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CIVIL ADMISSION FOLLOWING A FINDING OF UNFITNESS TO PLEAD

Jill Peay

The problems posed to legal systems by persons accused of criminal offences who, at the point of their trial, are in no fit mental state to participate in that trial, manifest themselves in a number of ways across a number of jurisdictions.[1] Similarly, the statutory provisions vary in their relative friendliness to the accused, the nature of the disorders they embrace and the aspects of the trial process they cover.[2] In England and Wales, the focus of this chapter, such persons may be subject to a finding of 'unfitness to plead', which is still governed by the *Pritchard* test dating back to 1836.[3] At that time the science of psychiatry was, as the Law Commission recognise, 'in its infancy', and the criteria are now widely regarded as outmoded and outdated.[4] They are, in essence, a test of whether an accused can comprehend the course of proceedings so as to make a proper defence. But the test benefits from none of the advances in modern psychiatric thinking which might better discriminate between accused persons who can and should be exposed to a criminal trial and those vulnerable mentally disordered persons who manifestly should not. The scope of the law on unfitness is currently being reviewed by the Law Commission.

This chapter considers questions of rights-based legalism in the context of those who straddle the range between wholly civil commitment, a health-based disposal following a criminal conviction, and a punitive sentence. Depending on what test is applied, what procedures followed and what objectives sought, these disordered individuals facing criminal proceedings might find themselves either within a health based system or a penal system or neither. Would a broader test of 'unfitness to plead' result in a fairer disposal of those who have committed the *actus reus* of an offence, but who do not have the necessary mental capacity at the point of trial to determine whether they met the necessary *mens rea* criteria, and accordingly be in a position to be held culpable of a criminal offence? Is subsequent civil commitment in this context an example of rights-based legalism working, or of a health-based system governed by paternalism? Indeed, are some offenders convicted, following a guilty plea, of offences for which they could not be held liable in a full trial process if a test more in keeping with current understandings of the nature of mental responsibility were devised?

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[1] See for example N Poythress, R Bonnie, J Monahan, R Otto and S Hoge, *Adjudicative Competence: The MacArthur Studies* (Kluwer Academic, Plenum Publishers, 2002). J Dawson, 'Capacity to stand trial: old and new law in New Zealand' (2008) 15 *Psychiatry, Psychology and Law* 251-260. T Exworthy 'Commentary: UK Perspective on Competency to Stand Trial' (2006) 34 *Journal of the American Academy of Psychiatry and the Law* 446-471. T Rogers, N Blackwood, F Farnham, G Pickup and M Watts 'Fitness to plead and competence to stand trial: a systematic review of the construct and its application' (2008) *Journal of Forensic Psychiatry and Psychology* 576-596:578.

[2] For example, in section 2 of the Criminal Code for Canada, 'unfit to stand trial' means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (*a*) understand the nature or object of the proceedings, (*b*) understand the possible consequences of the proceedings, or (*c*) communicate with counsel. Similarly, in section 4 of the New Zealand Criminal Procedure (Mentally Impaired Persons) Act 2003, unfit to stand trial (a) means a defendant who is unable, due to mental impairment, to conduct a defence or to instruct counsel to do so; and (b) includes a defendant who, due to mental impairment, is unable (i) to plead (ii) to adequately understand the nature or purpose or possible consequences of the proceedings(iii) to communicate adequately with counsel for the purposes of conducting a defence. Neither provision makes explicit reference to the person's ability to give evidence in their own defence. Jersey's approach of requiring the defendant to have 'the capacity to participate effectively in the proceedings' arguably separates the ability to make rational decisions which reflect true and informed choices about plea and those about participation in the trial: see R Mackay, 'On being insane in Jersey Part Three– the Case of *Attorney- General v O'Driscoll'* (2004) Criminal Law Review 291-296.

[3] *R v Pritchard* (1836) 7 C & P 303

[4] http://www.lawcom.gov.uk/insanity.htm The Pritchard test is also in conflict with the test of capacity in the *Mental Capacity Act* 2005 and with the new definition of mental disorder in the *Mental Health Act* 1983, as amended by the *Mental Health Act* 2007.

Since the various outcomes of a determination of fitness include full trial followed by acquittal or conviction and conventional punishment, or by a determination that the accused performed the *actus reus* of the offence (followed by health disposal), or did not (followed by acquittal), the nature of the test used to determine unfitness will be critical. Should its scope be primarily legalistic, or capacity based, or based on a best interests determination? Consideration of unfitness to plead thus permits an examination of the range of potential bases for mental health law; whether primarily legalistic, paternalistic or dominated by a human rights framework in the context of what are difficult cases with complex and overlapping objectives for all the participants concerned.

FITNESS TO PLEAD: THE PROBLEM OF NUMBERS

In all jurisdictions significant numbers of mentally ill and cognitively impaired individuals pass through the criminal justice system. In a proportion of these cases, psychiatrists and psychologists will be asked to advise upon whether the defendants are capable of fairly standing trial. But without a proper clinical test or evidence base for the legal test these judgements are likely to be inconsistent and arguably arbitrary. A number of such clinical tests do exist,[5] but within England and Wales the approach is currently ad hoc. And whilst clinicians may agree on their findings, they may disagree on how they relate to the legal test; or they may just disagree on their findings *per se*.[6]

What is evident is that many unfit defendants end up in the penal system following conviction. The numbers revealed by Singleton et al (1998) on learning disability alone in the prison population are worrying.[7] In July 1997 the prison population was 61,944: 5% of the male sentenced population (then at 46,872), would, according to the authors, have fallen into the lowest category on the Quick Test of intellectual functioning (25 and below, which is the approximate equivalent of 65 on the IQ scale[8]). Thus, there would have been some 2,340 men in the sentenced population with the most serious of learning disabilities. How many of these men pled guilty in either the Crown Court or the Magistrates is hard to determine, but their mere presence in the prison population should raise concerns. And, in particular, raise concerns about the viability of the test for unfitness to plead; for, in 1997, there were only 50 findings of unfitness to plead.[9]

Nor has the situation seemingly changed: other research, based on a systematic review involving some 12,000 prisoners, has estimated that up to 1.5% of prisoners would be diagnosed with intellectual disabilities.[10] Even given the preponderance of sentencing by Magistrates in short-term sentences of imprisonment, and their evident failure fully to utilise their powers under the *Mental Health Act* 1983 (MHA), it is clear that the test of unfitness to plead is failing to filter some of the most intellectually impaired away from the criminal justice process. Moreover, arguments that the disability might have developed after sentence (as can happen with some mental illnesses) are less persuasive with respect to mental impairment. Two other recent reports have also confirmed worryingly high levels of mental disorder in the prison population.[11] And Lord Bradley's review has only served to

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[5] For example, the AAPL guideline which also incorporates decisional incompetence, see R Mackay, 'AAPL Practice Guideline for the Forensic Evaluation of Competence to Stand Trial: An English Legal Perspective' (2007) 35 *Journal of the American Academy of Psychiatry and the Law*: 501-504 and the MacCAT-FP instrument, see A Akintunde, 'The MacArthur Competence Assessment Tool – Fitness to Plead: A Preliminary Evaluation of a Research Instrument for Assessing Fitness to Plead in England and Wales' (2002) 30 *Journal of the American Academy of Psychiatry and the Law* 476-82.

