Responsibility, culpability and the sentencing of mentally disordered offenders: objectives in conflict

Responsibility, Culpability and the Sentencing of Mentally Disordered Offenders: Objectives in Conflict

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'The issue on appeal to this court is whether the judge's sentence of custody for life was wrong in principle. It raises once again the complex relationship between custodial sentences and orders under the MHA in relation to an offender who suffers from a mental disorder.'[1]

Introduction

Assessing culpability in mentally disordered offenders poses complex challenges for both lawyers and psychiatrists. But this issue has become both more pressing and more problematic following the recent judgment of the Court of Appeal in *Vowles and others*.[2] The guidance in *Vowles* concerns sentencing and disposal decisions and raises many of the same dilemmas that have bedevilled the assessment of the degree of responsibility in someone where there is a plea or finding of diminished responsibility manslaughter: as Lord Justice Moses put it, this is 'a question of acute difficulty'.[3] This article reviews some of those dilemmas both from the perspective of the court and from that of the psychiatrists who become involved. For the courts the dilemmas seem to revolve primarily around management of the perceived future risk posed by mentally disordered offenders. For the psychiatrists, they concern primarily the ethically problematic issue of contributing to decisions about punishment.

Psychiatrists' involvement with the criminal courts can occur in a number of ways, but two are of concern here. First, they may give expert evidence in relation to s.2 of the Homicide Act 1957 as amended. This evidence will go to the issue of the level of the conviction, potentially reducing a murder conviction to one of manslaughter by reason of

* Professor of Law, London School of Economics and Political Science. I am grateful for the comments I received when I delivered a version of this paper to the Royal College of Psychiatrists at the Third UK Conference on Philosophy and Psychiatry 'Moral and legal responsibility in the age of neuroscience' 24th September 2015; and for comments emanating from the editorial process.

[1] Lord Justice Aikens *Fort* [2013] EWCA Crim 2332 at para 5.

[2] *Vowles and others* [2015] EWCA Crim 45.

[3] *Welsh* [2011] EWCA Crim 73 at para 11.

diminished responsibility. This is not ethically problematic. Second, they may give evidence or submit expert reports where an offender has been convicted and there are concerns that the offender's mental state at the point of sentence may render him or her suitable for disposal under the Mental Health Act 1983 (MHA). This is also not problematic, since the psychiatrist's contribution will be potentially to divert the offender from a punitive disposal to a therapeutic one under s.37 or s.37/41 of the MHA. However, since amendment by the Crime (Sentences) Act 1997, disposal under s.45A of the MHA – the hospital and limitation direction – has also been available to the courts.[4] This hybrid disposal enables the judge to order a sentence of imprisonment, but direct that the offender goes first to hospital for a period of treatment under the MHA. It is thus a mixed therapeutic-punitive sentence which Eastman and Peay described in 1998 as potentially 'a substantial change of psychiatric jurisprudence as applied to all MDOs'.[5] We called at that time for the operation of the Act to be 'closely monitored'.[6]

Involving psychiatrists in a part-punitive order is ethically profoundly problematic for them in the same way that their involvement was in the now repealed 'longer than normal sentences' under the s.2 (2) (b) of the Criminal Justice Act 1991.[7] As doctors, psychiatrists are first enjoined to 'do no harm', or as Sokol has put it more appropriately 'do no net harm'; and even following this more nuanced edict entails balancing other moral principles.[8] Yet the s.45A hybrid order necessarily draws psychiatrists into considerations of punishment, albeit second-hand where their recommendations on the applicability of a therapeutic order are used in part to justify the part-punitive order; or by the back door where patients are transferred from hospital to prison.

When the 1997 Act was passed the s.45A hybrid order applied only to offenders suffering from psychopathic disorder. For the first ten years of its operation it was used rarely, with numbers never rising into the teens in any one year.[9] The Mental Health Act 2007 extended its application to offenders suffering from any form of mental disorder which fell within the revised MHA 1983. However, by 2013 there were still only 18 orders made in that year; this contrasted markedly with the 294 hospital and restriction orders (a non-punitive order) made under s.37/41 in the same year.[10] This article draws in part on an

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[4] Amended by s.46 Crime (Sentences) Act 1997.

[5] N. Eastman and J. Peay, 'Sentencing Psychopaths: Is the "Hospital and Limitation Direction" an Ill-Considered Hybrid?' [1998] Crim. L.R. 93-108 at 108.

[6] Ibid at 108.

[7] B. Solomka, 'The role of psychiatric evidence in passing "longer than normal" sentences' (1996) Journal of Forensic Psychiatry 7,2, 239-255.

[8] D. Sokol '"First do no harm" revisited' (2013) British Medical Journal 347:f6426.

