined.

There are specific rules applicable to an expert witness, involving the expert’s obligations to the court and the proper process to carry out an assessment and provide a report.

In Nigel’s case, given that you have been asked by the police to provide a statement about your medical contact with him, you will be acting as a *professional witness*. Staying properly within that designation, you may describe Nigel’s presentation in the ER, using your professional training to comment upon symptoms, diagnosis, cause, prognosis, treatment, and also what you learnt about his medical history in the course of assessing and treating him. However, it would be for a properly instructed *expert witness* to give an opinion beyond that – including, for example, on what his mental state might have been at some time other than when you assessed him, and/or in relation to any legal questions, such as his fitness to plead and stand trial.

Treating clinicians can act as expert witnesses in relation to their own patients. However, there is the potential for ethical and clinical conflict in doing so – for example, in terms of inherent bias, the perception of such bias, or damage to the therapeutic relationship with the patient should the opinion not assist him/her legally. It is, therefore, usually unwise for a treating clinician to stray from acting as a professional witness into an expert witness.

You are then asked whether, during the time he was in the police station, he was likely to have been fit to be interviewed

The Code of Medical Ethics – The Malaysian Medical Association [2002]

The doctor and the law courts

The doctor's usual course when asked in a court of law for medical information concerning a patient in the absence of that patient's consent is to demur on the ground of professional secrecy. The presiding judge however may overrule this contention and direct the medical witness to supply the required information. The doctor has no alternative but to obey unless he is willing to accept imprisonment for contempt of court.

If you respond to this, you will have moved from being a professional to an expert witness – both because you did not assess him in the police station (so did not witness his state then for yourself) and because you are being asked to go beyond medical description, to offer an opinion on the implications of such description in relation to a legal test. In regard to the latter, *any* opinion expressed that 'maps' a medical description onto a legal test (see Handbook) is, by definition, an expert opinion.

Again, if, for example, having said that you cannot comment because you did not assess the man in the police station, you were then shown a witness statement of a forensic medical examiner who assessed the man there, you would then be acting as an expert witness.

Finally, you should note that expert witnesses are properly appointed by either side, or by the court, and not by the police.

Much later, you are then asked by Nigel's defence lawyers to comment upon his fitness to plead and stand trial

Once you accept such an instruction you are again accepting that, should you comply, you will be acting as an expert witness. And this will necessitate a further assessment of the defendant, going beyond your knowledge of him gained in the course of your previous 'professional' contact with him.

Although a full clinical assessment will be necessary, the likely main concern will be Nigel's cognitive deficits, especially his memory impairment. And, very likely, this will likely result in a request by you that a clinical psychologist also be instructed.

Ultimately, you will have to relate your – and the psychologist's – clinical findings to the specific legal criteria for unfitness to plead (see Case 4), so you will need to address the questions:

- Is Nigel's short-term memory so impaired that he cannot understand the charges against him?
- Does he have the ability to decide whether to plead guilty or not, with understanding?
- Does he understand the implications of entering a particular plea?
- Could he exercise his right to challenge a juror?

- Could he instruct his legal representatives so that they can properly defend him? (This is often problematic in defendants who are cognitively impaired, especially if they have short term memory difficulties; and Nigel will need to be able to concentrate and retain complex information in order to be able to discuss this with his solicitor and counsel as the trial unfolds.)
- Is Nigel likely to be able to follow the course of proceedings? (This might well be difficult for him, so you will need to test his attention span and to look for evidence concerning his ability to concentrate, for example, in terms of his day-to-day functioning.)
- Could Nigel give evidence in his own defence? (Amnesia for events related to the alleged offence does not determine legally that Nigel is unfit to plead; however, he needs to be able to achieve some knowledge, if only from witness statements of others, of the circumstances relating to the allegation against him, in order to be able to instruct his legal representatives.)

Finally, you should consider – if Nigel were to be found unfit to plead and stand trial – what would his prognosis be? That is, is it likely that he will regain fitness over time with treatment and/or if he abstains

Outcome of fitness to plead – Jamaica

Criminal Procedure Code

Criminal Justice (Administration) Act, as amended by the Criminal Justice (Administration) (Amendment) Act 2006

- a) Order that the defendant be remanded in custody at the Court's pleasure;
- b) Order, in accordance with the provisions of the Fifth Schedule, that the defendant be admitted, at the Court's pleasure, to a psychiatric Facility named in the order;
- c) Make, in accordance with the provisions of the Sixth Schedule, a supervision and treatment order in respect of the defendant;
- d) Make, in accordance with the provisions of the Seventh Schedule, a guardianship order in respect of the defendant.

Transfer to hospital for assessment of fitness to stand trial – Malaysia

Criminal Procedure Code

Some jurisdictions have statutory procedures for the hospitalisation of people so that their fitness to stand trial might be assessed.

- *If not satisfied that the person is capable of making his defence, the Judge or Magistrate shall postpone the trial and shall remand that person for a period not exceeding one month to be detained for observation in any psychiatric hospital in Malaysia.*
- *The Medical Director of the said psychiatric hospital shall keep that person under observation during the period of his remand and before the expiry of that period shall certify under his hand to the Court his opinion as to the state of mind of that person, and if he is unable within the period to form any definite conclusion, shall so certify to the Court and shall ask for a further remand. Such further remand may extend to a period of two months.*

- *The Public Prosecutor may at any stage of any proceedings prior to the trial order that any accused person whom he suspects to be of unsound mind be sent to a psychiatric hospital for observation for a period not exceeding one month. The Medical Director of that psychiatric hospital shall keep that person under observation during the said period and before the expiry of the said period shall certify under his hand to the Public Prosecutor his opinion as to the state of mind of that person. If the said Medical Director is unable within the said period to form any definite conclusion he shall so certify to the Public Prosecutor, and the Public Prosecutor may order that person to be detained in that psychiatric hospital for a further period not exceeding two months. The Medical Director of a psychiatric hospital may, notwithstanding anything in the Mental Health Act 2001 [Act 615] contained, detain any accused person in respect of whom an order has been made under this subsection for a period not exceeding the period specified in the order.*

from alcohol and, if so, over what time period, since you might wish to recommend that any addressing of unfitness to plead be postponed whilst he receives treatment. Establishing this will depend upon gaining an understanding of the nature of his memory problems and aetiology – for example, if he has a dementing illness, the severity of this will need to be established and also whether his functioning could be improved, despite the diagnosis, by, for instance, treating any current factor that is worsening his functioning.

Ethical and professional issues

Can you refuse to provide an expert report?

This will depend upon the jurisdiction in which the case is located. However, if you do not believe yourself to be competent to be an expert witness, or believe that there are factors that would compromise your ability to be an unbiased and independent expert witness, then you *must* refuse instruction, even if it comes from the court – albeit with an accompanying detailed explanation of your refusal.

Additional information

Neuropsychological assessment of Alcohol-Related Brain Damage (ARBD)

Chronic alcohol use is associated with brain changes involving the prefrontal cortex, limbic system, cerebellum and hippocampus. Whilst their general intellectual functioning tends to be intact, individuals with a history of alcohol misuse may present with impairments in memory; executive functioning (abstract reasoning; impulse control; problem solving); visuo-spatial functioning; speed of processing; and verbal fluency.

A neuropsychological assessment of suspected alcohol-related cognitive impairment should involve a comprehensive test battery, including: a symptom validity test; *Test of Premorbid Functioning (ToPF)*; *Wechsler Adult Intelligence Scale, Fourth UK Edition (WAIS-IV UK)*; *Wechsler Memory Scale, Fourth UK Edition (WMS-IV UK)*; and executive functioning tests (*Stroop Neuropsychological Screening Test (SNST)*; *Hayling and Brixton Test*; *FAS*, verbal fluency test).

Decision-making capacity – Draft legislation in Dominica

Draft legislation in Dominica provides an alternative approach to fitness to plead in the form of 'decision-making capacity'. This test adopts recommendations made by The Law Commission (England and Wales)

In determining the decision-making capacity of a defendant under subsection (1), the court shall take account of –

- a) The complexity of the particular proceedings and gravity of the outcome;
- b) How important any disability is likely to be in the context of the decision the accused must make in the context of the trial which the accused faces;
- c) The ability of the accused to –
 - i) understand the nature of the charge;
 - ii) understand the requirement to tender a plea to the charge and the effect of such a plea;
 - iii) understand the purpose of, and follow the course of, the trial; (iv) understand the evidence that may be given against him;
 - v) instruct and otherwise communicate with his legal representative; and
- b) any other factor which the court considers relevant.

Case 6

Key themes

- *Clinical* – intoxication without dependence; substance-induced psychosis
- *Legal* – capacity to form specific intent
- *Clinico-legal* – retrospective reconstruction of mental state

Handbook references

- Functional psychosis, including paranoid schizophrenia (p20)
- Alcohol and drug misuse and dependence (p21)
- What is special about the context (p29)
- Incapacity to form specific intent (p108)
- Informed consent (p143)

Case history

Charles is charged with the murder of a young woman.

Charles, who is 25 years of age, spent much of the afternoon of the alleged killing drinking strong rum and playing rock music. He picked up the alleged victim, and a male friend, in his car and they drove to a quiet location, where he continued to drink and listen to music.

His friend has stated that the defendant started touching the alleged victim sexually but that she pushed his hand away.

During a subsequent police interview Charles gave the following account: 'A "demon" rose up inside of me and I choked her for about one minute...I then pulled her out of the car...I blocked her mouth and slit her throat... she fell to the ground...I stabbed her in the chest before driving off... I didn't intend to kill her...it was a demon inside my head...I didn't know what I was doing... I was seeing a dark object in front of me and I didn't know what it was... I was not seeing or hearing her in front of me...I didn't know that I was stabbing her.'

He admitted to the police that he had smoked marijuana and crack cocaine over several hours before the killing, adding that he had never smoked these drugs before, and he described himself as 'very high' on drink and drugs at the time of the killing. In addition, he reported that his drinking had steadily increased during the two years before the killing. Witnesses both confirm this and report that he had reported suffering blackouts on three occasions in the past when drinking. However, there is no clear evidence of dependency on alcohol.

Later, he again stated that he did not intend to kill the victim, claiming that he did not know what he was doing and did not see or hear her.

A post mortem showed a slash on the front of the neck, which had cut through the windpipe and the major blood vessels in the neck, plus multiple stab wounds and bruises on the face and down the upper part of the body. There was no evidence of sexual interference.

You are asked to assess whether Charles' use of drugs and alcohol determined that he lacked the capacity to form the intent to commit murder at the time he killed the victim.

Statutory definitions – intoxication – The Bahamas, Grenada

Penal Code and Criminal Code

The use of voluntary intoxication as part of a defence is strictly circumscribed. Some jurisdictions have enacted specific statutory provisions relating to intoxication. In outline, the statutory defences require that the intoxication produced a mental state akin to insanity, but each jurisdiction's provisions should be analysed individually.

Intoxication shall be a defence to any criminal charge if by reason thereof the person charged, at the time of the act or omission complained of, did not know that such an act or omission was wrong or did not know what he was doing; and —

- a) The state of intoxication was caused without his consent by the malicious or negligent act of another person; or*
- b) The person charged was by reason of intoxication insane, temporarily or otherwise, at the time of such act or omission.*

Clinical

A very detailed account of his level of intoxication at the time of the killing will be needed, including:

- How much alcohol he had taken
- Over what time span
- When he had eaten
- Exactly what illicit drugs had he taken
- What was his subjective level of intoxication
- Objectively, how intoxicated he was (for example, how was he able to drive to the scene of the killing, or in what manner did he drive?)
- Does he suffer from any physical conditions that might exacerbate a state of intoxication (for example diabetes, resulting in hypoglycaemia from insulin therapy or hyperglycaemia)?
- What account is there of his use of substances during the weeks before the killing; and what does such use imply in regard to whether he had developed a degree of tolerance – and, if so, to what degree?

- What his behaviour has been when previously intoxicated (for example, is Charles typically violent, losing control, when under the influence of drink and drugs?)
- Does he suffer from any mental disorder beyond episodes of intoxication or dependence? (Co-morbid mental disorders are very common in people who use drugs and/or alcohol.)

Further, you will need to try to determine whether Charles was ‘intoxicated’ or in a ‘substance-induced psychosis’ at the time of the killing.

Legal

All offences, other than those of strict liability, require proof of both *actus reus* and *mens rea* (see Handbook), wherein the *mens rea* will be particular to the offence defined. The required *mens rea* for many offences is ‘intent’ (others include, for example, ‘recklessness’). Further, offences are divided (without much rationality) into those requiring proof of ‘specific intent’ and those requiring proof of only ‘basic intent’. And, whereas severe intoxication can, potentially (though, in practice, very rarely), result in a finding that the defendant lacked the capacity to form the intent for the offence charged if it is an offence requiring proof of specific intent, the same does not apply if the offence requires proof of only basic intent.

Murder is an offence requiring proof of specific intent. It requires ‘the intention to kill or to do really serious harm (where death then results)’.

Clinico-legal

How should you approach determining whether Charles was likely to have had the capacity to form the specific intent to murder?

Charles, if his account is accurate, had consumed large amounts of alcohol and illegal drugs over several hours before the killing. His account raises the possibility that he might not have been able to form the specific intent required in order for him to be convicted of murder (see above). However, his account needs to be weighed against the other available evidence – for example, is there any account from witnesses of what he said or did immediately before, during or after the killing that is relevant? Indeed, whatever view you might form in retrospect of his capacity to have formed the required intent, there might be contemporaneous evidence that he did, in fact, form such intent. Also, how believable is it that he was experiencing a ‘demon’? What is the phenomenology of this experience? And does it suggest psychosis going beyond mere intoxication?

It is crucially important that you do not try to establish what Charles’ intent actually was, but rather focus upon the impact of his mental state upon his capacity to have formed the two required intents. Hence, the aim is to establish what his mental state was likely to have been, and what impact this mental state would have had on his reasoning and decision-making abilities at the time.

Clearly, even if there is a reliable ‘back-tracked’ account of his levels of intoxication, the impact of a given level of alcohol – or other substances – can vary greatly between individuals. Hence, for example, Charles may have been someone who was tolerant to alcohol, so that assessment of his likely blood levels may not be accurate, or his ‘brain response’ to a given level may be characteristically different from ‘the

average person'. He may not have been severely affected by other drugs. Therefore, his capacity cannot be determined ultimately by reference to the quantity of alcohol or drugs he had taken but, rather, on an assessment of what the impact was on him at that time. And, commonly, this is best answered by reference to witness statements of those present at the time of the killing, rather than by way of expert evidence, given the many factors that likely influenced his state.

Finally, the 'threshold' for a finding of incapacity to form specific intent, for whatever offence, is set extremely high in most jurisdictions, such that the defendant must have been all but unable to control his limbs as a result of intoxication (*R v Majewski* [1977]).

All of the above said, it will be important to try to determine whether, in fact, Charles was not merely severely intoxicated when he killed but psychotic – such that the alternative defence of 'insanity', or the partial defence of 'diminished responsibility', might be available to him. So, although he would have been capable of forming the specific intent required for a finding of murder, he would have formed such intent in the context of an abnormal mental state qualifying for one of those two defences.

In addition, you will need to form a view as to whether 'intoxication' and 'substance-induced psychosis' are distinguishable from one another.

Instructions – capacity to have formed intent

1. Indicate, with reference to any condition diagnosed, the likely mental state of the defendant at the time of the alleged offence.
2. Describe the impact of any intoxication with drugs or alcohol on the defendant's mental state at the time of the alleged offence.
3. Describe whether, at the time of the alleged offence, the defendant was likely to have been able to form the intention required for this crime.
 - a) The intention for this offence is described in law as.....
4. Describe, in detail, how you have reached this conclusion, but do not indicate what you believe the defendant's intention to have been.

Ethical and professional issues

How should you take consent from Charles before you interview him?

Defendants who participate in a psychiatric assessment in the course of criminal proceedings are in an unusual and potentially difficult position, in that they are assessed by a doctor employing his usual techniques for engaging with a patient, so as to take a history and complete a mental state examination – but the information obtained will not be held confidentially, as is usually the case in an ordinary doctor-patient encounter. Rather, the information will be shared, at least with the defendants' lawyers and, potentially, far more widely – including with the prosecuting authorities, judge and jury, and even with friends and family, through repetition in court, and with members of the public, via the media. Further,

it will be applied to a non-clinical, justice purpose. All this emphasises the importance of the assessing doctor making the defendant's situation during the assessment plain to him, and doing so before the assessment commences.

Before starting an assessment, it is therefore beholden on a psychiatrist to take full and informed consent from that defendant. In order to give such valid consent, the defendant will need to know who will – or could – gain access to its contents, so the lack of confidentiality applied to the assessment needs to be clearly explained, and documented as having been so. Charles should also be told that the duty of the expert is not to him, or the instructing party, but to the court.

If a defendant, having heard this, refuses to consent, then the assessment should go no further. Perhaps, after discussion with their legal representatives, a defendant might change his view; but a refusal to engage in the production of a report in legal proceedings made with capacity must be respected.

The situation is more complicated if the defendant lacks the capacity to refuse to participate in an assessment. In such a case, the doctrine of 'acting in the individual's best interests' – as is applied in respect of other clinical medical situations – needs to be followed, in conjunction with consultation with his lawyers. And often preparing a report will be the right way forward, because for a defendant to lack capacity it is likely that they have significant mental health and/or cognitive problems, so it is not likely to assist them if the court is deprived of information about these. However, it is particularly difficult in such cases to balance the overriding duty to the court to be impartial and frank with the medical prerequisite of doing no harm; and care will be needed only to include material in the report which is necessary for the court to know.

Finally, any matter relevant to the obtaining of consent – or failure to do so – including your reasoning, needs to be clearly documented.

Code of ethics – Pakistan Medical and Dental Council

Prisoners

Prisoners who are ill must be treated in the same manner as other sick people. However, doctors have a right to take appropriate precautions if they think there is a possibility of physical violence by the patient. Where a suspect refuses consent to a medical examination, the doctor unless directed to the contrary by a court of law, shall refuse to make any statement based on his observation of the suspect other than to advise the police whether or not the suspect appears to require immediate treatment or removal to hospital. This does not, of course, preclude the doctor from making a statement in court based on such observation in circumstances where the accused later gives his consent to disclosure.

Case 7

Key themes

- *Clinical* – delusional disorder; drug-induced psychosis or intoxication
- *Legal* – insanity
- *Clinico-legal* – retrospective reconstruction of mental state

Handbook references

- Functional psychosis, including paranoid schizophrenia (p20)
- Alcohol and drug misuse and dependence (p21)
- Assessment (p33)
- Insanity (p104)

Case history

Ten years ago, Anthony, a 36-year-old man, was given a mandatory death sentence after being convicted of two offences of murder. He was not assessed psychiatrically pre-trial.

On the evening before the offences, he and his co-accused purchased two containers of gasoline from a petrol station. Early the next morning, armed with wooden posts and manufactured torches, they entered a cathedral where a communion mass was being celebrated. They lit the torches and sprinkled gasoline over members of the large congregation, beating those who attempted to disarm them. The two men then walked towards the altar. An elderly, frail, male priest approached them carrying a silver cup, as if to offer them communion. Anthony threw gasoline over the priest and said: 'Don't do that!' A few seconds later, he set the priest alight, who later died of severe burns. An elderly female nun then ran towards the men, and Anthony turned to face her and said: 'Don't do that, don't do that!' He then struck the woman with a wooden post he had with him, causing three deep lacerations to the head, which led to her death.

Both men were arrested at the scene. At trial, the prosecution described Anthony's actions as being pre-meditated and wilful, a cold-blooded attack on the worshippers at the cathedral.

Anthony has lodged an appeal against both his conviction and sentence. He has recently produced a witness statement in which he states, regarding the attack: 'I wanted to burn the Vatican and the demons there...I wanted to destroy the Cathedral...I thought this would bring about the destruction of the Pope and the Queen of England...which would have been a punishment for their crimes committed against the humanity of black African people...I told lots of people what my plan was...I was surprised that people were shocked.'

A probation report prepared at the time of sentencing contained some background information:

Anthony had an abusive childhood... he passed the Common Entrance Examination and gained admission to secondary school, where he was disruptive and engaged in fights using dangerous weapons, such as knives. He was defiant and refused to accept school rules. He was suspended for his aggressive behaviour and later expelled... he shows absolutely no remorse...indeed, Anthony feels pleased with his actions, claiming that he has been appointed to destroy the oppressors, the church and the government... they are both convinced that their actions were justified and that they should be allowed to continue their mission...they are happy that their deeds will be recorded in the annals of history...'

You are asked by Anthony's current lawyers to provide an opinion on whether Anthony was insane at the time of the offence in order to assist with an appeal. You are told that the jurisdiction in which he committed the offences does not allow the defence of 'diminished responsibility'.

Case – unfit for punishment

Phillip & John v The Queen – St Lucia [2007]

It is necessary to prove first that the defendant suffered from a delusion or delusions, as defined by the medical witnesses in this case, not shared by any significant group such as the adherents of a religious sect. The second criterion is that the delusion must be of such a nature as to render him an unfit subject for punishment of any kind. The latter in their Lordships' opinion carries the connotation of a delusion of the presence of some outside influence which operates upon the defendant's mind in such a way that he is impelled or persuaded to commit acts which he knows to be forbidden. The threat of punishment would have no deterrent effect, one of its main objects. The object of retribution would be repugnant to the conscience of the ordinary citizen. Accordingly, punishing such a defendant with ordinary criminal sanctions would be both inappropriate and pointless.

Clinical

There is no recorded history of mental illness, so how could you approach determining whether Anthony was mentally ill at the time of the killing?

This will be a complex and time-consuming task, given the length of time since conviction.

Information from other than Anthony

Interviewing Anthony will be necessary. However, before doing so, you will need to gather as much background information as possible about Anthony in order to try and piece together his life story, from his childhood, with the help of his lawyers. The probation report gives some details, but more will need to be known about his personality, including his capacity to form relationships, and his general propensity for violence. School records, if available, might explain something of the nature of the abuse Anthony is said to have suffered. Given the nature of the offence, his religious views will be important to understand. And any material that helps determine his likely mental state during the months leading up to the offence will be particularly useful.

Even in the absence of a documented history of mental illness, it will be essential to read his medical records, both primary care and hospital records – for example, there might be symptoms of mental illness that were complained of, or described, but not recognised as such, or responded to, at the time. If Anthony was the subject of any ‘care proceedings’ as a child, or other social services intervention, then you should read the relevant files. His educational records should also be sought.

The witness statements gathered for the original trial should be scrutinised for evidence of Anthony’s thought content specifically at the time of the killings; his remarks to the victims give some evidence relevant to retrospective reconstruction of his likely mental state. However, it will be important to determine whether these are consistent with things he may have said to others, including friends and family members – possibly including members of the church congregation where he may have worshipped, if he did. If such accounts are not available, then Anthony’s lawyers could assist by taking statements from those to whom he was close. However, interviewing informants from a detailed clinical perspective will, almost certainly, be necessary, or at least beneficial. Although it would be ideal to be able to interview individuals who were present at the commission of the offences, they will have been prosecution witnesses and will, almost certainly, not be available to you. Also, if there had been previous criminal offending by him, it will be necessary to review the detail of this in order to determine whether this was likely – or not – ever to have been influenced by mental abnormality.

How should an interview with Anthony be conducted?

It will be important to take a detailed history of any mental symptoms or distress that Anthony may have experienced from childhood, including both their nature and their association with drug or alcohol ingestion, if any. It will be important to gain a picture of the pattern of Anthony’s mental functioning unconnected with the index offence, as well as any association of such symptoms with violent behaviour in the past. That is, first try to gain evidence that might point towards a diagnosis, and/or formulation, in relation to his mental functioning unconnected with the index offences. And clearly close attention should be paid to his religious beliefs, both during childhood and later, in regard to whether these changed at some point.

Any remarks made by him at all suggestive of symptoms of mental illness – especially psychotic illness – should be followed up closely and meticulously, in terms of both their form and implications for any possible diagnosis. If he offers nothing suggestive of illness, it will still be necessary to ask ‘direct questions’ concerning whatever range of diagnoses you consider could be possibly valid from what he says at interview or from what he said during commission of the offences. Given that – unless you have discovered evidence suggestive of illness from records and informants (see above) – you will likely be reliant substantially upon what you gain from Anthony in clinical interviewing, it will be important to include in your manner of interviewing him, and interpreting the results of the interviewing, consideration of the possibility of ‘faking’ (see Handbook concerning relevant techniques, and see Case 2). That is because under cross-examination, you will likely be challenged that your diagnosis is simply based upon what the appellant told you (assuming you come to an opinion that lays a foundation for an appeal).

If you have come to a provisional view concerning a possible diagnosis of mental illness being present prior to commission of the index offences – whether ‘drug-induced’ or not – then this will provide a foundation for asking Anthony in detail about his mental functioning, and likely mental state, at the time of commission of the offences.

However, in any event, the interview with Anthony should then become focused upon trying to establish his 'most likely' mental state at the time of the offence (any defence that might, on appeal, be available to him will be tested by the court to the standard of 'on the balance of probability' and not 'beyond reasonable doubt'), based on a background understanding (hopefully already achieved) of his mental functioning at other times. Beyond taking a standard psychiatric history, you will need to try to establish from Anthony a detailed timeline of events prior to the offences: was there any change or development of his mental functioning during the weeks and days prior to the killings?; was any change associated with ingestion of drugs or alcohol?; when did he first think of committing the offences, and why?; why did he purchase the gasoline the evening before?; why target the cathedral?; why the two particular victims?; why that day?; and why not flee the scene afterwards? Essentially, the questions asked need to be posed in such a way that any information gained can, if relevant, be mapped onto the potential psychiatric defence that you have been asked to comment upon. In respect of the defence of insanity, you will need to have asked sufficiently detailed and specifically oriented questions for you to be able to take a view not only on the nature of any abnormality, if any, of Anthony's mental condition per se at the time of the offences but also how any symptoms he likely experienced were linked causally to his actions. The specific legal criteria for a finding of insanity must be directly referenced when providing an opinion on this issue.

An added issue is the relationship between Anthony and his co-defendant, who appears to have taken a lesser role in the offending. You will need to address with Anthony directly the nature of their relationship prior to committing the offences, as well as how it was they came to offend together. This will include trying to address whether there is any evidence that his co-defendant was mentally ill, and how this related, or not, to any symptoms in Anthony. For example, you may need to address whether Anthony was in a '*folie a deux*' and, if so, who was the dominant partner in the illness. Ideally, you would wish to interview the co-defendant, either to gain further information about the relationship between the two of them or to gain information from him of Anthony's functioning. However, he is unlikely to be available to you.

Finally, Anthony's current mental state will not only be important in terms of its potential relevance to what might have been his state when he killed – and whether he continues to exhibit symptoms of illness he may have experienced prior to the offences – but it may also be relevant to a re-sentencing hearing, in the event that he is found insane (you will need to be advised whether a finding of insanity infers an automatic or discretionary disposal) or, in the event that the appeal is unsuccessful, to a 'mercy hearing'.

Legal

The defence of insanity, unlike the partial defence of diminished responsibility,⁹ is not limited to the offence charged of murder. The threshold is, ubiquitously across jurisdictions, both narrow drawn and high, since a successful plea of insanity amounts to a 'full defence', leading to a verdict of 'not guilty', or 'guilty but insane'. And neither a prison sentence nor the death sentence is mandatory in any jurisdiction upon a finding of insanity.

Although the definition of insanity varies somewhat between common law jurisdictions, the essence of it is that it is written in terms solely of disabilities or abnormalities of 'cognition' so that, for example, disorders of emotional regulation or expression are irrelevant to it.

It will be necessary for you to receive detailed advice from counsel for Anthony as to what is the precise definition of insanity in the jurisdiction relevant to his trial and appeal. Do not simply assume that it is 'the same as in England', or in other jurisdictions with which you are acquainted.

Assuming, however, that the relevant definition is identical to that in England and Wales, in order to succeed in the defence, a defendant first needs to prove (sanity is presumed) that, on the balance of probability, s/he was suffering from a mental condition – in England, a 'disease of the mind', that seriously affected their ability to reason, defined in terms of 'a defect of reason' – the result being that they either 'did not know the physical quality of their actions' or, if they did, they 'did not know that what they were doing was legally wrong'.

Most commonly, a delusional disorder will be required in order to meet the very narrow and high threshold definition of insanity – although some have argued that other forms of psychosis can deprive sufferers of the ability to concentrate and retain information to such a degree that they cannot make reasoned decisions in terms of their defence.

In regard to 'knowing' that what they were doing was legally wrong, some jurisdictions may adopt, or might be encouraged to adopt, a somewhat flexible interpretation. So, for example, being capable of knowing that what they were engaged in were they to have been interrupted might not make the defence unavailable to them if, at the time of the offence, they were (for example) so 'psychotically driven' that they did not 'appreciate' that what they were doing was legally wrong while they were doing it.

Most commonly, it is defendants who express delusions of persecution and/or control that can convincingly succeed in arguing their actions followed from such disordered reasoning as to qualify for the defence. But, even here, the detachment from reality needs to be severe; for example, it is not enough simply to feel compelled to attack another because of a delusional idea. Rather, for the defence of insanity to succeed, the defendant needs to prove that they believed that they were acting in self-defence (in other words, in their mind their actions were lawful). Alternatively, those with bizarre delusional beliefs focused on the victim of the offences can sometimes successfully argue insanity; for example, if it can be shown that they did not believe that the victim was human but understood them to be a robot, or the devil, and hence did not know that their actions were unlawful.