[6] D James, G Duffield, R Blizard and L Hamilton, 'Fitness to plead. A prospective study of the inter-relationships between expert opinion, legal criteria and specific symptomatology' (2001) 31 *Psychological Medicine* 139-50.

[7] N Singleton, H Meltzer and R Gatward, *Psychiatric Morbidity among prisoners in England and Wales* (London: The Stationery Office, 1998).

[8] R Ammons and C Ammons 'The Quick Test (QT): Provisional Manual' (1962:50) 11 *Psychological Reports* 111-161 Monograph Supplement I-VII.

[9] R Mackay, B Mitchell and L Howe 'A continued upturn in unfitness to plead – more disability in relation to the trial under the 1991 Act' (2007) *Criminal Law Review* 530-545

[10] S Fazel , K Xenitidis and B Powell , 'The prevalence of intellectual disabilities among 12000 prisoners — A systematic review' (2008) 31 *International Journal of Law and Psychiatry* 369–373.

[11] Prison Reform Trust *Too Little, Too Late: An independent review of unmet mental health need in prison (*Prison Reform Trust, London, 2009). HM Inspectorate of Prisons, *The mental health of prisoners. A thematic review of the care and support of prisoners with mental health needs (*HM Inspectorate of Prisons, London, 2007).

emphasise the seriousness of the situation with his assertion that 'Custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide'.[12]

Indeed, the Bradley Report[13] estimates that there are some 9,143 people appearing at Magistrates' Courts annually with a serious mental illness, having been bailed, and a further 8,081 with serious mental illness having been held in custody before their court appearance (out of a total of approximately 821,000 defendants making their first appearance). Amongst Lord Bradley's recommendations is the proposal that 'Immediate consideration should be given to extending to vulnerable defendants the provisions currently available to vulnerable witnesses';[14] in short, special measures to reduce the stresses associated with the court environment and facilitate effective communication.

Documenting the extent of mental ill health and mental incapacity within those caught up in the criminal justice process should come as no surprise. Research on incapacity amongst those admitted to acute medical in-patient wards[15] and to those admitted to psychiatric wards from the community[16] reveal significant levels of incapacity at the point of critical decision-making in people's lives. What is also interesting is the evidence of clinical professionals failing to pick-up on the incapacity documented by researchers.[17] This may be in part because such professionals are focussing on other things at the time of admission: and in this sense, lawyers at pre-trial hearings may be similarly distracted.

Given the general incidence of incapacity in the population and the levels of mental disability within the prison population all of the figures would suggest that there is either a failure to detect problems of fitness to plead amongst defendants, or, if it is detected, a failure by the legal system to be able to respond appropriately. Either way, there is a clear problem to be resolved. Getting the balance right is critical since too low a threshold for establishing unfitness will result in many accused persons being diverted into the health system inappropriately, when they could properly be tried, whilst setting it too high produces the alternative problem of too many unfit accused being tried and, potentially inappropriately punished.

FITNESS TO PLEAD: BACKGROUND, PROCEDURE, THEORY AND PRACTICE

Statutory Background

The law governing fitness to plead is to be found in the *Criminal Procedure (Insanity) Act* 1964. This Act has been subject to considerable procedural reform; first, the *Criminal Procedure (Insanity and Unfitness to Plead) Act* 1991 provided more flexible disposal options. Prior to these amendments indefinite confinement in a mental hospital followed a finding of unfitness and counsel would occasionally advise clients to avoid such mandatory outcomes by pleading guilty to minor offences even where there may have been doubt about the prosecution's ability to prove the accused's guilt. Not surprisingly, findings of unfitness were uncommon.[18] Although the *MHA* 1983 had also introduced the entitlement to be discharged by a Mental Health Review Tribunal (MHRT), where the presence of continuing disorder could not be established, use of the provisions remained minimal. Given the underlying ethos of unfitness findings, under-usage of these orders was an indictment of the law's fairness, a frustration of the purposes of punishment and led to the possibility of unnecessary but costly appeals. The second procedural reform came via the *Domestic Violence,*

[12] The Bradley Report, *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system* (Executive Summary at para 1, Department of Health, COI 2009).
[13] The Bradley Report p. 59, citing the work of J Shaw et al 'Prevalence and detection of serious psychiatric disorder in defendants attending court' (1999) 353 *The Lancet* 1053-1056.
[14] Supra at p.61 of the Bradley Report
[15] V Raymont, W Bingley, A Buchanan, A David, P Hayward, S Wessely and M Hotopf 'Prevalence of mental incapacity in medical in-patients and associated risk factors: cross-sectional study' (2004) 364 *Lancet*1421-7.
[16] G Owen,,G Richardson , A David, G Szmukler, P Hayward and M Hotopf, 'Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study' (2008) BMJ.COM 8th September 2008
[17] See also Richardson, this volume
[18] R Mackay, 'The decline in disability in relation to the trial' *Criminal Law Review* (1991) 87-97. R Mackay, *Mental Condition Defences and the Criminal Law (*Oxford, Clarendon Press, 1995).

Crime and Victims Act 2004 which abolished the remaining mandatory disposal to hospital where the charge was murder.[19] This had, of course, been in conflict with the need to satisfy the criteria for the deprivation of liberty of those of unsound mind under Article 5 of the European Convention on Human Rights. Undoubtedly, these statutory reforms have increased the use of the unfitness procedures, but, even so, they remain palpably low.[20]

Procedure

The legislation now requires unfitness to be determined by a judge, on the evidence of two or more doctors, according to the *Pritchard* criteria. If an accused is found unfit, the trial will not proceed, but a jury will then consider whether the accused did the act or made the omission charged.[21] The provisions accordingly do not allow for the legal issues to remain in limbo; accused persons found to be unfit will either be acquitted if the *actus reus* is not made out, or be found to have done the act or made the omission charged and be liable to therapeutic intervention.[22]

During the 'trial of the facts' there is no examination of the accused's intention *per se*, although the House of Lords have asserted (obiter) that if there is objective evidence of

> *mistake or accident or self-defence, then the jury should not find the defendant did the "act" unless it is satisfied beyond all reasonable doubt on all the evidence that the prosecution has negatived that defence*.[23]

Mackay et al note that having raised the issue of unfitness successfully, some defendants are acquitted following the trial of the facts or, curiously, such a trial does not take place at all.[24] If the *actus reus* is made out then the court has access to the range of disposals for unfit accused, namely:

- a hospital order under s.37, with or without an indefinite restriction order under s.41 (*MHA* 1983 as amended by the *MHA* 2007)
- a supervision order (under which treatment can be given for both physical and mental disorders, although it is a non-punitive order and there are no sanctions for non-compliance)
- an order for absolute discharge

Hospital orders may only be made, regardless of the charge, where the accused meets the criteria for admission. Medical evidence is required. Notably, the court has the power to *require* a hospital to admit the accused: it does not have this power generally with respect to admission under s.37, and this reflects the unusual position of the courts in not having the option of a criminal disposal where the accused is found unfit. This anomalous position, of the Courts having the power to, in effect, order clinicians to provide a treatment environment, is in conflict with the otherwise prevailing situation that the decision as to whether treatment is appropriate for any patient is a clinical one.[25] The situation contrasts with other cases where the court is considering making a s.37 order as the offender will have been convicted and accordingly a penal option remains possible.