[9] See J. Peay 'Sentencing Mentally Disordered Offenders: conflicting objectives, perilous decisions and cognitive insights' (2015) LSE Legal Studies Working Paper 1/2015 at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2549653

[10] Ibid at p.5. For reasons discussed in the working paper these figures should be treated with some caution.

analysis of the tranche of Court of Appeal cases in s.45A orders.[11] But it also considers the implications of the post *Vowles and others* era, guidance having now been given in the Court of Appeal that s.45A orders are to take precedence over s.37 or s.37/41 orders.[12] And hence the substance of this article: the anxiety about involving psychiatrists in the assessment of culpability second-hand, and the difficulties of assessing culpability *per se* in mentally disordered offenders.

Responsibility and culpability

One of the reasons this area is so tricky has to do with language. Legal responsibility is used here as a binary concept to distinguish those found guilty from those found not guilty (a lay/jury decision about conviction). Where there is no legal responsibility (either by way of acquittal or by way of a finding of not guilty by reason of insanity) there can be no punishment. For those found guilty the use of the term culpability, in essence blameworthiness, then regulates in part the nature, quantity and quality of the punishment/disposal that follows. This judicial decision is one that theoretically should be in proportion to moral blameworthiness for desert-based theorists or for consequentialists, by reference to the impact punitive intervention has on the offender's subsequent behaviour; for example through deterrence, rehabilitation, or incapacitation. Under s.142(1) of the Criminal Justice Act 2003 (CJA) these purposes of sentencing are blended, together with the need for offenders to make reparation for their offences to those affected by those offences. And the case law illustrates that culpability is a graded concept: it can range from full, through various degrees of partial, to wholly absent – albeit punishment for those with no *mens rea* culpability can still occur for strict liability offences.

But lawyers also sometimes use responsibility/culpability interchangeably. And, the neat division breaks down most obviously with respect to mentally disordered offenders charged with murder, where concepts of diminished responsibility can come into play. A plea to diminished responsibility manslaughter can be accepted by the judge, or diminished responsibility can found by a jury following a contested murder trial. Diminished responsibility is used in a graded way with frequent case reference to responsibility being 'diminished but not wholly extinguished'.[13] Thus, diminished responsibility can lie at the top end, just short of a conviction for murder, or at the lowest end where it can be almost non-existent (some element will necessarily exist given there has been a conviction).

Psychiatric involvement in cases of potential diminished responsibility is inevitable. Moreover, since the amended s.2 of the Homicide Act 1957 now makes reference not to diminished responsibility but to a defendant's impaired abilities to do particular things and

[11] Ibid.

[12] See fn 2 above.

[13] See, for example, Lord Mustill in *Birch* (1990) 90 Cr App R 78.

to the need for a causal/explanatory relationship to be established between the defendant's abnormal mental functioning and the homicide, it makes psychiatrists central to the process of evaluation. Indeed, the CA has noted in *Brennan* that the amended s.2 is altogether more tightly structured than the original value-judgement infused s.2, and that 'most, if not all, of the aspects of the new provisions relate entirely to psychiatric matters'.[14] Indeed, the CA has expressed itself content for psychiatrists to express a view on the 'ultimate' issue as to whether there was substantial impairment.[15]

However, do psychiatrists and lawyers share common concepts in this area? Indeed do all lawyers share the same concept? This is tricky. As James Penner has illustrated it is perfectly understandable that lawyers and psychiatrists can use the same concepts, without agreeing about the properties such concepts represent.[16] He argues that acquiring a concept, in this case like responsibility or culpability, can come cheap, whilst acquiring knowledge of its properties may be much more hard won: knowledge requires investigation and thought. Thus, we can share the same concept but have many different beliefs about it and we can disagree about them. Concepts have an essential quality, his example being that even children don't believe that you can convert a horse into a zebra by painting stripes on it, whilst they still recognise that dogs come in all different colours. Thus, we can use the same word – for example, culpability – without necessarily referring to the same constituent elements. This can make culpability a dangerously unstable concept. Indeed, whilst there are statutory offence based limits with respect to cardinal proportionality, and the relevant Sentencing Council Guidelines further refine these, there is no natural limit to how much punishment is justified by how much offending. As Lacey and Pickard have argued, drawing on the work of Murphy, a desert-based model can be justice based with a respect for responsible agency, but it can also be vulnerable to emotive and retaliatory sentencing.[17] The two are not compatible. Combining an unstable concept with the CJA's blended approach to the purposes of sentencing and then adding in the new element of MHA disposal, means the evaluation of culpability will inevitably stray outside the strict confines of a sentence of imprisonment subject to the sentencing guidelines. The moral equation is opened up in unpredictable ways.

Two illustrations of the problem from two different cases should suffice. First, *Clarence*, who killed her three disabled children. Her plea to diminished responsibility manslaughter was accepted by the judge. At sentence the judge took the view that both her responsibility for the offences and her culpability were low, since her mental disorder

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[14] *Brennan* [2014] EWCA Crim 2387, paras 49-51.

