Psychiatric evidence in diminished responsibility

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J. Crim. L. 442 **Abstract**
Diminished Responsibility is a statutory partial defence to the charge of murder in the Homicide Act 1957 which has been amended by the Coroners and Justice Act 2009. In *R* v *Brennan,* the Court of Appeal described the new criteria as relating "entirely to psychiatric matters'. This article will explore to what extent such a conclusion is warranted. The statutory wording of the 2009 Act will be analysed and the role of expert psychiatric evidence will be considered. It will conclude that the new Diminished Responsibility is not a purely psychiatric matter. This is because of the moral dimensions inherent in the defence, the ambiguity in the statutory wording and the fundamental problems of psychiatry usurping the function of the jury in relation to the ultimate issue. This results in inconsistent application and role confusion in relation to the defence and asks psychiatric evidence questions it cannot answer.

Keywords
Diminished Responsibility, psychiatric evidence, murder, manslaughter, *Coroners and Justice Act 2009*

Introduction

Diminished Responsibility is a statutory partial defence to the charge of murder in the Homicide Act 1957 which has been amended by the Coroners and Justice Act 2009. In *R* v *Brennan,* [1] Lord Justice Davis claimed that the new defence related "entirely to psychiatric matters'. [2] This article will explore to what extent such a conclusion is warranted. It will consider the role of expert psychiatric evidence and analyse the statutory wording in the 2009 Act. [3]

This article will demonstrate that although the new Diminished Responsibility gives greater weight to psychiatric evidence, the fundamental issue of moral responsibility remains and is obscured by ***J. Crim. L. 443*** "medicalising' of the defence. This has implications for medical experts in providing evidence in relation to the ultimate issue and the admissibility of evidence. Following *R* v *Turner,* [4] there is ambiguity about what is within the common experience and understanding of a jury. It is unclear which parts of the Diminished Responsibility defence are matters for the jury especially since psychiatrists were encouraged to comment on the ultimate issue in *Brennan.* [5]

The statutory wording will be analysed including the abnormality of mental functioning arising from a recognised medical condition. It is unclear which conditions are sufficient for the defence. The problems of alcohol intoxication in *R* v *Dowds* [6] and of drug-induced psychosis in *R* v *Lindo* [7] and *R* v *Joyce* [8] will be explored. Whether a condition is recognised is a matter of law, not of psychiatry. The confusion inherent in the term "substantially impaired' will be explored in the Supreme Court case of *R* v *Golds*. [9] Although substantial impairment is ultimately a matter for the jury, it is unclear how much weight should be given to psychiatric evidence.

The statutory abilities to understand the nature of one's conduct, rationally form a judgment, and to exercise self-control will be considered. Understanding the nature of one's conduct will be compared with the McNaughten Rules [10] which ultimately involve moral issues for a jury to decide. Defining the ability to rationally form a judgment is difficult because of differing social, philosophical, legal and psychiatric perspectives on rationality. Defining rationality as merely logical thinking is problematic. The cases of *R* v Conroy [11] and *R* v *Blackman* [12] will be considered.

When analysing the ability to exercise self-control, the statutory defence of Loss of Control [13] will be discussed. This exposes the inconsistency in Loss of Control and Diminished Responsibility and demonstrates that loss of self-control cannot be a purely psychiatric issue, given that it is entirely within the experience and understanding of a jury for the Loss of Control defence.

The need to demonstrate a causative link in relation to the killing adds further problems. It is unclear to what extent psychiatric evidence can answer this question and whether causation must be proved or only an "explanation' offered. The ambiguity surrounding this link and doubts about the possibility of scientific proof demonstrate that it cannot be a purely psychiatric issue and in some cases, may not be answerable by anyone.

Finally, this article will conclude that the new Diminished Responsibility does not relate to entirely psychiatric issues and that "medicalising' the defence adds to the role confusion with regard to the ultimate issue. The new Diminished Responsibility obscures the fundamental issue of moral responsibility under the guise of psychiatric terminology and allows psychiatrists to usurp the function of the jury.

Moral Responsibility Under the Guise of Medical Terminology

Section 2 of the 1957 Act as amended by the 2009 Act states that:

(1) A person ("D') who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which--

J. Crim. L. 444 (a) arose from a recognised medical condition,

(b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A) and

(c) provides an explanation for D's acts and omissions in doing or being a party to the killing.
<DPA5>(1A) Those things are--</DPA5>
(a) to understand the nature of D's conduct,

(b) to form a rational judgment and

(c) to exercise self-control.
<DPA5>(1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct. [14] </DPA5>
The new abnormality of mental functioning replaced "abnormality of mind' [15] and the substantial impairment of abilities replaced "substantially impaired his mental responsibility'. [16] In removing "mental responsibility', Fortson argues that the new Diminished Responsibility defence "no longer involves a moral question'. [17] While this may appear to be the case, a successful defence still leads to a conviction for manslaughter rather than murder, [18] which implies a significant change in the moral responsibility of the defendant. Griew famously called the old Diminished Responsibility wording "elliptical almost to the point

of nonsense'. [19] Howard still considers the new Diminished Responsibility to be conceptually flawed [20] since being partially responsible is illogical. [21] The relevance of this is that if the new Diminished Responsibility is still fundamentally about reduced moral responsibility, then it is not a purely psychiatric question.