Once an accused person has been found unfit to stand trial, the House of Lords have further noted[26] that the trial of the facts under s.4A of the 1964 Act strives to achieve the balance inherent in the European Convention on Human Rights

> *The purpose of section 4A …..is to strike a fair balance between the need to protect a defendant who has, in fact, done nothing wrong and is unfit to plead at his trial and the need to protect the public from a defendant who has committed an injurious act which would*

[19] For a detailed analysis of the effects of the DVCVA 2004 see Home Office Circular 24/2005
[20] Mackay et al (2007) supra: they report 329 unfitness findings for the period 1997-2001, an average of less than 66 accused persons per year. Notably, findings relating to serious mental illness marginally outweighed those relating to learning disability.
[21] See *AG's Reference (No 3 of 1998)* [1999] 3 All ER 40
[22] Notably, Szymon Serafinowicz, the first person (not) to be tried under the *War Crimes Act* 1991, was found unfit to plead by a jury who heard conflicting evidence as to his dementia. Rather than moving to a 'trial of the facts', the Attorney General entered a plea of *nolle prosequi* permanently staying the proceedings.
[23] Lord Hutton in *R v Antoine* [2001] 1 AC 340 at 376
[24] Mackay et al (2007) supra: namely, in 31 cases of their sample of 329
[25] *R (Leslie Burke) v General Medical Council* [2004] EWHC 1879 (Admin)
[26] Lord Hutton in *R v Antoine* supra 375-376

> *constitute a crime if done with the requisite mens rea. The need to protect the public is particularly important where the act done has been one which caused death or physical injury to another person and there is a risk that the defendant may carry out a similar act in the future. I consider that the section strikes this balance by distinguishing between a person who has not carried out the actus reus of the crime charged against him and a person who has carried out an act (or made an omission) which would constitute a crime if done (or made) with the requisite mens rea.*

As ever, it is clear that this balance is found to be most difficult to draw if the issues relate to instances where serious harm has occurred, and there is a perceived risk of future harm. No mention is made here of the seriousness of the accused's disorder or of any perceived need for treatment. Here the legalistic, protective model is dominant in the procedural arrangements.

One other procedural matter is worthy of note. Under s.4(2) of the 1964 Act the Court may postpone consideration of the question of fitness to be tried until, at the latest, the opening of the defence case. The Court would need to be of the opinion that it would be expedient and in the interests of the accused so to do, but such a tactic on the part of the defence does allow the strength of the prosecution case to be tested on both the issue of *actus reus* and *mens rea* without formally assessing the accused's fitness. As Mackay and Kearns note[27] this could lead to some odd conclusions; for example, a special verdict of not guilty by reason of insanity where an individual suffering from epileptic automatism is fit to plead but then found legally insane, but a complete acquittal either where the individual has their fitness put into abeyance and the prosecution then fail sufficiently to negative any factual evidence of automatism, or where the prosecution fail to negative an arguable defence during a trial of the facts The decision in *Antoine* similarly has the potential to lead to inconsistent conclusions: even though a plea of diminished responsibility could not be relied upon during a trial of the facts for murder,[28] the prosecution still have to negative any arguable defences of mistake, accident or self-defence. If the s.4(2) route is chosen the position with respect to diminished responsibility is even more complex.

Finally, it should be noted that in the Magistrates' Court, which will inevitably account for the greatest number of sentenced mentally disordered offenders, there are no provisions for determining fitness to plead *per se*. Proceedings can be discontinued by the Crown Prosecution Service in accordance with the terms of the Code for Crown Prosecutors; accused persons may thereafter be civilly admitted to hospital where they meet the necessary criteria under the *MHA* 1983. And, in a procedure more akin to that in the Crown Court, Magistrates can, where they are satisfied both that the accused 'did the act or made the omission charged' and that they satisfy the criteria for a hospital order admission, make the order without, obviously, convicting the individual (s.37(3) *MHA* 1983).

Theory

The justifications for having 'fitness to plead' safeguards have been set out by the House of Lords

> *Throughout history, seriously anti-social acts, particularly acts of violence, have been committed by people whose mental capacity was such that they were not responsible, or not fully responsible, for their acts, or could not fairly be required to stand trial. Such cases pose an inescapable public, moral and human rights dilemma: for while such people may present a continuing danger from which the public deserve to be protected, it would be offensive to visit the full rigour of the law on those who are not mentally responsible, or not able to defend*

[27] R Mackay and G Kearns, 'An Upturn in Unfitness to Plead? Disability in Relation to the Trial under the 1991 Act' (2000) *Criminal Law Review* 532-546 at 544

[28] In *Antoine*, the House of Lords expressly overruled *Egan* [1998] 1 CR App R 121 which had problematically held that it was necessary for the prosecution to establish during any trial of the facts both that the defendant did the act charged and had the necessary *mens rea* at the time.

> *themselves, as an ordinary person of sound mind would be taken to be, and who may (despite their mental incapacity) have done nothing wrong or dangerous.*[29]

Thus, fitness to plead in part stems from a desire to protect the individual from what could be an unfair trial; and in part constitutes a forward looking and necessarily quite broad approach with its desire to protect others from the potential for further injurious acts. Whether the phrase 'the full rigour of the law' implicitly acknowledges the problems of imposing punishment on those of questionable mental capacity is unclear. For the moment it is sufficient to note the complexity of the dilemmas individuals with reduced capacity pose for both criminal law, and, for the purposes of this chapter, to the subsequent civil provisions that follow a finding of 'unfitness'.

The 1836 *Pritchard* criteria draw a distinction between those who have the ability to enter a plea (in the sense of being able to indicate what their plea is) and those who, despite this, are still considered unfit to plead.