[15] Ibid at para 51, citing Ormerod's paper on diminished responsibility available on the Judicial College website; see also commentary by Fortson [2015] Crim L R 291-294.

[16] J. Penner 'Concepts and Rules: A Philosophically-Minded Introduction to Private Common Law Reasoning' (2015). Paper presented at the LSE Law Department 2nd July 2015.

[17] N. Lacey and H. Pickard 'The Chimera of Proportionality: Institutionalising Limits on Punishment in Contemporary Social and Political Systems' (2015) Modern Law Review 78, 2, 216-240; citing, at 226, J. Murphy *Punishment and the Moral Emotions* (2012) Oxford, OUP.

wholly accounted for these offences – they would not have happened in the absence of her severe depression.[18] So whatever planning had gone into the killings, and the fact that the three children would have been smothered sequentially, introducing an important time element, did not enhance her culpability since, as the judge said, what you did 'was a product of your mental illness'. In contrast, the prosecution asserted that even though her culpability may be low, her responsibility was significant: indeed, a plea to manslaughter by reason of diminished responsibility necessarily entails both an acceptance of an intention to kill (in these circumstances three times) and of a degree of responsibility for that. The prosecution submitted that a prison sentence should be imposed. The judge gave *Clarence* a s.37 hospital order, asserting that she did not qualify for a s.41 restriction order or a s.45A order since she wasn't dangerous. Clearly it is possible for the courts to be satisfied, on the basis of medical evidence, that a mental disorder can produce offending in a way that all but extinguishes both responsibility and culpability, even though the offence involves elements of premeditation, planning and takes place in a non-spontaneous way.

Contrast this with the case of *Brennan*[19] where there was a contested diminished responsibility trial and the jury returned a verdict of murder. *Brennan* worked as a male escort and in a particularly savage manner, killed a client who he said required him to engage in degrading acts. At his trial, there was uncontested psychiatric evidence to the effect that he was suffering from an abnormality of mental functioning which arose from Schizotypal Disorder and Emotionally Unstable Personality Disorder and which substantially impaired his ability to form a rational judgment and to exercise self-control at the relevant time. There was evidence of premeditation, but the psychiatric expert told the court that the undoubted preparations and planning did not affect her diagnosis: 'Core rationality is still retained by people with severe disorders...such people can present a facade of being entirely rational' (para 31). In cross-examination she added 'The planning for the killing was a logical consequence of his illogical thought process. He has the illogical thought that he has to kill someone and then goes about planning it in a logical way' (para 33). Thus, setting up a situation to kill was not inconsistent with him experiencing profound mental health problems. He was 'driven by an abnormal, out of control, belief system at the point of killing' (para 33). However, the judge invited the jury to consider the weight to place on the defendant's ability to conduct his life in many respects coherently and normally (even though there had been uncontradicted medical evidence on this point). He told the jury they did not have to 'buy into [Dr M's] conclusions in their entirety to the degree that she suggests is appropriate'.

The jury convicted of murder and the Court of Appeal, in due course, quashed the conviction for murder on the grounds that there was no rational basis on which the jury could decline to accept the expert evidence (thus, the judge had wrongly invited the jury to

[18] https://www.judiciary.gov.uk/wp-content/uploads/2014/11/r-v-clarence-sentencing-remarks.pdf

[19] See fn 14 above; and commentary by Fortson [2015] Crim L R 291-294.

enter into an essentially psychiatric domain).[20] And whilst cases of uncontradicted psychiatric evidence may be rare, it is notable that the Court of Appeal was also prepared to embrace within its test for withdrawal other evidence that was too tenuous to permit a rational rejection of diminished responsibility. This potentially will give further weight to the role of psychiatric testimony.[21]

Why was the treatment by the trial courts of *Clarence* and *Brennan* so different? In the first the judge accepts a plea, in the second a trial occurs. Contrasts can be drawn between the nature of the killings (domestic vs 'sexual'), the savagery of the killings (smothering small children vs knifing and clubbing with a hammer), and the nature of the diagnoses (Depression vs Schizoidal Disorder and Emotionally Unstable Personality Disorder). But seemingly the issues of culpability and responsibility could be equated, both psychiatrically and legally, since the offenders' disorders were the explanation for the occurrence of the offences. However, what is clear is that in the final analysis, both of these cases were heavily influenced by psychiatric reasoning.