Clinico-legal

How would you address the defence of insanity?

In Anthony's case, if clinically you have come to the conclusion, for example, that it seems more likely than not that he harboured religious – and possibly grandiose and persecutory type – delusional beliefs in relation to members of the church, particularly focused upon priests and possibly nuns, then this may lay a foundation for supporting a defence of insanity. However, it will be necessary to establish the 'full detailed content' of his beliefs. For example, you might discover that, in his mind, he was acting in 'self-defence', believing himself to be under imminent threat from a powerful external morbid force, and that the two victims had physical powers beyond their objective power. However if, on the other hand, you find that he harboured resentment – even ill-feeling based on pathological feelings of persecution towards the church – it would be hard to see this as being enough to satisfy the legal test of insanity (although it might do so for a defence of diminished responsibility in a different jurisdiction that allowed this defence).

If you conclude that Anthony had a psychotic illness at the time of killing that, given its specific symptoms, does satisfy the terms of the insanity defence but was precipitated by drugs, then there will be likely be dispute over whether the appellant's mental state was indeed one of 'psychosis' or whether it reflected 'intoxication'. So, for example, if you were to conclude that Anthony was in a drug-induced psychosis, then you will need to be able to distinguish this from 'self-induced intoxication', which would not, of course, lay the foundation for the defence – albeit it *could* possibly lay the foundation for 'incapacity to form the specific intent for murder', if his state was so disordered as to come within the terms of this alternative defence (see Handbook and Case 6).

What would be the likely challenges to a defence of insanity?

In every case where a psychiatric defence is proposed, it is important to consider whether other hypotheses might explain the offending concerned, including those suggesting no connection with mental disorder.

In this case, the lack of prior medical evidence of mental illness is likely to be emphasised, as is Anthony's antisocial behaviour as an adolescent. So the lack of any medical evidence having been offered at trial will need to be explained; for example, was this because Anthony, in hindsight, was not properly able to instruct his lawyers, or because he was not adequately assessed clinically pre-trial? And the suggestion might be made that Anthony harboured ill-feeling towards the church that had little to do with mental illness; for example, he may have expressed angry beliefs about the church that were 'extreme' but not apparently related to symptoms of illness.

Even if it is accepted that Anthony acted in a general sense 'because of delusional beliefs', the specific reasons why he assaulted the two elderly victims who posed no threat to him will need to be carefully explained. Indeed, the lack of any 'rational' explanation may assist the defence.

Finally, if you express the opinion that Anthony was in a drug-induced psychosis when he killed, then undoubtedly the prosecution will suggest that he was 'merely intoxicated'.

Statutory definitions – insanity

- 1. If he was prevented, by reason of idiocy, imbecility or any mental derangement or disease affecting the mind, from knowing the nature or consequences of the act in respect of which he is accused;**
- 2. If he did the act in respect of which he is accused under the influence of an insane delusion of such a nature as to render him, in the opinion of the jury or of the court, an unfit subject for punishment of any kind in respect of such act.**

The
Bahamas
Belize
Ghana
St Lucia*

No criminal responsibility shall arise from the act or omission of a person suffering from mental illness which deprives him of all will-power or of the knowledge that what he does is blameworthy.

Cameroon

A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is through any disease affecting his mind incapable of understanding what he is doing, or of knowing that he ought not to do the act or make the omission; but a person may be criminally responsible for an act or omission, although his mind is affected by disease, if such disease does not in fact produce upon his mind one or other of the effects above mentioned in reference to that act or omission.	Botswana Kenya Malawi** Uganda Zambia**
...at the time of the commission of the offence he or she was suffering from mental disorder of such a nature that he or she was substantially unable to appreciate the wrongfulness of his or her actions or that he or she was unable to conduct himself or herself in accordance with the requirements of the law.	Lesotho
...if at the time of doing the act or making the omission he is in such a state of mental disease or natural mental infirmity as to deprive him of capacity to understand what he is doing, or of capacity to control his actions, or of capacity to know that he ought not to do the act or make the omission.	Nigeria
...he is through any disease affecting his mind incapable of understanding what he is doing, or of knowing that he ought not to do the act or make the omission	Tanzania
<p>Suffering from a mental disorder or defect when the person did or omitted to do anything which is an essential element of the crime charged shall be a complete defence to the charge if the mental disorder or defect made him or her –</p> <p>(a) Incapable of appreciating the nature of his or her conduct, or that his or her conduct was unlawful, or both; or</p> <p>(b) Incapable, notwithstanding that he or she appreciated the nature of his or her conduct, or that his or her conduct was unlawful, or both, of acting in accordance with such an appreciation.</p>	Zimbabwe
Nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law.	Bangladesh India Malaysia Pakistan Singapore Sri Lanka

* Replace 'any mental derangement or disease affecting the mind' with 'mental disorder'. 'Mental disorder' means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind, except intoxication.

** Subtle grammatical variations.

Insanity – verdict

Guilty but insane	Not guilty by reason of insanity
Antigua	Bangladesh
The Bahamas	Barbados
Belize	India
Botswana	Malawi
Ghana	Malaysia
Grenada	Nigeria
Guyana	Pakistan
Jamaica	St Kitts and Nevis
Kenya	St Vincent and the Grenadines
St Lucia	Sierra Leone
Trinidad and Tobago	Singapore
	Sri Lanka
	Tanzania
	Zambia
	Zimbabwe

Ethical and professional issues

One of the challenges in this case is the need to reconstruct Anthony's mental state 10 years after the offences. Can and should you do this?

It is an accepted legal maxim 'absence of evidence is not evidence of absence'. Hence, the fact that no evidence of Anthony having had a record of mental illness was discovered at the time of his trial, or of him having acted upon delusions (beyond the rather odd things he said to both victims), does not amount to evidence that he was not mentally ill or driven to kill the victims by delusions. Much of the preceding section amounts to a description of how it is possible – and correct – to do one's best clinically to reconstruct Anthony's 'most likely' (not 'possible') mental state at the time of the killings, plus establish linkage of this to the killings. For example, Anthony's memory for events and symptoms might have been poor or inaccurate even quite soon after the killings – many defendants, even those who are not suffering a mental illness, such as a psychotic illness, fail to recall the circumstances of their crimes even soon after their offences. This is aside from being unable to do so many years later, for example, because psychosis concurrent with commission of an offence can affect the registration of data sufficient for subsequent accurate memory. This can be for a variety of reasons, including being in a high state of arousal, or being subject to intrusive hallucinations, at the time of their offending.

A number of issues are likely to be closely examined at appeal, including evidence of consistency, or of inconsistency between: accounts by Anthony on different occasions; the account of others and Anthony's account; Anthony's present account and his account at the time of the offences; and the symptoms described by Anthony and typical symptoms of mental illness. And it is likely that a major focus of prosecution attack will, indeed, be framed in terms of: 'Doctor, your opinion is based upon what the

appellant told you, now, after time for reflection and discussion with others in prison ... he is making it all up.' The proper response to this, both technically and ethically, is to explain that determining a diagnosis, or its absence, requires looking at all of the information available – as it they are pieces in a jigsaw – in order to see whether there are sufficient pieces (of evidence in fact) to give a 'picture' of the diagnosis, or mental state at the relevant time, and the absence of pieces that would be inconsistent with the picture.

Case 8

Key themes

- *Clinical* – depression with psychosis; diagnosis of children and adolescents
- *Legal* – insanity
- *Clinico-legal* – detailed ‘mapping’ of mental state onto components of insanity

Handbook references

- Functional psychosis, including paranoid schizophrenia (p20)
- Depression (p22)
- Insanity (p104)
- Bias and its minimisation in expert witness practice (p138)

Case history

Radhika is a 17-year-old girl charged with the murder of her two-year-old child. She is alleged to have drowned her child in the bath at home. Her mother was at home at the time and discovered the child’s body. Radhika then said that she had taken an overdose. She was admitted to hospital but suffered no harm from the overdose. Radhika has only patchy memories of what happened.

Radhika was treated for depression after the birth of her child when she was 15, from which she recovered fully. However, eight weeks before the killing she again began to feel low in mood. She stopped going out and her mother became concerned that she was not feeding her child regularly. Radhika also started to say some strange things about how she felt – such as like she was dead and that her baby was dead. Her mother had therefore not left her alone with the baby.

After the killing, Radhika was admitted to hospital and diagnosed with ‘depression with psychosis’, and treated with antidepressant and antipsychotic medication. She disclosed that she had believed that she and her child had died, and were about to go to hell unless they killed themselves again. She said that she drowned her child in the bath because her child was already dead, and she needed to save her from going to hell. She had then tried to kill herself so that she could be with her daughter in heaven.

Radhika was sexually abused by an uncle between the ages of five and eight years. She started to cut herself on her arms from the age of 12 years, but this had ceased two years ago, and she had never seriously injured herself before taking the overdose. Her mother also has a history of depression. She has never used any drugs.

You are asked to assess Radhika and to give an opinion on whether she was suffering from ‘a mental disorder’ at the time of the killing, and on whether she was insane at the time.

Clinical

What is depression with psychosis?

Depression is a mental illness characterised by the presence of symptoms that include low mood, loss of interest or pleasure, feelings of worthlessness, poor sleep, poor appetite, poor concentration, low energy levels, thoughts of lack of self worth, plus sometimes suicidal thoughts. Depression, in its most severe state, can be accompanied by delusions and/or hallucinations; such psychotic symptoms are often congruent with other symptoms of depression, and commonly involving themes of guilt, nihilism and death. In some cases, however, they are not ‘mood congruent’. Depression, including psychotic depression, is more common after childbirth.

To what should you pay particular attention when assessing someone under the age of 18 years?

In most developed countries, psychiatrists subspecialise, and child and adolescent psychiatry is one of these subspecialties. There are, therefore, psychiatrists who specialise in the assessment and treatment of people under the age of 18 years. In larger countries, there may also be specialists who have trained in both child and adolescent *and* forensic psychiatry, and are therefore highly specialised in this field. The gold standard for a case involving a person under 18 years of age is the instruction of one of these highly specialised professionals. However, where this is not available, the appropriate expert will depend upon the particular nature of the case and of the mental disorder that is suspected.

Some of the key reasons for the use of child and adolescent psychiatrists in clinical and clinico-legal practice are that there are diagnoses particular to those not yet adult; presentation of diagnoses that can occur in both adults and children can differ; and diagnosis of mental illness in those not yet adult can be made difficult because the person is still developing, and that such that aspects of such development can be confused with symptoms of mental illness (for example, ‘adolescent turmoil’ may be mistaken for illness).

This case involves a 17-year-old with a mental disorder that can affect adults, and in many ways is indistinguishable from its presentation in an adult. Hence, it may be reasonable for the expert appointed to be an adult psychiatrist, particularly bearing in mind that most adult psychiatrists will properly have undergone some training in child and adolescent psychiatry during their postgraduate psychiatric training, prior to being appointed as a consultant. However, any expert appointed should pay particular attention to aspects of Radhika’s presentation that may arise from her youth – taking particular note also of her history of self-harm, which is not uncommon in adolescents. There will be other circumstances where the mental disorder falls much more naturally within the expertise of a child and adolescent psychiatrist, so an adult psychiatrist should be very wary indeed in accepting instruction. Finally, in some circumstances the involvement of two professionals from differing specialties might be necessary.

Are there any diagnoses that cannot be made in people under the age of 18 years?

DSM5 incorporates definitions and criteria that attempt to include the way in which children experience symptoms of mental disorder, and most mental disorder diagnoses can be made in children. However, personality disorders are *not* usually properly diagnosed in children, given that children are still forming their personality, and can also exhibit symptoms suggestive of personality disorder that are, in fact, a representation of developmental turmoil. This heavy caution is based upon an understanding of the way in which personality develops and the need to observe stability in the observed personality traits before personality disorder can properly be diagnosed; many traits observed in children do not persist into adulthood. Guidance suggests children *can* rarely be diagnosed with personality disorder, with the exception of antisocial personality disorder.

What attention should you pay to the diagnosis already made by the treating clinicians?

An expert will properly pay attention to the diagnosis made by the treating clinician. However, it is very important that you do not assume that the diagnosis is correct. Your role is to give your opinion based upon your own assessment, albeit using all of the data available – including those originating from the treating clinicians – rather than to seek to confirm (or refute) the diagnosis already made. This will involve pursuing an ordinary, comprehensive approach to assessment. Crucially, approach the case without any pre-conceptions about it, including in regard to diagnosis.

Legal

Insanity

In regard to the terms of the legal definition of insanity, which can vary somewhat between common law jurisdictions, see Case 7 (also the Handbook). In essence, however, the defendant first needs to prove (sanity is presumed), on the balance of probability, that she was suffering from a ‘defect of reason’, arising from a ‘disease of the mind’, such that she ‘did not know the physical quality of her action’ or, if she did, that she ‘did not know that what she was doing was legally wrong’.

Clinico-legal

How should you approach the question of insanity?

The questions in your instructions include whether the defendant comes within the insanity defence – although, where available legally within the relevant jurisdiction, ‘diminished responsibility’ is also likely to be under consideration (‘infanticide’ will not be in contention, since this requires not only that ‘balance of the defendant’s mind was disturbed’, but also that this arose from failing to get over the results of birth or lactation, and that the killing occurred within a year and a day of the birth of the child). However, the role of an expert is to describe the defendant’s likely mental state at the time of the killing and its likely causal relationship to the killing, and not to opine definitively upon whether the insanity defence is satisfied. To do so could infer taking a view on the legal meaning of elements of the defence – although courts not uncommonly do ‘ask the ultimate question’ of an expert, without reference to the distinction between medical description and legal interpretation of that description.

The approach should include breaking down the insanity test into its individual components, and describing the way in which any mental state abnormalities present at the time of the killing ‘map onto’ each of those components. For example, if you are satisfied that there was psychosis present – in the form of delusions – then explanation of what these delusions likely were and how they might map onto the legal term *defect of reason* is required. Also, description of the underlying diagnosis – and the status of the diagnosis medically as a recognised disorder – that might go towards the legal requirement of *disease of the mind*, will also be necessary.

The greater potential complexity comes in explaining the ways in which the symptoms might have affected the functional abilities of the defendant ‘*to have known the nature or quality of her actions*’ or ‘*to have known that what she was doing was legally wrong*’. The diagnosis and description of the symptoms is ‘ordinary psychiatry’, but description or explanation of how these symptoms likely operated in relation to the killing, and might map to aspect of the legal definition of insanity, is more complex and often uncertain – as well as requiring strict boundary-keeping between psychiatry and law.

Instructions – insanity

Instructions will vary according to the test in the specific jurisdiction. The following instructions derive from the M’Naghten test.

1. Explain whether, at the time of the alleged offence, the defendant was suffering from a defect of reason.
 - a) If, in your opinion, the defendant was, describe the relationship between this and symptoms of any condition diagnosed or described.
2. Describe whether this defect of reason arose from a medical condition or mental disorder.
3. If you find that there was a defect of reason, describe whether this prevented the defendant from knowing what the nature of their conduct was. Did he know what he was doing? If he did not, describe what, in his mind, he thought he was doing.
4. If you find that there was a defect of reason, describe whether this prevented the defendant from knowing whether their conduct was unlawful. Did he know that his acts or omissions might constitute a criminal offence?

Ethical and professional issues

Should you raise with defence lawyers the possibility of an alternative plea of ‘diminished responsibility’?

The nature of the relationship between lawyer and expert is in terms of the former ‘instructing’ the latter, including which legal questions the lawyers wish addressed by way of expert opinion. However, sometimes lawyers are ill-informed, or can think in ‘simple straight lines’. So, for example, in Radhika’s case, it is possible that, because they have read medical records suggesting that she was ‘psychotic’ when she killed her child, they assume that this must infer legally ‘insanity’. However, of course, there is no necessary relationship between any particular medical diagnosis and any given legal defence.

Also, the lawyers may be ‘going for broke’, in terms of achieving a ‘not guilty’ (‘by reason of insanity’) result (if that is the terms of the defence in the relevant jurisdiction), and be unwilling to ‘muddy the waters, or to raise any possibility in the mind of the prosecution that the defence of insanity might not be a robust one to run.

Also, they may not have ‘thought through’ that ‘psycholegal mapping’ of their client’s mental state when she killed onto the insanity defence may not be robust, so they should consider a ‘fall-back position’.

An experienced expert witness psychiatrist will be aware of subtleties at the interface between psychiatry and law that may not be appreciated by the defence lawyers – especially as they may come across a case of possible insanity only once in several years. Therefore, it can be reasonable to ‘raise’ with instructing lawyers the question ‘Would you wish me to address also the partial defence of diminished responsibility?’ and to explain, in whatever of the above terms that may be relevant, the reason for sensibly doing so.

How can you approach a case such as this objectively and minimise bias?

Cases involving the death of children can be emotionally highly affecting and poignant, and also appear ‘beyond comprehension’, so the aim of objectivity can be especially difficult to achieve. There is no clear direction in which expert opinion might be affected by such factors; for example, the apparent horror of a case of this nature might invoke feelings of retribution or anger, which may then be expressed in the medical opinion offered. Or the opposite might occur – trying to make sense of the apparently ‘unnatural’ nature of the killing of her child by a mother, by assuming there ‘must be’ a mental disorder explanation.

As with any case, you should attempt to anticipate your own likely responses to it, and actively to consider alternative explanations of the killing, plus alternative opinions that might properly be offered to the court. Drawing a clear boundary between medical description and legal interpretation (see above) will serve further to protect you, and the court, from the impact of your own ‘values incursion’.

More generally, both your clinical practice and your medico-legal practice should be subject to peer review, which should include case discussions, so that your practice is subject to some form of informed appraisal *ex post*. However, asking for colleagues to review your report *before* a trial can be more difficult to justify, since the opinion must be yours and not a ‘joint’ opinion. As a result, it can greatly assist you to engage, for yourself, in actively considering the ‘opposite’ opinion, and then questioning why you hold your opinion and not this ‘opposite’ one. Doing so will also ‘protect’ you, and your opinion, within cross-examination, since you should know better than the opposing counsel what the ‘counter points’ are to the opinion you express, and have already worked out for yourself why they do not, on balance, overturn the opinion to which you have arrived.

Case 9

Key themes

- *Clinical* – schizophrenia
- *Legal* – diminished responsibility
- *Clinico-legal* – substantial impairment of mental responsibility; denial of the *actus*; refusal to discuss the *actus*

Handbook references

- Functional psychosis, including paranoid schizophrenia (p20)
- Medical limits (p80)
- Possible alternative opinions (p80)
- Diminished responsibility (p109)
- Expertise (p138)

Case history

Benedict is to stand trial charged with murder, following an incident in a pharmacist's shop in which a security guard was killed.

A summary of his medical records reads:

'Benedict is 39 years old and has a history of schizophrenia, which has resulted in his admission to a psychiatric hospital on five occasions, beginning at the age of 23 years. On the occasion of his first admission, he was brought to the hospital by his father "talking about a conspiracy". He was also described as "addicted to marijuana". When unwell, he has typically been disheveled and unkempt, has been "deluded", describing "grandiose ideas" and being suspicious and paranoid. He has continued to use cannabis regularly.

'During admissions to hospital, Benedict has been violent to staff. He has been treated successfully with antipsychotic medication in hospital several times. When mentally well he has never presented in an aggressive way. Benedict has never accepted that he has been mentally unwell.'

Benedict has also received some outpatient treatment with oral antipsychotic medication; but the last time he accepted medication was just over one year before the alleged offence. And in the days before the alleged offence, he was seen wandering the streets in an unkempt and dishevelled condition.

It was Benedict's habit sometimes to visit the pharmacist's shop where the killing took place in order to beg for snacks or soft drinks. The proprietor had known Benedict for many years. On the day of the alleged offence, he returned to the shop for a second time that day at around 5pm. His clothes were ragged

and he was barefoot. He was carrying a metal bar and stood tapping this on the floor. The proprietor told him that he was not supposed to be there, having already been in that morning. And, although he was asked on something like seven occasions to leave, Benedict remained in the shop. He eventually went to the door, opened it, flapped it to and fro, and invited the proprietor to put him out. The latter then asked his security guard to deal with the defendant.

When the guard went up to him, the defendant first laughed at him and said he could not put him out if the proprietor could not. He then swung the metal bar at the guard in a way that brushed him lightly about three times. At that, the guard took out his sidearm, placing his other hand on Benedict's neck. In response to this, Benedict swung the bar, this time forcefully from behind his back, and struck the guard on the back of the head. Within a second or two, the guard's gun was fired and both men fell to the floor. The guard had sustained fatal injuries. Benedict had been shot under the left arm. He ran from the shop, but was seen to return to stand on the opposite side of the road watching for two to three minutes, before eventually walking away.

He was found shortly afterwards, sitting on the kerb two streets away, bare backed, trembling and rocking back and forth in an agitated manner. When approached by two uniformed policemen, he repeated: "You is Carl; you is Carl" (not the name of either officer). He was arrested.

Some three weeks after the killing, Benedict was admitted to hospital, from prison, with florid symptoms of schizophrenia, experiencing delusions and hallucinations. He was agitated, irrational and incoherent. When questioned by doctors about the alleged offence, he said that the man he had been charged with killing had, in fact, murdered the shopkeeper.

You are asked to prepare a psychiatric report considering the partial defence of diminished responsibility.

Clinical

Given your instructions, what factors in Benedict's history and recent mental state are likely to be important to explore clinically?

Benedict has a well-established diagnosis of paranoid schizophrenia, which has been severe enough to require treatment in hospital on several occasions, plus attempts at outpatient follow up. For over a year, leading up to the alleged offence, Benedict was without antipsychotic medication, which would have significantly increased the risk of him suffering a psychotic relapse around the time of the killing.

His behaviour and presentation at the time of the killing strongly suggest that he was psychotic. He is described as being unkempt and dishevelled, these being features consistent with how Benedict has presented historically when psychotic. He is also said to have behaved in an agitated and aggressive way, features again both consistent with his behaviour when psychotic and out of keeping with his behaviour when well. Such association between psychosis and aggression in him was also demonstrated by his conduct in hospital both before and after the current alleged offence – Benedict's medical records consistently report him as being aggressive when admitted to hospital in a psychotic state, and then typically becoming calm when his mental state improves on medication.

Benedict's behaviour appears to have been disorganised in the pharmacist's shop – this, again, being historically consistent with Benedict's behaviour when psychotic. He also made no attempt to conceal himself after the alleged offence, again suggesting a degree of disorganisation, while his comments when arrested – 'You is Carl? You is Carl?' – also suggest disordered cognition. He required treatment in a mental health hospital shortly after the alleged offence, which is consistent with him being psychotic at the time of the killing – although you should at least consider the possibility in cases such as Benedict's that the act of exhibiting severe violence, especially homicidal violence, might have in itself caused a psychotic relapse or worsened it.

However, although there is a wealth of information in this case that appears to point to a clear clinical diagnosis and mental state, and the case might appear straightforward, there is still a need to employ careful and detailed assessment of Benedict, plus scrutiny of all medical and legal documents. That is because there is a risk of overconfidence, resulting in lack of care in assessment, and unconscious 'confirmation bias' ('surely the case is obvious'). Further, your assessment will need to include consideration of any factor that might have contributed to the killing, psychotic or otherwise, given that you are asked to address the defence of 'diminished responsibility' (see Clinico-legal below).

Legal

The partial defence of 'diminished responsibility', which reduces murder to manslaughter, is relatively similar across many common law jurisdictions.⁹ In terms of the Section 2 Homicide Act 1957 in England, it requires proof, on the balance of probability, of there having been an 'abnormality of mind' that 'substantially impaired the defendant's mental responsibility' in doing the killing (see Handbook).

Clinico-legal

Substantial impairment of mental responsibility

Given the strong evidence suggesting that Benedict was suffering from a relapse of the illness paranoid schizophrenia, proving there was 'abnormality of mind' seems relatively straightforward. The more difficult question is whether this abnormality substantially impaired his mental responsibility in undertaking the killing. This is because of potential uncertainty concerning what factors might have driven his behaviour (psychotic or 'ordinary') *and* because of the need for consideration of whether there should properly be 'translation' of a medical explanation into partial moral excuse (in that medical formulation does not amount to moral excuse), which is for a jury to determine.

Symptoms of psychosis are likely to have had a significant impact upon Benedict's actions at the time of the current offence; he is likely to have behaved in a disorganised way and to have been far more aggressive and agitated than he would otherwise have been, as a result of being acutely psychotic. Further, he might well have misperceived the actions of the victim – possibly holding paranoid thoughts about him – as a result of being psychotic.

⁹ Although note, particularly, that the defence has been amended substantially in England and Wales, towards arguably making it more 'congruent' with medical constructs, by way of S.52 Coroners and Justice Act 2009 (see Handbook)

However, in considering whether the partial defence of diminished responsibility should succeed, the jury will be properly directed to consider *all* factors that might have ‘caused’ the defendant to kill the victim, including factors unrelated to his psychosis (for example, not wishing to leave the shop per se – see also below). And the expert should avoid directly addressing whether diminished responsibility should be found, both because this may involve taking a view about ordinary evidence in the case (which may be conflicting) and because, ultimately, the defence is a moral one. Therefore, to do otherwise would be to become ‘a thirteenth jury person’.

Rather, you should focus your opinion upon the likely impact of his mental state upon his decisions about, and control of, his behaviour, in terms of: what from his psychosis likely drove his behaviour; did he have an impaired ability to form rational judgments about what to do; or was he impaired in his ability to understand what he did, and its likely consequences?

What factors should you consider that might go against diminished responsibility?

Beyond the foregoing caution, in Benedict’s case several points will need to be addressed that potentially go against success in the defence of diminished responsibility.

There was nothing in his behaviour at the time of the killing to suggest that he was experiencing frank delusions or hallucinations, and certainly no psychotic experiences that appeared clearly to ‘relate’ to the victim. And, particularly, there was nothing to suggest that he would not have understood the consequences of hitting the guard with the metal bar.

Instructions – diminished responsibility

In jurisdictions where diminished responsibility is a partial defence to murder, there are subtle variations. The suggested instructions will apply to most jurisdictions.

1. Does any condition you have diagnosed amount to an abnormality of mind?
 - a) Explain your response to this with reference to the nature of any condition and the impact on the defendant’s mental function
 - b) Explain whether any condition diagnosed arose from a condition of arrested or retarded development or inherent cause or whether it was induced by disease or injury
2. Describe how any condition affected their mental state at the time of the killing.
3. Describe how any symptoms of any condition affected the defendant’s ability to exercise control over their behaviour.
4. Describe how any symptoms of any condition affected the defendant’s ability to understand their own conduct.
5. Describe how any symptoms of any condition affected the defendant’s ability to form rational judgements or make rational decisions.
6. Describe how any symptoms of any condition had any other effects on the defendant’s behaviour.

The availability of diminished responsibility as a defence

Statutory defence	Antigua and Barbuda The Bahamas Barbados Belize Jamaica St Kitts St Lucia St Vincent Singapore Trinidad Uganda Zambia
Mitigation only	Cameroon Zimbabwe
Defence unavailable	Bangladesh Botswana Dominica Ghana Grenada Guyana India Kenya Malawi Malaysia Nigeria Pakistan Sierra Leone Sri Lanka Tanzania

Nonetheless, delusions and hallucinations are only two of the manifestations of schizophrenia. Others include severely disordered thinking; the inability to make sound judgments about what is going on around oneself; disinhibition; and loss of care for oneself. These might, in themselves, have contributed to Benedict attacking the victim, so the jury – and not you – will need to consider whether Benedict's mental responsibility for the killing was substantially impaired by all of the effects of his schizophrenia that they decide were operating at the time of the events.

A further objection might be that schizophrenia is often an episodic illness, with it perhaps being suggested that Benedict, whilst suffering from the condition, might have been in a more stable mental state at the time of the killing than he was soon afterwards (see also above). However, the evidence of his

abnormal behaviour both before the killing and soon afterwards, plus his mental state when admitted to hospital, go somewhat against any suggestion that he was mentally well when he killed.

What if a defendant denies commission of the actus?

Denial of an offence is understandable, particularly in capital jurisdictions. And, on the face of it, denial would appear to preclude raising the defence of diminished responsibility. If Benedict said he didn't do it, then how can he have been diminished in his responsibility ('for a crime he didn't commit')? However, as a psychiatrist, you can simply provide opinions on the basis of different factual situations, allowing for the court to adopt your opinions in relation to the facts that they decide on. Hence, in Benedict's case you will still be able to provide evidence relevant to a plea of diminished responsibility, in the event that – after your assessment and reporting – he changes his plea so as to accept that he committed the *actus* (and, in that case, you may wish to interview him on a further occasion).

What if a defendant accepts he committed, but refuses to discuss, the actus?

Again, this should not inhibit you per se from expressing an opinion on 'ways in which his commission of the *actus* may likely have at least be partially explained by likely coincidental psychotic symptoms'. So, for example, in a different case, the defendant might describe florid psychotic symptoms that appear, on the face of it, likely to be directly relevant to the killing, but he refuses to talk about any of it. However, the expert might opine on a likely causal relationship, despite the unwillingness of the defendant to discuss the killing, or this thoughts going to the killing.

Ethical and professional issues

The boundaries of expert evidence

The primary duty of any expert, whether instructed by the defence or the state, is to the court – specifically, to provide an opinion that is balanced, honestly held, and which acknowledges all of the relevant evidence.