> *There are three points to be inquired into--first, whether the prisoner is mute of malice or not; secondly, whether he can plead to the indictment or not; thirdly, whether he is of sufficient intellect to comprehend the course of proceedings on the trial, so as to make a proper defence--to know that he might challenge any of you to whom he may object--and to comprehend the details of the evidence, which in a case of this nature must constitute a minute investigation. Upon this issue, therefore, if you think that there is no certain mode of communicating the details of the trial to the prisoner, so that he can clearly understand them, and be able properly to make his defence to the charge; you ought to find that he is not of sane mind. It is not enough, that he may have a general capacity of communicating on ordinary matters.*[30]

The case law on what the criteria have come to include is somewhat contradictory. The recent summary in *Friend* [31] is helpful; and it also stresses the element of the defendant being able to give evidence in his own defence[32]

> *the accused will be able to comprehend the course of the proceedings so as to make a proper defence. Whether he can understand and reply rationally to the indictment is obviously a relevant factor, but [the jury] must also consider whether he would be able to exercise his right to challenge jurors, understand the details of the evidence as it is given, instruct his legal advisers and give evidence himself if he so desires.*

The *Pritchard* criteria have been repeatedly approved even though they do not necessarily include accused people with various handicaps that might impair the chances of a fair trial. For example, in *Podola* (1959) loss of memory about the events themselves would not qualify; indeed the Court of Appeal rejected the notion that comprehending the course of proceedings entailed an ability properly to 'appreciate the significance of the evidence', rather the test was narrow – could the defendant understand the case as it proceeded?[33] There is thus a problem for a defendant affected by delusional thinking where a disorder of mind may cause them to act unwisely. One consequence of the rejection of this approach is that a defendant may well have the capacity to enter a plea, in the sense of knowing what guilty or not guilty means, but be unable to appreciate the significance of failing to act on legal advice to pursue a defence of diminished responsibility because the defendant's disorder leads him or her wrongly to conclude that they will be acquitted.[34] In turn, this would militate in favour of treating the ability to enter a plea, and the ability to stand trial separately.

In short, fitness to plead means fitness to enter a plea and to be tried if that plea is not guilty. The conflation of the two under *Pritchard* is problematic: can the anticipatory nature of a decision about the likely elements of a trial and their complexity be properly evaluated? If not, legal and health based approaches will come into conflict. Moreover, the *Pritchard* criteria do not equate with legal

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[29] Lord Bingham *R v Antoine* [2001] 1 AC 344
[30] Baron Alderson in *Pritchard* supra at 304
[31] Otton LJ, in *Friend* [1997] 2 All ER 1012 at 1018
[32] See also *M (John)* [2003] EWCA Crim 3452 and *R v Stewart Michael Diamond* [2008] EWCA Crim 923 at 44
[33] *Podola* (1959) 43 Cr App Rep 220 at 229 and 238-9
[34] See *Diamond* [2008] EWCA Crim 923

certifiability, which lead to problems with the Article 5 (deprivation of liberty) provisions under the *Human Rights Act* 1998,[35] nor do they 'fit neatly with any diagnostic criteria'.[36] Questions have also been raised about their potential conflict with the Article 6 (right to a fair trial) requirements, although the House of Lords in *R v H* [37] held that the procedural arrangements for dealing with unfitness do not require compliance with Article 6(2) as they do not constitute criminal proceedings.

Practice

The empirical evidence suggests that the application of the test is malleable in the hands of those who apply it: psychiatrists, for example, will also take into account other criteria, such as whether the defendant can understand the consequences of the charge or whether they would be able to control themselves during a trial.[38] Similarly, in practice, those with psychotic illnesses do seem to be included in 'unfitness' findings,[39] and now are as frequently imposed in practice as in cases of intellectual impairment, implying an expansive application of the test in defiance of the more narrow legal approach.[40] Some criminal barristers regard the threshold for fitness as too low, meaning that unfit defendants do stand trial unfairly, and that defendants with mood disorders and delusions who don't satisfy a cognitively based test may, in practice, be unable to appreciate and contribute to their own trial.[41] In short, whilst the courts[42] may have asserted that the test of fitness is not set at too low a level, practitioners' actions and beliefs, and the evidence from prison populations, and studies of incapacity in those not involved with the criminal justice system, would suggest otherwise.

Very little, if anything, is known about the determination of unfitness by the judge; and the absence of reasoned decisions will only hinder such understanding. Whilst research[43] sheds light on the numbers and types of accused persons who are found to be unfit, little is known about the numbers and types of cases where, the issue of fitness having been raised, it is rejected by the judge (or in earlier times, the jury). Even less is known about cases where unfitness might properly be raised, but is not. What is known is that 1991 Act has enhanced the use of the 'unfit' provisions: the indications are that these have begun to rise as lawyers and psychiatrists have become more familiar with the workings of the revised legislation.[44]

In Mackay and Kearns' (2000) study of 110 disposals under the 1991 Act, 77 per cent received hospital disposals, with or without restrictions.[45] Whilst this might suggest that judges are still not making as great a use of the new flexible (non-hospital based) disposals as they might, the authors note that defendants found unfit to plead at trial are quite likely to be ill at the point of trial and accordingly in need of hospital treatment. This contrasts with those pleading not guilty by reason of insanity, where the disorder has to have been present at the time of the offence, but not at the time of trial. Here, over 50 per cent of disposals were non-hospital based.[46] Therapeutic imperatives at the point of plea may thus be a current concern, rather than as an issue that touches merely on the question of responsibility for the crime.

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[35] Resolved under the *Domestic Violence Crime and Victims Act* supra; see also L Scott-Moncrieff and G Vassall-Adams , 'Capacity and Fitness to Plead: Yawning Gap' *Counsel*; Oct: 2-3

[36] D Chiswick, 'Fitness to stand trial and plead mutism and deafness' in R Bluglass and P Bowden (eds), *Principles and Practice of Forensic Psychiatry (*Edinburgh, Churchill Livingston, 1990)

[37] *R v H and Secretary of State for the Home Department* [2003] UKHL 1

[38] R Mackay and G Kearns (2000) supra. See also T Ward 'Hearsay, Psychiatric Evidence and the Interests of Justice' (2009) *Criminal Law Review* 415-426. Ward notes two examples from *Friend* (no 1) 1997 1WLR 1433 CA (Crim Div) at 1442 where the Court of Appeal acknowledged that the sorts of condition that might satisfy s.35(1)(b) of the *Criminal Justice and Public Order Act* 1994 would be epilepsy and latent schizophrenia where the experience of giving evidence might trigger an attack or florid state. In *Friend* (no 2) [2004] EWCA Crim 2661 the CA added Attention Deficit Hyperactivity Disorder where a defendant might blurt out something or give conflicting evidence. Thus, a defendant in such circumstances might be fit to plead but not to give evidence under s.35 and have adverse inferences drawn.
Ward also notes (at p. 419) the CA's approval in *M (John)* [2003] EWCA Crim 3452 wherein the Court approved a direction adding an ability to give evidence, namely to understand questions and give intelligible replies, to the *Pritchard* criteria

[39] See, for example, the case of *R v Davies* (1853) cited in Rogers et al (2008) supra

[40] Mackay et al (2007) supra; see also James et al 2001 supra

[41] T Rogers, N Blackwood Farnham , G Pickup and M Watts 'Reformulating Fitness to Plead: a Qualitative Study' (2009) *Journal of Forensic Psychiatry and Psychology*

[42] eg in *Robertson* [1968] cited by Mackay et al (2007) supra

[43] Mackay et al (2000) and (2007) supra

[44] Mackay's work generally has noted significant increases in the use of 'unfit' provisions rising from 13 in 1990 to 76 in 2001: see Mackay et al (2007) supra; and Mackay and Kearns (2000) supra