***Vowles* and s.45A orders**

The judgment in *Vowles and others* has already been subject to an extensive critique in this Review by Professors Ashworth and Mackay.[22] Suffice it to reiterate that they argue (1) it is not for psychiatric expertise to determine what part the mental disorder plays in assessing culpability, but rather advise as to the disorder's part in the offending behaviour (2) the Court placed an inappropriate emphasis on punishment not treatment, reversing the presumption in earlier cases and (3) the Court emphasised the role of any 'element or particle of responsibility for wrongdoing'[23] and the importance of finding the most suitable disposal with reference to the method of release and risk posed. The latter acknowledges the reasoning in the *Attorney General's Reference No 54 of 2011*[24] that release is to be preferred by the Parole Board rather than by the First Tier (Mental Health)Tribunal for two reasons. First, the Parole Board needs to be satisfied that the defendant is no longer a danger to the public for any reason and is not at risk of relapsing into dangerous crime; whereas the under the hospital order regime release depends on there being no danger which arises from the offender-patient's medical condition. Second, recall from licence arrangements can occur if a danger to the public arises from criminal activity; whereas recall to hospital is available only if the defendant's medical condition relapses. Thus,

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[20] Thus, the judge should have withdrawn the murder charge from the jury following *Galbraith* (1981) 73 Cr App R 124. Fortson, above, identifies the key passage in the judgment at para 44 'Where there simply is no rational or proper basis for departing from uncontradicted and unchallenged expert evidence then juries may not do so'.

[21] *Brennan* para 65.

[22] A. Ashworth and R. Mackay [2015] Crim L R 542-547.

[23] Ibid at 545.

[24] *Attorney General's Reference No 54 of 2011* [2011] EWCA Crim 2276 at para 17.

following *Vowles*, the pure therapeutic approach looks to take second place to a mixed precautionary punitive approach.[25]

Since s.45A orders fall under the MHA how might the Court of Appeal in *Vowles* have become so focussed on punishment? When they were first introduced the s.45A orders created a disposal option for offenders suffering from psychopathic disorder, where a judge had already rejected a recommendation for a s.37/41 order because of an offender's high culpability for the offence or because of the serious risk the offender posed to the public.[26] As such, that small cohort of treatment rejectees who would have been sentenced to custody became open to the new mixed punitive-therapeutic order. The order both encouraged psychiatrists to have a therapeutic go with the difficult to treat psychopathic offenders, and retained a cautious and flexible approach to release.[27] Indeed, this latter element, of public protection, ultimately became dominant in the government's thinking.[28] The s.45A order also, paradoxically, provided a way of avoiding the then new automatic life sentence under s.2 of the Crime (Sentences) Act 1997: paradoxically because this avoidance measure was not to apply to any other offender suffering from mental disorder.[29]

The decision in *Vowles* arguably turns this on its head. The judgment asserts that where medical practitioners suggest that an offender is suffering from mental disorder, and where the offending is wholly or in significant part attributable to the mental disorder, and treatment is available, and a hospital order may be the appropriate way of dealing with the case, then the courts should first consider using a s.45A order. Only once that has been rejected should they consider the s.37 or s.37/41 order. Yet, if the offending was wholly or in significant part attributable to the mental disorder that would seemingly imply that culpability was low or absent. Logically, it should result in a real shift in the numbers from the use of s.37/41 orders to the s.45A order.

One can only assume, since the Court of Appeal used *Vowles* as the leading case in this guidance on s.45A, that they could have considered this defendant suitable for such an

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[25] Commentary by A. Ashworth [2015] Crim L R 921-922 on the post *Vowles* cases of *Turner* [2015] EWCA Crim 1249; *Gaciano* [2015] EWCA Crim 980 and *Smith (Gregory)* (unreported) shows that the Courts have drawn on *Vowles* in an inconsistent way. Indeed, as Ashworth points out, the Court in *Turner* makes explicit reference to *Vowles* but at no point mentions s.45A orders. Indeed, the judgment makes early reference to para 51 of *Vowles* which asserts 'There must always be sound reasons for departing from the usual course of imposing a penal sentence'; and notes that the original sentencing court had no grounds to impose a MHA disposal.

[26] See *Birch* (1990) 90 Cr App R 78 at 89; and Peay 2015 above.

[27] See Eastman and Peay (1998) above at 96.

[28] Ibid at 97.

[29] See *Drew* [2003] UKHL 25.

order had it been available to them.[30] *Vowles* was the quintessential case of someone with a difficult background who was difficult to diagnose, difficult to place, difficult to treat and yet who was still considered dangerous. She had borderline personality disorder, had made a previous suicide attempt leading to brain damage, had previous psychiatric admissions, and had set fire to newspapers in a flat day the day after she discharged herself from hospital. A psychiatric report said she was 'not likely to benefit from admission to hospital' and the trial court gave her an IPP (an indeterminate sentence for public protection) sentence with an 18 months tariff. She was later transferred to hospital under s.47 of the MHA.

