

Unfitness to Plead, Insanity and the Law Commission: Do We Need a Diagnostic Threshold?

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Abstract

This article examines one aspect of the new test of effective participation at trial proposed by the Law Commission of England and Wales. This proposal aims to replace the current criteria for fitness to plead originating from *Pritchard* and developed more recently in *M (John)*. Specifically, this article offers a critical examination of the Commission's refusal to incorporate a so-called 'diagnostic threshold' within their proposed test. After reviewing the arguments for and against this decision, attention is drawn to the clear presence of diagnostic thresholds within other areas of law, such as the mental condition defence of insanity. Overall, the Commission's proposals are a vast improvement upon the archaic rules of present day, and, contrary to the views of some scholars, their decision to omit a diagnostic criterion is no exception to this. In fact, the implications of this decision reach far beyond the particular context of unfitness proceedings and ultimately cast doubt on the significance of diagnostic thresholds in all areas of law. By focusing exclusively on the relationship between unfitness to plead and the defence of insanity, this piece demonstrates how both tests can be reformulated so as to avoid any explicit reference to a diagnostic criterion.

Keywords

Unfitness to plead, capacity, insanity, diagnostic threshold

Introduction

The law relating to unfitness to plead should exempt an individual from a criminal trial, either permanently or temporarily, when he is considered incapable of comprehending and meaningfully participating in court proceedings.¹ Some may disagree with this statement by arguing that, irrespective of a

1. A Loughnan, *Manifest Madness: Mental Incapacity in the Criminal Law* (OUP, Oxford 2012) 67.

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defendant's fitness, a trial should always proceed as normal. For instance, advocates for victims may cite the necessity of 'closure' and the importance of the victim's voice being heard.² Nevertheless, it is submitted that the initial position—that the law should exempt an unfit defendant from a criminal trial—is to be preferred. This is because the notion of proceeding with a trial regardless of a defendant's fitness would be an abuse not only of their individual rights but also of the rule of law.³ As Brown opines, '[i]f a defendant cannot properly defend themselves, it could lead to inaccurate or unjust verdicts and, at worst, imprisonment for an offence which they did not commit'.⁴ In the end, the purpose of fitness-to-plead laws is twofold: to balance the rights of vulnerable defendants with the need to protect the public and to balance natural justice with the desire to see justice served.⁵

In 2016, the Law Commission of England and Wales published their final report concerning their recommendations arising from a six-year consultation into fitness to plead.⁶ The Commission propose that the current common law criteria for determining an accused's fitness should be replaced with a new statutory test aimed at establishing whether the defendant lacked the 'capacity to participate effectively' with the trial process.⁷ This article offers a critical examination of one element that is noticeably missing from the Commission's proposed test; specifically, a 'diagnostic threshold'. In other words, the Commission were not in favour of requiring a link between the lack of capacity and, for example, a recognised medical condition—preferring instead to prioritise the lack of capacity *itself* as the sole determinative factor.⁸

The Commission's refusal to explicitly incorporate such a threshold is consistent with the current law on unfitness, as governed by the case of *Pritchard*.⁹ However, their decision continues to render this area anomalous in comparison to related sectors of law, such as the mental condition defences,¹⁰ and the civil law criteria of decision-making capacity encompassed within the Mental Capacity Act (MCA).¹¹ After initially presenting the arguments in favour of including a diagnostic threshold within the fitness-to-plead framework, the article dedicates significantly more attention in the latter half to critically reviewing the persuasiveness of the preceding submissions. Ultimately, it is proposed that the Commission were correct to exclude such a requirement. It is conceded that this conclusion has important implications for the aforementioned areas of law, since, if it is preferable for unfitness to exclude a diagnostic requirement, then why should insanity, the MCA or diminished responsibility be drafted any differently? By focusing exclusively on the relationship between unfitness to plead and the defence of insanity, this article demonstrates how both areas can be reformulated so as to exclude any explicit reference to a diagnostic criterion.¹²

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2. N Padfield, "'Prosecuting' Those Who Are Unfit to be Prosecuted?" [2016] Crim LR 227 at 227.
 3. RA Duff, *Trials and Punishments* (CUP, Cambridge 1991) 174.
 4. P Brown, 'Unfitness to Plead in England and Wales: Historical Development and Contemporary Dilemmas' (2019) 59 *Med Sci Law* 187, 187.
 5. *Ibid.*
 6. Law Commission, 'Unfitness to Plead, Vol 1: Report' (Law Com No 364, London 2016).
 7. Law Commission, 'Unfitness to Plead, Vol 2: Draft Legislation' (Law Com No 364, London 2016) at cl 1.
 8. Law Commission (n 6) at para 3.127.
 9. *R v Pritchard* (1836) 7 C & P 303.
 10. That is, the defences of insanity and diminished responsibility (see below).
 11. Section 2(1) of the Mental Capacity Act 2005.
 12. Note that this article will not discuss the compatibility of fitness-to-plead laws with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). This is because most contemporary writers perceive fitness-to-plead laws, in any form, as incompatible with a strict reading of the UNCRPD treaty, ie because defendants deemed unfit are denied legal capacity on an equal basis with others, contrary to art 12. Consequently, the mere addition or exclusion of a diagnostic threshold would not resolve the underlying crux of the problem. For an excellent discussion, see T Minkowitz, 'Rethinking Criminal Responsibility from a Critical Disability Perspective: The Abolition of Insanity/Incapacity Acquittals, Unfitness to Plead, and Beyond' (2014) 23 *GLR* 434.