[45] Mackay and Kearns (2000) supra

[46] R Mackay and G Kearns, 'More facts about the insanity defence' (1999) *Criminal Law Review* 714-725

OPTIONS AND OUTCOMES

To summarise, under the current arrangements for trial accused persons finding themselves in the Crown Court will be faced with a range of potential options. Where there are doubts about an individual's fitness to plead, or fitness to stand trial, that range becomes confusingly complex for both the accused and the legal advisor. And the issue is further complicated where an accused's mental state may fluctuate or deteriorate during a trial. But in short they can:

1. Plead not guilty – with capacity - trial with formal legal safeguards

2. Plead guilty – with capacity – a calculated decision with advantages that stem from an early plea of sentence discount

3. Plead not guilty – without capacity – trial, but may not benefit from safeguards – risk of inappropriate conviction and inappropriate disposal

4. Plead guilty – without capacity – risk of inappropriate sentence (ie may not benefit from health based disposal)

5. Raise the issue of potential disability and ask the court to postpone the consideration of fitness to be tried until the opening of the defence case; if the prosecution fails to make out the *actus reus* or present sufficient factual evidence to allow the jury safely to infer that the accused had the requisite *mens rea* then the defence can make a submission of no case to answer. The Judge can accede to this, leading to a complete acquittal, or move to the assessment of the defendant's fitness to stand trial; s.4(2) 1964 Act

Or…. raise the issue of unfitness to plead at the start of proceedings and be found

6. Currently unfit to plead – judge based determination on 1836 criteria, leading to

7. Trial of facts before jury – finding of did or did not commit the act or make the omission charged

7a. Did commit act: leads to health based disposal

7b. Did not commit act: acquittal but possible risk of civil admission

Perceived difficulties or uncertainties with the fitness to plead criteria, or a desire to avoid any determination of unfitness, can lead to errors (3) and (4). Similarly, an outdated or outmoded test for fitness (6) can lead to both inappropriate guilty pleas and findings of guilt: and can fail to embrace defendants who are not fit to plead, but are treated as such.

Limitations in the trial of the facts 'test' can result in not guilty offenders being inappropriately held to have committed the act and hence receive an inappropriate (potentially) health-based disposal. And potentially, accused persons who are found not to have committed the act or made the omission charged will nonetheless have drawn their mental state to the attention of those who have the power thereafter to pursue civil admission if thought appropriate. Whether this ever happens is a moot point; but it is not wholly illusory.

What is evident from the case law is that accused persons whose fitness to plead is compromised, even though they may be deemed fit to plead under the current narrow legal test, find themselves, often many years later, caught up in complex appeals. Most frequently, these appeals concern cases where defendants have been convicted of murder and they subsequently seek to have a finding of diminished responsibility substituted for the murder conviction. Such cases may arise where a defendant refuses, for reasons attributable to their mental state at the time, to allow such a defence to be put forward: improvement in their mental state over a period of years can lead to a re-

evaluation by them (if not by the courts) of the wisdom of this course of inaction.[47] Perhaps most poignant is the case of *Murray*, who killed her five year old daughter, pled guilty to murder seemingly because she wished to be punished for her crime.[48] Her paranoid schizophrenia was sufficient in the eyes of the clinicians to prevent her from understanding the impact of her disorder on her actions, but it was not sufficient to bring her within a legal test of unfitness; nor, accordingly, to prevent her rejecting advice to plead to diminished responsibility.[49]

Problems and Possibilities

It is evident that the current test of unfitness is insufficiently defined or consistently applied to ensure that those with mental disorder are appropriately protected, where that mental disorder is likely to have an impact on the fairness of the plea or trial. Only a tiny proportion of arguably the most worrying cases gain any benefit from the current provisions. The judicially-based case specific approach to this is deficient where there is no objective standard by which the judge can judge unfitness, and no guarantee that relevant cases will be brought before the judge for such a determination.

Aside from this fundamental difficulty, a series of mismatches can occur between rights based and paternalistic objectives because decisions about fitness to plead do involve a clash of ideologies, perspectives and objectives between the criminal justice system and the health system. At trial, and somewhat crudely, the criminal justice system's general approach is that the interest in not convicting innocent people takes precedence over ensuring that everybody who is guilty is convicted (although this has shifted over the last 12 years with a 'rebalancing' of the justice system in favour of victims and the protection of wider society); at sentence, the dominant philosophy to determine what is appropriate punishment involves a determination of the seriousness of the offence and the culpability of the offender, tempered by the secondary objectives of deterrence, compensating the victim and rehabilitating the individual; incapacitative and protective objectives remain pertinent. Criminal trials, partly in anticipation of the consequences that can follow, are subject to the Article 6(2) and (3) protections, as evidenced in *R v H,* but preventive detention, even for those found unfit, is a justified outcome.[50]

Yet, in contrast, the health system's dominant philosophy is in the health interests/needs of the individual, arguably tempered by a growing interest in public protection, albeit that this interest may be imposed uncomfortably on clinicians. Indeed, 'the primary purpose of mental health units is to provide healthcare and to promote the physical and mental health of the patients.'[51] Article 6(1) should apply to proceedings prior to compulsory admission following an unfitness determination. So, when unfitness determinations intercede in a criminal trial the objective would appear to be avoiding manifestly unfair trials (and hence the exposure of unfit individuals to the potential rigours of punishment; either just or unjust punishment) and ensuring an appropriate disposal where justified. Having an inappropriate test, getting the determination wrong, or having an unfair 'trial of the facts' have potentially grave consequences for the individual; although the risks for inadequate societal protection are partially ameliorated by the potential for a secure health disposal, but then only if the individual meets the criteria for compulsory admission to hospital; and largely only if a finding that the individual 'did the act' is made.

Whether the 'unfitness test' and in particular whether the 'trial of the facts' under s.4A is essentially criminal or civil in nature has been determined by the House of Lords in *R v H*. The case concerned two charges of indecent assault by a 13 year old boy on a 14 year old. The boy was held unfit to plead, but was determined to have committed the acts alleged, and given an absolute

[47] See eg *Diamond* [2008] EWCA Crim 923; *Moyle* [2008] EWCA Crim 3059; *Neaven* [2006] EWCA Crim 955.
[48] *Murray* [2008] EWCA Crim 1792
[49] I am indebted to Ronnie Mackay for drawing attention to these cases in his presentation to the Law Commission seminar on unfitness on 19 March 2009
[50] Lord Bingham *R v H and Secretary of State for the Home Department* [2003] UKHL 1 at para 2 (with additions)