In the event, the Court of Appeal took the view that she was most appropriately left on her s.47 transfer order; and rejected the psychiatric opinion favouring a s.37/41 order. Of the other five cases brought together with *Vowles,* the three which most clearly involved mental illness, and a causal connection was asserted, had their sentences quashed and replaced with s.37/41 orders. The other three, including *Vowles*, were characterised as cases where either a drug addiction was regarded as the driving force behind the defendant's behaviour, or punishment was justified by the offender's high culpability and continuing risk to the public, or, in *Irving's* case below, that the causative link was insufficient. The cases are an object lesson in just how problematic these issues are: all the offenders had long, complex histories with multiple diagnoses, some co-occurring and some conflicting contemporaneously between assessing psychiatrists. Psychiatric diagnosis may be both an art and a science, but its conclusions are clearly subject to the vagaries of time and location.

Perhaps the most interesting of the six is that of *Irving*. First because it illustrates how the Court looked askance at some of the psychiatric evidence it had reviewed. Thus 'mental illness ….is <u>not</u> a passport to a medical disposal as many of the psychiatric opinions we have considered in this case appear to presume' (emphasis in original).[31] And secondly, because the Court makes explicit observations on the graded nature of causative links. Thus, at para 197

'Acknowledging that there is no necessity for the sentencing judge to be satisfied of a causal link between a defendant's mental disorder and the offences in order to make a hospital order under s.37 or to direct hospital admission under s.45A it remains a legitimate factor to weigh in the balance of the circumstances as a whole.'

In *Irving's* case the causal link was not sufficient to conclude that the sentencing judge was wrong in principle to impose a prison sentence rather than a hospital order (despite, notably, that *Irving* had been held on a s.47/49 order since 2002, having been sentenced to life imprisonment with a minimum term of eight years in 1997).

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[30] The order was not available in any of the six cases as they had all been sentenced prior to the 2007 amendments. Indeed, *Irving* had been sentenced prior to the initial introduction of the S.45A order.

[31] *Vowles and others* above at para 196.

All of this could support a conclusion that the Court of Appeal, following its own guidance, would probably have given three s.45A orders in place of the s.37/41 orders it imposed (the offending was wholly or in significant part attributable to the disorder – low culpability) and in the three other cases the sentence of imprisonment would have been left in place (on the basis of culpability, insufficient causation or 'autonomous' drug addiction). Thus, the traditional notion of the s.45A order as providing an option for treatment in cases of high culpability and high risk would be all but extinguished. And the future s.45A orders would draw not from the potential prison population, but from the potential s.37/41 population. This would, in turn, create real ethical difficulties for psychiatrists. And, ironically, run counter to the oft neglected observations of the House of Lords in *Drew* that they would need to be persuaded that any significant change in the prevailing practice was desirable given 'the difficulties caused to prison managements by the presence and behaviour of those who are subject to serious mental disorder'.[32] Giving s.45A orders to those who would otherwise receive s.37/41 orders would do just that, albeit not immediately.

The lessons of the existing s.45A appeal cases.

One further feature of the *Vowles* case is the discernible shift to a more sceptical approach to psychiatric evidence. Thus, the Lord Chief Justice, in giving the Court's general guidance about the approach to dealing with mentally disordered defendants, noted 'the judge must carefully consider all the evidence in each case and not, as some of the early cases have suggested, feel circumscribed by the psychiatric opinions'.[33] Given the understandable lack of precision in psychiatric diagnosis one can have some sympathy with the difficult position in which the Court finds itself. However, this seeming preference for a lay/legal based assessment of culpability over a medical based assessment of capacity as impaired by disorder or frank mental illness can also be seen in the Court's handling of the tranche of s.45A appeals.[34] The capacity-causality nexus can be conceived as two interlinked sliding scales filling the space between non-responsibility and full culpability.

Insert Figure 1 here

If the courts will use sufficient residual culpability to negate the use of s.45A, how frequently are they likely to find residual culpability amongst those with mental illness? This question explicitly excludes those with severe personality disorder/psychopathic disorder, the original intended subjects of the s.45A order. This is because it seems

[32] *Drew* [2003] 1 WLR 1213 at para 22.

[33] *Vowles* para 51.

[34] For an analysis of the tranche of ten cases see Peay 2015 above; and see now also *Graciano* [2015] above.

inevitable that this group will be counted out from an initial hospital-based disposal on the grounds of higher culpability, and a continuing risk due to the reduced prospects of therapeutic success. In the Court's reasoning, such factors make desirable, if indeed not necessary, any ultimate discharge through the Parole Board and not the First-tier Tribunal (Mental Health). Perhaps ironically, in one of the few post *Vowles* cases, that of *Turner*, the Court was prepared to quash an IPP sentence and replace it with a s.37/41 order on the basis that the offender had already spent the equivalent of a 17 year determinate term in confinement, where the original court viewed her offences as meriting a 3 year determinate term.[35] Whatever culpability had been present, had thus already been richly rewarded.