The Current Law and the Commission's Proposed Alternative

Originating from *Pritchard*¹³ and developed more recently in *M (John)*,¹⁴ an accused will currently be found unfit to plead if he presents an inability in one of six ways:

1. understanding the charges;
2. deciding whether to plead guilty or not;
3. exercising his right to challenge jurors;
4. instructing solicitors and counsel;
5. following the course of proceedings;
6. giving evidence in his own defence.¹⁵

Evidently, this test addresses *cognitive* criteria, inquiring whether the accused has a basic understanding of the trial process.¹⁶ This disproportionate emphasis on cognitive abilities was the primary focal point of concern for the Law Commission, who commented that the test only covers 'extreme cases of a particular type (usually bearing on cognitive deficiency)',¹⁷ and fails to sufficiently address an accused's capacity for *rational decision-making*.¹⁸ Thus, so long as a defendant has the intellectual ability to comprehend the basics of a trial process, he is unlikely to be found unfit under the *M (John)* criteria.¹⁹ Concerningly, this may fail to capture the defendant who is suffering from a delusional disorder that impacts upon his capacity to make rational decisions which are in his own best interests.²⁰ The latest alternative proposed by the Law Commission is a combination of decision-making capacity and the current *M (John)* criteria:

A defendant is to be regarded as lacking the capacity to participate effectively in a trial if the defendant's relevant abilities are not, taken together, sufficient to enable the defendant to participate effectively in the proceedings on the offence or offences charged.²¹

The Draft Bill further provides a non-exhaustive list of abilities relevant to the assessment of capacity.²² If implemented, the proposed test is likely to lower the threshold for unfitness,²³ and it is estimated that the number of defendants found unfit to plead will double as a result.²⁴ Undoubtedly, these recommendations have been broadly welcomed as a vast improvement upon the archaic rules of present day.²⁵ Interestingly, however, the Commission did not propose that any changes be made to the lack of a diagnostic threshold within the current *Pritchard/M (John)* criteria. Rather, they were 'squarely of the view'²⁶ that a reformed test of unfitness should continue to conform to the current law in this respect. As will be discussed, such a view is not without its supporters,²⁷ nor its critics.²⁸ The following sections will

13. *Pritchard* (n 9).

14. *R v M (John)* [2003] EWCA Crim 3452.

15. *Ibid* at [20].

16. D Grubin, *Fitness to Plead in England and Wales* (Psychology Press, London 1996) 32.

17. Law Commission, 'Unfitness to Plead: Consultation Paper' (Law Com No 197, 2010) at para 2.47.

18. Law Commission, 'Unfitness to Plead: An Issues Paper' (2014) at para 2.23.

19. H Howard, 'Unfitness to Plead and the Vulnerable Defendant: An Examination of the Law Commission's Proposals for a New Capacity Test' (2011) 75 JCL 194, 197.

20. *R v Moyle* [2008] EWCA Crim 3059; *R v Erskine* [2009] EWCA Crim 1425.

21. Law Commission (n 7) at cl 3(2).

22. *Ibid* at cl 3(4).

23. P Brown, 'Modernising Fitness to Plead' (2019) 59 Med Sci Law 131, 132.

24. Law Commission, 'Unfitness to Plead: Report, Appendix B: Impact Assessment' (2016) at para 203.

25. RA Duff, 'Responsibility and Reciprocity' (2018) 21 *Ethical Theory and Moral Pract* 775, 787.

26. Law Commission (n 6) at para 3.127.

27. A Loughnan, 'Between Fairness and "Dangerousness": Reforming the Law on Unfitness to Plead' [2016] Crim LR 451, 459.

28. H Howard, 'Lack of Capacity: Reforming the Law on Unfitness to Plead' (2016) 80 JCL 428, 434.

critically examine the arguments for and against the inclusion of a diagnostic threshold within the fitness-to-plead framework, before turning to address the author's own deductions on the matter.