[51] Pill LG in *R (G) v Nottinghamshire Healthcare NHS Trust* at para 33 summarising the view of the smoke free legislation team at the Department of Health

discharge. However, this finding attracted the application of the *Rehabilitation of Offenders Act* 1974 and the notification requirements under the *Sex Offenders Act* 1997. The House of Lords concluded that both of these orders were non-punitive: the first was for the purposes of rehabilitation, and for the benefit of the accused person; and the second was to protect the public and not to punish the accused. Thus, they asserted that these were orders analogous to civil anti-social behaviour orders (ASBOs).[52] In so doing the House of Lords relied on the tests laid down by the ECHR in *Engel*;[53] and concluded that the preceding s.4A procedure was not criminal in nature. It could not result in conviction, only acquittal; and a positive finding could not be followed by punishment. Although there was a finding 'adverse' to the accused the procedure for so doing lacked the essential features of a criminal process, since the interventions that could follow were not essentially 'criminal'. Although the degree of severity of the penalty the person risked incurring was relevant to a determination of what was 'criminal', some deprivations of liberty were not, since 'by their nature, duration or manner of execution' they could not be 'appreciably detrimental'.[54]

That criminal proceedings culminate in the potential to impose penalties is their purpose. And, as any first year criminal law student will know, it is the marking out of defendants through this act of censure that defines the scope of criminal law and deters that conduct deemed sufficiently damaging to merit penal sanctions. But it is essentially a circular argument. We know what is criminal because it is followed by punishment: we know what is punishment because it is preceded by criminal processes.

Arguably, the strength of the appellant's argument in *R v H* lay in the notification and rehabilitative requirements mentioned above. To the unfit accused person these may well be experienced as censuring and punishing. Similarly, other compulsory rehabilitative measures, which can be imposed under the *Criminal Justice Act* 2003 would be deemed punitive; moreover, these follow conviction. Thus, whilst rehabilitation is said to be for the benefit of the offender, such measures are clearly demanding and are intended to have a symbolic punitive value. For the House of Lords to cite authorities to say that notification and registration measures are not punitive, is not determinative of their reality. Is it hair splitting to maintain a rehabilitative measure cannot be punishing because the Court says so when they are applied in a civil context, even if they can have a punitive element in a criminal context? Is it a failure to appreciate the fundamental qualities of these orders which leads the House of Lords inextricably to the conclusion that the decision that precedes them cannot be criminal in nature? Undoubtedly, it is not going to be to the individual's advantage in finding work, for example, if he or she is obliged to disclose an adverse finding under the *Criminal Procedure (Insanity) Act* 1964. Indeed, since a restriction order can otherwise only be made following conviction in the Crown Courts, this would imply that the restriction order has a dual potential status, following both criminal convictions and findings adverse to the accused. In essence these are muddy and muddied waters with considerable overlap between civil and criminal provisions and one might expect some greater cognitive dissonance here from the courts; particularly since the application of Article 6(2) and (3) would make a difference to the nature of 'trials of the facts'

This raises the third problem, of whether this is essentially an exercise by the courts in civil admission based on the nature and degree of the individual's disorder, leavened by some appreciation of the likelihood of harm to others, or whether this is the criminal courts essentially disposing of an accused person to a secure environment, but recognising that the objective of security is being achieved through a health based route since the penal route is unavailable in the absence of a criminal conviction? Although not a sentencing function, requiring admission to a psychiatric hospital under a s.37/41 order (hospital order with restrictions) will necessarily entail both deprivation of liberty (on grounds of mental disorder) and potentially entail the subsequent continuation of that deprivation of liberty on grounds of risk to the public, even where the disorder may ameliorate or be unresponsive to treatment.[55] It achieves an amalgam of penal and health objectives, where these could not be justified in a purely criminal context.

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[52] *R v H* (2003) supra para 16

[53] The third *Engel* test, European Court of Human Rights (1976) 1 EHRR 647

[54] See *Engel* at 678-679, paragraph 82; cited in *R v H* at para 19

[55] *Hutchison-Reid v UK* (2003) 37 EHRR

Fourth, it is open to accused persons and their representatives to be treated as mentally competent up until the close of the prosecution case. Thus, it is possible for the defence to attack the merits of the prosecution case without jeopardising (if jeopardising it is) the accused's position with respect to their mental state (s.4(3) 1964 Act). Similarly, both findings of fitness and unfitness may be appealed under the (s.6(1)(b) and 15(1) respectively) preserving the legalistic approach beyond the disposal stage. Moreover, the finding by a jury that the unfit accused did the act or made the omission charged is also subject to appeal (*Criminal Appeal Act* 1968 s.15). Thus, legal certainty about final disposal may take some time to crystallise: meanwhile, treatment in conditions of uncertainty about the permanence of the therapeutic disposal may undermine both the offender's motivation to engage and the therapist's ability to deliver treatment. But equally, the results of therapeutic endeavours, for example, in enabling an accused to recover sufficiently to acknowledge their own part in an offence, may be too delayed to ensure a legally just outcome: a greatly delayed appeals process may prevent the Courts from being able, retrospectively, to accept that the accused was sufficiently disordered at the point of offending to merit, for example, a finding of diminished responsibility.[56] After disposal and treatment, and assuming a s.37/41 order was made, a full trial can subsequently be held, to determine guilt or innocence. But for those given other disposals, for example an unrestricted hospital order, there is no right to a subsequent trial and any such determination would lie with the CPS; given their public interest criteria, this is unlikely to be exercised. Decisions about disposal *per se*, since they do not follow a conviction and are not sentences, are not subject to appeal, only to subsequent review by the MHRT.

This raises the fifth problem of uncertainty from an accused's perspective. Whilst the introduction of indeterminate sentences for public protection under the *Criminal Justice Act* 2003 somewhat lessens the power of this point, it remains true that for an accused the choice between an indeterminate and uncertain therapeutic disposal and a certain, albeit unattractive, penal disposal may incline an accused towards the latter. And although counsel may be alive to the consequences of the differing legal provisions, it is expecting a great deal of them to expect them also to be alive to the realities of indefinite detention under either a penal or therapeutic regime, and the operating standards of the various safeguards and decision-makers (Parole Board, MHRT, Secretary of State) who will affect and effect the implementation of those detention periods. Thus, much decision-making is likely to take place on the basis of 'best guesstimates' as to what will transpire.

Sixth, the criminal justice system has an operating assumption that defendants will act strategically, sometimes with the benefit of legal advice, but nonetheless act in their own best interests. Where an accused person's fitness is in doubt, acting strategically cannot be relied upon as an operating assumption. Thus, an accused's (disordered) beliefs about a number of aspects relevant to the decisions to be made may well interfere with informed decision-making.[57] Similarly, an accused's prior experience of either health or penal disposals may influence decision-making, unbeknownst to a legal advisor. What role, for example, is the ban on smoking in health disposals, but not in prison, likely to have on decision-making where an accused might go in either direction? Similarly, instability in an accused's condition might enable them to act strategically and make consistent decisions at one point in the process, only to revoke those decisions or refuse to engage or be unable to make any further decisions at another point in the process. These are not easy cases to deal with but they have a chronology of their own. In other jurisdictions, such decisions faced by the accused may be even more dramatic: the role of 'three strikes and you are out' provisions in the US, and the continuing existence of the death penalty, has seemingly contributed to the inexorable rise in the population of detained incompetent persons, which now includes those with personality disorder who would not normally be considered lacking in capacity or unfit to plead; evidently, standards are relaxed where the consequences of not so doing are manifestly harsh. Whether in England and Wales, where the broadened definition of mental disorder under the amended *MHA* 1983 (now including those with personality disorder) will have similar unintended consequences has yet to be revealed; but the risk of a many-headed health hydra eating-up scare resources in diverting accused persons from trial and punishment is ever present.