In a case where the defence of diminished responsibility is being advanced, as already described, the decision rests with the jury trying the case (unless the question is removed by the judge from the jury). And however strong the psychiatric evidence may appear, this cannot – and should not – determine the issue in your mind, so that you express an opinion on the availability of the defence per se. As already described, other motivations for the killing – notwithstanding how poor the defendant's mental health might have been – might have played a role. It is the function of the jury to consider all of the evidence, both expert and ordinary, and to weigh up the importance of the psychiatric evidence. Essentially, they will address the evidence in terms of a 'set of scales' – placing the 'abnormality of mind', as you (or as other experts) describe its nature and severity to be, on one side of the balance, and its impact upon determining the killing, plus other factors, on the other side. And it is not your role to say either what should be placed in the other side of the scales *or* how the balance should be struck.

How should you express the uncertainty of your conclusions?

There are arguments on both sides of the issue in this case. The 'good' expert will acknowledge the weakness of any conclusions that they reach, pointing out evidence that goes against their views, but also

making it plain why, despite this, they have reached their opinion ‘on balance’. Indeed, an expert who acknowledges evidence that potentially goes against their conclusion in their written report is in a better position to explain, and also justify, their conclusions than one who fails to do so – and is then confronted with such counter-evidence during the trial.

It is particularly important to bear the above in mind in a case that looks straightforward, with an accompanying risk therefore that you might simply ‘confirm’ what seems obvious at the outset. Benedict seems to have been psychotic, so there is a risk that you will pay more attention to information that confirms your first suspicion, even before you have seen him. Therefore, ‘challenge your first, and even second, thoughts’.

Case 10

Key themes

- *Clinical* – psychopathy and paraphilia, including their diagnostic status
- *Legal* – diminished responsibility; conditions accepted as ‘abnormality of mind’
- *Clinico-legal* – types of mental pathology and abnormality of mind

Handbook references

- Personality disorder (p21)
- Assessment of personality and of clinical syndromes (p47)
- Diminished responsibility (p109)
- Bias and its minimisation in expert witness practice (p138)

Case history

Prince is a 24-year-old man who is the son of a government minister. He is charged with the murder of two men whose bodies were found buried in his garden. There is evidence from post mortems that they had been bound, gagged and tortured before they died. There is also evidence to suggest that the defendant had anal intercourse with both men before death. Further, there is evidence also of infliction of post-mortem injuries, in terms suggestive of beating. Prince admits that he killed the two men, and that he had picked both men up in a bar. He says that they were killed two days apart, and that he had intended to kill yet more men.

Prince says that he is a Christian and is vehemently opposed to homosexuality, and he described the killings as ‘necessary acts for the good of the country’. He denies that he is homosexual, but says he has had sexual relationships with both men and women. He was using cocaine around the time of the two killings. He gave a full and detailed confession during his police interview.

Prince was successful at school but left his subsequent degree course after one year, because he felt that it did not stimulate him enough. He then spent some time in the United States with relatives. He has never worked.

Prince is now studying in prison, and claims to have a very good relationship with all of the prison officers. He asserts that he is ‘of highly superior intellect’ and that it is ‘his destiny to be in prison’. He sees his offences, which have attracted significant publicity, as being very important in stimulating public debate about homosexuality.

Prince has already been assessed by a clinical psychologist, who conducted various psychometric tests and found personality traits indicative of high levels of narcissism. A Psychopathy Checklist (PCL-R) was

also conducted, which resulted in a score of 26, with a very high score in factor 1. The psychologist also found that Prince had deviant sexual interests, including sexual sadism.

You are asked to assess the defendant and provide an opinion as to whether there is any mental disorder and, if so, whether he might have available to him the partial defence of diminished responsibility. Your contract of employment is related to a government hospital.

Clinical

This case raises the possibility of several categories of mental disorder. The primary diagnostic question implied is that of personality disorder, although assessment for other mental disorders will still be necessary. There is a suggestion of drugs also being relevant, so there will also need to be assessment for the presence or absence of substance misuse disorder, and for the severity of that if it is present. The other potential disorder implied relates to paraphilias.

If, as is implied, the defendant exhibits a personality disorder, then that should be investigated in terms of the details of its manifestation, plus its categorisation within DSM5. And, in the event that he can be diagnosed with ‘antisocial personality disorder’, there should be consideration of whether he can be described as within the subset of that disorder represented by ‘psychopathy’.

Thereafter, there should be consideration of how his diagnosed disorder (if any) might have affected his behaviour in relation to the killings – specifically, his capacity for empathy; his ability to have controlled himself; his ability to have been rational; and his ability to have understood his own conduct. It is not enough, for example, to (1) give a diagnosis and (2) suggest diminished responsibility (see below). And, in this case, the most complex issue is not whether there is a diagnosis, or what it is – albeit there might be dispute about the status of some of the putative diagnoses – but how any mental disorder, and its symptoms, might have operated in relation to commission of the *actus* in each killing. It is then for the court to determine whether this should be held to have affected the defendant’s mental responsibility to a ‘substantial’ degree (again see below).

Mental disorder in law – Jamaica

Mental Health Act

Criminal law often uses terms implying mental disorder but rarely provides definitions. In some jurisdictions there may be ‘borrowing’ from mental health law.

‘Mental disorder’ means –

1. A substantial disorder of thought, perception, orientation or memory which grossly impairs a person’s behaviour, judgment, capacity to recognize reality or ability to meet the demands of life which renders a person to be of unsound mind; or
2. Mental retardation where such a condition is associated with abnormally aggressive or seriously irresponsible behaviour,

Is personality disorder and/or psychopathy a mental disorder?

Antisocial personality disorder is a disorder long recognised in both the Diagnostic and Statistical Manual for Mental Disorders (DSM) and the International Classification of Diseases (ICD).

Psychopathy is not a DSM or ICD-recognised diagnosis. Therefore, in order for it to be relevant in a legal context, it is arguable that, in terms of law, the defendant must first come within a recognised personality disorder diagnosis, so that consideration of possible psychopathy is considered 'within' that (see further below under 'Clinico-legal'). That is, it is not a diagnosis in itself.

In simple terms, it is almost ubiquitous that an individual exhibiting psychopathy will also exhibit antisocial personality disorder, but only a (relatively small) proportion of those with anti-social personality disorder exhibit (within that diagnosis) psychopathy. Hence, loosely, psychopaths represent a subset of those with antisocial personality disorder – albeit it is possible to be a psychopath without exhibiting the behaviour required to diagnose antisocial personality disorder (for example, there are examples of 'business, or event academic psychopaths' who do not behave physically aggressively – see below 'factor 1 psychopaths').

Psychopathy is a collection of behavioural, emotional and psychological traits measured with a standardised assessment called the Psychopathy Checklist (PCL-R). It is closely related to criminal offending, and there has been extensive research of it in criminal settings. The PCL-R consists of twenty items that are rated on a three-point scale (0-2). The assessment is usually completed face to face, but must also incorporate other information (as with any psychiatric assessment). The overall results are usually broken down into (two, three or four) 'factors'. In the two-factor model, factor 1 refers to psychological, interpersonal and emotional aspects, specifically to 'cold, unemotional and callous traits' plus 'lack of empathy'; and factor 2 relates to antisocial behavioural aspects. Hence, those high in factor 2 will almost automatically satisfy criteria for antisocial personality disorder (which is defined almost wholly in behavioural terms), whereas only a subset of those with the latter disorder will exhibit high factor 1 scores (which represent psychopathological underpinnings of the person's antisocial behaviour). Alternatively, a subject might be high on factor 1 and low on factor 2 (see above regarding 'business, or event psychopaths'). The overall 'score' is out of a total of 40, and the cut-off for psychopathy in the United States is usually taken as 30, while in the UK the cut-off is usually 25.

Clearly 'factor 1 psychopaths' (those with high factor 1 scores) are more likely to be seen by the courts as mentally disordered in ways potentially relevant to legal responsibility, given that those high predominantly in factor 2 scores are more likely to be seen as 'merely failing to conform to social behaviour'.

Is sexual sadism a mental disorder?

Paraphilia is a term describing sexual interests other than those pursued with consenting, adult, human partners. Deviation from primarily genital stimulation is included in this definition. The term paraphilia is, in general terms, based upon defining the sexual interest as compared with what is considered 'normal'. Paraphilias include sexual interests as well as sexual activity. Sexual interest in violence inflicted on other people would be considered a paraphilia. A paraphilia is considered a paraphilic 'disorder' when there is distress or harm to the individual exhibiting the sexual preference, or to others.

Sexual sadism disorder is diagnosed when there is a combination of sexual arousal in relation to physical or psychological suffering of other people, and there is distress or harm caused to the person concerned or to other people. It is included and defined within diagnostic manuals. However, that does not infer that the courts will accept such a medical diagnosis as amounting to mental disorder for legal purposes (see Clinico-legal below). Perhaps this is even more so than in relation to personality disorder, since paraphilias can be seen more as specific abnormal types of behaviour – albeit there is likely to be a high degree of psychopathology underpinning the behavioural preference, or behaviour, it includes, whereas personality disorders exert their impact upon function much more widely.

Legal

Can personality disorder, psychopathy or a paraphilia support in law a partial defence to murder?

The status of personality disorder in medicine is now established both in medical literature and in diagnostic manuals. However, its status in relation to a defence – or, more likely, partial defence – in law is much more controversial. Some personality disorders (antisocial, borderline) include criminal or aggressive behaviour as symptoms and criteria for their diagnosis. And this leads to a potentially perverse situation where the worse or more frequent the criminal behaviour, the more likely there is to be a diagnosis of a severe personality disorder, and consequently *potentially* the greater the chance of succeeding in a defence on the basis of personality disorder – subject to how a jury might respond to such a disorder in its pursuit of natural justice.

Ultimately, however, determination of the legal relevance of such a disorder is likely to fall to a more morally determined question as to an individual's responsibility for their own actions, with reference more to their psychopathology than to their behaviour within their diagnosis.

It is, perhaps, more straightforward to conclude that a delusional belief arising from illness indicates some reduction in culpability than where there is predominantly disordered behaviour, however frequent and statistically severely abnormal it may be, and however it looks as if it is grounded in mental pathology.

Where there is demonstrable abnormal mental functioning – for example, in a 'factor 1 psychopath' – there might, perhaps, be more likelihood of this being perceived as relevant to responsibility than where the determination of psychopathy is based predominantly upon factor 2 scores. However, whether a person with high levels of narcissism – including lack of empathy and consequent behavioural disregard for other people – should properly be considered to have reduced culpability is more complex. Ultimately, the psychiatrist should, as far as is possible, explain the medicine or psychiatry of the condition concerned and, crucially, should guard against straying into making moral pronouncements. For example, if a defendant's personality disorder affects their ability to exercise self-control, then this should be explained; but determination of whether what is described medically should be seen as reducing a defendant's responsibility must be left solely to the court.

The defence of diminished responsibility in many jurisdictions is based upon English law as it was before amendment by way of greater complexity (see Case 2). In England, it is well established that personality disorder – including psychopathy and sexual sadism – *can* qualify legally as 'abnormality of mind'. However, even if this is accepted, it needs still to be determined whether such symptoms – in the

individual defendant and in the particular circumstances of a killing – should be seen as substantially impairing their mental responsibility in killing.

Clinico-legal

Types of mental pathology and abnormality of mind

In the case of Prince, the argument capable of being made on behalf of the defence is that his narcissism and sexual sadism fundamentally alters his perception of others, including those who may be potential victims. This includes having likely altered his perception of his victims in the alleged offences, and that he was therefore ‘driven to act’ – being unable to reflect upon himself or his actions, and being unable to consider or perceive his actions in the way that others would see them. Further, it might reasonably be suggested that Prince’s pathological sense of entitlement contributed to his offending, with him being unable fully to understand the moral codes of others. The prosecution would be likely to respond by asking rhetorically: ‘Was it that he *could* not resist, or merely that he *did* not resist killing?’

Ethical and professional issues

Are there valid ‘medical conditions’ that an expert might reasonably refuse to put forward as the basis of a mental condition defence?

Some forensic psychiatrists would not be prepared to acknowledge ‘personality disorder’ or, more likely, ‘sexual sadism’ as a valid basis for a legal finding of diminished responsibility – possibly because of their own values (see below). Is this a valid position to take?

It can be argued that it is not, as it is for the law – and not the expert – to determine whether any medically described condition can, or should, in law amount to a relevant condition for defined legal purposes. For example, ‘substance misuse disorder with dependence’ would be accepted by most psychiatrists as a ‘medical condition’, and yet the courts – in England at least – have determined that it is not always so in law. So, for example, in pleading diminished responsibility, it can only amount to an ‘abnormality of mind’ – determining that an episode of intoxication relevant to a killing was not ‘voluntary’ – if the defendant, in becoming intoxicated, had an ‘irresistible impulse’ to take the first substance of the day (*R v Tandy* [1989]).

It is for the courts to decide what medical conditions are, or are not, to be recognised in a given domain of law, since the expert’s proper role is to ‘aid the effecting of justice’, and not to ‘affect justice’. As a result, the expert should merely describe fully the nosological nature of a recognised diagnosis, and perhaps even its ethical nature (see Chapter 15, Handbook), and leave the court to determine whether it will accept it as a relevant disorder in law.

How might your values influence your approach to this case?

Objectivity is an impossible aspiration in any case; rather, insight into, and honesty about your own values – and identification of how these values might influence your opinion – is the best that can be attempted. In a case such as this one, where there are multiple aspects that might be particularly affecting, there may be even more need to examine your own views, and to engage in a self-checking process, than is always

Statutory definitions – diminished responsibility

Where a person kills or is a party to the killing of another, he shall not be convicted of murder if he 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 his acts and omissions in doing or being a party to the killing.	Antigua and Barbuda The Bahamas Barbados Belize Jamaica St Kitts and Nevis St Lucia* St Vincent and the Grenadines Trinidad and Tobago Zambia
Where a person is found guilty of the murder or of being a party to the murder of another, and the court is satisfied that he or she 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 or her mental responsibility for his or her acts and omissions in doing or being a party to the murder, the court shall make a special finding to the effect that the accused was guilty of murder but with diminished responsibility.	Uganda
Culpable homicide is not murder if the offender 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 his acts and omissions in causing the death or being a party to causing the death.	Singapore

* Some change in phrasing.

required in psycholegal practice. This might be achieved by reviewing the opinion to which you arrive, and considering in depth any alternative opinion to which you, or another expert, might come. Directly addressing possible alternative opinions in detail within your report will assist, and you should ensure that you have the opportunity for peer review – particularly in such complex cases as this one.

When are you conflicted in accepting instructions?

If approached to conduct a forensic assessment, the first question to ask yourself is whether the proposed assessment is within your fields of expertise, or whether – even if it ‘just is’ – it would be more so within the expertise of a different doctor. So ask yourself:

- Have I undertaken the necessary training, not just in psychiatry but also in the application of psychiatry to legal process?
- Do I have enough experience, including of giving evidence in court?
- Do I know enough to be able to assess the defendant and to answer the questions posed?

Consider also whether taking instructions in a particular case could lead to any conflict of interest. This might include providing an independent report on a patient already under your care, where the fact of a therapeutic relationship is likely to give rise to the risk of bias or, at least, the perception by others – including the court – of bias. Prince is the son of a government minister, so any relationship you might have with this minister would need to be examined. While it would not bar you from giving an opinion, it should be disclosed. If you do not believe it causes a conflict of interest, you should also consider why you don't.

Case 11

Key themes

- *Clinical* – depressive illness; psychological consequences of abuse; malingering (of mental illness)
- *Legal* – provocation; relevant mental characteristics
- *Clinico-legal* – expressing psychiatric factors within provocation

Handbook references

- Depression (p22)
- Malingering, feigning and deception (p51)
- Changing and adding to reports (p82)
- Provocation (p112)

Case history

Three years ago Edwin, who is now 35 years old, was convicted of the murder of his girlfriend. No psychiatric evidence was offered at trial. Indeed, Edwin's defence was that his girlfriend had been killed by a man who she had met after they had separated. He claimed to have seen the man running away from the scene of the killing shortly before a police officer arrived. The police officer that arrested Edwin said at trial that he had witnessed Edwin first striking his girlfriend with his fists and then stabbing her with a knife. The police officer claimed that, when he was arrested, Edwin had said: 'I don't care what you do. I'd made up my mind to kill her.' In response, Edwin accused the police officer of lying, alleging that there was previous 'bad blood' between them.

After his arrest, and before his trial, Edwin claimed to have attempted suicide on several occasions, including by cutting himself and taking an overdose of medication; and there is evidence that he had required short periods of treatment in hospital as a result.

You have been provided with a statement from Edwin which reads: *'I now accept that I killed my girlfriend and that my previous account was false. We had separated a few weeks before the killing... I got really down, I lost my appetite, I was always crying, I couldn't sleep and I tried to kill myself... on the day of the killing we met up and she said that she had met someone else, and taunted me that I was "always depressed" and that "our children weren't mine"... I lost it... I "saw red"... I had a knife in my pocket and I lunged at her, stabbing her.'* Later in his statement, Edwin describes a difficult childhood, during which he claimed that he was physically and sexually abused, explaining that this had left him with 'strong feelings of rage'. He claims also to have attempted suicide on several occasions during his adolescence.

You are asked to consider whether Edwin might be entitled to attempt appeal on the basis of the partial defence of provocation.

Clinical

How should you approach this case?

It is first essential to recognise that, although in limited circumstances psychiatric evidence can be relevant within a partial defence of provocation, it is not a psychiatric defence per se; and that psychiatric evidence can be of potential relevance only if the primary elements of the defence required by the law are made out.

Edwin may have had a psychiatric disorder at the time of the killing. But it will be crucial to try to establish whether any psychiatric condition he may have had was ‘in operation’ at the time of the alleged offence; and, if there was such a psychiatric disorder present, how it might have operated so as to influence his behaviour, within the primary terms of the defence of provocation.

The defence of provocation can be complicated for a psychiatrist to address, not least because it can ‘cross over’ with the alternative partial defence of ‘diminished responsibility’. If you are uncertain as to how your evidence might be used it is important, before engaging in any clinical assessment, to establish precisely what your instructions are. However, in essence, the focus in such a case as this should be upon any ‘unusual vulnerability’ of Edwin, by virtue of any mental disorder or characteristics, expressed in terms of any unusual ‘woundability’ on his part in relation to the things allegedly said or done that he claimed provoked him. By contrast, it is not allowed within the defence to propose any unusual general tendency towards loss of control, arising from mental disorder or characteristics. (See detailed description of the law below.)

Case – provocation

Cleon Smith shot and killed another man. He raised the defence of provocation. The prosecution evidence relied on eye witnesses. On appeal, four questions were set out that should have been part of the directions to the jury.

1. Was there evidence of a situation in which the appellant was justified in causing some harm to the deceased?
2. Was there evidence that the appellant had caused harm in excess of the harm he was justified in causing?
3. Was there evidence that the appellant was acting from terror of immediate death or grievous harm?
4. Was there evidence that such terror deprived the appellant for the time being of the power of self-control?

Cleon Smith v The Queen (Belize) [2001]

Could Edwin be malingering symptoms of illness?

[The reader is referred to the text dealing with the assessment of malingering detailed in Case 2.]

However, beyond information presented in Case 2, malingering is the intentional feigning of symptoms of illness, or their exaggeration, motivated by an external gain. Defendants facing serious criminal charges

sometimes believe that it would be an advantage to them if they could persuade others that they were, or are, mentally unwell – for example, in the belief that this will lead to the charges against them being dropped or reduced, or a prison sentence not being imposed. Hence, when carrying out an assessment in serious criminal cases, a psychiatrist needs to keep in the mind the possibility of malingering.

Determining whether a defendant is malingering can be challenging, especially if they have previously suffered from a mental illness and so have knowledge of possible symptoms. Clinically, it is important to consider the following factors:

- Is the defendant presenting with usual symptoms of mental illness?
- If not, their validity needs to be explored in depth
- What is the internal consistency in the defendant's account
- Has the defendant's account been consistent over time?
- Is the defendant's account consistent with the other evidence?
- Does he describe any symptoms inconsistent with a depressive illness?
- Is his description of his symptoms at interview such that it is in common in those validly ill, and is it clinically coherent?
- What is the defendant's response to his symptoms, and is this typical of those in a depressive illness?
- How well does the defendant's account accord with the usual natural history of such an illness?
- Is there consistency between symptoms and behaviour?
- Are any of the symptoms or mental state signs difficult to feign?

Instructions – malingering

1. Describe whether the symptoms you have described are genuine.
2. Explain how you distinguish malingering from true mental disorder
3. Explain what steps you have taken to verify that the symptoms are genuine.
4. With reference to any relevant research, describe whether amnesia for offences in the circumstances of this defendant is common.

Psychological testing can help – for example administering the *SIRS*, a structured clinical interview for malingering, which checks for the internal consistency of a defendant's self-report and the typicality of symptoms, and *TOMM*, a visual recognition test used in people potentially malingering memory problems (see Handbook).

The court will likely have concerns that Edwin is indeed malingering, given that he has changed his account of the killing. Why has he done this? Also is there any evidence other than his account of his childhood abuse? Were the attempts at suicide real attempts or manufactured with a view to portraying himself as mentally unwell?

A careful and detailed clinical interview will be needed. Given the gravity of the case, and its complexity, specialist psychological testing for malingering might well assist. This will also need to include a detailed

account of any symptoms at the time of the killing, and of his mental response to what the victim said to him.

Legal

In most jurisdictions in the Caribbean, Africa and Asia, the law on provocation derives from Section 3 of the England and Wales 1957 Homicide Act (as described, this has been replaced in England and Wales by the defence of ‘loss of control’).

Essential elements of provocation

The provocation defence has been the subject of extensive, varying and conflicting judicial decisions in, for example, English law in relation to expert psychiatric evidence. This became sufficiently unsatisfactory to result in its replacement – based upon recommendations of the Law Commission – by a new, and significantly different, defence of ‘loss of control’. However, in most Commonwealth common law jurisdictions, some version of ‘provocation’ still holds; and it will be necessary to be instructed in detail on the particular provisions in the jurisdiction in which Edwin’s case was heard.

In essence, however, provocation requires satisfaction of two elements. First, the ‘subjective’ element that the defendant ‘lost mastery over his mind’ – usually in a ‘sudden and temporary’ fashion – and did so in response to the ‘provocation’ represented by things said or done by the victim or someone else, directed either at the defendant or another significant person. The requirement is that ‘loss of mastery’ of the mind occurred – not just ‘anger’ – and that it occurred in direct response to things said or done that the law recognises as being of a nature and degree as to be regarded as ‘provocative’. Jurisdictions may vary in regard to the definition of each, but although jurisdictions vary in regard to the ‘level’ of provocation required for the defence to succeed – and the definition of an acceptable response to such provocation – the essence of the required response of the defendant is in terms of ‘loss of mastery over the mind’, or ‘loss of control’, and in response to some defined nature and degree of provocation.

Second, is the ‘objective’ element – which is that ‘the reasonable man’ would have lost control in response to the provocative things said or done. And, in essence, this is designed to pull the defence away from allowing simply that the defendant lost control and was provoked to do so. However, determination of whether any special characteristics of the defendant should be allowed to ‘modify’ the strict objective reasonable man’ has – at least in English law – veered first towards ‘subjectifying’ the objective test and then pulling it back towards greater objectivity (see further below).

In summary, what is required is:

- The defendant was *subjectively* ‘provoked by things done, said or by both together’
- To ‘suddenly lose his/her self control’
- The provocation must have been enough to make a ‘reasonable man’ do as the defendant did (‘ordinary man’ in some jurisdictions; and in some this is further qualified as meaning an ‘ordinary man of the community to which the defendant belongs’)

‘Provoked’

In some jurisdictions, the provocation needs to be ‘extreme’ (for example, in Grenada).

In some jurisdictions, specific forms of behaviour that might amount to provocation are detailed in legislation, including adultery or an assault on a member of a defendant’s family (for example, in the Bahamas).

‘Loss of self control’

In some jurisdictions, it is explicitly stated that the defendant needs to act in the ‘heat of passion’ – in effect, very soon after being provoked (for example, in St Vincent and the Grenadines).

In some jurisdictions, the loss of control needs explicitly to have been ‘instant’ (for example, the Bahamas) and ‘proportionate’ to the provocation (for example, Nigeria).

‘Reasonable man’

The ‘reasonable man’ is taken to be of the same age and sex as the defendant (there is evidence that men and women react differently to provocation: men tend to react quickly; many women react after a delay – so-called ‘slow burn’ provocation).

Some jurisdictions refer to a person of ‘ordinary character’ (for example, St Vincent and the Grenadines).

Psychiatric factors relevant to provocation

It is necessary to understand in some detail the law of provocation, as rehearsed above, in order to understand what psychiatric factors can be relevant within it – and what cannot – in order then properly to direct your clinical interviewing.

Turning directly to the nature of any psychiatric or psychological factors that potentially might have relevance to either the ‘subjective’ (whether the defendant lost control) and ‘objective’ (whether ‘the reasonable man’ would have lost control) elements of the test, the law has generally restricted the role of expert evidence to application, or modification of the objective test. That is, it is not accepted that there can be expert evidence towards determining whether the defendant lost control in response to provocation.

As regards the objective test, the extent to which the ‘reasonable man’ can be modified to take account of the mental characteristics of the defendant is not clearly and firmly established in case law, and may vary across jurisdictions. This emphasises the importance of gaining clear instructions on what precisely is ‘allowed’ as expert evidence in the jurisdiction concerned. However, adopting the (somewhat vacillating) approach of English law when the defence of provocation still applied, in essence initially only ‘status’ variables – such as age, intelligence and race – were allowed to modify the ‘reasonable man’. But this was then expanded to allow in any characteristics, including mental characteristics, that would have made ‘the modified reasonable man’ more ‘woundable’ by the things said or done that are relied upon within the defence (albeit, this appears somewhat to ‘make subjective’ the objective test). However, whatever may be the vacillation or jurisdictional variation in what characteristics are allowed as just described, what is

clearly *not* allowed is evidence that the defendant is, in general terms, more likely to respond violently to any given provocation.

Instructions – provocation

Provocation is subject to the most variation between jurisdictions and is not directly a ‘psychiatric defence’. The following are intended as generic instructions.

1. Describe how any condition that you have diagnosed is likely to have affected the defendant’s response to things that were said and done to them.
 - a) If your opinion is that it would, describe this with reference to specific symptoms of any disorder you have diagnosed.
 - b) Did their mental condition make them susceptible to any specific words or actions?
2. Describe how any condition you have diagnosed is likely to have affected the defendant’s ability to control their behaviour.

Clinico-legal

How would you address the issue of provocation in your report?

Edwin claims to have lost control of his actions after being hurt by his girlfriend’s remarks that he was ‘always depressed’, and that he was ‘not father of the children he had been led to believe were his’.

The provocation allegedly occurred immediately before the killing, so that his *subjective* loss of control, if it was such, did occur ‘suddenly’. And, in terms of the *objective element*, being taunted about his depression and his children’s fatherhood would likely have had more of an impact upon any defendant who is in a depressive illness than upon a person in ‘normal’ mental health – for example, because of lack of self-esteem and shame at being mentally ill. But advancing such a proposition will depend upon establishing the details of what his girlfriend said and whether it would likely have ‘played upon’ a particular vulnerability that you have identified clinically.

However, ‘being left’, and any feelings of jealousy he might have then developed, could not be ‘allowed in’ to the objective test – albeit it might explain why he had become depressed.

Edwin’s proneness to anger as a result of his abused childhood cannot be allowed in as modification of the ‘reasonable man’ test, since it goes to his general ‘reactivity’ and not to his ‘woundability’. And neither could any element of his depressive illness that made him more ‘irritable’, and therefore likely to lose control. However, if his girlfriend had taunted him about his ‘past abuse’, and/or had he been aware that her new boyfriend had abused his own children, then this might well be allowed to modify the objective ‘reasonable man’ test.

Surmounting the difficulty of giving expert evidence that Edwin was, by virtue of his depressive illness, more ‘woundable’, while not being allowed to say that such illness was also likely to have made him more

irritable, seems impossible. Yet this has to be attempted for the purposes of the judge properly directing the jury on the law concerning what expert evidence can and cannot be relevant to within the defence.

The childhood abuse might also, of course, be of relevance to the *subjective* test, in that his response to this of ‘rage’ would make it more likely that he did, in fact, lose control. But, again, this cannot be referred to in expert evidence. However, it might be relevant in terms of his greater likelihood of having experienced a depressive illness, and so could be relevant to ‘validation’ of his account of such illness (see above concerning ‘malingering’).

Also in regard to the *subjective* test, clearly the court will place importance on analysis of witness statements for descriptions of Edwin’s behaviour immediately around the killing – did he appear ‘out of control’ to those who saw him?

Of course, accepting anything of the above in favour of a successful provocation defence, there is a strong piece of evidence against Edwin’s claim of provocation in his comment, when arrested, that he had made up his mind to kill his girlfriend. This suggests both that he did not lose control per se and, even if he did, it was not ‘sudden’. And, although you might be tempted to explore this carefully with Edwin at interview, it amounts to ‘ordinary evidence’, which is beyond any relevance of expert psychiatric evidence. That is, it goes to a decision of the court that does not require expert assistance. Rather, your interview should concentrate on matters relevant to modification of the objective reasonable man test, as described above.

As will be evident from the description of the law of provocation already given, the defence is a terrain within which the psychiatrist needs to be extremely cautious, so as to maintain the boundary around what it is proper for him to address, both clinically and then in his report. Such care will also need to be exercised in the giving of oral evidence, where there is greater danger of spontaneous expression, under pressure, of opinion that transcends the proper boundary of relevant expertise.

Ethical and professional issues

Should you change your report if a lawyer asks you to do so?