Arguments in Favour of a Diagnostic Threshold

There are compelling practical reasons for why a reframed test of unfitness should include a diagnostic threshold, ie a requirement that the defendant be found to have a diagnosis of disorder, or some other qualifying condition, before he can be said to lack the capacity for effective participation.²⁹ For instance, when referring to one of the Commission's earlier proposals which similarly omitted such a criterion, Howard questions whether this provision may permit an individual claiming 'stress, crippling shyness, overwhelming tiredness, nervousness, or poor social background to escape a full trial?'³⁰ It is interesting to note that Howard's concerns regarding the potential breadth of an unfitness test are not novel. Indeed, similar views were expressed by the late-Victorian prison doctor, Hamblin Smith, who asked:

How many prisoners are capable of making what may reasonably be called a 'proper defence', or of giving proper instructions for their defence? But surely it is clear that mere ignorance, or lack of education, or ordinary stupidity, should not be enough to justify a verdict of unfitness to plead.³¹

The crux of the preceding statements is the desire to place appropriate parameters on findings of unfitness/lack of capacity.³² Accordingly, a qualifying diagnosis may help to ensure that such a test is not impracticably wide.

In a similar vein, it can be said that the presence of a diagnostic threshold may add objectivity to the fitness criteria. For instance, a finding that a defendant suffers from paranoid psychosis at the time of the trial may add objectivity, and thus *reliability*, to the conclusion that he lacks the capacity to meaningfully participate in court proceedings.³³ As Morse opines, '[o]ne could jettison the mental disorder criterion in mental health laws, but the presence of a mental disorder allegedly provides an "objective marker" which shows that the person genuinely lacks the required rational capacity'.³⁴ In this sense, mental/physical disorder may not so much add another *requirement* as add *objectivity* to the other criteria. Evidently, adding reliability to capacity-based assessments is also heavily intertwined with the desire to prevent malingerers from being erroneously deemed unfit to plead.³⁵ The validity of the preceding concerns will be examined in the subsequent part of this article. For present purposes, alternative reasons have been suggested for why the law should insist on a medical condition as a prerequisite for unfitness; reasons which have less to do with maintaining practicality and ensuring public protection and are more aligned with safeguarding an individual's right to legal capacity.

Ever since the passing of the Human Rights Act 1998, the need to safeguard individual rights gained prominence. In particular, ensuring the right to a fair trial under art 6 of the ECHR inevitably resulted in scrutinisation of the fitness-to-plead framework.³⁶ Anticipating these issues, the starting point of the Law Commission's recommendations is that a normal trial should proceed wherever possible and that removing a defendant from that process should be an option of 'last resort'.³⁷ Two avenues by which the Commission intend to facilitate a conventional trial is through maintaining the presumption of capacity,

29. Law Commission (n 6) at para 3.122.

30. Howard (n 19) at 202.

31. HM Smith, 'Unfitness to Plead in Criminal Trials' (1916) 62 *J Men Sci* 763, 768.

32. Law Commission (n 6) at para 3.123.

33. G Meynen, *Legal Insanity: Explorations in Psychiatry, Law and Ethics* (Springer, New York 2016) 97.

34. SJ Morse, 'Mental Disorder and Criminal Law' (2011) 101 *J Crim L & Criminology* 885, 895–96.

35. Law Commission (n 6) at para 3.126 (quoting Dr Andrew Bickle).

36. T Exworthy, 'Commentary: UK Perspective on Competency to Stand Trial' (2006) 34 *J Am Acad Psychiatry and Law Online* 466, 469.

37. Law Commission (n 6) at para 1.12.

ie that a defendant is presumed to be fit to plead until the contrary is proven,³⁸ and by expanding the availability of ‘special measures’, which potentially allow an otherwise unfit defendant to exercise their legal capacity in a normal and fair trial.³⁹ Nonetheless, the Commission concede that ‘there will be a small group of defendants who will be unable to participate effectively in a trial, no matter the level of support provided to them’.⁴⁰ A defendant’s right to a fair trial may be breached if the current law is unable to accurately distinguish those who can participate meaningfully in a trial from those who cannot. This may occur when a defendant who is unfit to plead is erroneously deemed fit to plead. But it may *also* occur when a defendant who is truly *fit* to plead is deemed unfit to plead. This could inevitably lead to a situation in which an accused is erroneously treated *as if* they lack the capacity for effective participation. Accordingly, depriving a defendant of the most fundamental right to stand trial is a decision which ought to be robustly defensible.

The discussion above shares much similarities with Howard’s most recent position on the suitability of a diagnostic threshold for fitness-to-plead laws. Howard refers to the theoretical concept of ‘moral agency’,⁴¹ which she argues ‘should be present not only at the time of committing the act, but also at the time of standing trial’. According to the leading theory of culpability—known as choice (or capacity) theory—only a defendant who possesses the capacity and a fair opportunity to make choices is able to be tried and held accountable for his actions.⁴² Lacking capacity is certainly one way in which a vulnerable defendant may cease to be a moral agent. More specifically, Howard asserts that we must be ‘sure of our reasons’ before depriving an individual of this agency, especially since the accused will be deprived of his fundamental right to a fair trial.⁴³ She proposes that requiring a link between the lack of capacity and a recognised medical condition would provide ‘support for those reasons’,⁴⁴ thereby ensuring that the law enables a defendant to exercise their legal autonomy in all but the most justified of cases.