Finally, there is the issue of the extent to which an accused needs to be 'fit to be punished' as opposed to being sufficiently unfit to merit a therapeutic disposal. Meeting the criteria for admission

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[56] See *Diamond* supra

[57] Instructions may be based on false premises (eg *Diamond*, where there was an unrealistic expectation of an acquittal and a desire, arising out of paranoid beliefs, to 'get one over on the police') or out of a deluded belief that they deserve punishment on the most serious charge (eg *Murray*).

under the *MHA* 1983 does permit those who deteriorate in prison to be transferred away from circumstances where they no longer remain fit to be punished. But should there be some other determination of fitness for punishment before it is imposed on those of already suspect mental vulnerability? One interesting development is noteworthy. In the recent case of *Cooke v DPP,*[58] which concerned the imposition of an ASBO, the Court made plain that when imposing this civil order, where the consequences of breach led to punitive interventions, decision-makers should not make an order where the individual, by reason of mental ill health, did not have the capacity to understand and comply with the terms of the order being imposed; without such capacity the accused was being doomed to future failure. Developing this approach one might question whether we ought to think more carefully about the need to meet some threshold for fitness to be punished, rather than adhering to the default position, namely that those who are not convicted, but sufficiently disordered, can only be held in a therapeutic environment, whilst those who deteriorate in prison will only be transferred once the criteria are met, a bed is available and clinicians are willing to accept the patient.

Further problems arise out of the disjunction between the law's binary, one point in time, approach to decisions (fit/unfit; guilty/not guilty; punishment/health disposal) and the clinical approach which is based more on degrees of disorder and uncertainty, with its sliding scales of capacity and the recognition that individuals can vary in their abilities, needs and treatability not only over time, but within relatively brief periods of time. Thus, someone may have the capacity to instruct counsel but not to give evidence on their own behalf; they may have the capacity to understand the basis of the prosecution case, but not to be able to give a coherent account of their own defence where that intersects with their mental disorder and the medical assessment of that disorder (where, for example, an accused refuses psychiatric assessment); and an individual may be well enough at the point of plea to plead with capacity, but then deteriorate during the demands of a trial so as not to be in a position properly to comprehend the course of proceedings. Leaving an appeal system to sort out these unfairnesses, perhaps many years later, is not a solution where it becomes so much more difficult with hindsight to ascertain exactly what the accused's mental state was at the time determinations were made (or not made) about their fitness.

In summary, considering the role of unfitness to plead as a basis for civil admission raises a number of difficulties, arising out of the clash of multiple perspectives which are concentrated on this particularly complex junction for decision-making in mental health. Even the roles of the various parties do not conform to traditional expectations. Counsel, who act on instructions from their clients, may find themselves precluded from pursuing the best defences and yet bound to accept instructions from those clients who meet a narrow test for fitness, but who are manifestly not thereafter able to act in their own best interests vis a vis any subsequent trial. And Judges sitting in the Crown Court, who are now asked to adjudicate on unfitness on the basis of expert medical evidence, may equally find themselves managing the process where the accused person appears only briefly in court, and then does not behave in the traditional self-interested mode of the bulk of defendants.

REFORM

Whilst the Law Commission has launched an initiative to explore the possibilities of developing a better legal test and rules for determining fitness to plead two other issues arise; the processes for determining whether an individual meets the criteria (namely, the clinical assessments that feed into the judicial determination) and the underpinning philosophy of the law, with which this book is primarily concerned. With respect to the former, it is worth noting that research is underway to develop a bespoke dynamic test of fitness which more accurately reflects the nature of the capacities people need to participate in the decision about plea and the process of trial. [59] If capable of consistent application such a test might better meet the needs of both justice and an individual's interest in treatment, by initially delineating those who can and those who can't fairly stand trial, on the minimum grounds of their inability to comprehend trial proceedings.

[58] [2008] EWHC 2703

[59] N Blackwood, J Peay and M Watts, 'Fitness to Plead: The impact of cognitive abilities and psychopathology' (2008) Application to the Nuffield Foundation (funded from January 2009).

With respect to the latter, the legal approach might best underpin decisions about unfitness and the disposal of those found unfit, three possible albeit crude bases present themselves; a formally legalistic approach which may trade-off health considerations for the individual against protective imperatives with respect to the public's risk of future harm (albeit not offending *per se*); an approach which attempts to treat the mentally incapacitated on the same basis as the physically incapacitated, and which draws on human rights principles of non-discrimination; and a best interests approach which is most clearly paternalistic and is heavily influenced by an assessment of the individual's clinical needs.

Legalistic

Putting the prosecution to proof before having the issue of unfitness determined would be one route to injecting a more legalistic approach; giving primacy to a legal determination by the Judge that there was sufficient evidence that the act or omission had occurred as alleged (as would happen with any half-time submission of no case to answer) would put the accused on a more equal footing with ordered defendants. Following on from a determination of unfitness a health-based disposal would result; no conviction as such would arise for those found unfit since the accused would not have been able fully to participate in the trial, so could not satisfy the requirements of Article 6(2) or (3). This approach should lead to more acquittals (since the prosecution would have to establish any mental element, insofar as it required rebutting any evidence of mistake, accident etc to a beyond reasonable doubt standard). From the perspective of protecting an accused's legal rights this has the advantage of potentially securing more acquittals without formally raising their mental health status and ensuring that, for those found unfit, conviction *per se* cannot ensue; but it has the marginal disadvantage of exposing an unfit accused to the unfairness of a hearing of the prosecution case without their being able properly to participate in that hearing. But, if they are found fit, the ensuing full trial still holds out the possibility of a complete acquittal. There would need to be consideration of whether the unfitness relates primarily to entering a plea, taking part in a trial, or being punished. Whether this is a formally legalistic approach, or one seeped in 'new legalism', will depend on the extent to which it facilitates entitlements and ensures outcomes that are the least restrictive in their nature.

Capacity based – Human Rights

With the passage of the *Mental Capacity Act* 2005 (*MCA*), some statutory assistance with the meaning of capacity has occurred. In an ideal world, which applied legal concepts consistently, only those who were sufficiently capacitous according to the *MCA* 2005 to make a decision about plea would be permitted to engage with the criminal justice process. The *MCA* presumes an individual to have capacity until they are unable to make a decision because of 'an impairment of, or a disturbance in the functioning of, the mind or brain' (s.2(1)) with respect to a particular matter; the capacities entailed include understanding and retaining relevant information, being able to use it and to communicate any decision made. Critically, with respect to its potential application to unfitness, s.3(4) notes that 'relevant information' includes 'information about the reasonably foreseeable consequences of (a) deciding one way or another, or (b) failing to make the decision'. And although the capacity test might be thought as being set at a low threshold, to facilitate autonomous decision-making, in the context of unfitness, where the decisions are both complex and have foreseeable consequences down the line, many accused may find the task more demanding than their capacities permit.