You include reference to your assessment of malingering in your report, albeit you conclude that Edwin is not malingering. The instructing lawyer asks you to remove this from your report, saying: ‘Don’t do the prosecution’s job for them.’

It is important to remind the instructing party in these circumstances that you are not ‘for’ the defence or prosecution but for the court, and that the report is ‘your’ report. Of course, if you are told that you have made errors of law, and that your clinico-legal opinion is flawed by way of such errors, then you should properly amend your report. However, you should make plain the source of your understanding of the proper law, and what that understanding is, so that the account you include can potentially be challenged by the other side – and such that you might be asked then to offer two opinions based upon the two legal narratives. Of course, if you are asked to correct typographical errors or factual inaccuracy (for example, mis-recording a witness statement), then clearly you can, and should, do this. But if you are asked by lawyers to remove a section of your report simply because it does not help ‘their’ case, then you must not do this.

Statutory definitions – provocation

These definitions are not exhaustive and represent only an example of a section of the statute from each state noted. Common law provocation defences are omitted.

...the person charged was provoked (whether by things done or by things said or by both together) to lose self-control, the question whether the provocation was enough to make a reasonable man do as he did shall be left to be determined by the jury.	Antigua Barbados Jamaica* St Lucia* Trinidad and Tobago*
...an unlawful assault and battery committed upon the accused person by the other person, either in an unlawful fight or otherwise, which is of such a kind, either in respect of its violence or by reason of accompanying words, gestures or other circumstances of insult or aggravation, as to be likely to deprive a person, being of ordinary character, and being in the circumstances in which the accused person was, of the power of self-control...	Bahamas Belize* Ghana Grenada
...means and includes any wrongful act or insult of such a nature as to be likely, when done to an ordinary person, or in the presence of an ordinary person to another person who is under his immediate care, to whom he stands in a conjugal, parental, filial or fraternal relation, to deprive him of the power of self-control and to induce him to assault the person by whom the act or insult is done or offered...	Botswana* Kenya Lesotho Malawi* Nigeria* St Vincent Uganda* Zambia*
Responsibility shall be diminished for an offence immediately provoked by the unlawful act of another against the offender or, in his presence, against his spouse, descendant or ascendant, brother or sister, employer or employee, or a minor or incapable in his charge. Provided that the reaction be proportionate to the provocation.	Cameroon
...has completely lost his or her self-control, the provocation being sufficient to make a reasonable person in his or her position and circumstances lose his or her self-control.	Zimbabwe
...deprived of the power of self control by grave and sudden provocation...	Bangladesh India Malaysia Singapore Sri Lanka

* Subtle changes in wording.

Case 12

Key themes

- *Clinical* – withdrawal from substances; intoxication
- *Legal* – provocation; capacity to form specific intent; insanity; diminished responsibility
- *Clinico-legal* – ‘woundability’ within provocation; withdrawal or intoxication in relation to capacity to form specific intent, insanity, diminished responsibility

Handbook references

- Alcohol and drug misuse and dependence (p21)
- Before accepting instructions (p31)
- Incapacity to form specific intent (p108)
- Provocation (p112)
- Intoxication (p115)

Case history

Tyrone, a 25-year-old man, is charged with the murder of a male friend. At the age of 14 years, Tyrone started to drink rum, typically drinking half a litre a night. His use of alcohol increased when he was aged around 17 years, when he started to go to bars with friends; and by his account, *‘not a day went by without a drink’*.

There were periods when he did not feel in control of his use of alcohol, particularly after his mother died when he was 23 years old. He would often drink a litre bottle of rum each day, starting to drink from mid-morning. He would then sweat and shake when he woke from sleep. To avoid this, he started to keep a cup of rum by his bed at night. He also then found himself drinking throughout the day, including at work. He was eventually dismissed for being intoxicated, six months before the alleged murder. As a result, Tyrone then lost his accommodation and started to sleep on the street.

In the weeks leading up to the alleged offence, Tyrone’s drinking increased further, in that he would regularly drink four litres of rum a day, stealing drink from shops. He developed jaundice and went to see a doctor, who diagnosed alcohol-related liver damage. Nonetheless, he continued to drink heavily.

Two days before the alleged offence, a friend, Mr Barrett, said that Tyrone could stay in his living room, on condition that he didn’t drink alcohol. In a state of desperation, Tyrone accepted the offer.

On the night of the alleged offence, Tyrone and Mr Barrett had a disagreement at Mr Barrett’s home, arguing about Tyrone’s use of alcohol. Two other men were present. Mr Barrett was heard to call Tyrone *‘a lazy rum-head’* who had *‘wasted his life’*.

Tyrone had not taken alcohol since moving into Mr Barrett's home, so he was sweating profusely, had a severe tremor, couldn't sleep and was feeling very anxious and irritable.

According to witness statements, Mr Barrett then asked Tyrone for money. Mr Barrett was said to be shouting. Tyrone subsequently stated: *'I said to him "hit me if you want!"... he hit me in the eye...I got the better of him and he was on the floor...I went to the front room...but went back to the kitchen to say "sorry".'* Tyrone told the police that Mr Barrett then grabbed a knife, that he managed to wrestle this from him, and then, in a state of 'terror', he stabbed Mr Barrett 12 times. He said: *'I left him in a bit of a mess on the floor.'* The other men present raised the alarm. Tyrone was then soon arrested by the police.

You are asked to give an opinion on possible defences of provocation and diminished responsibility.

Loss of control – England and Wales

In England and Wales the partial defence of 'provocation' is now known as 'loss of control' and can be pleaded in response to a charge of murder.

- The D's acts and omissions resulted from their *loss of control* (which need not be sudden)
- The loss of control had a *qualifying trigger* (fear of serious violence and/or acts or words that constitute circumstances of an extremely grave character and give a justifiable sense of being seriously wronged)
- A person of D's sex and age, with a *normal degree of tolerance and self-restraint*, and *in the circumstances of D*, might have reacted in the same or a similar way to D; and
- D did not act in a considered desire for revenge

Sexual infidelity is excluded as a ground for feeling seriously wronged.

The *circumstances* of D can include aspects of history and mental state that impact on D's 'woundability' and/or their reaction to the *qualifying trigger* but not their capacity for self-control. Psychiatric evidence can be called to assist the court in understanding this – for example, a depressed mood might make a defendant more 'woundable' by criticism due to their self-esteem being low.

A successful defence of loss of control results in a conviction for manslaughter.

Clinical

There are various stages of the disorder of alcohol dependence, and in this case there is a need to assess carefully what Tyrone's state was likely to have been at the time of the killing. His alcohol use appears to have been very severe, and there is an implication that the state he was in at the time of the killing was one of physiological withdrawal. However, of particular note is that, in some cases, there can be uncertainty about whether someone is in a withdrawal state – whether they have drunk sufficiently so that they are 'topped-up', or whether they are intoxicated. Attempts to explore this must be detailed and involve consideration of the defendant's usual drinking, the effects of alcohol (both in general and upon him) and the details of what he had drunk during the days leading up to the offence.

Tyrone's apparent dependence on alcohol at the time of the killing, is demonstrated by the following:

- A strong desire or sense of compulsion to take alcohol
- Having difficulty in controlling his use of alcohol
- A physiological withdrawal state when alcohol use had ceased
- Using alcohol with the intention of relieving or avoiding withdrawal symptoms
- Evidence of physical tolerance, such that increased doses of alcohol are required in order to achieve effects previously produced by lower doses
- Progressive neglect of alternative pleasures or interests because of alcohol use
- Persistent use of the substance despite clear evidence of harmful consequences, including physical, such as liver damage through excessive drinking

Based upon the above, it seems clear that, at the time of the alleged offence, the defendant was suffering from severe alcohol dependence. However, the opinion you come to concerning his state acutely at the time of the alleged offence – essentially, in terms of whether he was in a withdrawal state or was intoxicated – will depend upon careful consideration of his symptoms at the time (as reported by him and by others), and of his pattern of withdrawal in the past.

Legal

A defence to murder of provocation exists in many jurisdictions. This is a partial defence, reducing the conviction from murder to manslaughter (see also Case 11).

The legal test in most jurisdictions derives from Section 3 of the England and Wales Homicide Act 1957 (which has been repealed in the United Kingdom and replaced by a test of 'loss of control'; see Case 11 and also below for detailed description of the defence and of the limits of the potential role of psychiatric evidence within it. Again, the boundaries of admissible expert evidence are rehearsed in detail within Case 11).

Other defences, beyond that which you are asked to address, *may* also be relevant – specifically, 'incapacity to form specific intent' (although unlikely); 'insanity'; and 'diminished responsibility' (see both the Handbook and other Cases referenced below in relation to the law concerning each of these).

Clinico-legal

The defence will likely argue that the defendant's account is that he was 'provoked by things said and done' to 'suddenly lose his self-control' before attacking Mr Barrett – although it will be for the trial judge to determine whether the 'provocation' was sufficient to raise the defence (in England, there is much case law supporting the notion that provocation should almost always be left to the jury if there is any significant provocation asserted).

In this context, psychiatric evidence will need to consider Tyrone's 'woundability' in relation to the things allegedly said and done, which may be relevant to the 'objective' test of the 'reasonable man' in regard to Tony's sensitivity. It will also assess the impact of his mental state upon his ability to exercise self-control

(see below), and whether that mental state arose from intoxication or from withdrawal, in terms of the 'subjective' test (again see below). However, the question of *whether* he lost control is for the jury and not for expert comment.

The comments that Mr Barrett made to Tyrone, calling him a 'rum-head' and criticising him for 'wasting his life', are likely to have left Tyrone feeling inadequate, and might well have caused him to become angry, while similar comments made to someone who was not an alcoholic are not likely to have had the same effect. He will, therefore, be judged as 'the reasonable man who is an alcoholic', and not as 'the reasonable man not an alcoholic' (*HM Attorney-General for Jersey v Holley* [2005]).

Either a state of withdrawal or of intoxication in the defendant would very likely have increased his level of irritability, making it more difficult for him to exert self-control than otherwise would have been the case. And, although it may be open to argument as to whether expert evidence in support of this should be allowed – in that it would go to the subjective test of whether he did lose control – expert evidence will likely be admissible in terms of which was the *cause* of his mental state – withdrawal or intoxication.

However, as regards whether it was the things said that played upon Tyrone's 'woundability' that accounted predominantly for his violent response, this may be open to dispute. The argument between Tyrone and Mr Barrett appears, in part, to have been caused by Mr Barrett asking for money, and Tyrone's annoyance at this was not directly due to any sensitivity on his part about his problem with alcohol (although indirectly it would likely have had an effect, as he had come to rely on Mr Barrett because of his alcoholism). So the jury will need to decide what factors were important, and each in what measure – hence, the relevance of, or weight to be attached to, the psychiatric evidence in regard to 'woundability' will depend upon how important the jury decides the taunt about Tyrone's alcoholism was in triggering his violent response.

Depending upon the jurisdiction, it is likely to be argued by the prosecution that Tyrone's actions were 'disproportionate' to the provocation from Mr Barrett, whatever his experience of being provoked and 'wounded'. That is, although Mr Barrett was holding a knife, Tyrone's response was to stab him 12 times, arguably not only employing more violence than needed to protect himself (in self-defence, a defence not raised) but also suggesting a reaction disproportionate to the provoking remarks (perhaps suggestive, therefore, of a violent disposition per se). This said, the defence of provocation perhaps *infers* a 'disproportionate' violent response, in that it requires 'loss of control' or 'loss of mastery over the mind'. (Of course, the question of whether it was a proportionate response, or whether Tony 'lost control' or 'lost mastery over his mind', is not the subject of expert evidence.)

As regards Tyrone's violent reaction in response to either or both the taunt and the argument, and whether this was enhanced by withdrawal or intoxication, it will be necessary for the jury first to determine his underlying level of self-control when not either withdrawing or intoxicated. Hence:

- Does he easily lose his temper?
- Has he been in any fights before, and how were these precipitated?
- How well does he usually cope in an argument?

If the court were to decide that Tyrone's normal personality was *not* unusually prone to offering a violent response, it would then be necessary to offer expert evidence in regard to the two alternative scenarios (1)

he was withdrawing; or (2) he was intoxicated, since the legal implications may differ between the two findings (see below).

However, if he was in *either* state, then it will be necessary to offer evidence towards whether he was ‘capable of forming the specific intent required for murder’ (see Handbook and Case 6) – albeit the threshold for such a finding is extremely high, and unlikely to be met in this case.

If, based partly upon expert evidence, he is determined to have been in a state of *withdrawal*, then expert evidence would likely be allowed in regard to whether his mental state, words and behaviour supported, or not, the ‘insanity’ defence (see Cases 7 and 8) or the partial defence of ‘*diminished responsibility*’ (see below).

If he was *intoxicated*, then the effect of that state in determining the killing would be irrelevant to his legal situation (since he should have had foresight that he might be violent if he drank). That is, unless it could be argued that his intoxication was non-voluntary, because – within the partial defence of ‘*diminished responsibility*’ – his alcohol dependence amounted to an ‘abnormality of mind’, because he had an ‘irresistible impulse to take the first drink of the day’ (a legal test that sets a very high threshold for a finding of ‘involuntary intoxication’). The victim’s taunts would be seen then as ‘triggers’ acting upon his abnormal intoxicated mental state; and in being so, they would not be required to come within the standards or relevance of ‘things said or done’ defined within provocation.

Ethical and professional issues

How should you respond to questions that you do not believe you should answer?

Provocation raises the sometimes uncomfortable issue of being asked questions that you do not believe you should answer. This can either be in written instructions or in court – the most difficult situation being where you are asked by a judge. Hence – in one context or another – you might, for example, be asked to say whether, in your opinion, Tyrone ‘lost control’ (the ‘subjective test’ within provocation). This is not a question that a psychiatrist should answer; however, it comes very close to areas that are, arguably, within a psychiatrist’s expertise. It is, therefore, easy to be pulled across the boundary from proper to improper expression of expert opinion.

Control and inhibition of behaviour is central to some psychiatric disorders, and this can cause some confusion (amongst legal and medical professionals); but in a case of this nature, the question of whether the defendant did, in fact, lose control is solely one for the court. The expert should focus on features of his mental health that increased his woundability, and do so without expressing a view as to in what proportion different factors provoked his violence. Similarly, although an expert might properly express an opinion on whether the defendant was likely in a state of withdrawal or was intoxicated, and how each might relate respectively to insanity and diminished responsibility, it is not proper for an expert to say whether the defendant was, in fact, legally insane or whether his intoxication was involuntary – merely, whether he was incapable of avoiding taking the first drink of the day.

How should you respond to a request to consider one defence, when you are aware that other defences are potentially relevant?

The starting point of your relationship with the instructing lawyer is that they pose the legal questions and you respond to them.

However, to rehearse some of the text from Case 8, and to develop it further in relation to this case, sometimes lawyers are ill-informed about the potential relevance of psychiatric conditions and mental states to a range of legal defences. And further, they may not have ‘thought through’ ‘psycholegal mapping’ of their client’s mental state when he killed onto the alternative defences other than provocation (as rehearsed above).

An experienced expert witness psychiatrist will, by contrast, be aware of subtleties at the interface between psychiatry and law that may not be appreciated by defence lawyers – especially since the latter may come across complex ‘psycholegal cases’ very infrequently. Therefore, it can be reasonable to ‘raise’ with instructing lawyers the question: ‘Would you wish me to address also the defences of “insanity”, “capacity to form specific intent” and “diminished responsibility?”’ And to explain, in the above terms, how each *may* be relevant – thereby initiating a discussion. Of course, once the discussion has been initiated, it will be for the lawyers to define the law for you, and for you then to offer your opinions within such a definition.

Case 13

Key themes

- *Clinical* – battered woman syndrome
- *Legal* – battered woman syndrome and provocation
- *Clinico-legal* – battered woman syndrome in provocation and diminished responsibility

Handbook references

- Post-traumatic stress disorder (p23)
- Validity and classification (p58)
- Diminished responsibility (p109)
- Provocation (p112)
- Self-defence (p114)

Case history

Vena is 36 years old. She is charged with the murder of her male partner, it being alleged that she threw petrol on him and then set him alight. He died from his injuries one week later. Prior to his death he was able to give a statement.

At the time of the assault, the victim was sitting smoking a cigarette, when he felt liquid being poured onto him from behind. He then felt the heat from being set alight, caused by Vena throwing a lighted match onto him. The victim ran outside, where the fire was then extinguished by a neighbour who had been watering his front garden with a hose. An ambulance was called; and the victim told the paramedics that, before attacking him, Vena had said to him: 'I will kill you boy.' On arrival at hospital a few minutes later, he was found to have extensive burns

In her police interview, Vena said that they had been arguing, and then the victim had sat down to smoke. She said that he had his knife with him, and that he had made a motion when they were arguing that he was going to use the knife upon her. She then gave further details about the day of the offence. She said that she had been sleeping when the victim had come to ask her for money, and she had told him she had none. She said that he was annoyed and angry, and came to her again a few minutes later, threatening her with the knife.

Vena described the victim as a drug addict who had been in and out of prison. She also described having received repeated beatings from him over the last 10 years, and said that he would also beat her son. He had also choked her to the point of unconsciousness on one occasion. She said she had sustained multiple injuries over the years, and had also been subject to multiple threats from him, including threats to kill her. However, she had not attended for medical care, or told others about it, for fear that the victim would respond by attacking her again. Further, she described him being abnormally jealous, such that he would attack her sometimes after they had been out in the street together, alleging that she had flirted with men

they had passed – so she would always walk with her eyes down, in order to avoid the accusation. He also frequently used to check where she was, and demanded to see her mobile phone twice a day.

Vena described having felt unable to leave her partner. She also said she had tried to throw him out on many occasions after arguments, but that he would always apologise for his behaviour, begging her to forgive him, and she would then let him remain in the family home, hoping that he would change. She said she did not sleep when he was in the house, for fear of him, and she would experience anxiety symptoms on hearing him open the front door. She would have nightmares, including ‘repeating’ past attacks he made upon her. She said she had been very reluctant to make any reports to the police when he had assaulted her, again, for fear of his violent reaction, and had played down the severity of his assaults to friends and family – from whom, in any event, the victim had isolated her.

She described that she had feared for her life on the night she had killed him. She said that if she had not done what she did, she believed that he would have killed her.

Vena said she had also been a victim of physical abuse as a child, and had been raped by an uncle at the age of 15.

You are asked to consider whether Vena suffers from ‘battered woman syndrome’; and, if so, whether it could be used as a defence to the offence with which she charged.

Clinical

‘Battered woman syndrome’ (BWS)

BWS (now sometimes referred to as ‘battered person syndrome’, as the condition is seen in both men and women) is a well-described ‘syndrome’. It involves characteristic reactions on the part of the abused person to the threats and abuse of her/him; characteristic patterns of behaviour on the part of the abusing partner; and characteristic interactions between the two. The syndrome, first described in the 1970s, while not in ICD10 or DSM5, characteristically includes aspects of other mental disorders occurring in the victim, specifically symptoms of ‘post traumatic stress disorder’ (PTSD), anxiety and depression.

BWS arises typically after the victim of violence in a relationship has experienced repeated cycles of violence and reconciliation, resulting in the abused victim:

- Thinking that the violence is his or her fault
- Having an inability to place the responsibility for the violence elsewhere
- Fearing for her/his life, and/or, the lives of loved ones whom the abuser might, or has threatened to harm (for example, children in common, close relatives or friends)
- Developing an irrational belief that the abuser is omnipresent and omniscient
- Experiencing a state of ‘learned helplessness’

A ‘three-stage cycle’ relating to each episode of abuse has been described in many cases of prolonged domestic violence. First, tension builds in the relationship, with the victim often trying to find ways, or devise strategies, to avoid a further violent episode. Second, the abusive partner releases the tension via violence, while blaming the victim for having caused the violence. Third, the violent partner makes

gestures of contrition. However, the victim does not find solutions to avoid another phase of tension building and release, and so the cycle is repeated.

Such repetition of the violence, despite the abuser's attempts to adopt strategies that will placate the abuser, results in the abused partner feeling at fault for not preventing a repeat cycle of violence. And, ultimately, failure to find any strategy that avoids being attacked – often because the abuser 'changes the rules' – results in feelings of both helplessness and self-blame. The feeling of being both being responsible for, and helpless to stop, the violence leads in turn to depression and passivity – often alongside 'post trauma' symptoms. This 'learned helplessness', learned depression', and 'passivity' makes it difficult for the abused partner to marshal the resources and support system needed to leave the abuser. Indeed, she will tend to perceive him as 'all-powerful'.

The assessment of BWS is unusual, in that it involves consideration of both the victim – here, the defendant – *and* of the relationship between the abused and abuser (which includes 'assessment' of the abuser, through the descriptions of him given by the victim).

Commonly, the features of the abuser are more 'consistent' across couples even than are features in the victim. So, for example, the abuser is very commonly 'insecure' and 'dependent', and uses violence and control in order to shore up his position, as he perceives it, within the relationship.

Assessment of Vena

On assessment by you, Vena shows many of the features of the syndrome, including 'learned helplessness', in the context of experiencing many years of violence, and her describing having felt unable to leave her partner – instead, allowing him repeatedly to remain in the family home after episodes of violence. She tells you that she has never had the courage to try to leave.

Legal

Can BWS be used in a defence of provocation?

In summary, the presence of BWS may properly result in consideration of both 'provocation' and 'diminished responsibility'. The law in relation to each is described in both the Handbook and in other cases in this text. The law of provocation is described, and explored in relation to expert psychiatric evidence, in cases 11 and 12.

Clinico-legal

Provocation

As regards the '*subjective element*', the court will have to determine whether Vena (a) 'was provoked' and (b) 'lost control', or 'mastery over her mind'. And this is not a matter for expert comment, unless you determine that the Vena exhibited 'mental symptoms' that can properly be described by an expert as relevant to determining whether she 'lost control', and the court determines that the jury could not take account of those symptoms without expert assistance. Further, the court, in some jurisdictions, will need

to assess whether Vena lost control, if she did, ‘suddenly’ (the exact terms of the defence vary somewhat between jurisdictions, again see Cases 11 and 12). Again, this is almost certainly not a matter properly subject to expert comment.

In terms of the ‘*objective element*’ of the test, the ‘reasonable man’ is considered to be of the same gender as the defendant; that is, ‘the reasonable woman’. Further, in this case, she is ‘the abused reasonable woman’, including all elements of, for example, BWS that are potentially relevant to whether she would be more ‘woundable’ by such provocation as she alleges occurred. So, for example, if she had been in a depressed state and the victim had taunted her about being ‘always depressed and useless’, or ‘not good at sex’, then she might reasonably be more woundable by such taunts than would the non-abused, depressed or anxious woman. Again, it might be argued that ‘one more threat presaging a further attack upon her’ would give her the message ‘you are worth nothing other than to be abused’. And each of these, and other, possibilities would have to be assessed for by you clinically.

As regards Vena’s violent reaction to any ‘threat’ or ‘taunt’, she will be adjudged as a woman, not a man; and here it has been argued that the ‘old law’ of provocation in UK (now replaced by ‘loss of control’), and the law in many common law jurisdictions, arguably discriminates against women with BWS. This is because there was/is a need for ‘sudden’ loss of control, and the perception by the woman of her abuser as being ‘wholly in control’ means that she can only ‘defend herself’ by attacking him while he is in a reduced state of power to respond (for example, asleep, or intoxicated). Hence, women exhibiting BWS often demonstrate violence in response to ‘slow burn’; that is, they attack in a ‘considered’ way some time after ‘the last provocative words or actions’ emitted by the victim, by way of a train of cognition, plus emotion, developing thereafter that leads eventually – sometimes after some hours – to the attack by her. That is, having developed a state of ‘learned helplessness’ typically over the course of many months or years – perceiving her abuser as ‘all-powerful’, and feeling unable to leave the relationship, plus being highly fearful and believing that there is no other way for her to defend herself, since she lacks the physical strength to fight back when being attacked, or when threats are made to her or her children or other loved ones – she eventually takes an opportunity to attack when he is reduced in his capacity to respond. Put in more of a background context, in the face of increasing violence, the woman comes to believe that the only way she can protect herself, and her children, is to eliminate the partner when he is vulnerable.

The rule that the required loss of control must be ‘sudden’ is determined essentially for an evidential reason, in that ‘the longer the delay from the last provocative words or actions the more difficult it is to exclude the motive of “revenge” (rather than loss of control)’. And in a major case on the point in English law (*R v Ahluwalia* [1992]), the then Lord Chief Justice observed that, although delay was not necessarily fatal to the defence of provocation, the longer the delay, the more a jury was likely to challenge ‘loss of control’, by comparison with the alternative of ‘revenge’.

The case law in other jurisdictions varies. In some, the loss of control explicitly needs to have been ‘instant’ (for example, the Bahamas), and in these jurisdictions introducing BWS as a factor in provocation is likely to be very difficult, unless the modification adopted in *Ahluwalia* is adopted, so as to allow ‘slow burn’ and some delay, with the jury left free to decide ‘how long’ is reasonable in the particular case.

Hence, in summary, although Vena exhibits BWS, so that she may be able to explain ‘why she did not leave’ – and why she was more ‘woundable’ by things said or done to her prior to the killing – she may have great difficulty in satisfying the legal test of ‘loss of control’, or ‘loss of mastery over the mind’ (*R v*

Duffy [1949]). Although it might be arguable that Vena was indeed not mistress of her own mind, as she or any ordinary woman would be – because her perception of the options available to her was profoundly distorted by her BWS – if the court resolves ultimately onto ‘loss of control’ rather than, for example, ‘loss of *ordinary* control’, then Vena’s counsel may fail in attempting to make the point.

Diminished responsibility

As already described, BWS is not a diagnostic entity (indeed, since it involves the ‘triad’ that includes also the behaviour of each partner and the interactions between them, it cannot be so). However, if the defendant has symptoms, within BWS, sufficient to diagnose a recognised medical condition – for example, PTSD, anxiety disorder, or depressive disorder – then that can amount to ‘abnormality of mind’; and then all of the ‘mental mechanisms’ within such abnormality can serve to support ‘substantial impairment of mental responsibility’.

However, beyond this, in search of ‘natural justice’, courts may accept that BWS is sufficiently recognised as a mental condition to be a legal ‘abnormality of mind’ and, again, as capable of founding ‘substantial impairment of mental responsibility’. However, in drafting your report, and giving evidence, you should be careful to be clear about the medical (non-) status of BWS, and allow the court to use your properly and fully given evidence as it wishes.

Self-defence

A lawyer for the defendant might (erroneously) suggest that Vena might have available to her the full defence of ‘self-defence’, based somehow upon her chronically abused state and acute fear at the moment she attacked the victim.

However, success in that defence depends upon the defendant having been in imminent fear of death or really serious harm, and as having had no opportunity to withdraw to safety, while the response in self-defence must be proportionate. Any enhanced fear of harm to self on the part of Vena that might arise from her PTSD, or anxiety disorder, does not remove these core requirements of the defence.

Also, there is no such defence as ‘psychological self-defence’; that is, ‘defence of your sense of psychological wellbeing, or existence’, as has been proposed in some of the literature in the USA.

Ethical and professional issues

To what extent should you use medical literature in your reports?

The engagement of a witness as an expert relies upon their field of expertise being based upon a recognised body of scientific research or clinical knowledge. As with all areas of scientific research and clinical knowledge, there are differences in results from different studies that might reflect study design, plus various biases or cultural and geographical variations. And this can give rise to expert evidential complexity. However, what is crucial – as in all aspects of expert witness practice – is scrupulous avoidance of selectivity. Referencing one study that backs an assertion that you make, without referencing competing literature or without setting the study within the broader literature, is wholly unacceptable. Rather, what is reasonable and proper is to write, and say that there is a reasonable body of literature that describes and

accepts, for example, the phenomenon of BWS. And, if you use any statistics or factual statements, you should reference them, and always be explicit about alternative findings if they exist.

It is also valid to opine that BWS has been observed commonly in association with distinct mental disorders such as PTSD, depression or anxiety disorders occurring in the woman, while it is also likely to be necessary to explain that ‘diagnoses’ such as BWS have resulted in some controversy, and that this likely explains – at least partly – why BWS has not been included in diagnostic manuals.

In a case such as this, therefore, it can be particularly helpful to keep in the forefront of your mind that the role of an expert is to assist the court with matters outside of the expertise of the court.

Ethical Code and Ethical Guidelines – Singapore Medical Council [2016]

Doctors as expert witnesses

You may occasionally be required to give medical evidence as expert witnesses in tribunals and courts. This is an important responsibility. Performing such a role responsibly means:

1. You must ensure that you are competent, objective and impartial when giving your expert opinion as an expert witness to a court or inquiry.
2. You may disclose confidential information on the patient that you received as a result of such engagement to the extent it is relevant to the discussion at hand. You must not disclose anything more than is necessary in the context of the case and you must not use such information as a means to embarrass or otherwise pressurise any party involved.
3. You must ensure that you have sufficient information to give your expert opinion and if not, you must qualify your opinion.

Case 14

Key themes

- *Clinical* – acquired brain injury; cognitive impairment; epilepsy
- *Legal* – automatism
- *Clinico-legal* – frontal lobe syndrome; epilepsy in automatism, and sentencing

Handbook references

- Acquired brain injury (p24)
- Epilepsy (p24)
- Instructions (p32)
- Neuropsychological assessment (p49)
- Automatism (p106)
- Incapacity to form specific intent (p108)

Case history

Jamal is a 26-year-old man charged with the attempted murder of his mother. Three years ago, Jamal was diagnosed with a meningioma, a benign form of brain tumour, which was removed. However, he was left with some cognitive disabilities thought to be associated with damage to his frontal lobes.