Seemingly influenced by the previous concerns, the test for unfitness to plead currently adopted in Scotland requires the defendant to be incapable, by ‘reason of a mental or physical condition’, of participating effectively in a trial.⁴⁵ Virtually identical provisions have also been incorporated into the jurisdictions of Jersey,⁴⁶ Canada⁴⁷ and New Zealand.⁴⁸ Consequently, within these jurisdictions, incapacities in themselves do not constitute incompetence to stand trial; these incapacities *must be the result* of a mental/physical impairment.

Finally, as alluded to above, it may be added that the presence of a diagnostic threshold would promote consistency, and thus greater certainty, throughout both civil and criminal law. In civil law, the MCA, which deals with a person’s decision-making ability, requires an impairment of, or a disturbance in the functioning of, the mind or brain.⁴⁹ This defect must result in an inability to understand, retain, use or weigh information relevant to a decision, or to communicate a choice,⁵⁰ for that person to lack capacity. Once again, incapacities *in themselves* do not constitute incompetence; they must *result* from a defect in the mind/brain. In the criminal law context, the same is true for the mental condition defences of insanity and diminished responsibility. The defence of insanity, for instance, requires a

38. *Ibid* at para 4.3.

39. *Ibid* at para 1.25.

40. *Ibid* at para 1.12.

41. Howard (n 28) at 433.

42. HLA Hart, *Punishment and Responsibility: Essays in the Philosophy of Law* (OUP, Oxford 1968) 152.

43. Howard (n 28) at 433.

44. *Ibid*.

45. Section 53F of the Criminal Procedure (Scotland) Act 1995, as amended by s 170(1) of the Criminal Justice and Licensing (Scotland) Act 2010.

46. *R v O’Driscoll* [2003] JRC 117 at [29].

47. Section 2 of the Criminal Code of Canada 1985.

48. Section 4 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

49. Section 2(1) of the Mental Capacity Act 2005.

50. *Ibid* at s 3(1).

defendant to suffer from a ‘disease of the mind’ which caused him not to know the nature and quality of the act or that it was legally wrong.⁵¹ Interestingly, when the Commission proposed reform recommendations for the defence of insanity in 2013, they chose to *retain* a diagnostic threshold.⁵² To satisfy their new defence, the party seeking to raise it must establish that the defendant wholly lacked the capacity to:

- i. rationally form a judgment about the relevant conduct or circumstances;
- ii. understand the wrongfulness of what he or she is charged with having done; or
- iii. control his or her physical acts in relation to the relevant conduct or circumstances

*as a result of a qualifying recognised medical condition.*⁵³

As such, while the Commission have clearly altered the criteria within the defence, they have retained the requirement of a diagnostic component—merely substituting ‘disease of the mind’ for ‘a qualifying recognised medical condition’. Howard logically purports that if a diagnostic threshold is contained within other areas of law—such as insanity—then ‘compelling reasons should exist’ for why it should *not* be required for unfitness.⁵⁴ Alternatively, however, it can equally be suggested that neither unfitness *nor* insanity should require such a threshold. The remainder of this article intends to address this latter proposal by drawing upon the work of scholars who have criticised the diagnostic criterion. It will become clear that the vast majority of critiques can be applied across both contexts. Thus, an argument opposing a threshold for the insanity defence is also an argument against a threshold for unfitness—and vice versa.

Arguments Against the Inclusion of a Diagnostic Threshold

Primarily, the Commission have omitted a diagnostic criterion from their test of unfitness in order to ensure the test is broad enough to encompass all potential reasons for participation difficulties.⁵⁵ In other words, because there are a myriad of ways in which a defendant could lack the capacity for effective participation, it may be difficult to draft a diagnostic threshold that could easily account for *all* of them.⁵⁶ In turn, some defendants may be unfairly deemed as fit to plead simply because their particular condition escapes definition. Furthermore, the Commission commented that, ‘we doubt whether imposing a diagnostic threshold would be likely to assist in maintaining the threshold of unfitness at a suitable level’.⁵⁷ Thus, if a diagnostic threshold *were* capable of a suitable definition (ie it were so widely drawn as to encompass all possible barriers to participation),⁵⁸ it would ultimately make no difference to the test.⁵⁹

In order to further substantiate the reasoning of the Commission, it is worth examining the work of scholars who have comparably advanced the removal of diagnostic-based criteria from the mental condition defence of insanity. Within this context, the philosophers Matthews⁶⁰ and Vincent⁶¹ have both notably proposed an incapacity-based, rather than a mental disorder-based, approach to criminal responsibility. According to these writers, it is morally irrelevant whether certain incapacities were

51. *M’Naghten Rules* (1843) 10 Cl & Fin 200.

52. Law Commission, ‘Criminal Liability: Insanity and Automatism: Discussion Paper’ (2013) at para 3.1.

53. *Ibid* at para 4.160.