Were a substantive test for fitness to be updated in this way a number of issues would arise: many more offenders might be drawn into a health based disposal when they might otherwise have been appropriately eligible for a criminal justice based determination; if the capacity required to plead guilty and the capacity required to plead not guilty are not coterminous there could not be a perfect allocation between the two options - is more capacity required to risk the higher penalty of conviction following a contested trial, or is more capacity required to acknowledge legal (as opposed to moral) guilt, without an independent determination of guilt? A more forward looking approach would be required since complex anticipatory questions entailing consideration of the consequences of different pleas would arise, particularly with respect to the differing disposal options, some with a more punitive

element than others, some with greater indeterminacy. A capacity based approach is also decision specific, not person specific, so a person may have the capacity to plead guilty to an offence that, for example, is unlikely to result in a custodial sentence, but not to a more serious charge that might result in imprisonment. This will complicate any negotiations over charge or plea.

A test of 'decisional incompetence', as advocated by Mackay (2004) and adopted in Jersey, could form the basis of a capacity-based test of unfitness, by expanding it beyond its current narrow cognitive base.[60] This would better capture the defendant's ability to participate meaningfully in the trial process, and could embrace principles such as the need for everything that can reasonably be done to be done to assist people to have the capacity to make particular decisions, and that one is entitled to make foolish, risky and unwise decisions that are not in one's best interests without being found to lack capacity.

But, the complexity of the decisions faced along the way (plea, instructing counsel, understanding proceedings, giving evidence etc) may also result in accused persons shifting above and below the threshold for unfitness as proceedings progressed. Disposal following unfitness and an adverse finding on the facts would be governed by the need for treatment and a continuing lack of capacity. Deprivation of liberty to facilitate treatment would need to be justified under the *MHA* or *MCA*. For an equitable approach this would need to apply both to compulsory treatment for physical and mental disorders (raising further problems). For those lacking capacity, where there may be no disorder to treat, some form of third way civil detention might, albeit controversially, be justified on grounds of proven and continuing dangerousness. Depending on the threshold for what constitutes a lack of capacity for the task(s), this is a potentially highly interventionist route. Whilst it avoids the stigma of conviction, it replaces punishment with a potentially open-ended form of detention. Given the very widespread nature of offending, and the demonstrated levels of task specific incapacity in the population, this could draw in large numbers of people. Proper representation might permit people with minimal capacity to be tried, but then result in the problem of punishing those without the capacity to benefit from it; and potentially ineligible for a health-based disposal. And since capacity is task specific, it would need to be constantly under review, both in respect of individual fluctuation, and in respect of the different decisions over time with which people are faced; without careful review the possibility remains that punishment would be imposed on those who cannot benefit from it.

Best interests/paternalism

Without a good definition of what is meant by best interests in this context (what interests? from whose perspective?) this is tricky. If one assumes best health-interests then that would entail having a very inclusive test for unfitness to plead on the grounds that punishment, or the conditions in which it is imposed, are rarely good for one's health. The accused's choice at the point of trial would not be central; rather professionals' views about their mental state and health needs would determine the route followed and the alleged offending would just be another way of drawing attention to such needs. Intervention thereafter would be determined by a continuation of those needs. This approach is, of course, redolent of the albeit controversial mental health courts in, for example, North America; the denial of a 'right to punishment' and its replacement with the medicalisation of offending being amongst those controversial elements.

A paternalistic approach would probably also suggest that after the period of health intervention there would be no return to court for trial since this would not be in one's overall best interests: the risk of undoing the good interventions to date outweighs the stigma of unresolved allegations. This reflects the current arrangements, where Magistrates can make an order for admission under s.37 without any formal determination of the facts, as is required in the Crown Court; or where the Crown Court makes a hospital order without restrictions, and there is no right for the accused to return to court to contest the allegations should their mental state recover. Unfitness would be determined on a case-by-case basis, perhaps invoking a sliding scale of seriousness of offending and degree of unfitness to inject some element of proportionality into the compulsory health intervention.[61] The task of determining individual unfitness could also be supplemented by some

[60] Mackay (2004) supra
[61] See the discussion of Winnick's 'sliding scale of competence' in Loughnan (2008:780): *Mental Incapacity Defences in Criminal Law.* Thesis submitted to the Law Department, London School of Economics and Political Science for the Degree of Doctor of Philosophy (unpublished)

objective criteria to determine whether a given standard of unfitness was met. Under this process, it is not immediately evident how the interests of any victim might be met.

CONCLUSIONS

None of these three models looks particularly attractive. Yet both the latter two look likely to divert a significantly greater number of accused persons away from the criminal justice system, and potentially into the health system if the necessary criteria for admission or supervision are satisfied. Given the numbers of individuals in prison with serious mental disorder and significant learning disability that may be regarded as a good thing. And even the legalistic model has the potential to divert given a more inclusive test for unfitness. Of course, in the absence of a robust and agreed basis on which to determine unfitness there would be an enhanced risk of clinician-based inconsistent (and potentially discriminatory) practice. The lessons learnt on the use of compulsion under the *MHA* 1983 do not suggest that this is likely to be the fairest of approaches between individuals.[62]

All three models also raise the potential for greater conflict between hospitals and the courts, since in unfitness cases the courts exceptionally have the power to order a hospital to admit a patient. Of course, the court has to hear medical evidence that the patient satisfies the criteria for admission, but not evidence that a bed is available and being offered. Moreover, if the pool of unfit but potentially untreatable accused persons is significantly increased, the courts' well-documented anxieties about future offending may come to play a more prominent role.

Would the ideal solution be a pluralistic merging of the best features of each approach, or perhaps, as Exworthy notes, the injection of more rights-based thinking, for example of proportionality, into heath care decisions?[63] Even so, the reality is that such rights are context specific in their application; the moving feast of dilemmas that the unfit accused pose will shift as the individual moves through the different systems and is differently perceived by individuals wearing different hats. Thus, procedural rights can trump in the criminal context, human rights trump potentially for the competent patient, and paternalism triumphs with incompetent individuals, tempered by protectionism for competent risk posers. Perhaps the real answer lies in ensuring that fewer people pass through the criminal justice process; that more are dealt with voluntarily in the community where their disorders can be dealt with on the same basis as those with physical disorders; and that we dramatically reduce the size of our prison population. Achieving the latter would in turn make prison a potentially less damaging and more therapeutic environment for all. And to end with an adynaton: pigs might fly.

[62] J Peay, *Decisions and Dilemmas: Working with Mental Health Law (*Oxford, Hart Publishing, 2003).
[63] Exworthy (2006) supra