Jamal reports having had no problems at school. And, before he became symptomatic from the meningioma, he had had many friends, was well liked and had a calm temperament. He had close relationships with his parents, but lived separately from them. He had never been violent.

From immediately after the operation, Jamal was cared for by his family. And they soon noticed a significant change in his personality, his mother describing him as having become impulsive and irritable. He also suffered ‘seizures’. Around the time of having a seizure, he would sometimes act strangely, including picking up knives, and on a few occasions he had coincidentally threatened his parents, yet afterwards had no memory of having done so.

The current allegation is that Jamal attacked his mother with a knife. The attack is said to have taken place in his parent’s garden, where the family had been enjoying lunch. His mother suffered multiple stab wounds in the attack, which was not witnessed by anyone else. Jamal’s father then immediately came out of the house in response to hearing his wife’s screams, where he saw Jamal with blood on his hands. Jamal seemed disorientated, vague and perplexed. On being questioned by the police, he claimed to have no memory of what had taken place. Meanwhile, his mother underwent surgery and remained in hospital for two weeks thereafter. The parents subsequently reported that Jamal had had two bottles of beer during the lunch they had all had together.

You are asked to consider what was the cause of the attack; and whether it could amount to a legal automatism.

Instructions – automatism

1. Does any condition that you have diagnosed mean that the defendant was likely to have been acting in an involuntary way at the time of the alleged offence?
 - a) Explain this with reference to specific symptoms or manifestations of any condition
2. Explain how any condition you have diagnosed affected the defendant's level of consciousness at the time of the alleged offence.
3. Was the condition you have diagnosed, intrinsically or extrinsically caused?
 - a) Was it caused by an injury, insult or substance?
 - b) Was it caused by a disease?
4. Was the state of the defendant at the time of the alleged offence caused by voluntary intoxication with a drug or alcohol?

Clinical

This is a complex case, involving the possible effects of a brain injury arising from a tumour and then surgery; the possibility of organic psychosis associated with epilepsy; and the additional factor of the effects of a relatively small amount of alcohol on the functioning of a damaged brain. Plus a key question will be whether the attack was determined within ordinary consciousness *or* within a seizure or peri-ictal period.

Assessing for acquired brain injury causing possible neurocognitive disorder

The long-term effects of brain injury are highly variable and depend upon the severity, nature and location of the injury.

Neurocognitive disorders are diagnosed when there has been a significant cognitive decline from a previous level of function in one or more cognitive domains, with initial clinical assessment being based upon the subject's account, plus that of a reliable informant such as a family member or friend or a clinician. This is followed by straightforward 'bedside' tests. However, such assessment should always then be accompanied by the administration of standardised neuropsychological testing by a clinician qualified to do so (almost always a clinical neuropsychologist), plus brain imaging (by way of either or both MRI and CT scanning). And, in this way, the location – and therefore functional implications – of the damage can be most accurately determined, by way of 'cross-validation' between clinical assessment, psychometric results and neuroimaging. Of course, traumatic brain injury is only one cause of neurocognitive disorder, and the clinical history will point to the likely cause of any observed abnormalities, as may some aspects of the psychometric and imaging results. Other causes include dementias, chronic alcohol or drug use, infections and other medical conditions.

Frontal lobe injury (especially orbito-frontal) commonly has consequences of:

- Behavioural disinhibition
- Mood changes
- Perseveration
- Apathy
- Executive dysfunction, evidenced by problems in planning and organising behaviour

The foregoing is sometimes referred to as ‘frontal lobe syndrome’.

There is an association between significant traumatic brain injuries (TBIs) *and* impulsive violence and disinhibited behaviour – enhanced when combined with substance use or a dissocial personality disorder (notably, though, psychometric evidence suggestive of dysexecutive syndrome can be found in antisocial personality disorder, or psychopathy, unrelated to brain abnormality).

Although not directly relevant to Jamal’s case, where brain damage has been brought about by a single episode of trauma, post-traumatic amnesia (PTA) is an important index of the severity of the brain injury suffered. PTA is the interval from the injury until the patient is orientated and can form, and later recall, new memories. A PTA of one to 24 hours is considered to indicate a TBI of ‘moderate severity’.

Other markers of severity include:

- Loss of consciousness for more than 30 minutes
- Open brain injury
- Skull fracture
- Evidence of neuroradiological abnormalities (including subdural haematoma, cerebral contusion, and haemorrhagic contusion – all forms of bleeding in or around the brain)]

Assessing for epilepsy

In this case, it is necessary also to consider whether the attack by Jamal occurred within, or around, the time of a seizure – that is, in a state of altered consciousness rather than in normal consciousness and determined by his frontal lobe damage (as above).

Epilepsy is almost inevitably diagnosed and described by neurologists rather than by psychiatrists, and so there will likely be the need for more than one medical expert in a case with such a degree of uncertainty. Jamal’s past brain injury, his history of seizures, his unusual behaviour around the time of seizures, the account by his father of his presentation immediately after his violence towards his mother, the lack of any violence by Jamal before the brain injury, and the lack of any clear precipitating event (such as an argument between Jamal and his mother) all suggest that epilepsy might have played a role.

Although investigations such as electroencephalogram (EEG) and brain imaging might be indicative, the diagnosis of epilepsy is almost always made on the history from the patient and an informant who has witnessed possible seizures. However, even if there is a clear history of past seizures, and it is possible to identify an epileptic focus on EEG investigation of Jamal, looking at his likely state coincidental with the alleged offence, much will depend upon witness statements concerning Jamal’s behaviour around the

time of the alleged offence (since there is no way of identifying the timing of ‘some previous fit’) – that is, statements from both his parents.

The latter raises a particular problem of clinical assessment within legal process, in that, ideally, any expert would wish to ‘take a history’ of events around the time of the alleged offence from Jamal’s parents. However, both are likely to be prosecution witnesses, so it will be necessary to approach the prosecution in order to ‘gain permission’ to interview them. This should be requested on the basis that questions posed will be ‘solely clinical’ in nature (although it may be difficult to ask only questions the answers to which will have no legal implications *per se*).

Voluntary intoxication will need to be considered as a factor. However, if Jamal truly drank only two bottles of beer – which on their own in a person of normal non-violent propensity would be unlikely to precipitate serious violence – then careful consideration will be needed of whether the effects of such mild intoxication either were enhanced by his brain damage or precipitated a seizure in him (which, in turn, might have been relevant in determining the attack – either ictally or peri-ictally).

Finally, psychosis can occur before, during and after seizures (pre, inter and post-ictal respectively); such psychosis tending to be intense and relatively short-lived. Post-ictal psychosis is the most common of the psychoses associated with epilepsy, seen in two to eight per cent of people with epilepsy. And, again, ruling this out or in will depend upon very careful history-taking, including from the parents.

Statutory definition automatism – St Lucia

Criminal Code

A person is not guilty of an offence if –

- a) He or she acts in a state of automatism where the act alleged to constitute the offence is committed by him or her involuntarily so that he or she has no control over his or her physical activities due to some external factor which causes him or her to be unconscious or otherwise act without his or her will; and
- b) The act or condition is not the result of anything done intentionally or recklessly or as a result of voluntary intoxication.

Legal Automatism

An automatism occurs, in essence, when someone behaves without any conscious awareness or control. Strictly legally, it must rule out the possibility of there having been an *actus reus*, on the basis that there was no ‘willed action’ (although some legal commentators suggest that automatism negates the possible presence of *mens rea*). Automatism is not described in every jurisdiction’s statute, but it is likely to be a common law test in those where it does exist within criminal codes.

Automatism in law is further complicated by the distinction between ‘non-insane’ and ‘insane’ automatism – whereby finding the former results in acquittal, whereas finding the latter results in a finding of ‘insanity’ per se, with whatever legal consequences that the law allows. The distinction between the two categories of automatism is in terms of its cause; in that if the cause is a legal ‘disease of the mind’ (within the McNaghten Rules) then the automatism is an insane one, and not if not. Hence, if the cause was ‘intrinsic’ to the defendant it will be deemed ‘insane’, and if ‘extrinsic’, then ‘non-insane’ (from the case in English law of *R v Quick* [1973]). Alternatively, if violence from the automatism is ‘prone to recur’ then, again, the automatism will be deemed insane (*Bratty v Attorney General for Northern Ireland* [1963]).

Statutory definitions – automatism

Automatism, in law, refers to a situation where the actions of the defendant at the time were wholly involuntary. This has been referred to as complete destruction of voluntary control. Automatism results in complete acquittal.

Automatism has a similar meaning in medicine, referring to behaviour lasting a short period of time that is unconscious. It is not common but most frequently seen in epilepsy. It can vary from simple movements to more complex actions like sleepwalking.

No criminal responsibility shall arise from accident or from irresistible physical compulsion.	Cameroon
A person who acts in a state of unconsciousness, or whose consciousness is so impaired as to make him or her unable to control his or her actions, shall not be liable for any offence committed during such a state.	Lesotho
... a person is not criminally responsible for an act or omission which occurs independently of the exercise of his will, or for an event which occurs by accident.	Tanzania Zambia
...the person did or omitted to do anything that is an essential element of the crime without conscious knowledge or control, shall be a complete defence to the charge.	Zimbabwe
...he or she acts in a state of automatism where the act alleged to constitute the offence is committed by him or her involuntarily so that he or she has no control over his or her physical activities due to some external factor which causes him or her to be unconscious or otherwise act without his or her will.	St Lucia

Clinico-legal

How should you address the issue of legal automatism?

The opinion expressed in relation to automatism will depend entirely upon the clinical opinion reached concerning the defendant's mental state coincidental with the alleged offence, with reference to the law described immediately above. If Jamal was in an ictal or peri-ictal state, then this would amount to an 'insane automatism'.

How should you address the legal relevance of 'frontal lobe syndrome'?

In the event that the defendant was not in an ictal, or peri-ictal state at the time of the alleged offence, but it is determined clinically that he exhibits 'frontal lobe syndrome', with dysexecutive syndrome, then you will have to address how this might, or might not, bear upon his legal situation.

If his mother had died from the attack, then he would have a clear basis for a partial defence of 'diminished responsibility'. However, that defence only applies to a charge of murder, and his mother did not die, so other possible defences have to be considered.

Capacity to form specific intent

It is possible that Jamal's cognitive disabilities could have deprived him of the capacity to form the specific intent required for conviction of attempted murder. However, frontal lobe syndrome most typically disinhibits behaviour, rather than removing the capacity to form an intention. Hence, Jamal is unlikely to be able to plead lack of capacity. Put otherwise, 'intention' is a rather simple legal notion and does not have to include some identified motive for the action taken.

Insanity

Again, it is highly unlikely – unless Jamal was in a state of automatism, and it would then be an insane automatism – that he would be able to plead insanity just on the basis of his cognitive disabilities, as they exhibit themselves in a state of clear consciousness, given the narrow and high threshold for a finding of insanity. You must, however, at least address the possibility.

Sentencing

It is most likely that if Jamal was not in a state of abnormal consciousness coincidental with the alleged offence, then the legal relevance of his frontal lobe syndrome will be at the sentencing stage, either by way of mitigation or in respect of a 'mental health disposal'.

Ethical and professional issues

The importance of instructions

The risk of confusion arising out of the complexity of this case will be minimised by way of very clear instructions, in order to assist the psychiatrist towards (1) deciding on what matters he can comment; and (2) providing a report that is of most use to the court legally. Whatever the legal instructions, you should

consider all the possible clinical scenarios that may have pertained at the time of the alleged offence, and offer a balanced opinion on ‘what is most likely’. You should then respond to detailed legal instructions, or questions in court, in respect of the potential legal implications of the most likely clinical conclusion to which you have come, as well as of other possible clinical conclusions.

How should experts respond when they reach different conclusions?

Suppose that you and an expert appointed for the other side differ in your clinical conclusions?

Differences in opinion between expert witnesses are not uncommon and are anticipated by courts. It is not a cause for concern, as long as all witnesses express their genuinely held opinions, and clearly give their reasons for holding them.

This case is complex and may well result in differences in opinion, so all of the experts will need to behave professionally and with courtesy. However, it is reasonable not only to explain the basis of our opinion, but also to highlight the weaknesses in the opinion of the ‘opposing’ expert’s evidence, explaining why you believe that you are correct. Of course, any weaknesses in the other experts’ opinions, or your own, will properly be explored in cross-examination.

In some situations, a court might invite experts to meet and to prepare a ‘joint statement’ summarising areas of agreement and difference. Within this:

- Offer an impartial opinion
- Give reasons for your opinion, plus evidence for and against your conclusion
- Acknowledge any limits of your expertise
- Be prepared to change your opinion if new facts emerge

Additional information

Neuropsychological assessment of people with traumatic brain injury

Neuropsychological assessment of people who have suffered traumatic brain injury (TBI) involves addressing the complex interplay between anatomical *and* emotional and cognitive changes. Such injury is often associated with behavioural and affective changes – such as depression, anxiety, and post-traumatic stress disorder (PTSD) – that may share symptoms with TBI, and so can present a challenge in clinical assessment and decision-making. Therefore, neuropsychological assessment of TBI requires reviewing of all medical records, conducting a clinical interview, and administering a large battery of cognitive tests and personality inventories. This is in order to discern whether there is the presence of brain injury, and/or (non-organic) post-traumatic symptoms, and/or symptom exaggeration and malingering.

DSM5 diagnostic criteria for mild or major ‘neurocognitive disorder due to TBI’ require that there must be evidence of there having been impact to the head or of an event having occurred capable of producing rapid movement or displacement of the brain within the skull (‘contra-coup’), with one or more of the following resulting: loss of consciousness; post-traumatic amnesia; disorientation and confusion; neuroimaging demonstrating injury; and neurological signs (for example, an onset of seizures or a marked worsening of a pre-existing seizure disorder, visual field loss, anosmia or hemiparesis). The criteria also

require that the neurocognitive disorder presented immediately after the occurrence of the injury or immediately after recovery of consciousness, and that it has persisted past the acute post-injury period.

Clinical neuropsychologists properly have a flexible battery approach in TBI cases, wherein they can chose to use tests that are relevant to the individual's presentation (for example, using a large battery of frontal lobe tests where there are clear signs and imaging suggestive of frontal lobe damage). This approach can ultimately increase the precision of the assessment, as well as potentially offering evidence of direct relevance to legal definitions or test.

All of the tests used must have high levels of reliability and validity and, ideally, should meet 'the Daubert standard' for the admissibility of scientific evidence¹⁰ – although, ultimately, admissibility is dependent upon law within the jurisdiction in which the case is being heard. If the jurisdiction does *not* apply the Daubert standard, then this *emphasises* the duty of the expert giving evidence properly and fully to describe the reliability and validity levels of the tests that have been applied.

¹⁰In *Daubert v Merrell Dow Pharmaceuticals, Inc.* [1993], the US Supreme Court changed the standard for admissibility of expert testimony, so that the trial judge has a duty to scrutinise evidence rigorously to determine whether it meets the requirements of Federal Rule of Evidence 702, which states: 'If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, only if (1) the testimony is based upon *sufficient facts or data*, (2) the testimony is *the product of reliable principles and methods*, and (3) *the witness has applied the principles and methods reliably* to the facts of the case; and that evidence based upon innovative or unusual scientific knowledge may be admitted only after it has been established that the evidence is reliable and scientifically valid.'

Case 15

Key themes

- *Clinical* – intoxication and dependence; drug-induced psychosis
- *Legal* – automatism; insanity; incapacity to form specific intent
- *Clinico-legal* – intoxication; drug-induced psychosis; automatism; insanity

Handbook references

- Functional psychosis, including paranoid schizophrenia (p20)
- Alcohol and drug misuse and dependence (p21)
- Medical limits (p80)
- Insanity (p104)
- Automatism (p106)
- Incapacity to form specific intent (p108)
- Intoxication (p115)

Case history

Oliver is a 41-year-old man. He is charged with the attempted murder of his girlfriend, with whom he was living at the time of the alleged offence. He has criminal convictions for theft and burglary, but none in the last five years. The alleged offence occurred at the beach. Both Oliver and his girlfriend had been drinking alcohol. Oliver had also chewed khat, and both had also taken crack cocaine, plus a tablet that was assumed by them to be a stimulant drug.

Oliver has been taking crack cocaine and heroin for 12 years. He does not drink alcohol regularly. He uses crack cocaine and heroin most days, and his longest period of abstinence from drugs was three years ago for one year. He does casual work but has not had consistent employment for more than ten years. His parents are both deceased and he has no contact with any other family members. One of his brothers died from a heroin overdose and a sister died from hepatitis C.

Oliver recalls going to the beach. He recalls that they both ‘smoked some crack and took the tablet’. He recalls that they were getting on well and that they were not arguing. He also recalls an experience of the sky starting to open up, but says he has no memory after that until he was in the police station after his arrest. He had injuries and was confused as to how he had received them. He has consistently said he does not remember what happened.

Oliver’s girlfriend’s statement described that they had been to the beach and were using crack cocaine, and that they both took a tablet. She recalled hallucinating and lying on the beach. She is not sure how much time passed, but she awoke as Oliver was trying to assault her. He was throwing rocks at her head. She was only conscious briefly. She suffered severe head injuries, including a skull fracture, and was

hospitalised for eight weeks. She has emphasised that Oliver has never been violent to her, or anyone else, before and that the attack was out of character.

Oliver and his girlfriend were observed by three witnesses, who describe Oliver being ‘wild and out of control’, and as suddenly attacking his girlfriend. The three witnesses restrained Oliver until the police arrived, when he continued to be very disturbed, according to police witness statements.

You are asked to assess whether Oliver was insane or whether he acted in an automatism when he attacked his girlfriend.

Clinical

How should you approach this case?

Your opinion will depend significantly upon you having a clear understanding of the common effects of various substances that may be ‘in play’, in terms of abuse patterns, patterns of common effects of intoxication, and whether any of the substances ever taken by Oliver are known to precipitate psychosis. You also need to consider whether Oliver exhibits, or exhibited at the time, any kind of mental disorder – particularly any drug or alcohol use disorder(s). The nature and effect of any such disorder(s), and your determination of Oliver’s likely mental state coincidental with the alleged offence, will then inform determination of your opinion as it may relate to the legal issue.

Full assessment of the defendant will include a detailed assessment of his history of drug use, and the effects of various drugs upon him in the past. There should also be questions about any previous episodes of unexplained behaviour, memory loss or violence – including, if possible, by interviewing informants (his girlfriend may be an obvious and key source of such information. However, see Case 14 in respect of limitations on the clinical interviewing of prosecution witnesses). The approach to the diagnosis will include determining the presence or absence of substance use disorders, the presence or not of dependence, and the severity of any disorder identified. If the precise substances that were taken cannot be verified, then there is likely necessarily to be enhanced uncertainty in any opinion that can be expressed.

The medical diagnosis is then likely to be accompanied by an opinion concerning whether the likely mental state at the time can be estimated, as well as what was the likely relationship between the substances consumed and that mental state. It is highly likely that there will be an instruction to consider the apparent amnesia for the offence, so there should also be careful questions about what memories Oliver has for the offence, as well as concerning any previous episodes of amnesia, and associated substance ingestion or mental state changes. Finally, witness statements may assist in determining Oliver’s likely mental state at the time of the alleged offence (but again, see Case 14 in respect of clinically interviewing prosecution witnesses).

Legal

Intoxication, insanity and automatism

The relationship between intoxication, insanity and automatism can be very complicated medicolegally, so it is important that the opinion you eventually express is based upon a good understanding of this as

it is dealt with within the relevant jurisdiction – and that thereby you also maintain respect for the limits of psychiatric expertise. The instructing lawyer should therefore play an important role in explaining this to you, and you should not proceed without detailed legal instructions and questions.

Automatism

The law on automatism is summarised in Case 14. However, essentially it is any situation where ‘the mind does not go with the action’, so that there is no ‘willed action’ and so no *actus reus*.

How do insanity and automatism relate to each other?

The English case of *Quick* assists in understanding this. Quick was accused of assaulting a patient at the hospital he worked in as a nurse. Quick was diabetic, and he claimed he had been in a state of hypoglycaemia at the time, and had thereby lost control of his actions. The judge ruled that if he was telling the truth, then this would infer not ‘automatism’ but rather ‘insanity’. The case was appealed on the grounds that automatism should have been available, and the appeal was successful, in that it was determined that (non-insane) automatism was available when the cause of the person’s condition was an external factor.

Insane v non-insane automatism

The distinction is important in law but not necessarily intuitive from a medical perspective. The similarity between the legal and medical approach to automatism can worsen the confusion.

Insane (intrinsic; likely to recur)

- Epilepsy
- Dissociation due to borderline personality disorder
- Arteriosclerosis causing a transient ischaemic attack

Non-insane (extrinsic, unlikely to recur)

- Acute head injury
- Overdose of insulin leading to hypoglycaemia
- Dissociation in response to extreme stress

Clinico-legal

In the case of *Quick*, the cause was not the diabetes but the insulin he took for it. However, importantly for Oliver’s case, it could not be automatism if the external factor was voluntarily ingested, and the defendant ought to have foreseen that taking it might lead to the condition.

The distinction between external and internal factors can be difficult to operate at times, or can give rise to somewhat odd legal results in respect of particular medical conditions. For example, if the cause of the abnormal mental state in *Quick* had been a high blood-sugar level, caused by the diabetes itself, this would have amounted to an internal factor, such that diabetes would be considered legally to be a ‘disease of the *mind*’, with a finding of insanity. Indeed, in the – again English – case of *Sullivan* [1984], it was

determined that epilepsy was a legal ‘disease of the mind’; and, although perhaps less odd than diabetes being deemed a ‘mental’ condition, still most psychiatrists would deny that epilepsy is a mental disorder. However, it is clear that the courts are concerned, ultimately, with the result in respect of public safety of adopting any given legal definition of ‘disease of the mind’, as evidenced by *Bratty v Attorney General for Northern Ireland*, within which was the risk of ‘repetition’ of violence that determined whether a given medical condition amounted to a legal disease of the mind (again, see Case 14).

Instructions – drug and alcohol use

1. Describe any diagnoses you have made in relation to drug and alcohol use conditions.
2. Explain the diagnoses, with reference to recognised diagnostic criteria.
3. Describe whether any symptoms of dependence are present and whether, in your opinion, the defendant was suffering from a *dependence syndrome*.
4. Describe whether the taking of drugs and/or alcohol was voluntary or involuntary. Was the taking of drugs/alcohol the result of an irresistible impulse?

Intoxication and any psychiatric defence

Assuming that Oliver was (merely) intoxicated when he attacked his girlfriend, can such intoxication with drugs be capable of leading to a defence to the charge he faces?

In practice, the answer is ‘almost never’, based upon a clear public policy stance adopted by the courts. The clear exception to this is when intoxication is involuntary – for example, if a drink has been ‘spiked’ – reflecting the principle that voluntary intoxication should be accompanied by ‘foresight’ that one might thereby enter a dangerous mental state.

In addition – more in theory than in practice – if the intoxication rendered the defendant incapable of forming the intention to commit the offence, and the offence is one of ‘specific’ and not ‘basic’ intent (for example, causing ‘grievous bodily harm with intent’ compared with ‘without intent’), then acquittal may result (see the English case of *R Majewski* [1977]). But the threshold for loss of capacity is extraordinarily high, and will likely be better evidenced – or not – by way of statements made by witnesses present at the offence than by attempts by a doctor to ‘back-calculate likely blood levels’ or ‘back-assess’ an individual’s likely mental state at the time of the offence.

Drug-induced psychosis

However, if it is the case that the defendant was not ‘intoxicated’ but was precipitated into a state of ‘psychosis’ by drugs, then the psychosis might then found a defence of ‘insanity’ (or of ‘diminished responsibility’ if the victim dies, see also below), because of the different legal status given to psychosis as compared with intoxication. However, this enters clinically into a complex arena, in terms of the validity of the clinical distinction per se. For example, was Oliver hallucinating as a result of using drugs and being intoxicated, or was he suffering from a mental disorder – psychosis – induced by drugs?

Intoxication – Zimbabwe

Criminal Law (Codification and Reform) Act

The statute in Zimbabwe considers the following specific circumstances:

- When involuntary intoxication a complete defence to crimes
 - If involuntarily intoxicated
 - If they lack requisite intention, knowledge or realisation
- Intoxication no defence to crimes committed with requisite state of mind
 - May be regarded as mitigatory except in crimes requiring proof of negligence
- Voluntary intoxication leading to unlawful conduct
- Intoxication facilitating the commission of a crime
 - May be convicted on the basis of their original [pre-intoxication] intention
- Voluntary intoxication leading to provocation
 - May be regarded as mitigatory
- Intoxication leading to mental disorder
 - The disorder or disability shall be capable of constituting a defence of mental disorder

What about the relevance of ‘drug or alcohol *dependence*’ upon whether a given episode of acute intoxication was ‘voluntary’ or ‘involuntary’? That is, where the defendant is physiologically and psychologically dependent upon, and subject to withdrawal, of a substance. Surely that ought, in law, to be taken account of? In fact, with the one exception of where the defence of ‘diminished responsibility’ is offered to a charge of murder (for example, if Oliver’s girlfriend had died from his attack upon her), it is not. That is, ‘involuntariness’ and ‘voluntariness’ are ‘binary’ and not ‘graded’ notions –; you are ‘one or the other’, with the presumption of ingestion being voluntary ‘simply when you take it’. And only where the defence of diminished responsibility is pleaded to a charge of murder is this binary approach (only apparently) modified, in that a defendant can plead that their intoxication resulted from an ‘abnormality of mind’ – that is ‘dependence’ – but only where s/he ‘had an irresistible impulse to take the first drink or drug of the day’ (*R v Tandy* [1989]). This is an extremely high threshold that has been modified only slightly in subsequent cases (*R v Wood* [2008] and *R v Stewart* [2010]).

In summary, therefore, in many cases intoxication or drug use will be legally an aggravating factor, rather than founding a defence – although it is *capable* of providing mitigation within sentencing, where the rules are less ‘binary’ and more ‘graded’, and so capable of better reflecting medical reality, rather than legal fiction driven by public policy.

In psychiatric practice, there can be difficulty in establishing the distinction between substance use worsening, or precipitating, an underlying mental disorder *and* substance use causing a state mimicking other mental disorders, while in fact amounting to intoxication. However, while the distinction is often not of crucial importance in clinical practice, it is often crucially important legally – amounting to another example of ‘paradigm conflict’.

Overall, the status of intoxication in criminal law is subject to some variability across jurisdictions.

Statutory definitions – intention and intoxication

Voluntary intoxication is only a defence at common law if it resulted in the defendant being in a state where they were unable to form the required intention to commit the offence. This is reflected by those states with statutory reference to voluntary intoxication.

<p>Intoxication shall be taken into account for the purpose of determining whether the person charged had formed any intention, specific or otherwise, in the absence of which he would not be guilty of the offence.</p>	<p>The Bahamas Belize Botswana Ghana Grenada Kenya Malawi Malaysia Nigeria St Lucia Singapore Tanzania Uganda Zambia</p>
<p>Intoxication shall be taken into account for the purpose of de-termining whether the person charged had formed that intention, specific or otherwise, necessary for conviction of the offence charged.</p>	<p>Lesotho</p>

Ethical and professional issues

Should you comment on the ultimate issue?

In this case, the question is whether Oliver is ‘not guilty by reason of insanity (or guilty but insane)’ or ‘was in an (non-insane) automatism’. And addressing the ultimate issue would involve giving unambiguous opinions on these matters – for example: ‘In my opinion, he was insane.’ However, arguably the expert should restrict himself to commenting on the nature of any mental disorder likely to have been present; its likely cause; the way in which the defendant’s mental state was related to their intoxication with drugs; and the way in which this mental state is likely to have operated to determine their mental state. And, while the potential relevance of such clinical matters to the legal tests might be discussed, the expert should refrain from ‘interpreting for him/herself the meaning of any legal test’ and ‘whether the mental condition and state described comes with it’, thereby respecting the ultimate authority of the court in respect of both aspects. However, despite the foregoing proper legal description, it is not uncommon for a trial judge to ask an expert to go beyond the boundaries just described. This can cause difficulty for the expert, in that refusal to reply can be perceived as being ‘unhelpful’. However, clear explanation of ‘what is medical’ and ‘what is not, and therefore is legal’ can usually overcome any difficulty.

The above said, and unrelated to Oliver's case, the procedure in relation to determining, for example, specifically '(un)fitness to plead and stand trial' will often 'require' the psychiatrist to address the issue directly. And if the psychiatrist avoids any comment upon the ultimate issue, they are likely to be pressed in terms of: 'Come on doctor, is he fit to plead or not?' If the legal implication of the expert's clinical opinion is 'obvious', then there may, in fact, be little harm in offering a response. However, if the issue is at all finely balanced medicolegally, it may be better to stick to 'the general rule'. Finally, there is no prohibition on addressing this ultimate issue in most jurisdictions (in contrast to the United States); but whether the expert does, or does not, do so is perhaps a matter that lies 'ultimately' within the domain of professional ethics.

Case 16

Key themes

- *Clinical* – personality disorder; vulnerability
- *Legal* – duress
- *Clinico-legal* – inadequate instructions; expert witness boundary

Handbook references

- Personality disorder (p21)
- Instructions (p32)
- Assessment of personality and clinical syndromes (p47)
- Duress (p114)
- Expertise (p138)

Case history

Ferdinand is 26 years old, homeless and unemployed. He is charged with a violent robbery. The offence is alleged to have occurred when Ferdinand was intoxicated with alcohol and drugs. Ferdinand had left a bar and walked for some time before allegedly punching a woman in the head from behind and stealing her jewellery, before then leaving the scene. She was found unconscious between six and 10 hours later, and has subsequently made only a partial recovery, in that she still has some relatively minor residual symptoms resulting from brain injury.