54. Howard (n 28) at 432.

55. Law Commission (n 6) at para 3.127(1).

56. *Ibid* at para 3.124.

57. Law Commission (n 17) at para 2.40.

58. L Series, ‘Article 12 CRPD: Equal Recognition Before the Law’ in I Bantekas, MA Stein and D Anastasiou (eds), *The UN Convention on the Rights of Persons with Disabilities: A Commentary* (OUP, Oxford 2018) 361.

59. Howard (n 28) at 432.

60. S Matthews, ‘Failed Agency and the Insanity Defence’ (2004) 27 *Int’l JL & Psychiatry* 413.

61. NA Vincent, ‘Responsibility, Dysfunction and Capacity’ (2008) 1 *Neuroethics* 199.

brought about by mental disorder, or by any other condition. Therefore, the reference to ‘disease of the mind’ in the *M’Naghten* Rules, or to a ‘recognised medical condition’ within the Law Commission’s proposals, should be omitted. If such references are removed, the term ‘insanity’ would no longer be an appropriate label. Instead, the relevant defence would simply be one of incapacity.⁶²

Matthews initiates his argument with a straightforward thought experiment. Suppose a very young child, Ben, is playing on a freeway overpass and ‘gleefully throws rocks over a wall and into the path of oncoming traffic. A fist-sized rock smashes through the windscreen of a vehicle and seriously injures the occupant’.⁶³ Ben will, of course, not be blamed. But why? The simple reply is that Ben is not responsible because he is only a child; but Matthews is dissatisfied with this response. In essence, he argues that there is a deeper reason for not holding Ben—and young children in general—responsible for their conduct. For Matthews, the rationale behind exculpation is that they lack the *capacities* required for being held a morally responsible agent.⁶⁴ This ties in well with Howard’s assertions regarding the importance of moral agency to trial and responsibility.⁶⁵ The same is true for cases of insanity: moral responsibility is withheld because of the lack of relevant capacities on the part of the defendant.⁶⁶ Taking the example of the Commission’s newly proposed test for insanity, if a defendant lacks the capacity to form a rational judgment, to understand the wrongfulness of his actions, or to control his behaviour, then surely the lack of capacity *itself* should be sufficient to negate responsibility. It is compelling to question just why we really need to know that such an incapacity *resulted* from a mental disorder.

Along the same lines, Vincent argues that mental disorder is ‘neither necessary nor sufficient for reduced responsibility’.⁶⁷ First, by comparably referring to children, she states: ‘[t]hat disorder is not *necessary* for reduced responsibility is plain when we consider young children—a group whose responsibility is negated despite the absence of a clinically recognised disorder’.⁶⁸ Furthermore, Vincent argues, mental disorder is not *sufficient* for reduced responsibility either. This is because the mere existence of a mental disorder is not sufficient to exculpate a defendant under current insanity standards. Rather, they all additionally require the influence of the disorder on the defendant or the relevant act, such as causing one to not know that the act was wrong.⁶⁹ This is understandable. After all, an insanity test which *merely* required the presence of a mental disorder (such as psychosis) would be open to the challenge that it suggests psychotic people are generally not responsible for their actions and may also contribute to stigma of those who suffer from this disorder. In brief, tests for legal insanity are virtually never phrased so as to exempt individuals from responsibility *solely* because they are mentally ill.⁷⁰ As such, Vincent succinctly concludes by declaring that ‘capacity and *not* disorder is what determines responsibility’.⁷¹

Evidently, an explicit diagnostic criterion—whether for unfitness or insanity—would be otiose if defendants who lack the requisite capacity will *always* suffer from a diagnosable medical condition.⁷² There is certainly room for argument about this. After all, an incapacity is a ‘condition’ and could be argued to be a medical condition in the sense that it is the *kind* of condition in which doctors (whether

62. Meynen (n 33) at 95.

63. Matthews (n 60) at 413.

64. *Ibid* at 415.

65. Howard (n 28) at 433.

66. Matthews (n 60) at 414.

67. Vincent (n 61) at 202.

68. *Ibid* at 203.

69. *M’Naghten* (n 51).

70. The only exception to this general principle is Norway. Section 44 of the Norwegian General Civil Penal Code 2008 merely states that, ‘[a] person who was psychotic or unconscious at the time of committing the act shall not be liable to a penalty’. Thus, in Norway, the disorder itself suffices.