Two cases are telling in the Court's general approach to assessing residual culpability in the mentally ill. First *Cooper*.[36] *Cooper* pleaded guilty to diminished responsibility manslaughter and attempted murder. The two offenses were separated by a brief car drive, and it was accepted that the offences would not have occurred but for his acute psychotic state. The court distinguished between the first offence where his responsibility was held to be significantly diminished, and the second, which was cast more as an act of revenge for which he retained significant culpability. The time gap was deemed significant in a way it was seemingly not in *Clarence*. The court also gave some weight to the fact that his illness may have been brought about by a much earlier usage of illegal drugs (for which he was held responsible) and from which he may have been suffering from the effects of withdrawal. *Cooper* was given two IPPs and a s.45A order.

Second *Fox*[37]. *Fox* was found guilty of kidnapping and grievous bodily harm with intent in the context of an acute psychotic breakdown. Five psychiatric opinions agreed his culpability was very low as the disorder caused the offences. But the court rested culpability on issues such as the formation of his intention to cause grievous bodily harm, his choice to take alcohol before the offences, taking deliberate measures to effect his escape, and being able to drive. For both of the latter the psychiatric evidence was that this was consistent with being in the grip of psychosis. Perhaps most curiously, the court also cited *Fox's* failure to resist his command hallucinations: choosing not to follow his 'good voices' implied the capacity to choose. Finally, they engaged in some 'reverse reasoning', implying the trial judge must have thought *Fox* bore a significant degree of responsibility because a s.45A order was made, together with an IPP.

In both of these cases the Court of Appeal supported the trial judges in favouring traditional methods of assessing culpability: and rejected psychiatric opinions favouring s.37/41 disposals. Thus, any element of drug or alcohol abuse or elements of pre-meditation, planning, or attempts to cover-up the offence or escape the scene all contribute to a view that partial culpability exists. Partial culpability pre *Vowles* could result in a s.45A disposal. Post *Vowles* it looks more likely to favour a prison disposal.

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[35] *Turner* [2015] above at paras 50-51.
[36] *Cooper* [2010] EWCA Crim 2335.
[37] *Fox* [2011] EWCA Crim 3299.

Assessing culpability: the challenges

Sentencing convicted ordered offenders under the Criminal Justice Act 2003 and the Sentencing Council Guidelines is governed primarily by an assessment of the seriousness of the offence, which in turn rests on the harm caused or intended by the offender, together with his or her culpability.[38] Culpability in ordered offenders is based on a number of different factors, some of which are offence specific, and some are more generally applicable. Planning, premeditation, the targeting of vulnerable groups and previous convictions all commonly feature. Mental illness or disability in convicted offenders formally indicates significantly lower culpability.[39] However, the Sentencing Guidelines are not specific about the extent of this reduction in culpability or how it is to be assessed in specific offenders, albeit the latest Theft Guideline does make clear that a medical condition can make a community order a proper alternative to a moderate custodial sentence.[40] The Australian case of *Verdins* also gives helpful indications of why punishment should be reduced; assessing by how much is the more difficult task.[41] How, when considering the use of s.45A, are judges to fix the punitive part of the sentence? Should it simply be done by reference to the conventional culpability factors, with a discount applied? But this would imply that an offender's mental disorder is somehow divisible from his or her otherwise ordered behaviour. This is a trap that the Court of Appeal has already once had to avoid in *Brennan*[42] but is it one that will now also regularly occur in the s.45A cases? *Cooper* and *Fox* above illustrate just how difficult some of these issues are once psychiatric evidence (which is not always so conveniently uncontradicted as it was in *Brennan*) arises. And post *Vowles*, as in the case of *Graciano*, the Court may find itself concluding that culpability could not have been wholly extinguished because the defendant did not seek a verdict of not guilty by reason of insanity, had pled guilty to diminished responsibility and had 'retained some significant elements of rationality'.[43] In rejecting the views of three psychiatrists, who all recommended that *Graciano* be subject to a s.37/41 order, the Court upheld the IPP with a s.45A order asserting that in so doing it was reflecting the guidance in *Vowles*.[44]

Clearly, some psychiatric reasoning runs counter to the intuitive assessments of culpability that sentencing judges have developed over years of sentencing ordered offenders. Yet as Freckelton and List have noted, with respect to defendants with Asperger's, these cases are not easy for lay assessors.[45] Not only are threshold issues of diagnosis instantly less

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[38] See Sentencing Council Guidelines *Overarching Principles: Seriousness* 2004 at para 1.15.

[39] Ibid at para 1.25.

[40] Sentencing Council Guidelines *Theft Offences Definitive Guideline* 2015 at page 6.

[41] *Verdins* (2007) 16 VR 269, Court of Appeal, Supreme Court of Victoria.