Ferdinand was born at home. His mother used crack cocaine, and he has never known his father. His mother is deceased, and he has no relatives to inform any assessment. His mother died when he was 15, and he has been homeless for most of the time since then.

He has been admitted to hospital on three occasions after suicide attempts, two by hanging and one after cutting his throat. He also has multiple other scars from injuring himself. He has had limited psychiatric treatment, and has defaulted on appointments that he has been offered. He has used cannabis and crack cocaine since he was a child but does not drink regularly.

Ferdinand attended school until the age of 11, and school reports indicate behavioural problems from an early age. His IQ has been measured as 79. He has never worked.

Ferdinand has given an account of the alleged offence. He admits that he committed the act, but says that he was threatened by a third-party to whom he owed money. This person had seen him in the bar on the evening of the alleged offence and grabbed him by the throat. He told Ferdinand that if Ferdinand did not pay some of the money that night, Ferdinand would have one of his hands cut off. Ferdinand says that he went straight from the bar and committed the offence ‘in a dreamlike state’, as if he wasn’t himself. He

said that he then met the person who had threatened him and gave him the jewellery. A statement from this person says that he has never met Ferdinand.

Ferdinand has a criminal record that includes theft and burglary, but he does not have any convictions for violent offences.

Ferdinand was arrested the day after the alleged offence. He gave the account described above in his police interview. He has cut himself in prison, but is otherwise relatively well and describes feeling better than he has for years.

You are asked to give an opinion on whether Ferdinand has any mental disorder and, if he does, whether his mental disorder determined that he was particularly vulnerable to the threats against him that he alleges, so that his actions ‘were not wholly voluntary’.

Clinical

There are various clinical diagnoses that might be considered here, including personality disorder, substance use disorders, mood disorders and developmental disorder, such as intellectual disability. Personality disorder is a diagnosis that can be controversial, particularly in legal settings, because it is not conventionally perceived to be ‘illness’; and, although often associated with traumatic childhood events, it is – including by some psychiatrists – not necessarily seen as being relevant in respect of involvement in legal process – for example, in reducing culpability. The requirement on the psychiatrist is, therefore, to explain in clear terms what personality disorder is – and why it is classified as a mental disorder – if you decide that is the diagnosis, or one of the diagnoses.

Specific personality disorder types with brief descriptions of characteristics

Paranoid personality disorder – mistrust and suspiciousness.

Schizoid personality disorder – social isolation and limited or flattened emotions.

Schizotypal personality disorder – abnormal cognitive or perceptual experiences. It is considered by some to be on a continuum with schizophrenia.

Antisocial personality disorder – violence to, or disregard for, other people.

Borderline personality disorder – impulsive behaviour, and unstable emotions and relationships.

Histrionic personality disorder – dramatic and attention-seeking behaviour.

Narcissistic personality disorder – grandiose and unable to appreciate other people’s emotions.

Avoidant personality disorder – socially avoidant and sensitivity to criticism.

Dependent personality disorder – needy and submissive.

Obsessive-compulsive personality disorder – perfectionism and need for control.

How is personality disorder diagnosed?

The diagnosis of personality disorder, while being based upon clinical interview, usually requires additional information from people who can provide evidence of the consistency and longevity of the person's patterns of emotional experience and behaviour. This might include interviews with other people, but also may include witness statements, school records, and work records. Good practice also requires that structured forms of personality assessment should be used to augment the clinical interview, usually carried out by a clinical psychologist. The ultimate diagnosis is based upon clinical judgement but incorporates all of the data that can be gathered to inform this judgement. A single interview can, however, sometimes be sufficient to make the diagnosis of personality disorder. The judgement about whether someone is personality disordered or, if so, what type of personality disorder it is, must not ignore the social and cultural circumstances of the person being assessed.

Otherwise, it will be important to explain that personality disorder is, indeed, different from mental illness or learning disability, in that it is 'developmental' in nature and essentially is 'part of who the person is' – so that diagnosis rests upon comparison with a normal population, rather than comparison of the individual now with some earlier state of normal mental health. It is also important to clarify that this involves an element of judgement, such that experts may agree on the nature of a person's personality, for example, but disagree as to whether it amounts to personality 'disorder'.

Finally, it may be necessary to point out that psychologists determine the presence of personality disorder, of different types, by virtue of statistical comparison of their traits with a normal population, without necessarily referring to the impact of the pattern of their personality traits for daily functioning – whereas DSM and ICD require the addition of dysfunction.

Legal

On the face of the case as described, and the legal instructions given, it seems likely that the only potentially relevant defence is that of 'duress'.

The basis of the defence is that another person's threats overwhelmed the defendant's will (a 'subjective test') and would have overwhelmed the will of a person of ordinary courage or fortitude (an 'objective test').

Threats may amount to duress if they concern serious bodily harm or death to the defendant, their immediate family, or someone else close to them; a reasonable person of their age and background would have been forced to act in the same way; the threats directly caused the criminal conduct; the criminal conduct could not have been avoided without incurring the threatened harm; and the defendant did not voluntarily run the risk of such threats. Duress is, of course, therefore not a mental condition defence.

The essence of potential relevance of mental disorder within a defence of 'duress' is in terms of whether the symptoms of that disorder rendered the defendant as 'less than of reasonable fortitude' (*R v Bowen* [1996]). And, within this, it is necessary that there be a 'recognised medical condition', and not merely 'vulnerability'. Otherwise, the threats made must be both directed at the vulnerability of the defendant, arising from a medical condition, *and* direct and immediate in their impact. In essence, the defendant must have subjectively perceived himself reasonably as having no way to react other than to commit the offence.

Duress

Duress is not a mental condition defence. However, in limited circumstances, a defendant's mental condition, defined medically, can be relevant to the defence. Specifically, the defence of duress assumes a defendant of 'reasonable fortitude'. Hence, if a defendant suffers from a mental condition that determines that they lack reasonable fortitude, then expert evidence of that condition can operate so as to overturn the assumption. However, at least in England and Wales, there must have been a medically diagnosable condition present and operating too to reduce fortitude. See Case 22.

Instructions – duress

1. Explain whether any condition you have diagnosed meant that the defendant was unable to resist the instructions they received.

Explain, with reference to specific symptoms, why this was

Clinico-legal

The instructions in this case as they are described above are inadequate. They imply that the legal issue to be considered is 'duress', although do not say so in terms. And, even if they had so, or were made so, it will would be necessary then to ask instructing lawyers to explain what they consider to be relevant law in relation to any diagnosable medical condition (see below).

It is important that the instructing lawyer considers very carefully the questions that they wish to pose. This is likely to include an explanation to you of the law concerning the potential relevance of any mental disorder you may find, so that you can properly discharge your function as an expert, and avoid straying inadvertently into the role of the jury. Similarly, you need to consider very carefully 'how far you should go' in addressing the instructions. Considering the presence or absence of mental disorder is clearly within a psychiatrist's remit, and this should be considered in an ordinary way. The impact of the symptoms of any mental disorder – for example, personality disorder – on Ferdinand's behaviour in relation to the alleged offence should then be considered. This is likely to include specific consideration of the impact of any threats made to Ferdinand.

There may be dispute between prosecution and defence about the fact of their having been threats – so any expert opinion is likely to be expressed in terms of: 'If there were threats in terms of X then the following symptoms would have been likely to have affected Ferdinand's response in the following ways ... if Y, then he would likely have been affected in the following (different) ways.'

Questions about the 'voluntariness' (or not) of his actions are at the border of what might be considered valid expert evidence. However, there might be relevant psychiatric factors in determining the degree of voluntariness, subject to legal advice, or the direction of the court.

Overall, proceed with great care.

Ethical and professional issues

Is personality disorder a specialist area and are you sufficiently expert in it?

Personality disorders are common, and all psychiatrists should be capable of assessment for – and diagnosing of – personality. However, expertise in law relies upon demonstrating knowledge, skill and experience. If, for example, you work in a psychiatric service that excludes people with personality disorder, then it might be difficult to justify your expertise in this area. And, although your expertise, or lack of it, can be determined by the court, there is a professional duty to consider whether (1) you are expert in the clinical area that you have been asked to consider and (2) whether you have sufficient expertise in acting as an expert witness in a case of this nature, with adequate understanding of the relevant law. It is not the case that you must be ‘the most expert’, or ‘a leader in the field’, but you should be prepared to answer questions about your experience in these two domains; indeed, ask them of yourself before you take on the case.

Additional information

Psychological assessment of suspected personality disorder

Personality is defined as individual, pervasive patterns of thought, emotion and behaviour that govern the way a person sees and relates to him/herself and to the world. *Personality traits* are prominent features of personality that are present consistently across time and different situations. *Personality disorder* is defined in terms of an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture; is pervasive and inflexible; has an onset in adolescence or early adulthood; is stable over time; and leads to distress or impairment.

Personality assessment amounts to a complex task involving a multi-method approach towards establishing whether the individual meets the criteria for a diagnosis of personality disorder. Within this, clinical psychologists often employ various self-report personality questionnaires, such as the *Millon Clinical Multiaxial Inventory (MCMI-IV)* or the *Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF)*, in order to identify the presence – or not – of personality problems. These instruments compare the individual’s responses with the available norms. Additionally, a number of semi-structured clinical interview tools, such as the *International the Personality Disorder Examination (IPDE)*, may be used. Their advantage is that they include specific questions related to each diagnostic criterion for various personality disorders, and rely upon multiple sources of information, including medical and school records and – in a legal context – witness statements.

In addition to assessing for, and diagnosing, personality disorders, clinical psychologists offer a ‘formulation’ of the individual’s personality difficulties. This will include both explaining the developmental origins of the subject’s personality difficulties (for example, early life trauma or neglect) and identifying predisposing, perpetuating and protective factors relevant to the individual’s presentation and offending.

Case 17

Key themes

- *Clinical* – battered woman syndrome (BWS), PTSD, anxiety and depressive disorders
- *Legal* – duress
- *Clinico-legal* – mental disorder and reasonable fortitude

Handbook references

- Depression (p22)
- Post-traumatic stress disorder (p23)
- Duress (p114)
- Bias and its minimisation in expert witness practice (p138)

Case history

Wanda is a 21-year-old woman who is charged with drug importation; it is alleged that she tried to smuggle 6kg of cocaine through an international airport. She was about to board a flight to Europe from a Caribbean island when the drugs were found in the false bottom of her suitcase during a routine search.

Wanda was sexually abused between the ages of five years and 13 years by a 'paedophile ring'. Her foster father, who was the instigator of the abuse, died before he could be brought to court. She had confided in her older foster brother about the abuse when she was nine years old, but he also then went on to abuse her. There were no adult figures in whom she felt able to confide as a child. The sexual abuse eventually came to light when she told her best friend what had happened, and her friend told a teacher. She received no therapeutic input, and attended a 'special school' for her secondary education because of problems with literacy.

Wanda was with her first partner for six years. She was 19 years old when they met and he was 26 years old. She experienced domestic violence throughout the relationship, including suffering black eyes and bruised ribs. The relationship ended when her partner met another woman.

She subsequently met a new partner. This relationship lasted for nine months, during which time Wanda experienced 'the worst' domestic violence that she had ever experienced. She said: "It was okay at first... but I didn't know he used cocaine...he attacked me twice...raped me...put a gun in my throat and strangled me...he tried to drown me.'

Wanda's partner threatened her that if she did not smuggle the cocaine in her belongings he would kill her. He too has been arrested and is Wanda's co-defendant.

You are asked to prepare a psychiatric report commenting upon her vulnerability, and whether any vulnerability can serve to reinforce her defence that she acted under duress.

Clinical issues

What aspects of Wanda's mental condition will it be important to assess?

The assessment should focus upon whether Wanda has developed a psychiatric disorder in response to the abuse she experienced, and how this has impacted upon her behaviour. It is insufficient simply to describe 'vulnerability' in her; rather, a diagnosis needs to be established if any expert evidence is to be deemed legally relevant (see the law, within Case 16 and below). In particular, given that she suffered sexual abuse as a child, and two partners have been violent to her, you will need to assess for symptoms of PTSD related to her abusive experiences, and for symptoms of anxiety and depression.

You will then need to consider elements of her mental condition that potentially affect her relationships with partners, including – crucially – with her co-accused, especially in respect of how (un)empowered she felt in the relationship; how (un)equal the relationship was; and how (un)able she was to exert her wishes. You should also address her 'mental reactions' to episodes of abuse (see Case 13 concerning 'battered woman syndrome' (BWS)).

Wanda also appears to be vulnerable intellectually. And, given her attendance at a 'special school', an assessment of her intellectual disability is necessary, bearing in mind that two disorders can be 'mutually reinforcing' in their effects upon functioning ('the whole is often greater than the sum of the parts').

Legal

How can a mental condition be relevant to a defence of duress?

As described in Case 16, duress is a defence for a defendant who has acted in a way that would otherwise be unlawful as a result of specific threats made – to him/her or others – plus attendant circumstances. There are subjective and objective elements to the defence, in that another person's threats must have overwhelmed the defendant's will (the 'subjective' test), and would have overwhelmed the will of a person of ordinary courage or fortitude (the 'objective' test). There is, therefore, a rebuttable presumption that a defendant possesses 'reasonable, or ordinary fortitude' (see detail of law in Case 16).

In limited circumstances, a defendant's mental condition can be relevant to the defence of duress. Hence, if a defendant suffers from a mental condition that determines that they lack 'reasonable fortitude', then expert evidence of that condition – and of its relationship with the threats allegedly made – can operate so as to overturn the presumption of reasonable fortitude. However, the defendant must have been suffering from a recognised medical condition (*R v Bowen* [1996]).

Clinico-legal

Most commonly, such a case as this involves a woman being used as a 'drug mule' who has been 'traumatised' by abuse, including by her co-defendant, so as to be exhibiting BWS (see Case 13). But expert evidence can only be relevant if Wanda exhibits symptoms of, for example, PTSD, anxiety disorder, or depressive disorder 'within her BWS' (again, see Case 13).

Wanda (by her account) was subject to threats from her partner – her co-accused. So the court will consider the questions: ‘Did these threats overwhelm her will?’; ‘Was she suffering from a mental disorder that contributed to her will being overwhelmed?’; *or* ‘Is there another explanation?’ (for example, that she was a willing participant motivated by money).

Was Wanda of reasonable or ordinary fortitude?

Assuming that, at the time of the alleged offence, Wanda suffered from a recognised medical condition, factors to consider are her likely dependency in relationships, whether this led her to develop a state of ‘helplessness’ in such relationships so that she was unable to leave her partner as would an ordinary woman, and that this made her co-defendant’s threats more powerful than they would otherwise have been. Further, it must be shown that any ‘positive’ answers to these questions arose from her recognised medical condition (for example, PTSD, but not BWS, since the latter is not a recognised medical condition – see above). Finally, if it can be shown that Wanda has suffered violence both in her relationship with her co-defendant and in relationships previously, you will need to pose the question ‘did this increase her perception of risk and associated fear?’ If you opine that it did, the court will then address the question of whether such increase overturns the presumption of reasonable fortitude.

Generally, Wanda seems to be fragile in her self-esteem, with little sense of self-worth. Possibly, she has an ingrained sense of not ‘expecting’ to be believed as a result of her experiences of reporting being sexually abused as a child. So, again, does this determine that she would be – and was with her co-defendant – more easily coerced than the ordinary person, again, in terms of overturning the presumption of reasonable fortitude?

Simply having been traumatised will not be sufficient to modify the presumption of ‘reasonable fortitude’ – as already described, the defendant is required to have been suffering from a diagnosable condition at the time of the alleged offence and duress. Hence, it is vital to comment specifically in the report on whether Wanda was suffering from a mental condition at the time of the offence.

Finally, you will need to address specifically ‘what happened’ – as she alleges and as the prosecution papers suggest – in respect of the behaviour of her co-defendant and how, in fact, she reacted to it. Any lack of reasonable fortitude must be shown to have ‘operated’ within the narrative of the alleged offence and, of course, there may be disputed narratives between the prosecution and defence, such that you may have to give ‘conditional’ opinions, in terms of: ‘If narrative D then... if narrative P then...’.

Ethical and professional issues

How should you respond to ‘feeling sympathy’ for the defendant?

Given the ‘clinical history’ of Wanda, which is likely to evoke sympathy in you ‘as a doctor’, it is particularly important to monitor your own reaction to her and to think solely of her in terms of ‘being a defendant’, and not as if she were a ‘patient’. Indeed, this emphasises why it is usually bad practice to give expert evidence on defendants you have treated as patients. Hence, strict ‘self-monitoring’ is required – in particular, ensuring that you fairly determine your opinion as to whether she exhibited a recognised, and diagnosable, mental condition at the time of commission of the alleged offence, given the strict legal rule that psychiatric evidence can be admitted to a defence of duress only if there was indeed such a recognised

medical condition in place. You must not have any interest in the outcome of Wanda's case; and, indeed, there may be evidence unrelated to expert evidence that points to her guilt, irrespective of any mental vulnerability – or even diagnosis – that she may exhibit, which you should not concern yourself with.

If you perceive that judges and juries are likely to be biased against people with mental illness because of cultural beliefs and stigma, how should you take account of this?

People, including judges, jurors and psychiatrists, are not objective, and are all subject to biases in their evaluation of others – as are doctors. Individuals suffering from mental disorder are often marginalised in society, and people frequently feel that they cannot 'admit' to having a mental disorder. Also, there is often suspicion about the validity of 'mental disorder', especially in the context of an individual charged with an offence and going through a criminal trial.

There are situations where psychiatrists might properly 'speak out' about these issues and, indeed, there are many examples of proper professional attempts to provide education about – and to reduce the stigma associated with – mental disorder. However, when you act as an expert witness, you must not attempt to 'redress any imbalance' that you might perceive there to be in the court room. Your role is to be as honest as possible (see the Handbook concerning 'bias, objectivity and honesty'); and, even if you sense cynicism, or even explicit bias against people with mental disorder, including the defendant, your role is to explain as clearly and fairly as possible what are your medical findings, and what the impact of any mental disorder you have diagnosed is likely to have had on a defendant's behaviour. Your role is not to use the court room to 'redress any social imbalance' you may perceive there to be.

Case 18

Key themes

- *Clinical* – autism and intellectual disability
- *Legal* – joint enterprise; diminished responsibility; rebutted confession
- *Clinico-legal* – developmental disorder; joint enterprise; diminished responsibility; rebutted confession

Handbook references

- Asperger's syndrome and other autistic spectrum disorders (p23)
- Learning disability (p23)
- Reliability of confessions (p96)
- Diminished responsibility (p109)
- Mitigation (p119)

Case history

Gregory is 31 years old. He, alongside two co-defendants, is charged with the murder of a police officer. He has always lived with his family – initially with his mother and brother and then, after his mother's death three years ago, with just his brother. He was thought to be a bit slow at school, and did not complete school and, since then, has worked for his uncle in a shop storeroom. He is single and has never had any intimate relationships. He has one criminal conviction, for drug possession, but has never served a prison sentence. He has always been thought to be 'a little odd'.

The police officer was killed shortly after finishing a shift. His car was blocked in by another car as he tried to leave the station, and three men then got out of the car. Two of the men shot the officer, who died at the scene. Gregory is not alleged to have had a gun, but it is alleged that he was present both in the car as it blocked in the officer and then outside the car when the officer was shot. A witness saw all three men then get back into the car and drive off. There is no evidence of any conversation between the three defendants during the sequence of events. They were then all arrested, at separate locations, three days later.

After three days in police custody, including being interviewed on five occasions, Gregory signed a confession. In essence, he had said in interviews that he went with the other two defendants 'because they had some business to take care of', and that his co-defendants had told him that they were going to 'deal with' the police officer in question. He initially said that he had no knowledge that they were going to 'kill or really hurt' the victim, but eventually signed a confession admitting to 'taking part in the killing'.

Gregory has told his legal representative that he did not know what his co-defendants were going to do, and he was just going along with them because they told him to accompany them.

You are asked to give an opinion on whether Gregory is mentally disordered and, if so, ‘how this would have affected his responsibility for involvement in the alleged offence’. You are additionally asked to consider ‘whether his confession was reliable’.

Clinical

Clinically, there are some indications suggestive of possible intellectual disability, most commonly present without any specific cause, but which can be associated with other developmental disorders, including autism. Hence, it is important to consider all potential developmental disorders; intellectual disability; autism; and ADHD.

Summary of diagnostic criteria for intellectual disability

1. There must be deficits in intellectual function based on standardised intelligence testing. These are usually conducted and interpreted by an appropriately qualified psychologist.
2. There must be deficits in functioning, considering developmental and cultural norms.
3. The onset of these problems must be during childhood.

The severity is classified as mild, moderate, severe or profound.

The results of standardised intelligence testing expressed as IQ is not sufficient for the diagnosis to be made.

How is intellectual disability diagnosed?

The diagnosis of intellectual disability is based upon clinical criteria. Crucially, it is not defined, or diagnosed, solely on the basis of a given IQ score (as lawyers commonly believe). Rather, the essence of the diagnosis is that there is objective evidence of impaired intellectual function *associated with* impaired social or occupational function. It is for this reason that – perhaps even more than with the diagnosis of most other mental disorders – there is a need to gain information from other sources, including detailed developmental information. This might include interviewing family or friends, requesting school and employment records – not just medical records (which may be unrevealing) – *and*, additionally, gaining access to objective psychological, psychometric assessment of intellectual function. An important factor in intellectual disability is that there is evidence of it having been present from childhood. For this reason, a parent or primary caregiver should be interviewed, if possible, in order to gain a detailed developmental history.

The ultimate decision about whether the diagnosis applies is made according to medical criteria; but this is a diagnosis that, dependent upon experience, might also properly be made by a qualified psychologist.

What is the difference between ‘mental retardation’, ‘learning disability’ and ‘intellectual disability’?

These terms are essentially synonymous, and represent the agreed terms within the mental health professions that have been applied over time across different eras. Such changes have been driven by a tendency for terms to be misused over time, either as a means of abuse or by becoming labels carrying stigma, and have been adopted as a way of trying to counter this. The terms used in different diagnostic manuals are likely to reflect the term that was contemporary with that publication.

How is autism diagnosed?

Autism is a developmental disorder that, although not necessarily diagnosed in childhood, is present from before the age of three. The main features include disability in social communication and interaction, in association with patterns of behaviour, or activities, that are highly restricted and/or repetitive. The diagnosis is based partly upon interviews with the person affected but, importantly, there is a need for detailed information concerning their early development, so that information must be collected from parents or other childhood carers, ultimately within a standardised protocol. Such historical information is extremely important, so its absence is a major handicap. Finally, autism is commonly associated with intellectual disability – albeit some individuals with autism are of normal intelligence, exhibiting instead Asperger’s Syndrome (which can include a very high level of functioning within narrow fields).

Legal

Joint enterprise

If it is an ‘agreed fact’ that Gregory was not the person who fired the shots that killed the victim, then it is incumbent upon the prosecution to prove its case against Gregory, in respect of ‘joint enterprise’, in the following terms.

The relevant law governs situations in which C takes part in a crime or crimes (‘a criminal enterprise’) along with A so that, broadly speaking, C and A are both responsible for each other’s actions in carrying out the criminal enterprise. Until the recent English case of *R v Jogee* [2016], the test – put in terms of Gregory’s case – would have been ‘whether Gregory was party to a plan to kill or seriously injure any victim or, if the co-defendants went beyond an agreed plan, that the defendant foresaw his co-defendant’s actions, such that he foresaw that his co-defendant might act with intent to kill or seriously injure any victim and, nonetheless, continued to participate’. So that key words or phrases would have been ‘*agreement to, and participation in, a plan*’; ‘*foresight that the co-defendant might well go beyond any agreed plan*’; and ‘*continued participation*’.

However, in a unanimous decision, a panel of five Supreme Court justices in *R v Jogee* said that ‘foresight’ is not the sole evidence of intent to assist or encourage. Rather, properly understood, the law is that there are two questions that must be asked in order to ascertain the guilt of a defendant via joint enterprise: (1) ‘Did the defendant *assist or encourage* the commission of the crime?’; and (2) ‘In any assistance or encouragement, did the defendant *act with the requisite mental element* of that offence?’ So, whereas the law had meant that defendants would be convicted if they could have foreseen that a murder or violent act was likely to take place, that is no longer sufficient.

Diminished responsibility

In the event that rebuttal of joint enterprise on the part of the defence fails, then potentially the partial defence of diminished responsibility may be relevant to Gregory's situation (see Handbook and Cases 10, 12, 13, 18 and 22 for expression of the law and its interpretation).

Clinico-legal

What is your first response to your instructions?

The instructions, as regards 'responsibility', are vague and you should ask for more detailed instructions – albeit your instructions in regard to Gregory's confession are clear. However, proceeding on the basis of proper instructions concerning 'joint enterprise' (see above), the following clinico-legal issues and approaches are relevant – to which should be added consideration of 'diminished responsibility', in the event that rebuttal of the prosecution assertion of 'joint enterprise' fails.

How could you assess clinically for any possible legal relevance to the verdict of the diagnosis of developmental disorder (intellectual disability and/or autism) in Gregory?

You will need to assess Gregory clinically, keeping in mind relevance of his condition(s) for both 'joint enterprise' and (if the jury were to find him to be guilty of 'joint enterprise murder') 'diminished responsibility'. Keep in mind that there will likely be two different psycholegal 'mapping exercises' needed in respect of trial issues.

In summary, therefore, it will be necessary to gain a detailed understanding of Gregory's various 'dysfunctions' per se, and then to address how one or more of these would likely have 'operated' (or not) in relation to what is required to prove 'joint enterprise', and in respect of the elements required to prove the partial defence of 'diminished responsibility'.

So there are two legal issues to address, leaving aside his rebutted confession. First, if you determine that Gregory suffers from some form of mental disorder (and you might have in mind, from the case description given above, the possibilities of learning disability and autism), might aspects of such disorder(s) be relevant to jury determination of whether Gregory did, in fact, come within the terms of what is required in law to convict on the basis of 'joint enterprise'? Second, if the court does not find in favour of the defence on the latter point – so that he would, if no defence were available to him, be found guilty of murder – is there a basis for a partial defence of 'diminished responsibility', again based upon either or both learning disability and/or autism?

Joint enterprise

Now, of course, there might be ordinary evidence wielded by Gregory's defence that he was not 'party to a plan', nor did he 'assist or encourage' the killing, and that he did not act with the required intention for murder.

However, expert evidence might be relevant to jury consideration of each of those contentions, or to the reverse view, as might be put by the prosecution. So, for example, you will need to consider whether – in

light of his various disabilities as you have come to understand them to be – Gregory had sufficient ability to understand what was intended, so as to ‘assist and encourage’ in the killing.

If otherwise Gregory would be guilty of joint enterprise murder, then only if his disabilities can be shown as likely throwing ‘some doubt’ (because of the standard of proof required of the prosecution) upon whether he ‘assisted and encouraged’ the other two defendants to kill – *and* if, in so doing, beyond reasonable doubt, he also formed the intent to kill or do really serious harm – will he be found guilty of murder.

For example, you might consider that his disabilities likely reduced his ability to have understood what the other two defendants intended. Again, for instance, you might consider that he may have adopted a concrete interpretation of the words ‘deal with’, without going beyond this so as to have some notion in his mind of what specifically they might intend, and to which he was agreeing to participate, and ‘join’. Further, and less specifically, there may have been a more generalised dependence upon the other two defendants, so that his actions were significantly influenced by them – even sufficient to cast doubt upon whether he ‘participated and encouraged’.

However, in all of this, you must take note of any ordinary evidence there might be that could suggest that, whatever his disabilities, Gregory did, in fact, ‘encourage and participate’ or ‘form the intention for murder’.

Diminished responsibility

Some of the same disabilities that you may have cited in respect of ‘joint enterprise’ may also be relevant in respect of the partial defence of ‘diminished responsibility’. Hence, beyond what may be undisputed evidence that Gregory exhibited an ‘abnormality of mind’, you may wish to argue that, although he formed the relevant intention to be guilty of murder, his disabilities are relevant to jury consideration of whether his mental responsibility for his actions is substantially diminished – albeit not addressing that ultimate issue.

Mitigation

In the event that Gregory is found guilty of murder in a jurisdiction that does not impose a mandatory sentence for that offence, then a similar description of Gregory’s disorder(s) and disabilities may be relevant to mitigation, upon conviction of murder. Or, if the jurisdiction does impose a mandatory sentence of ‘life imprisonment’, then expert evidence may be relevant to judicial consideration of the appropriate tariff.

In a jurisdiction that retains the discretionary – or, indeed, mandatory – death penalty, then it may be argued by counsel for Gregory that there is international jurisprudence that prohibits the imposition of the death sentence upon a defendant who is ‘mentally retarded’; and you may have to offer an opinion on whether Gregory medically comes within the terms of such jurisprudence.

If, in the jurisdiction in which the case is heard, the judge can impose the discretionary death penalty, then your evidence might be relevant in regard to the accepted test for imposition, in terms of whether the

defendant is deemed to be ‘beyond reformation’ (assuming that his offence had met the other requirement of it having been ‘the worst of the worst’).

Of course, it is for defence counsel and not an expert to ‘argue’ mitigation, and it will be important to ensure that you maintain your evidence within the bounds of the relevant legal framework and tests.

How would you address Gregory’s rebutted confession?