71. Vincent (n 61) at 208.

72. G Meynen, ‘Should the Insanity Defence be Replaced by an Incapacity Defence?’ in KTI Oei and MS Groenhuijsen (eds), *Progression in Forensic Psychiatry: About Boundaries* (Wolters Kluwer, Amsterdam 2012) 165.

physical or psychiatric) have a clear interest: being incapacitated, in a way that undermines the ability to lead an ordinary or normal life, *is* a way of lacking health—of being ill, disordered or deficient. Theoretically speaking, however, it is perhaps possible that a defendant may satisfy the latter half of the test (lacking capacity) and fail the former (having a relevant mental/physical disorder).⁷³ This is the view of the Commission within their discussion paper on insanity. They argue that a diagnostic threshold is *not* superfluous; indeed, they contemplated cases in which a defendant wholly lacks one of the three capacities relevant to their recommended test, but the defence fails because the incapacity cannot be attributed to a ‘qualifying recognised medical condition’.⁷⁴ For instance, the Commission opine that ‘any condition which is manifested solely or principally by abnormally aggressive or seriously irresponsible behaviour’ should not count as a ‘qualifying’ recognised medical condition. The concern here is with antisocial personality disorders, in particular, psychopathy. Those who believe that psychopathy can (or *should*) exempt an accused from criminal liability typically argue their case on the grounds that such a condition may substantially diminish or even destroy a relevant rational capacity.⁷⁵ This author does not intend to enter the discussion here, merely to point out the opinions of others who have argued in favour of this view of the disorder. To summarise, it is difficult to see what could possibly justify the conviction of a person who utterly lacked the capacity to conform his conduct to the requirements of law; precisely *how* this incapacity originated should be irrelevant.⁷⁶

Furthermore, even if, in practice, defendants who lack the relevant capacities will *always* suffer from a recognised medical disorder, this does not necessarily mean that the legal test could not simply be phrased in terms of the detrimental *effects* of these disorders, ie incapacities.⁷⁷ Matthews helpfully demonstrates how an insanity standard can be rephrased in such terms by using the Australian legal context—the Commonwealth Criminal Code Bill⁷⁸—as an example:

A person is not criminally responsible for an offence if, at the time he or she carried out the conduct constituting the offence, he or she *failed the test of responsible agency*. This test is failed if any one of the following three conditions is satisfied: (a) the person lacked the capacity to understand the nature of what he/she was doing; (b) the person lacked the capacity to understand that what he/she was doing was wrong; or (c) the person lacked the capacity to control his/her conduct.⁷⁹

In essence, Matthews has replaced the criterion of ‘a mental impairment’ with that of ‘failed the test of responsible agency’, which is understood in terms of three incapacities. As we shall see, there is no reason why a similar revision could not also take place within the *M’Naghten* Rules, or the Commission’s newly proposed ‘recognised medical condition’ defence.

A Critical Review of the Arguments in Favour

Nonetheless, these more conceptually oriented arguments may still fail to sufficiently outweigh the compelling practical concerns which are commonly advanced by those in favour of diagnostic criteria. The principal argument of these proponents is that such a threshold adds, in the words of Morse, an ‘objective marker’⁸⁰ to the conclusion that the defendant lacks capacity. Howard, in a similar vein, stated

73. *Ibid.*

74. Law Commission (n 52) at para 4.60.

75. T Nadelhoffer and WP Sinnott-Armstrong, ‘Is Psychopathy a Mental Disease?’ in NA Vincent (ed), *Neuroscience and Legal Responsibility* (OUP, Oxford 2013) 157.

76. Cases of prior fault aside.

77. Meynen (n 72) at 168.

78. Section 3 of the Commonwealth Criminal Code Bill 1995.

79. Matthews (n 60) at 420.

80. Morse (n 34).

that we must be ‘sure of our reasons’⁸¹ before depriving an individual of their capacity and that a diagnostic threshold strengthens and ‘supports’⁸² our reasons in this respect. It is this author’s view that the concerns of both Howard and Morse are inextricably linked. In other words, if a diagnosis of disorder truly adds objectivity/reliability to a finding of incapacity, then, contemporaneously, such a diagnosis also helps us to be sure of our reasons for wishing to deprive that individual of their legal capacity.

Consequently, for those who would advocate the explicit presence of a diagnostic requirement, much of their argument seems to hinge on the degree of objectivity that such a criterion adds. It is arguable, however, that diagnosis is not as objective as some scholars would appear to make out. This dilemma has been considered by Meynen, who asks the reader to consider depression, anxiety and craving—all of which are *subjective* states:

Generally, psychopathological core symptoms and phenomena are only immediately accessible from a first-person perspective. I (first person) feel depressed. Such a depressive state is not immediately accessible to other individuals, e.g. to a psychiatrist or psychologist. This is different from a broken leg: although I am in pain, the brokenness of that leg is clearly objectifiable for others. Subjective symptoms, in contrast, must be *reported* by the patient.⁸³

Indeed, a *DSM*-informed psychiatric diagnosis is based *primarily* on self-reports of feelings and experiences by patients and on clinicians’ understanding of psychiatric terms or observation of behaviour. Clearly, there are also more objective elements of *DSM*-criteria, such as weight loss in depression.⁸⁴ Nevertheless, it cannot be denied that subjectivity (and, thus, *unreliability*) plays an important role in diagnosing mental disorders and establishing the ‘objective marker’ to which Morse refers. Indeed, this inevitable lacuna is conceded by Morse himself, who, after initially asserting that diagnostic thresholds act as an ‘objective marker’, subsequently states ‘it achieves this goal only *imperfectly* at best’.⁸⁵