[42] See above.

[43] *Graciano* [2015] above at paras 20-21.

[44] At para 23.

[45] I. Freckelton and D. List 'Asperger's Disorder, Criminal Responsibility and Criminal Culpability' (2009) Psychiatry, Psychology and Law 16, 1, 16-40.

compatible with a legal approach, making culpability assessments difficult in those with mental disorder, but also because judges and juries can be misled without counter-intuitive guidance 'about the risks of drawing over ready (and inaccurate) inferences from the unusual manner of interviewees with Asperger's disorders.' For those with longer memories, these arguments are redolent of those which took place around the *Confait Inquiry*: arguments on suggestibility and the risk of false confessions by vulnerable interviewees were only put to rest by the sterling work of, amongst others, Gudjonsson.[46]

Freckleton and List identify as the most difficult challenge for the courts that of moving 'from the general to the specific – to isolate means of evaluating whether and to what extent the potential identified .....has been realised in the particular case and operated in a real sense upon the relevant conduct of the person'.[47] This, they argue, is a task for which the courts will require assistance from mental health professionals.

Where this relates to the issue of conviction, it is aproblematic for such professionals. But where it relates to sentence/disposal, it is ethically more problematic. And the risk for the mental health professionals is that a report prepared for one purpose may colour the conclusions of the court on another. As Commane has eloquently pointed out, observations made by clinicians in their reports for trial can be reproduced by the judge in reasoned decisions on sentence.[48]

The difficulties of assessing culpability, and the prior question of responsibility, in those with mental disorder are widely evidenced beyond this jurisdiction. Psychiatric commentary on the *Breivik* case in Norway acknowledges not only the conflicting psychiatric assessments over time, but also the court's reliance on a series of (non-psychiatric) common-sense alternative explanations for *Breivik's* statements and behaviours. As Melle judiciously observes 'The evaluation of what went on in a person's

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[46] *Report of an Inquiry by the Hon. Sir Henry Fisher into the circumstances leading to the trial of three persons on charges arising out of the death of Maxwell Confait and the fire at 27 Doggett Road, London, SE6*. 12th December 1977, HMSO, London; available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228759/0090.pdf ; and G. Gudjonsson *The Psychology of Interrogations and Confessions: A Handbook* (2003) John Wiley and Sons, Chichester.

[47] Freckelton and List at page 36.

[48] C. Commane 'Criminal Responsibility and Personality Disorder' (2015) Paper presented to the 3rd UK Conference on Philosophy and Psychiatry, Royal College of Psychiatrists, London 24th September 2015. Commane cites the example of the *Dennehy* case. *Dennehy* received a whole life order for her multiple offences of the utmost gravity; the judge was clear that her personality disorders/psychiatric condition, on which there was psychiatric evidence, afforded no mitigation. Yet the judge (at p.17) in rejecting her protestations of remorse with respect to the attempted murder convictions, cited what she had said to the psychiatrist pre-conviction: see https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Judgments/the-queen-v-dennehy-sentencing-remarks-28022014.pdf

mind while committing a crime will, despite technical innovations, in the end continue to rely on personal evaluations and interpretations'.[49]

Conclusions

The attractions to the courts of s.45A orders should be obvious: superficially, they offer a therapy-based response to offenders with evident need but combine this with both punishment for residual culpability and the possibility of an indefinite incapacitative sentence where offenders pose the highest risk. They also ensure that release is via the more trusted Parole Board and recall can be achieved on the basis of the risk of future criminality and not only on the basis of a deterioration in the offender's mental health. As such, they enable the courts to duck the hard issue of dividing offenders into those who are ill and require treatment and those who ill but require punishment. And provide a vehicle for managing perceived future risk. But these orders, given that they may, post *Vowles*, draw from the s.37/41 population and not from the prison population, run counter to the House of Lords cautionary words in *Drew.* S.45A cases now have the potential to dominate the sentencing of all mentally disordered offenders thought in need of some element of hospital disposal since any element of culpability will seemingly suffice. Even those offenders whose offending is 'wholly accounted for' by their disorders are eligible for the s.45A disposal as a first choice.

From the perspective of psychiatrists the orders enhance their ethically problematic position of when advising the courts. They also potentially send to treating clinicians a group of offenders who may be more treatment resistant because of the prospect of a transfer to a prison environment should effective progress in therapy occur. Indeed, the hybrid order may sustain a fear of transfer to prison which may in itself be damaging. Ultimately, in the eyes of psychiatrists, s.45A orders can result in the less effective post-release supervision which they believe follows on from release from prison.[50]

Whilst the courts have long experience in assessing the culpability of mentally ordered offenders, it is unclear how these approaches apply to mentally disordered offenders. The existing restraints on the use of punishment are vulnerable to the emotive issues identified by anxious desert theorists; therapy risks, in these circumstances, having a punitive edge. Judgments under uncertainty, as most if not all of these decisions about s.45A entail, are notoriously problematic[51] and perhaps acutely so in these decisions about mentally disordered offenders where perceptions of risk are pervasive and outcomes necessarily long-coming.[52]

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[49] I. Melle 'The Breivik case and what psychiatrists can learn from it' (2013) World Psychiatry 12, 16-21.