Separate from the foregoing, you will need to assess him in relation to any vulnerability he might have exhibited under police questioning regarding his confession to having taken part in the murder.

Ultimately, the reliability of a confession is a matter for legal consideration. However, if a defendant exhibits mental features that are likely to render his confession less than normally reliable, then expert evidence is admissible within a ‘*voir dire*’. Therefore, you will need to assess whether Gregory’s disabilities would likely have had an impact upon his understanding of his situation, and questioning within the police interviews. Further, it will be necessary to determine (almost certainly through instruction of a clinical psychologist) whether Gregory is abnormally *suggestible* and/or *compliant*, since it is well recognised that these two ‘traits’ are more common in those of low intelligence.

Ethical and professional issues

Can developmental disorders be diagnosed without additional information?

There is no sense in prohibiting diagnosis because of an inability to interview relatives or because school records are not available. In legal terms, this might result in less weight properly being applied to your opinion; but there will always be circumstances where information is limited and you should give an opinion as best you can – and express a view as to the likely reliability and validity of that opinion – in light of any data that you would have wished to have but did not. You can – and should – also include expression of what alternative opinions there might reasonably be, but why you favour your own opinion.

Assessing intellectual function in different cultural groups

It might be suggested that if someone is from a group within which a psychometric test has not been validated in research studies, these tests are invalid. This assumption is likely to be wrong, and the emphasis for the psychologist carrying out the testing will be upon considering this factor in their overall interpretation. They might perform additional tests, and they might not report the ‘scores’, but the testing is still likely to provide useful additional information. However, this is a matter for the clinical psychologist to address and not you.

Additional information

Psychological assessment for autism spectrum disorder

Autistic spectrum disorder (ASD) comprises a set of neurodevelopmental disorders characterised by deficits in reciprocal social interaction, communication and language, and flexibility of thought and behaviour. Many individuals with ASD fail to be diagnosed until they present with challenging behaviour or come

into contact with the criminal justice system in adult life. In a legal context, because of the nature of their deficits, individuals with ASD are more vulnerable to being ‘suggestible’ and offering false confessions, and they are likely also to struggle to understand the police caution and to follow court proceedings. Additionally, due to their reduced understanding of ‘what is happening in their interactions with others’, they may, in some legal contexts – for example, when charged with an offence based upon ‘joint enterprise’ – fail to form the *mens rea* for the alleged crime where, based upon similar evidence, someone lacking their disabilities might clearly have done so.

Assessment and diagnosis of ASD is a complex process that involves taking a detailed developmental history from parents or carers, carrying out clinical observations in different settings, and reviewing any available potentially corroborative information.

Clinical psychologists and psychiatrists are advised to consider an assessment for possible ASD if the individual presents with one of the following:

- a) Persistent difficulties in social interaction
- b) Persistent difficulties in social communication
- c) Stereotypic (rigid and repetitive) behaviours, with resistance to change or restricted interests and with one or more of the following:
- d) Problems in obtaining or sustaining employment or education
- e) Difficulties in initiating or sustaining social relationships
- f) Previous or current contact with mental health or learning disability services
- g) A history of a neurodevelopmental condition, including learning disabilities and attention-deficit/hyperactivity disorder, or mental disorder.

A number of instruments have been designed to assist in ASD diagnosis. The *Autism Diagnostic Observation Schedule-2 (ADOS-2)* offers a semi-structured standardised assessment of communication, social interaction, play, and restricted and reparative behaviours that can be used with children and adults who present with suspected ASD. It consists of various activities that are capable of eliciting behaviours characteristic of ASD. The assessor observes and codes observed behaviours, and the results can offer (or rule out) a definitive diagnosis of ASD.

The *Autism Diagnostic Interview Revised (ADI-R)* offers a comprehensive interview designed towards diagnosing ASD. It involves interviewing a parent or a carer, and can be used in the assessment of both children and adults. ADI-R includes three functional domains: language and communication; reciprocal social interactions; and restricted, repetitive and stereotyped behaviours and interests. While it is less time-consuming than *ADOS-2*, its assessment accuracy depends upon the quality of information provided by the informant – and in some instances, especially in a clinico-legal context, this information can be biased and inaccurate.

All of the ASD assessment instruments require the assessor to have undergone a specialist training in the particular instrument concerned, as well as knowledge of how the ‘differential diagnoses’ of the condition are established, which is particularly important in ‘high stakes’ criminal cases.

Case 19

Key themes

- *Clinical* – mania
- *Legal* – self-defence
- *Clinico-legal* – relevance of mental disorder to self-defence; insanity

Handbook references

- Mania (p22)
- Instructions (p32)
- Insanity (p104)
- Self-defence (p114)

Case history

Daniel, a 65-year-old man, is charged with attempting to murder a policeman, allegedly hitting the victim over the head with a piece of wood. He has no past history of violence, and no previous history of mental illness. You have assessed Daniel.

You have interviewed him, at the request of his lawyer, and he told you that, during the weeks before the incident, his neighbour ‘pulled up his carpet and dropped paper clips and marbles on the floor to create noise to disturb him’. He believed this was because his neighbour was ‘jealous of his special powers’ and of his ‘close relationship with God’. He went for ‘weeks without sleep’ and, as a consequence, he was ‘getting more and more run down’. He said: ‘I was so upset...thoughts were falling one on top of another.’ He also found it difficult to concentrate during this period.

His daughter has reported that it was difficult to understand her father’s thinking and behaviour during this period, commenting: ‘It was like the thoughts were ahead of each other...it was like he was racing in his thoughts.’

The police were called to her father’s flat by his daughter because she was concerned about his behaviour. Daniel then later told you that he has a poor recollection of what took place, but said: ‘The police weren’t able to deal with me...it felt like I was going to be treated cruelly.’ And he thought that one policeman, the alleged victim, was treating him especially badly, ‘sneering’ at him. He said: ‘it’s difficult to re-live... it’s like a nightmare.’ Daniel said: ‘I thought I was going to be killed...I shouted out the names of the people I loved.’

In their witness statements, the police officers describe Daniel taking hold of a piece of wood that was close by and swinging it wildly. Further, Daniel is said to have stepped forward and to have said something like ‘now you’re going to get it!’, then hitting one officer on the head, causing serious injuries. When you questioned Daniel about this, he explained that he has no memory of the alleged assault.

You are asked to advise whether Daniel likely had a mental illness at the time of the alleged offence, and whether any mental illness might have meant that he acted ‘as if’ in self-defence.

Clinical issues

How should you approach this case?

There is a strong suggestion of mental illness from the outline of this case. However, it will be necessary to explore in detail the nature of any symptoms Daniel may have had, and the way in which they developed. Drug and alcohol use should also be considered, and Daniel’s age should certainly not dissuade you from asking questions about all drug classes. And any history of previous similar episodes of altered mental functioning and/or behaviour should be noted. Organic causes of mental disorder should also be excluded. The relationship between the apparent symptoms of mental illness and the alleged offence should, if possible, be meticulously explored – albeit this may be difficult, or impossible, by clinical interview if Daniel continues to maintain lack of memory for the event – since this is a case wherein trying to establish what was in the defendant’s mind coincidental with commission of the *actus* is very important.

Legal

Self-defence

For self-defence to apply, the degree of force used must be *reasonable* in the circumstances, which includes that it must be *proportionate* to the harm that could result if such force were not used to prevent it. Also, the defendant must *withdraw* if that is possible, rather than attack. The test of whether the force used was reasonable is ‘objective’ – that is, would a reasonable person have used that type and amount of force in those circumstances, bearing in mind the difficulty of making such a judgement in the heat of the moment?

The role of psychiatric or psychological evidence in support of a justification such as self-defence is limited to assistance in understanding how any mental disorder might have affected what the defendant might have ‘subjectively’ believed the circumstances to be. The courts have repeatedly refused to allow evidence of mental disorder to be taken into account in the ‘objective’ test of whether the force used was reasonable and proportionate, so for example, the court held in one important English case (*R v Martin (Anthony)* [2002]) the defendant’s ‘misperception of risk’ due to his paranoid personality disorder and depression was deemed not relevant to the objective test. Even in a case involving a floridly psychotic patient (*R v Jason Cann* [2002]), the defendant’s mental disorder was discounted as not relevant.

Instructions – self-defence

These instructions will invariably be accompanied by instructions relating to insanity.

1. Explain whether any condition you have diagnosed meant that the defendant might have perceived that they were at imminent risk of death or serious injury.
 - a) Explain, with reference to specific symptoms, why this was

The concerns of the courts in regard to accepting mental disorder as a basis for modification of the objective test within self-defence is expressed in terms of: 'It could mean that the more insanely deluded a person may be in using violence in purported self-defence, the more likely that an entire acquittal may result. An insane person cannot set the standards of reasonableness as to the degree of force used by reference to his own insanity.'

Clinico-legal

The instructions you have been given are vague, and must be clarified with the instructing lawyers before you address clinico-legal issues (see also below).

Could psychiatric evidence be relevant to Daniel's counsel arguing 'self-defence'?

Daniel was irritable and disinhibited because of his likely illness. And he may have been unable to accurately assess the intentions of the police officers, feeling under threat from them in a way that objectively was not 'justified'. In Daniel's mind, he may likely have been acting in self-defence; however, at least under English law, expert evidence supporting such a contention would not be admissible.

Insanity

Nonetheless, if Daniel believed that he was genuinely defending himself (by virtue of his mental illness), and that defending himself was lawful given the perceived threat, then he may be entitled to a defence of 'insanity', if he otherwise meets the criteria for that alternative defence.

Of course, by contrast with the result of a finding of self-defence, which results in acquittal, insanity will have a different disposal result, depending upon the law in the relevant jurisdiction.

Ethical and professional issues

How should you manage the process of receiving inadequate or ill-informed instructions?

The legal instructions in Daniel's case were clearly inadequate, and ill-informed in terms of relevant law. Once realised, it would be important to request a new set of instructions – albeit this may be difficult to request with tact, since you are effectively telling a lawyer that he does not know the law relevant to the case. Worse, if you do not know the law for yourself (and it could be argued 'why should you?'), you are at risk of going down a blind alley accompanied by a wrongly drawn map.

When a psychiatrist instructed by either the state or defence solicitors to prepare a report in a criminal case, his aim should be to offer a focused opinion on the clearly expressed legal questions that are at issue. This requires communication between and doctor and lawyer. Hence, the initial stages of preparing a report need to be within a two-way process, especially given that lawyers are often unaware of what a psychiatrist can validly comment upon and what they cannot, and may need help in understanding this. From the doctor's perspective, in order to prepare a report that is helpful, the legal questions posed to them need to be correct and clearly expressed.

No work on the report should start until a letter of instruction is received. However, discussion between lawyer and doctor before the letter of instruction is finalised is often helpful, and entirely proper; far better that there is agreement about the focus and scope of a report at an early stage than waste effort and money producing something that does not assist the court process, or even goes up a legal blind alley. The responsibility is on the doctor to refuse to accept instructions if these are not adequate, and also if they encourage the psychiatrist to go beyond their area of expertise. However, often insight into inadequacy of, or error in, legal instruction depends upon psycholegal experience – that is, being a ‘frontiersman’ between ‘legal land’ and medical land’ (see Handbook).

Hence, it is important for the psychiatrist to ask the lawyer to explain the law to him/her, not because they will seek to answer legal questions but so that they can understand to what legal questions the clinical opinion they arrive at may be relevant. Indeed, understanding what legal questions are in play will inevitably be accompanied by enhanced, and not diminished, awareness of ‘what is medical’ and ‘what is legal’, which will consequently assist the doctor in staying within the limits of medical expertise.

In Daniel’s case, therefore, it will be important that, ultimately – perhaps after discussion – the lawyer sets out the law of self-defence, including the potential relevance of mental disorder.

Case 20

Key themes

- *Clinical* – high-functioning autism spectrum disorder
- *Legal* – discretionary death penalty; capacity for reformation, and corrigibility
- *Clinico-legal* – clinical correlates of ‘capacity for reformation’

Handbook references

- Asperger’s syndrome and other autistic spectrum disorders (p23)
- Assessment (p33)
- Beyond reformation (p126)
- Remorse (p127)

Case history

Idris has been convicted of rape and murder. He is 21 years of age, but the offence occurred when he was 19 years of age. He is the son of a businessman and has no history of previous offending. He was academically successful at school and was particularly good at mathematics and history. He has not had close friends but was always able to participate at school.

The victim of the offence was a young woman with whom he was at school. They were never friends and had never been in a relationship. For one year prior to the offence, Idris had been contacting her via social media, and occasionally by arriving at her home unannounced. She initially responded politely to his contacting her, but then asked him to stop doing so. However, he persisted, and his correspondence increasingly made reference to sexual acts. The last two messages he sent to her made reference to her interest in being tortured by him in the context of a sexual act. There was no response from her. Her body was found on a beach, and there was evidence of her having been cut pre- and post-mortem. The cause of death was reported on post-mortem examination to be strangulation.

Idris did not answer any questions during his police interview, and has always refused to speak to anyone about what happened, including his legal representatives. He spends time in his cell reading and writes to his parents asking for books. He has not made any reference to the offence in his correspondence. The only thing he has said relevant to the case was shortly after his arrest when he stated: ‘She said I’d have to torture her before she’d love me.’ Her last response to any correspondence from him had included, in a note: ‘You will have to torture me before I love you.’

Idris was assessed by a psychiatrist pre-trial and, while he did answer questions about himself, he would not answer any questions about the offence or the victim. He also made it clear that he would only meet with the psychiatrist once. The psychiatrist also interviewed his parents in some detail, and formed the opinion that he was likely to be suffering from an autism spectrum disorder (ASD), but no other mental disorder. He did not offer an opinion on diminished responsibility, or any other psychiatric defence –

explaining that he did not feel able to do so in the absence of any explanation, or even description, of the offence from Idris.

The court is now considering sentence, including the discretionary death sentence.

You are asked to give an opinion addressing whether Idris has a mental disorder; and, if so, what the prognosis is, and whether he has the capacity for reform. He maintains that he will not cooperate with any further interviews because he has already spoken with a psychiatrist.

Clinical

Can you make a diagnosis without seeing the defendant?

The starting point is that you cannot. However, in this situation, the diagnosis considered most likely is ASD, which – like other developmental disorders – is a diagnosis based, in very substantial terms, upon addressing collateral information. And, in this case, there is no restriction or difficulty in interviewing the defendant's parents, which is most likely to give rise to information capable of informing whether or not there should be diagnosis made of autism.

The assessment of the other psychiatrist is also important, and this is also likely to have an impact upon your opinion concerning diagnosis. In addition, as well as interviews with parents, there is likely to be value in obtaining the observations of prison officers, former teachers and employers, if these can be gained.

However, it is also important at least to attempt to interview the defendant, because even in the absence of any cooperation in the form of answering questions, there may be useful information gleaned by observation of him in a one-to-one encounter. And data from the combination of your own attempted interview and that of the previous psychiatrist may, together, be clinically helpful.

The importance of always expressing any limitations there may be of your opinion is highlighted in this case; even if you feel able to give an opinion on diagnosis, there should be no attempt to hide the limited reliability and validity that necessarily must accompany being unable to conduct a full clinical interview.

How should you describe prognosis in a disorder such as autism?

One of the intrinsic difficulties in assessing the prognosis of people with autism is that it is a mental disorder that is lifelong and relatively stable. However, this does not equate to it being an 'untreatable' condition; rather, it tends not to occur in episodes (unlike, for example, schizophrenia or depression), so that prognosis has to be seen in other terms than in regard to episodic, or even chronic, mental illness.

A further difficulty is that the data available in the aggregate is unlikely to relate specifically to people who are liable to be in prison. There is clearly a high likelihood that the prognosis for a young man with autism who is *not* in prison will be very different from that of a similar person facing a long prison sentence. So, in this situation, there is merit in describing what the best currently available evidence suggests about management, and how this might lead to changes in functional ability or recovery.

(As regards the implications of the defendant's prognosis for the test of whether the defendant can properly be seen as legally 'beyond reformation', see below.)

Legal

Capacity for reformation

The key legal criterion to which psychiatric evidence is applicable in most jurisdictions in relation to imposition of the discretionary death penalty is that the defendant is 'beyond reformation' (if the offence has already been deemed 'the worst of the worst').

The capacity for reform (or reformability, or corrigibility) is a legal test and does not admit of direct mapping onto it of any medical construct – albeit it is potentially related to 'prognosis' of the condition, plus 'treatability' and 'manageability' of it (see below). Hence, in a case in the Eastern Caribbean Appeal court (*Trimmingham v the State (St Vincent & The Grenadines)* [2009]), it was stated that one of the factors that must be demonstrated in order for the sentence of death to be imposed was that there was *no reasonable prospect of reform of the offender*. There is no direct medical meaning of this, and so any psychiatrist should almost certainly avoid directly addressing the issue in its terms.

However, psychiatric, or psychological evidence might assist the court in its ultimate determination of the issue, by way of considering the defendant's mental disorder in terms of:

- The risk of further violence associated with that mental disorder as expressed in the defendant
- The prognosis for that mental disorder in the defendant
- The appropriate treatment that should be provided for that mental disorder, and its likely effect in the defendant
- The likely impact of treatment upon any risk, again represented by the defendant

In summary terms, therefore, *if* the intended focus of the test of 'beyond reformation' is properly seen, legally, in terms of the risk of future serious offending –rather than solely in terms of the prognosis of the defendant's condition per se –then the test can be 'mapped onto' by way of clinical risk assessment and the potential for risk management.

Instructions – sentencing in capital cases – reformation

1. Describe whether any condition that you have diagnosed would be amenable to treatment and what that treatment would be.
2. Describe what the prognosis is for this defendant.
3. Describe whether this defendant would, in your opinion, benefit from treatment for any condition diagnosed.
4. Provide an opinion as to whether any treatment would reduce the risk of violence in the future.
5. Describe whether, in your opinion, the defendant is motivated to change.

Case – reform and capital sentencing

Trimmingham was convicted of murder after decapitating a man in his 60s in the context of a robbery. He caused further post-mortem injuries. He was sentenced to death. A principle of imposing the death sentence is that there must be no reasonable prospect of reform. This determination takes into account the character of the offender and any other relevant circumstances. These matters were not explored fully in the Privy Council because the other principle is that the death sentence should be saved for those cases judged as *'the worst of the worst'* or *'the rarest of the rare'*. Trimmingham succeeded in his appeal against sentence on this principle.

Daniel Dick Trimmingham v The Queen [2007]

Clinico-legal

How do you address the matters relevant to capacity for reform?

Describing the treatment in its broadest sense, and the intentions of treatment (reduction in symptoms, increase in functioning, reduction in risk) is likely to be of some assistance to the court. Indeed, it is highly unlikely that any mental disorder could ever be declared 'wholly untreatable' – although this will clearly depend on the meaning applied to the word and, notably, 'management' of a condition is a broader notion than is 'treatment' of it.

Schizophrenia might seem intuitively to be more 'treatable', because there are licensed pharmacological treatments and demonstrated symptom improvement arising from such treatments, while personality disorder – as in the current case of autism – might be viewed as less treatable because of the absence of licensed pharmacological treatments. However, 'treatability' of both personality disorder and autism does not rest solely with medication, and there are very clear guidelines for the treatment and management of all mental disorders – even if the expected beneficial outcomes may, sometimes, be modest.

Beyond the foregoing, the ability to achieve 'reformation' of a defendant exhibiting, for example, autism, or personality disorder, has to be seen beyond 'alteration of the individual with the condition'. It can be argued that if *not* being 'beyond reformation' can properly be seen in terms of 'the risk of future serious offending', then such risk must be assessed in terms not only of factors intrinsic to the defendant, but also in terms of what setting they will be in (almost certainly for many years, on conviction of murder), and what management techniques can be applied to them, within 'risk management' (albeit standard clinical management techniques for autism, for example, might not be readily available in prison).

In the case of Idris, there might be concern caused by his refusal to engage with further assessments. There is no reliable way of predicting how this might be overcome, but it would be highly speculative to suggest that he *could never* benefit from treatment, or management, on the basis of his current lack of cooperation. In the case of Idris, there may be extra emphasis placed upon risk management; that is, if something can be done to reduce the risk of future violence, then that might go towards the ultimate question of 'capacity for reform'. (Risk assessment is described in Case 22.)

How does remorse relate to reform?

Remorse is discussed within the forensic psychiatric literature but it is not clearly defined, so giving opinions on remorse should be approached with enormous caution. Indeed, it is not clear either ‘what it is’ or ‘how one can, or should assess it’. As with other court-related matters, the psychiatric expert should focus on any knowledge, paradigm or expertise he has that is not possessed by the decision-makers in court. In other words, although deciding whether someone is remorseful or not is almost certainly not a matter for expert opinion, there may be factors – defined and described within the psychiatric paradigm – capable of offering a contribution to the court’s understanding of Idris’s attitude to his offence, and thereby to its view of his degree of remorse or its absence. Put simply, psychiatric formulation may be relevant to remorse, although it is for the court to determine whether, and how, it is.

People with autism characteristically have deficits in ‘empathy’ so clear explanation, with examples, of how this can manifest itself – and may have done in Idris – is likely to be of assistance. The related concept of ‘theory of mind’ might also assist in this regard, in that people with autism are prone to ‘concrete’ interpretations of words and actions (such as the words written to Idris by his victim), which might be relevant to Idris having committed his offence.

The relationship between the concept of remorse and reform is not at all clear; indeed, it is not clear that the former is necessary in order to achieve the latter, in that remorseful people are not necessarily less risky. Yet there is clearly an understandable imperative on the part of, for example, parole boards, that defendants should be remorseful, and should not be released on parole if they are not.

Finally, if you do report any direct comments from a defendant potentially relevant to remorse (perhaps unlikely in Idris’s case), then it is safer to report words and actions directly than interpret them as representing remorse, or its absence. Your instinct, as a psychiatrist, as to whether someone might be remorseful or not, should probably not be given any ‘additional weight’, or even considered as expert evidence.

Appeal on grounds of diminished responsibility

Idris’s lawyers may have ‘missed a trick pre-trial’, in that, despite his refusal to discuss the then alleged offence, it may have been possible to gain expert opinions concerning whether Idris’s disorder was relevant to his commission of the *actus*.

Ethical and professional issues

What if Idris will not cooperate?

There is a very strong suggestion that Idris has an ASD. As described elsewhere, this is a mental disorder that is characterised by social and communication problems, so the ordinary psychiatric interview might need to be augmented with other methods. It is possible that the room where the interview is to take place is unsuitable. Some people with autism are particularly sensitive to noise, light or other aspects of the environment. Also, it is possible that Idris’s experience of the first interview caused distress that he has not disclosed. And, even if Idris will not meet with you, it might be possible to provide written questions to him, to which he might respond. Ultimately, when the stakes are as high as they are in his sentencing

hearing, there should be careful thought as to how to conduct the assessment as thoroughly as possible. If you need further time, then this should be requested vigorously, with clear description of the medical basis of the difficulties, in terms of Idris' likely disorder. Idris's offence is very serious, so it is ethically very difficult to give an opinion without proper information when the consequences for the defendant are so grave. There may be circumstances where, despite pressure from a court, you will need to stand your ground.

Case 21

Key themes

- *Clinical* – post-traumatic stress disorder; classificatory systems; rating scales
- *Legal* – sentencing; mitigation; risk assessment towards risk-based sentencing
- *Clinico-legal* – clinical data and mitigation; clinical risk assessment for penal purposes; going beyond instructions

Handbook references

- Post-traumatic stress disorder (p23)
- Diagnostic classification (p58)
- Risk assessment for offending (p63)
- Mitigation (p119)
- Assessment and reporting concerning risk of violence (p123)
- Expertise (p138)

Case history

Savannah has been convicted of causing grievous bodily harm following an incident in a nightclub.

When Savannah was three years of age she was raped by her father's adolescent nephew. Her mother told her father what had happened, but her father disbelieved her and continued to allow his nephew to have regular contact with Savannah. She 'confronted' her father about what had happened much later and he apologised.

She has worked for an airline for some years without difficulty.

She drank socially as a teenager, but when she met her former partner her use of alcohol increased, and 'for years' she would drink three bottles of wine a day. She would frequently and regularly suffer physical symptoms of withdrawal when without alcohol, including sweating profusely, although she never experienced delirium tremens.

Savannah's relationship with her former partner was 'very abusive', which she described in terms of 'he beat me up everyday...I had black eyes...I miscarried at four months after he kicked me...he'd tell me to kill myself...he changed my whole life'. She also described her former partner's demeanour changing very quickly from being 'very nice' to becoming 'the enemy'. She explained that, as a result of her former partner's actions, she lost confidence in herself and became depressed, so that she was prescribed antidepressant medication for several years.

Savannah experiences nightmares every other night that feature her former partner attacking her and, as a consequence, her sleep is poor. She also says that she is 'scared of everything (and) I've changed as a person...now I avoid social interactions...my memory is poor...I'm scared of people who speak loudly'.

On the night of the alleged offence, Savannah visited a nightclub with a female friend and they had some drinks. Then, at the end of the evening, Savannah and her friend were approached by a male 'bouncer', who Savannah described in terms of 'he was seven foot tall and very threatening...he was in my face'. Savannah says that she believed that the man was unfairly targeting her, explaining that he had told her and her friend to 'get out' of the nightclub, although other people were still dancing. This led her to challenge him. She said: 'I wasn't angry...I just wanted to know why...then he got in my face...he started to take things out of his coat...I felt he was preparing for something...to hit me...I felt threatened...scared...petrified...I thought I was going to be attacked.' She also said that she could feel her heart thumping in her chest, and she started to sweat profusely. She went on: 'I thought of my ex (partner)...of the abuse I've had, and thought "this is another man who wants to hit me"...I was scared.' She then attempted to throw her drink at the bouncer to make him 'back off', after he had grabbed her arm, explaining: 'I went to throw a glass of water...somehow the glass connected with his face.'

You are asked to provide a report considering whether Savannah might have post-traumatic stress disorder (PTSD); and to give an opinion for her sentencing hearing, including concerning her risk to others.

Clinical

What is PTSD?

Post-traumatic stress disorder develops following exposure to actual or threatened death, serious injury or sexual violence, or series of events (DSM5). The event itself should be of a kind that would cause distress in anyone. The condition comprises a 'triad' of symptom categories, in terms of 're-experiencing', 'hyper-arousal' and 'avoidance' symptoms. That is, symptoms that relate to re-experiencing the traumatic event, either by way of intrusive daytime memories or nightmares; avoidance of reminders of the trauma, including social withdrawal; and hyper-arousal symptoms that include physical and psychological anxiety, difficulty concentrating and irritability. The symptoms can also include episodes of mental dissociation. Finally, PTSD is associated with abuse of substances, particularly alcohol, which is used as an attempted means of controlling anxiety and arousal symptoms. The condition does not occur in everyone exposed to a major traumatic event, so that individuals vary in their 'constitutional' vulnerability to the condition; but as many as 25-30 per cent of people experiencing a traumatic event of the types experienced by Savannah will go on to develop PTSD. Finally, where the traumatic events, or some of them, occur chronically in childhood, the effects can include distortion of development into adulthood.

How do you assess for PTSD?

Symptoms of PTSD cause people to be anxious and fearful. Reluctance to discuss the cause of the trauma is common (reflecting 'avoidance'), as thinking about what took place is typically intensely upsetting and frightening. The clinical interview should therefore be conducted in a calm and quiet manner. Some people, for example women who have experienced sexual violence, might find the presence of a male interviewer especially difficult.

Establishing a collateral history of the traumatic event is important. This can be done through police records, if the trauma related to a criminal matter, or through medical records. Less commonly, it might be possible, with the defendant's permission, to interview an informant who can provide helpful information. It is also helpful to interview informants about any ongoing symptoms they may have observed in the person. As regards general practice records, because sufferers characteristically avoid discussion of the traumatic event, these often contain no information about the person suffering from symptoms of PTSD, since they do not disclose them to health staff.

Often, there have been varied sources and types of trauma, leading to the phenomenon of 'complex PTSD'.

There should be a careful clinical analysis of:

- The frequency and duration of different types of trauma
- When the events took place
- The defendant's perception of the trauma and injury
- How any symptoms experienced since relate to trauma
- Personal and family relationships, since sufferers often 'withdraw'
- How any dysfunction and disability relate to symptoms
- Co-morbidity, in particular depression, substance misuse

Some signs might be observable – for example, a hyper-startle response to noise, or apparent dissociation. Often, sufferers will change in their mental state when discussing their trauma; so that they may be very anxious or appear 'not to be there'.

Finally, there are schedules that can be applied that reflect anxiety and depressive symptoms (see also below).

Which classification system should you use?

As with most psychiatric disorders, PTSD is diagnosed on the presence of particular co-existing symptoms. The two diagnostic manuals, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD), adopt similar terminology and criteria for mental disorders, but they are not identical, and use differing descriptive styles. DSM offers clear 'symptom criteria', with a requirement of the presence of a given number of symptoms in order to make the diagnosis, while ICD is more 'prose'-like in its descriptions. Notably, PTSD is more likely to be diagnosed using ICD. The main reason for this is that DSM includes a specific criterion that the symptoms must cause harm or distress, which is not required in ICD. In many ways, DSM should perhaps be preferred, because the current edition (DSM5) is more recent than the current ICD10 edition, although a new edition of ICD (ICD11) is expected soon.