Moreover, it may be said that if the sole purpose of a diagnostic requirement is merely to add objectivity to a finding of incapacity, it need not become an explicit criterion in itself. It may be part of the relevant medical expert’s *explanation* of why the defendant meets the criteria, and it may also be helpful in persuading a court that the defendant legitimately does lack the requisite capacity, but it need not be a criterion of its own.⁸⁶ The Law Commission appear to express somewhat similar thoughts within their report on unfitness to plead, when they state that the absence of a diagnostic threshold ‘does not prevent diagnosis from being an important part of capacity-based assessments, a helpful guide to identifying malingering, and a tool for predicting future recovery’.⁸⁷ In legal practice, it might be hypothesised that a judge/jury will only accept that a defendant meets the criteria *if* the medical expert has diagnosed and clarified how the particular disorder affected the criteria of capacity.⁸⁸ Regardless of whether this hypothesis turns out to be true, it remains difficult for a court to make a determination on a defendant’s lack of capacity *without* the evidence of relevant medical experts. As cl 2(1) of the Commission’s Draft Bill provides:

81. Howard (n 28) at 433.

82. *Ibid.*

83. Meynen (n 33) at 97.

84. BJ Casey and others, ‘DSM-5 and RDoC: Progress in Psychiatry Research?’ (2013) 14 *Nat Rev Neurosci* 810, 812.

85. Morse (n 34).

86. Meynen (n 33) at 98.

87. Law Commission (n 6) at para 3.127(3).

88. Meynen (n 33) at 156.

The court may not determine that a defendant lacks capacity to participate effectively in a trial except on the written or oral evidence of two or more persons: (a) one of whom must be a duly approved registered medical practitioner, and (b) one of whom must be a qualified person or a second duly approved registered medical practitioner.⁸⁹

Consequently, given the continuing role of medical professionals in establishing incapacity, it is highly unlikely that the test will be readily open to abuse.

As mentioned, there is a second area of concern that is occasionally offered by proponents of a diagnostic threshold. Specifically, that its exclusion would potentially allow defendants to claim, in Howard's words, that 'stress, crippling shyness, overwhelming tiredness, nervousness or poor social background'⁹⁰ caused them to lack the capacity to stand trial. The same is true for a capacity-based version of insanity: if diagnosis were no longer an explicit criterion, could the defence be open to defendants claiming a whole range of physical/mental states which do not rise to the level of a 'medical condition'? At this juncture, a somewhat puzzling discrepancy emerges, because the Commission's reports on unfitness and insanity are contradictory on this very point. Within their report on unfitness, the Commission were adamant that a defendant's capacities, and not disorder, should be the focus of the new test.⁹¹ In contrast, the Commission attempt to restrict their recommended insanity standard by requiring the lack of capacity to be attributed to a 'qualifying recognised medical condition'.⁹² Notably, the Commission provide the following explanation for this latter requirement:

Abnormal states, [such as] those produced by shock and bereavement, which are not so severe as to trigger a medical condition, should not be enough to ground the defence.⁹³

Now we might well be inclined to expect that shock and bereavement, and the affliction of other similar misfortunes, should not be enough to render a person eligible for this defence; but that is precisely *because* we do not expect these ailments to utterly destroy the relevant rational capacity. This poses the following question, initially put forward by Duff: '[i]f we found a case in which this *did* happen—in which the shocked and bereaved person committed a crime because they utterly lacked one of the relevant capacities—why should we deny him the defence?'⁹⁴ From this perspective, it is difficult to view the Commission's rationale as anything but manifestly unjust.

In response to Duff's argument, it could be suggested that his proposal—of permitting exculpation in cases of proven incapacity, regardless of a recognised disorder—would undermine one of the most foundational purposes of the insanity defence, specifically, to separate the 'mad from the bad'. This may be demonstrated by considering the 'wrongfulness limb' of the insanity defence. According to *M'Naghten*, as well as the Commission's proposed test, an incapacity to know/understand the (legal) wrongfulness of what one is charged with having done will exculpate the accused from criminal responsibility *if* this incapacity can be attributed to a relevant medical condition.⁹⁵ In most circumstances, however, not knowing that conduct is prohibited by law will *not* exempt an accused from criminal liability⁹⁶: ignorance of the law *becomes* an excuse once it is attributed to a relevant medical condition. This implies that explaining the presence of an incapacity *within the context* of a recognised

89. Law Commission (n 7) at cl 2(1).

90. Howard (n 19) at 202.

91. Law Commission (n 6) at para 3.122.

92. Law Commission (n 52) at para 4.160.

93. *Ibid* at para 4.60

94. RA Duff, 'Incapacity and Insanity: Do We Need the Insanity Defence?' in B Livings, A Reed and N Wake (eds), *Mental Condition Defences and the Criminal Justice System: Perspectives from Law and Medicine* (CSP, Newcastle-upon-Tyne 2015) 172.