[50] See, for example, *Turner* [2015] at paras 41-42 and 52.

[51] D. Kahneman *Thinking, Fast and Slow.* (2012) Penguin, London; A. Tversky and D. Kahneman 'Judgment under Uncertainty: Heuristics and Biases' (1974) Science, New Series, 185, 4157: 1124-1131.

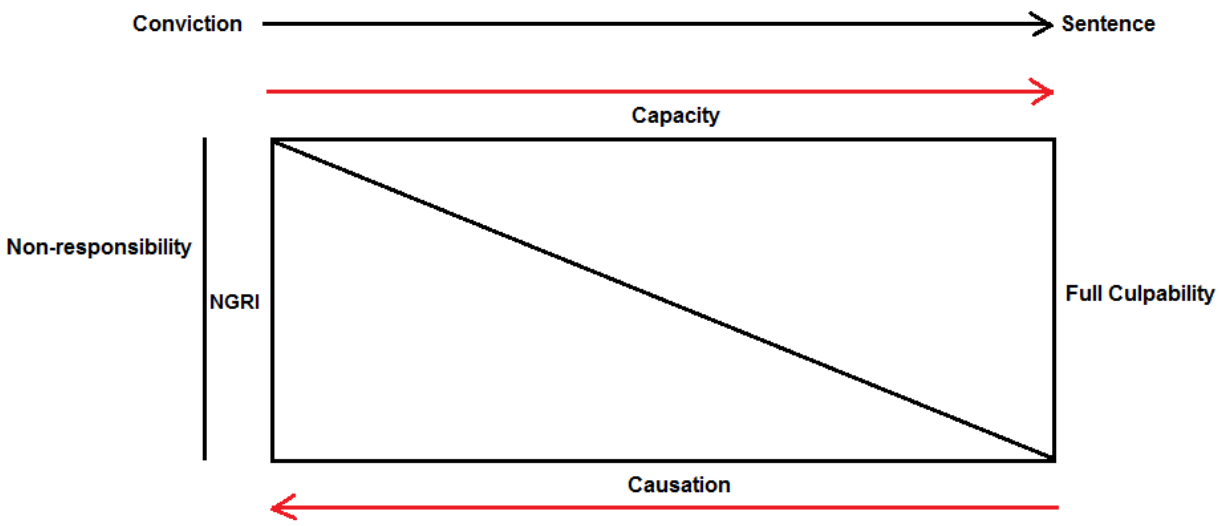
[52] See Peay 2015 above.

The assessment of culpability in the context of mental disorder is rudimentary. The courts seem to have been applying traditional approaches but it is not clear how valid these are in the context of acute mental disorder. Psychiatrists give expert opinion on the relationship between mental disorder and seemingly purposeful activity, but this isn't always heeded by the courts. In the area of diminished responsibility the Court of Appeal has been clear that psychiatric evidence cannot rationally be rejected on the basis of tenuous 'lay' opinion or common-sense understandings. But with respect to sentence and disposal psychiatrists are in a more difficult position.[53] It may be that psychiatrists want this position to remain ambivalent, to avoid becoming involved in ethically problematic decisions about punishment, but in retreating they risk having imposed on them offender-patients under legal provisions they may regard as both anti-therapeutic and unnecessarily dangerous to the public in the long term, where therapeutic release is trumped by Parole Board release.

Finally, it is arguable on the basis of the analysis of the s.45A cases that clinicians and lawyers may be using different language to get at similar phenomena. Thus, capacity and causation are counterpoised. Perhaps this is merely the traditional tension between free will and determinism. However, it is ironic that psychiatric dominance will occur where clinicians may feel least comfortable on empirical grounds (namely, that the illness wholly accounted for the behaviour and the causative link was high); and lawyers work with concepts that require high capacity for culpability to be attributed, such as planning and motivation. But capacity may be a concept with which they in turn feel less comfortable; and it is one that is more clearly associated with psychiatric modes of discourse. Hence, neither side rests on firm ground.

Figure 1. The Capacity- Causality Nexus

[53] Ironically, psychiatrists may be better positioned to advise on the possibilities relating to disposal, than to the certainties required for conviction: see A. Buchanan and H. Zonana 'Mental disorder as the cause of a crime' (2009) International Journal of Law and Psychiatry 32: 142-146.


Conviction
Sentence
Capacity
Non-responsibility
NGRI
Full Culpability
Causation