However, what is important is that, in your report, you specify which manual you have used, avoid a 'hybrid' approach, and explain why you have used the particular manual you have. Certainly, psychiatrists should always be asked which manual they have used to assist them in making any clinical diagnosis. However, the manuals are used to assist clinical judgement and not replace it. It is important to explain this to lawyers and courts, particularly when using DSM, which can easily be improperly challenged

legally by a ‘cook book’ approach that attempts to discredit a diagnosis made clinically, by questioning the presence of particular ‘required’ criteria or the number of criteria.

When should you use standardised rating scales?

In certain situations, it is useful to combine a clinical interview with psychological testing, since this allows for ‘triangulation’ of clinical findings with other methods of assessment.

A number of rating scales are available for use in PTSD, for example the *Trauma Symptom Inventory (TSI)* and the *Impact of Events Scale, Revised (IES-R)*. However, when using these, the assessing clinician needs to be careful to distinguish the specific apparent causes of the trauma that are reported – for example, distinguishing traumatic early life events from abuse in adulthood. It may also be appropriate to use scales that address anxiety and depression symptoms – for example, the *Hamilton Anxiety Rating Scale (HAM-A)* and the *Beck Depression Inventory (BDI)*. However, all of these scales contribute to, but are not ‘all of’, the assessment, and most are properly used to measure the severity of symptoms rather than to make diagnosis of the condition per se. Therefore, there should be careful explanation of the way you have interpreted any of the findings from the scales you have administered.

Should you go beyond your ‘clinical instructions’?

The answer to this question is almost always ‘yes’, but with care not to distort the ‘instructing-instructed’ nature of the ‘lawyer-expert’ relationship. Hence, in this case you might suspect that, because Savannah was abused in childhood – which will likely have affected her development – she might exhibit, beyond PTSD or complex PTSD, ‘personality disorder’. And in her case, you might suspect the possibility specifically of ‘borderline’ or ‘emotionally unstable’ personality disorder, given that this is commonly associated with childhood abuse (see Case 16 concerning diagnosis of personality disorder).

For the purposes of the rest of this ‘case’, however, assume that PTSD is the only diagnosis made.

Legal

Psychiatric evidence can be used by a sentencing court essentially in two ways: (1) mitigation; and (2) risk assessment, towards risk-based sentencing. Particular care should be taken in reporting towards both purposes in regard to keeping strictly to the proper boundaries of expert evidence (see also below).

Clinico-legal

Mitigation

You have not been asked by Savannah’s lawyers to describe her mental disorder in relation to him advocating for her in terms of mitigation. However, almost undoubtedly he will attempt to use your opinion in that way. Therefore, you should write with care to ensure that your text does not appear, in itself, to ‘suggest mitigation’; rather, you should describe Savannah’s symptoms and disabilities in a detailed way so that the court can take into account any aspects which it considers relevant to her ‘degree of culpability’ (see also below, in that ‘risk factors’ may also amount to ‘mitigation factors’).

Instructions – sentencing – mitigation

A full psychiatric assessment may reveal information that is subsequently used as mitigation (or aggravation). Specific questions may also be put to the expert.

1. Has the defendant ever suffered from any mental condition and, if so, what impact is this likely to have had on the defendant's behaviour?
2. Are there any psychological factors relevant to understanding this defendant's behaviour, even if you have not diagnosed any mental condition?
3. Are there any developmental factors that have shaped the defendant's character?
4. Did this defendant experience any traumatic events in their life that might have affected their behaviour in relation to this offence?

Risk assessment

You have been asked to address the risk of further offending that Savannah might present, to be used by the court in determining her sentence.

It is crucially important, ethically, that you approach this question with great care. First, you have expertise solely in mental disorder, so you should restrict yourself to consideration of the risk of behaviours that might arise from any mental condition you may have diagnosed. It is for probation officers, or forensic psychologists, to comment upon the overall risk she presents, within a different paradigm, and beyond that arising from her PTSD.

Further, it is important to provide a 'warning' to the court in terms of 'the limitations of clinical risk assessment', both per se and because it is designed for ongoing use within a therapeutic regime and not as a 'cine film snapshot' for the court's use in imposing sentence on a particular occasion (see text in Handbook).

In order to advise the court, it will be necessary to achieve a 'formulation', or clinical understanding, of how Savannah's offence came about, specifically in terms of any possible relationship of it with her symptoms of PTSD – for example, via 'misinterpreting' the behaviour of the victim, hyper-arousal, irritability, or having entered into a degree of mental dissociation. Additionally, you will need to deal with the fact that she was intoxicated, and 'allocate' causation between that and her PTSD – albeit, perhaps emphasising that her abuse of alcohol is, itself, likely to be a phenomenon that is 'secondary' to her PTSD. You should also include, however, any 'protective' factors that you might have identified.

In summary terms, what is perhaps most likely is that the actions of the bouncer potentially triggered flashbacks in Savannah of her partner's violence, inducing in her a sense of fear. Your report will need to consider the likelihood of Savannah having been triggered to retaliate against a threat that was 'over-perceived', so that the court can take a view on the likelihood of repetition of such a sequence.

Beyond the foregoing, you should describe what risk management techniques could be applied, reflective of the detail of your risk assessment of Savannah – albeit recognising that you are not in a position to

influence directly what strategies are capable of being applied, particularly in a non-therapeutic custodial or parole licence circumstance (see above in regard to misapplication of ‘therapeutically-based’ risk assessment techniques to once-off penal sentencing).

In the event that you consider that the nature and severity of Savannah’s disorder – and the risks of future violence that it represents – could and should be addressed properly by way of a medical disposal, if that were to be available in the jurisdiction concerned, then you may recommend that. However, it would be very unusual to recommend a ‘hospital disposal’ for a defendant with just PTSD – although if you were to determine that Savannah also exhibits a personality disorder, then it is possible, depending upon available services, that you might do so in her case.

Finally, returning to penal, including risk-based, sentencing, you may be presented with the problem that Savannah’s risk of future offending may depend intrinsically upon whether or not she receives some form of therapeutic intervention, but you are aware that this is not available or that you cannot be confident she will receive it.

Should a psychiatrist ever recommend a prison sentence?

In general, recommendations for sentencing by a psychiatrist should only focus upon data and opinion relevant to mitigation, medical needs, and describing the nature and degree of any risk of future offending that arises from mental disorder. And, if there is an option for sentencing to hospital, then you should consider this (see above). Where determination of whether a hospital sentence is recommended will depend upon the nature of the mental disorder and the legislation in that jurisdiction, as sentencing of mentally disordered offenders may fall within criminal or mental health law, and may only be available if there is a particular verdict finding – for example, of insanity.

You should therefore never ‘recommend’ a prison sentence, even if you perceive that this is ‘the way to achieve maximum public safety, given your risk assessment of Savannah’. Rather, you should solely offer your risk assessment and leave the judge to determine how s/he will use this in determining whether to sentence to prison and, if so, for how long.

Should you go beyond your legal instructions per se?

It is possible that within your formulation of Savannah’s case – achieved for reasons of risk assessment – assessment specifically of the likely ‘causes’ of the offence could draw you to the conclusion that, had you been instructed pre-trial, you would have offered an opinion that would have potentially underpinned a mental condition defence. Specifically, Savannah’s PTSD, plus the behaviour of the victim, could have caused her to enter a brief period of mental dissociation, so that it might have been possible for the defence to argue for an ‘insane automatism’ or ‘insanity’. However, this represents a somewhat complex meeting of psychiatry and law, especially given the concurrence of alcohol intoxication, and so there would need to be careful analysis of her likely mental state at the time of commission of the *actus*. Nonetheless, if you do come to a conclusion that could have laid the foundation for an insanity defence, then you should advise her lawyers of this. What they, and the court, then do with this opinion will be up to them. But, having already been convicted of the offence, Savannah is likely to be sentenced and then have to mount an appeal against her conviction.

It is also possible that Savannah lacked the capacity to have formed the requisite intent and, again, the same response on your part is implied as in regard to a possible insanity defence.

Ethical and professional issues

Can you give an opinion if features of PTSD are present but the diagnosis is not made?

Yes, if there are aspects of a defendant's mental state that are potentially important to his or her offending – as long as, in doing so, you remain within a clinical paradigm.

Individuals who have experienced severe trauma typically perceive threat more readily than the average person and, not unusually, can become irritable and aroused as a result. These symptoms can be present even if the full picture of PTSD is not seen, so that the diagnosis is not made.

If there is any doubt as to whether the opinions that you have given fall within what might properly be considered expert evidence, then the court can consider this separately. However, it is important to be clear about your opinion – including whether you have made a diagnosis *per se* or whether you are describing psychological consequences of trauma that fall short of meeting the diagnostic threshold.

Case 22

Key themes

- *Clinical* – treating doctor as expert; neurotic depression; adjustment disorder
- *Legal* – new evidence; appeal for unsafe conviction
- *Clinico-legal* – assessing for diminished responsibility on appeal

Handbook references

- Depression (p22)
- Diminished responsibility (p109)
- Conflicting duties and dual roles (p136)
- Clinician or forensicist (p143)

Case history

Six years ago, Howard, a now 60-year-old appellant, killed his wife in an explosive attack after marital discord lasting four years of a 15-year marriage. He had also occasionally hit her earlier in the marriage. He was 20 years her senior.

There was medical evidence at his trial suggestive that the appellant had been suffering intermittently from a neurotic depressive illness for four years, for which he had been treated – again, intermittently – by his GP with anti-depressant medication. There was also some evidence, from witness statements, that his symptoms became more severe during the weeks leading up to the alleged offence, associated with an attempted suicide by overdose four weeks prior to the offence, after which he was admitted for a few days to a psychiatric hospital. However, some witnesses described him as ‘laughing and joking’ a few days before the killing, and he continued to work as a lorry driver. The defence expert appointed for his trial diagnosed a ‘major depressive episode’ (within DSM5) as having been present at the time of the killing; but the state-appointed psychiatrist diagnosed ‘intermittent adjustment disorder’, opining that Howard’s symptoms clearly varied according to his wife’s attitude to him and the marriage.

Concurrent with the onset of his illness, Howard became impotent (possibly as a symptom of his depressive illness and/or as a side-effect of an anti-depressant), about which his wife frequently complained. She also often complained that he was ‘too old’ and ‘always depressed’. She allegedly repeated all of these complaints immediately before Howard killed her, also telling him that she intended to leave the next morning. Just before his overdose, Howard had become aware that she was having an affair.

The partial defence of ‘diminished responsibility’ was not accepted by the trial jury, so Howard was convicted of murder, and sentenced to life imprisonment, with a tariff of 25 years. Since then, as a visiting psychiatrist to the prison in which he is detained, you have been treating Howard, and you are convinced that he was, indeed, suffering from a major depressive illness at the time of the killing. This assessment is based not only upon the medical records and witness statements referred to at trial, but also on your own,

by now, detailed understanding of Howard's vulnerability to depression and you having obtaining a more detailed account of his symptoms prior to the offence than either of the two trial experts had gained. It also results from a better understanding of his mental functioning by you as a visiting psychiatrist than could have been achieved by any psychiatrist instructed solely as an expert in relation to Howard's trial.

You are asked by Howard's appeal lawyers to provide a report to allow him to appeal his conviction.

Clinical

What should your approach be to the request made?

You should approach this case with great caution, for at least two reasons.

First, his lawyers have not made plain to you the approach of the Court of Appeal to allegedly 'new evidence', which is highly restrictive in nature, in terms of what types of evidence are required in order even to mount an appeal. Second, you have a therapeutic relationship with Howard that infers a significant risk that you may be biased in your assessment of him, or at least perceived to be so.

Therefore, first, you should ask to be advised about what type of expert evidence and opinion is capable of laying the foundation for a potentially successful appeal – not in order for you to 'manufacture' such evidence, but in order for you clearly to assist the court, if the case gets that far, in addressing – within the terms it deems admissible – what 'new evidence' you are able to provide.

In essence, an appeal court will not even hear evidence 'of a similar type to that rejected by the jury', but only 'evidence of a new type', so it will be important for you to glean whether any of your clinical data on Howard is capable of falling into the latter category. In any event, when you come to write your report – if you do – you must be in a position to concentrate your clinical description upon data that the court *is* likely to accept as 'new evidence', albeit acknowledging the clinical data that the trial jury, by implication, did not accept, or did not consider of sufficient weight to found a defence of diminished responsibility.

Further, you should consider whether, as Howard's treating psychiatrist, you are capable of being – and being seen to be – 'unbiased' in your assessment of him, including historically. You may have more detailed clinical knowledge of Howard than a new expert appointed for a potential appeal would have, for example, but s/he will not be at risk of bias – at least not in the way that you are. Also, such a newly appointed expert will have access to all of your clinical records, and will be able to discuss Howard with you clinically.

How is depression diagnosed?

Depression or depressive disorders are diagnosed on the basis of the presence of combinations of symptoms that have lasted for at least two weeks. The core symptoms of depression are low or altered mood, and changes in emotions and feelings that affect a person's ability to function. Distinguishing depression from sadness, grief or a reaction to stress can be difficult. Ultimately, distinction from other causes of mood changes is reliant upon clinical judgement, based upon the information available, including from past medical records and witness statements. Any depression deemed to have been present is then classified in severity by the number of symptoms present, and by the presence of other features, including psychosis or atypical features.

How is adjustment disorder diagnosed?

Adjustment disorders result from an identifiable stressful event. People with adjustment disorders experience emotional or behavioural symptoms within three months of the stressful experience. The symptoms cause distress and impairment in function. The symptoms do not persist for more than six months. Termination of a relationship is a common cause for an adjustment disorder. If the person has symptoms that would meet the criteria for another psychiatric disorder – for example, depressive disorder – then that diagnosis is favoured.

There is some diagnostic controversy concerning adjustment disorder, as it probably represents one of the psychiatric disorders that is closest to a normal, certainly understandable, response to stress. It is, however, very clear that, for the diagnosis to be made, the response must be more than just a ‘normal’ one. Again, this judgement is ultimately one based upon clinical skill and experience.

Legal

Only ‘diminished responsibility’ will be at issue in any appeal, on the basis that the appellant’s conviction is ‘unsafe’ as a result of the trial jury not having had available to it evidence – ‘new evidence’ – that, had it heard, would likely have affected its verdict. Again, however, it is crucial to emphasise that there is case law concerning what can amount to ‘new evidence’, as opposed to ‘more of a type of evidence already heard by the jury’.

Clinico-legal

Given the core issue in any appeal relating to what can amount, in law, to ‘new evidence’, it will be crucial that you read all of the reports prepared pre-trial and also read the transcript of the expert evidence given at trial, plus the judge’s summing up. Indeed, almost certainly, you will also need to read the whole bundle of evidence that was prepared for the trial.

Diminished responsibility

If Howard was in a depressive illness at the time he killed his wife, then that could be seen as amounting to an ‘abnormality of mind’. And, even if he was suffering from ‘only’ an ‘adjustment reaction’, that too could amount to ‘abnormality of mind’. However, ultimately, it was for the jury to decide from which disorder he was suffering, if any. In order for your assessment of him to be admissible within an appeal, it would have to be demonstrated that you had clinical, or other, data that was relevant to the nature of any ‘abnormality of mind’ that was not available at trial, and that this amounts legally to ‘new evidence’. Of course, because juries do not give ‘reasons for verdict’, it cannot be known whether the jury in Howard’s trial accepted either diagnosis, or even rejected both.

As regards the ‘second limb’ of the defence – ‘substantial impairment of mental responsibility’ – Howard’s illness, whichever it was (if any), *could* be seen as of such severity that there could properly have been robust medical evidence presented to a jury in favour of the defence. Depressive illness, in particular, can result in distortion of how a person sees themselves and their situation, distortion of judgement, plus a

Sentencing for mentally disordered people

Most of the sentencing options below relate to findings of insanity. In some jurisdictions, mandatory sentencing means people with mental disorder cannot be sentenced to hospital. Those jurisdictions recorded as hospital sentencing frequently allow discretion so that the sentence may be to custody or, in the case of minor offences, probation.

Hospital sentencing available	Custody	No specific statutory provision
The Bahamas Bangladesh Botswana India Ghana Jamaica* Kenya Malawi Malaysia Nigeria Pakistan St Vincent and the Grenadines Sierra Leone Singapore Sri Lanka Tanzania Trinidad and Tobago Zimbabwe	Antigua and Barbuda** Grenada** Guyana** St Kitts and Nevis** St Lucia**	Barbados Belize Dominica (<i>draft bill for hospital sentencing</i>) Lesotho Uganda

* Not necessarily in a hospital but rather a hospital wing of a custodial setting.

** 'Safe custody, in such a place and manner as the Court thinks fit'.

somewhat diminished threshold for violence – most commonly towards self, but also towards others. The 'strength' of clinical evidence might well have been less if the court accepted only 'adjustment disorder' as the correct diagnosis, if any. And, again, it cannot be known whether the jury's verdict arose from not accepting either diagnosis, *or* from accepting one or either diagnosis but not accepting that it was sufficient to result in substantial impairment of mental responsibility.

However, beyond all this, a jury might reasonably have addressed the second limb not solely in terms of the nature and severity of whatever illness the appellant was suffering from, but also in terms of circumstances leading up to the killing acting upon his abnormality of mind. Hence, it could be suggested that Howard's allegation, if accepted as true – that his wife frequently complained about his impotence, told him that he was 'too old', and told him that he was 'depressed all the time' – likely played upon his mentally ill state. And if she did, as alleged, repeat these complaints immediately before the killing, they might well have acted as the 'trigger' for the killing. Such 'triggers', although nowhere near sufficient to found the alternative defence of 'provocation', could have acted upon Howard's 'ill state' so as to cause him

to be violent where – had he not been unwell – they would not have done. Therefore, the defence could have been ‘reinforced’ in these terms.

However, his wife also told Howard just before he killed her that she was going to leave him in the morning, and the jury were invited by the state, you understand from reading transcripts of Howard’s trial, to conclude that he killed her ‘because she threatened to leave’, and because of his jealousy and a tendency towards violence – as evidenced by his previous occasional hitting of her prior to him becoming ill.

All of the foregoing said, what matters in terms of the potential for an appeal is both whether there is new data – to the court, ‘evidence’ – capable of being seen as ‘new’, such that, had the trial jury known it, they might have decided in favour of the defence claimed, thus rendering Howard’s conviction ‘unsafe’. This would warrant either a ‘substituted verdict’ of manslaughter or, more likely, ‘re-trial’.

Ethical and professional issues

Is it proper for a psychiatrist who has provided treatment to offer an expert opinion?

This is an issue that is controversial. On the one hand, as Howard’s psychiatrist you are best placed to provide a clinical opinion because of your detailed, long-term and ongoing, knowledge of him – potentially including an opinion about his likely state at the time he killed his wife. On the other hand, you may be ‘conflicted’ in respect of your duty to Howard as a doctor (to a patient) and your duty to the court (as an expert witness) – or at least be perceived to be so. Further, you are at risk of a type of bias to which an expert appointed solely for legal purposes is not at risk (although s/he may be at risk of other sources of bias).

The decision on whether to accept instruction is for you to make, although it may be for the court to decide whether to accept your evidence as ‘expert’ evidence (if your duties as an expert are in doubt and this is raised). Therefore, you need to examine carefully whether your professional guidance, in terms of both law and ethics, assists – but, ultimately, you should ask yourself: ‘Can I, as much as is possible, offer an unbiased opinion as an expert witness?’ And, if you decide that you cannot, then you should avoid providing an expert opinion. You are still likely to be asked to provide a statement within any appeal detailing your clinical involvement, and even to attend court so as to offer ‘professional’ evidence, rather than ‘expert’ evidence.

Postface

We hope that use of this Casebook, in conjunction with the Handbook, has offered something of a 'dynamic' learning experience, in terms of 'learning by doing' or, at least, 'learning by doing on paper'. Ultimately, there is no substitute for experience in becoming more expert in dealing with cases – that is, in terms of 'becoming expert in being an expert'. However, assessing a difficult, serious, and possibly high-profile case can be daunting if one has never experienced 'a case like this one' before. And we hope, therefore, that assessing a variety of cases 'on paper' will at least offer an experience that determines that the expert can approach 'real cases' with more confidence.

We have suggested, both in this Casebook and in the accompanying Handbook, that cases can be perceived in terms of their 'psycholegal type'. That is, although the details of cases will vary, they can often be seen to fall into discrete 'psycholegal case types', wherein the combination of 'clinical nature' and 'legal question' is similar, in terms of 'mapping' of a given type of mental state abnormality onto a given legal test. We have been able, of course, to provide only a small number of case types in this Casebook – 22 in fact – and it is likely that the reader will come across many cases in their practice that are 'wholly different' in their 'psycholegal interfacing' from any of the cases in the text. However, we have tried to choose cases that represent *major* and *commonly occurring*, or sometimes *particularly difficult*, psycholegal case types. Also, gaining experience of a range of case types – be it 'for real' or through addressing the types represented in the Casebook – will be likely to lay a foundation for 'developing skill' in clinico-legal practice that will be applicable 'generically' to any case of a type that the expert has not yet encountered, either for real or in the Casebook. Whereas the 'issues at the interface between psychiatry and law' will be specific to any case at hand, there will be 'common themes' across cases, in terms of the relationship between psychiatry and law, so that learning will – increasingly as more cases are encountered – generalise beyond the specifics of any particular case.

Finally, the authors, and other members of Forensic Psychiatry Chambers, would greatly welcome responses from readers, including – but by no means restricted to – those with whom we might interact directly in courses or educational events we provide, concerning particular real 'case types' that colleagues may have come across in their practice. In expectation that there may eventually be a second edition of the Handbook, that new edition might add some of these cases that have been pointed out to us as being particularly problematic, or common, clinically, clinico-legally or ethically. And, in this regard, we would encourage not only clinical colleagues to 'register' such case types, but also lawyers and members of the judiciary.

To the latter end, therefore, we would welcome responses being sent to use by email at the address capitalcases@forensicpsychiatrychambers.com

APPENDICES:



Appendix one: Example of elements of a proper letter of instructions

You are requested to conduct a general psychiatric assessment of Mr X. In particular, you are asked to consider:

1. Does the accused display, or has he displayed, symptoms of any recognised mental disorder either:

- a) Now*
- b) At any time in the past, including at the time of the offence*
- c) At the time of his arrest*
- d) At the trial at which he was convicted*

And what is the evidence for these symptoms?

2. Please describe any other mental abnormality.

3. If the accused displays, or has displayed, symptoms of any recognised mental disorder, whether he might benefit from psychological testing (that is, to assess pre-morbid/current intellectual functioning, personality, substance misuse, etc.)

4. If the accused displays, or has displayed, symptoms of any recognised mental disorder, whether he might benefit from neuropsychological assessment (that is, to detect possible brain damage)

5. Is there anything to suggest that the accused's mental state altered between the offence, his arrest and his trial?

6. If you consider the accused to have a mental disorder, what do you consider to be the diagnosis? Please explain the essential features of any diagnosis you have made. If alternative diagnoses were considered, why were they rejected?

7. To what extent is your diagnosis based upon your interview with the accused and his experiences, and to what extent upon other, more objectively verifiable, evidence?

8. Does the accused display any long-lasting effect of substance dependence and, if so, what effect has this had, or does this have, on his mental health?

9. What is the likely validity of the diagnosis made, with particular reference to the possibility of feigning or malingering of symptoms, and why this is not considered to be likely (if it is not)?

Appendix two: Legal cases

R v Ahluwalia [1993] 96 CrAppR 133

Bratty v Attorney-General for Northern Ireland [1963] AC 386

R v Byrne [1960] 2 QB 396

R v Bowen [1996] 2 CrAppR 157

R v Jason Cann [2005] EWCA Crim 2264

R v Cannes [1971] 1 WLR 1600.

R v Dietschmann [2003] 1 AC 1209

R v Dix [1982] CrimLR 302

R v Duffy [1949] 1 All ER 932

Ford v Wainwright, [1986] 477 U.S. 399

HM Attorney-General for Jersey v Holley [2005] 3 WLR 29

R v Jogee [2016] UKSC 8

R v M (John) [2003] EWCA Crim 3452

R v Martin (Anthony) [2002] 1 CrAppR 27

DPP v Majewski [1976] UKHL 2

R v McNaghten [1843] 10 CI & F 200

R v Quick [1973] 3 WLR 26

R v Pritchard [1836] 7 CP 303

R v Podola [1960] 1 QB 325

R v Robertson [1968] 3 AllER 557

R v Stewart [2009] 1 WLR 2507

R v Sullivan [1984] AC 156

R v T [1990] CrimLR 256

R v Tandy [1989] 1 WLR 350

Trimmingham v the State (St Vincent & The Grenadines) [2009] UKPC 25

R v Windle [1952] 2 QB 826

R v Wood [2008] EWCA Crim 1305

Biographies

Professor Nigel Eastman is emeritus professor of law and ethics in psychiatry at St George's, University of London, and an honorary consultant forensic psychiatrist in the National Health Service. Alongside his medical training, he was called to the Bar. He has, over a long career, carried out research and published widely on the relationship between law and psychiatry, and is first author of the *Oxford Specialist Handbook of Forensic Psychiatry*. A major focus of his work has been in regard to public policy concerning law and psychiatry and he has, for example, been an advisor to the Law Commission for England and Wales and given evidence to UK Parliamentary Select Committees in this context. He has 30 years' experience of clinical forensic psychiatry. He also has extensive experience of acting as an expert witness in both criminal and civil proceedings, at all court levels, both in the UK and in the jurisdictions of other countries, including in relation to more than 500 murder cases, involving many capital cases undertaken *pro bono*. Throughout his career he has provided education and training to doctors, lawyers and the judiciary at the interface of law and psychiatry, both in the UK and abroad. He is a member of Forensic Psychiatry Chambers.

Dr Sanya Krljes is a clinical forensic psychologist in the Forensic Mental Health Service of the South West London and St George's Mental Health NHS Trust. She holds doctorates in cognitive neuroscience and clinical psychology, and has published a number of articles on the subject of neuropsychology and cognitive neuroscience. She has extensive experience of conducting complex psychology and neuropsychology assessments, and of preparing court reports in relation to murder and sexual offences trials, often being high-profile in nature.

Dr Richard Latham is a full-time consultant forensic psychiatrist working in the NHS in London. His current clinical practice involves the care of people detained under English mental health legislation in a secure hospital. In addition to being medically qualified, he holds a Master's degree in mental health law, for which his thesis concerned expert mental health evidence. He is an author of the *Oxford Specialist Handbook of Forensic Psychiatry* and has contributed chapters on mental health law, risk assessment and management to edited texts. He has an expert witness practice in two areas of law, serious crime and mental capacity law. His expert witness practice has included numerous murder cases, high-profile terrorist extradition cases and landmark cases involving mental capacity and refusal of medical treatment. He works *pro bono* for the Death Penalty Project and has conducted assessments on appellants in Kenya, Trinidad and Tobago, St Vincent and Belize. He has also conducted training sessions in Barbados, Trinidad and Tobago, Jamaica, Kenya and Taiwan on the use of expert evidence in capital cases. He is a member of Forensic Psychiatry Chambers.

Dr Marc Lyall trained in both general adult and forensic psychiatry. For the past 10 years he has worked as a consultant forensic psychiatrist in a medium secure unit in the East End of London. He is also an honorary clinical senior lecturer in psychiatry at the Barts and London School of Medicine and an examiner for the UK Royal College of Psychiatrists. Dr Lyall regularly prepares reports for the UK courts in criminal proceedings. On behalf of the Death Penalty Project, he has carried out assessments of defendants facing very serious criminal allegations in Malawi, the Democratic Republic of Congo and Trinidad and Tobago. He has also contributed to training events for doctors, lawyers and judges in the UK and in foreign jurisdictions. He is a member of Forensic Psychiatry Chambers.

The Death Penalty Project

The Death Penalty Project is a legal action charity working to promote and protect the human rights of those facing the death penalty.

We provide free legal representation to death row prisoners around the world, with a focus on Commonwealth countries, to highlight miscarriages of justice and breaches of human rights. We also assist other vulnerable prisoners, including juveniles, prisoners who are serving long-term sentences and those who suffer from mental health issues. For more than three decades, our work has played a critical role in identifying miscarriages of justice, promoting minimum fair-trial guarantees in capital cases and in establishing violations of domestic and international law. Through our legal work, the application of the death penalty has been restricted in many countries in line with international human rights standards. To complement our legal activities, we conduct capacity building activities (such as training for defence lawyers, prosecutors, members of the judiciary), and commission studies on criminal justice and human rights issues relating to the death penalty.

Since 2011, we have been delivering capacity building support on forensic psychiatric practice to lawyers and mental health professionals working in countries that retain the death penalty. In many capital jurisdictions, mental health issues are not raised at trial or insufficiently addressed by the courts. Few prisoners receive mental health assessments, which may impact on the safety of their convictions. Our training programmes seek to address gaps in the protection afforded to those with mental disorder and promote the implementation of minimum standards. We have delivered training programmes in many countries in the Caribbean, Africa and Asia, and we are constantly expanding to new jurisdictions. This updated Handbook and the compendium Casebook will accompany future training programmes, providing an invaluable reference guide for mental health professionals and instructing lawyers.

Forensic Psychiatry Chambers

Forensic Psychiatry Chambers is a medical chambers comprising experienced psychiatrists, who provide psychiatric advice and expert reports to courts and to the legal profession, in the UK and in other common law jurisdictions. Its members are independent practitioners. However, they operate in a collegiate context, offering collective knowledge and experience to courts and lawyers, as well as supporting a peer-review approach to their work that aims to support technically high-quality and ethical expert witness practice. A number of its members are committed to pro bono practice in the context of human rights law, including in regard to capital cases. The chambers also provides education and training to mental health professionals, lawyers and courts, in the UK and in other jurisdictions.



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