95. *M'Naghten* (n 51); Law Commission (n 52).

96. BA Garner, *Black's Law Dictionary* (5th edn West Publishing Co, Minnesota 1981) 673.

illness offers a *special* reason for concluding that this incapacity is responsibility-undermining.⁹⁷ Deleting the diagnostic threshold from insanity formulations may therefore threaten to confuse the relationship between insanity and mistake of law.

While it is true that a large number of defendants may be able to claim, successfully, that they did not *know* their conduct was prohibited by law, it would be incredibly difficult for them—without a recognised illness—to convince a court that they lacked the *capacity* to know the law. Nevertheless, *if* such a deficit can be robustly proven, irrespective of a recognised illness, then it seems unfair and arbitrary to exclude such a person from relying on the insanity defence.⁹⁸ To summarise, it is once again submitted that this suggestion fails to provide sufficient grounds for insisting on the presence of a diagnostic threshold as a legally formal criterion: indeed, diagnostic thresholds are either entirely otiose or demonstrably unfair.

Before concluding, it is worthwhile noting an alternative suggestion made by Duff regarding the issue of prior fault. Specifically, Duff suggests that the Commission viewed the inclusion of a diagnostic criterion as appealing because it would help to prevent cases of prior fault from wrongfully falling under the defence. Duff correctly purports, however, that this rationale is flawed for two crucial reasons. First, the conditions that the Commission provisionally propose should not qualify for the defence, such as ‘acute intoxication or any other condition which is manifested solely or principally by abnormally aggressive or seriously irresponsible behaviour’, are not necessarily caused by the person’s own culpable prior conduct.⁹⁹ And second, any ‘recognised medical condition’ could, in principle, *be* caused by the person’s own culpable prior conduct.¹⁰⁰

Conclusion

The preceding discussion has demonstrated that the arguments in favour of including an explicit diagnostic threshold do not appear persuasive when subjected to a thorough critique. While it is conceded that diagnosis has the potential to grant a *limited* amount of objectivity to the remaining criteria, and will continue to play an important role in psychiatric assessments, an explicit diagnostic requirement is not necessary to achieve these aims. Consequently, it is submitted that the approach taken by the Law Commission within their final report on unfitness to plead is to be preferred. Of course, such a position raises issues with regard to consistency, given that the custom in other areas of law is to incorporate an explicit diagnostic criterion within the relevant test. Perhaps the alleged ‘objectivity’ that such a threshold provides is more important when establishing a person’s *criminal responsibility*, rather than their ability to stand trial. Nevertheless, the conventional approach is not always the most appropriate. In fact, concerns regarding the *presence* of a diagnostic threshold are not novel and have been equally advanced within the context of the insanity defence. This article has ultimately proposed that both areas—unfitness and insanity—should be reformulated so as to avoid any explicit reference to a diagnostic criterion.

For unfitness to plead, the current law *and* the Law Commission’s proposed alternative omit a diagnostic requirement. It is stipulated, however, that the latter test should be preferred due to the numerous improvements it makes by bringing the law more into line with modern psychiatric and psychological knowledge. In stark contrast, the current insanity defence and the Commission’s proposed alternative both *include* a diagnostic requirement. It is unfortunate the Commission chose to retain this

97. L Malatesti, M Jurjako and G Meynen, ‘The Insanity Defence Without Mental Illness? Some Considerations’ (2020) 71 *Int’l JL & Psychiatry* 1, 2.

98. Bonnie suggests that someone suffering from borderline personality disorder could, in some circumstances, be unable to appreciate the wrongfulness of what he/she is charged with having done. Thus, he views the categorical exclusion of personality disorders from insanity jurisprudence as ‘arbitrary and unfair’. See RJ Bonnie, ‘Should a Personality Disorder Qualify as a Mental Disease in Insanity Adjudication?’ (2010) 38 *J Law Med Ethics* 760, 761.

99. *Ibid* at 171.

100. *Ibid*.

aspect of the law, given that the remaining elements of their proposals (such as placing a much greater emphasis on a defendant's rationality) are meritorious. It would not be too far a stretch, however, to reframe the Commission's new test *without* a diagnostic threshold, while continuing to retain these commendable elements. The revised test may be drafted as follows¹⁰¹:

A person is not criminally responsible if, at the time of committing the offence, he/she failed the test of responsible agency. This test is failed if the person wholly lacked the capacity to do any one of the following;

- i. to rationally form a judgment about the relevant conduct or circumstances;
- ii. to understand the wrongfulness of the charge; or
- iii. to control his/her physical acts.

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101. Evidently, this test is heavily influenced by Matthews' version of the Commonwealth Criminal Code Bill. However, this test has been modified in order to encompass the criteria proposed by the Commission.