All old Diminished Responsibility pleas used to be decided by juries until *R* v *Cox,* [22] in which it was held that the prosecution could accept a Diminished Responsibility plea with the approval of the court when there is clear evidence of mental abnormality. This remains the case. Nevertheless, this potentially leaves the new defence to be decided without the need for a jury. This implies that it is a purely psychiatric question, rather than a moral issue for the jury. As a result, Loughnan and Ward argue that "a balance struck between expert evidence and the autonomy of the jury … seems to have fallen away'. [23]

Kennefick argues that the majority of new Diminished Responsibility pleas are dealt with without trial because of the weight given to psychiatric reports. [24] Recent research, however, by Mackay and Mitchell found that more cases are being contested and possibly fewer pleas are being accepted overall. [25] This affects the relative weight given to psychiatric evidence and by implication, the extent to which it is in practice a purely psychiatric question.

J. Crim. L. 445 As Kennefick points out, the 2009 Act "is representative of a marked shift towards the medicalisation of this area of law'. [26] Mackay regards it as "a radical departure' [27] from the old defence. Despite this "medicalisation', psychiatrists argue that "there is no sound psychiatric methodology to address such questions'. [28] This is because the new Diminished Responsibility is still fundamentally a defence of reduced moral responsibility, reducing murder to manslaughter. Removing the statutory language of "responsibility' does little to change this. Rather it puts greater power in the hands of psychiatrists under the guise of medical terminology.

Juries, Psychiatric Evidence and the Ultimate Issue

Turner [29] states that expert opinion is only admissible if it "is likely to be outside the experience and knowledge of a judge or jury'. [30] *Turner* was a murder case where the defendant pleaded provocation. [31] Medical evidence relating to truthfulness was deemed inadmissible. [32] It was held that "Jurors do not need psychiatrists to tell them how ordinary folk … are likely to react to the stresses and strains of life'. [33] The problem with this view as Muzaffar points out is that it "assumes that there is a clear-cut distinction between mental illness and normality, a view that does not fit comfortably with the modern dimensional view of mental illness'. [34]

Mackay and Colman argue that jurors sometimes need help from experts in understanding the conduct of normal people. [35] Ordinary human behaviour may sometimes be beyond the appreciation of ordinary people. [36] They cite *R* v *Weightman* [37] where *Turner* was applied. [38] The court surprisingly claimed that histrionic personality disorder was not beyond the understanding of nonmedical people, [39] despite it being a diagnosable mental disorder. [40] They rightly conclude that this adds to the ambiguity as to what is within the understanding of a jury. [41]

Diminished Responsibility relates to types of mental abnormality which are outside the understanding of a jury and require expert evidence. [42] This has led some to question whether there is much for the jury to do. [43] Nevertheless, Ormerod and Laird argue that giving greater importance to expert evidence does not take the ultimate issue away from the jury but rather allows them to base their conclusions on evidence rather than intuition. [44]

J. Crim. L. 446 As Ormerod explains, "the ultimate issue--whether a person is not responsible due to his or her lack of capacity--is not ultimately an expert judgment. It is a judgment by a jury or magistrates, informed by expert opinion'. [45] Under the old defence, there were concerns about psychiatrists usurping the function of the court; "these cases of homicide are to be tried by judges and juries and not by psychiatrists'. [46] In research by the Law Commission, over two-thirds of psychiatrists were happy to comment on the ultimate issue in relation to mental responsibility. [47] This danger is even more apparent under the new Diminished Responsibility because of the greater weight given to psychiatric evidence. [48]

Ward has explored the various roles of medical, legal and lay members of the court process over time and argues that medical experts should adopt an "adviser' role rather than an "observer' or an "authority'. [49] The Royal College of Psychiatrists has previously warned against experts giving an opinion on the "ultimate issue'. [50] This is because it is wrong within the laws of evidence and wrong for an expert to take a view about matters of fact. [51] They suggest that commenting on the degree of substantial impairment "should be resisted' [52] because it relates to the ultimate issue. [53]

Under the new Diminished Responsibility, in *Pora* v *The Queen,* [54] it was felt that one of the psychiatrists went beyond his role in commenting on the ultimate issue in relation to the reliability of confessions. [55] An expert should only express an opinion on the ultimate issue if this is necessary for the court. [56] Yet there is a fine line between unduly restricting expert evidence and usurping the role of the jury. [57] Ormerod and Laird argue that for the new Diminished Responsibility, "in practice, it will often be difficult for an expert not to express an opinion … [on] the ultimate issue'. [58]

Brennan [59] profoundly influences the role of psychiatrists and juries in the new Diminished Responsibility. *Brennan* involved a defendant convicted of murder who had a personality disorder. [60] Psychiatric evidence stated that his personality disorder substantially impaired his ability to exercise self-control and form a rational judgment and that "the planning for the killing was a logical consequence of his illogical thought process'. [61] The psychiatric evidence was not disputed [62] but it was argued that the trial judge had allowed the jury to reject the psychiatric evidence due to "facts and circumstances present in the case over and above the psychiatric evidence'. [63]

Lord Justice Davis identified two potentially conflicting principles: "in criminal trials cases are decided by juries, not by experts' but also, "juries must base their conclusions on the evidence'. [64] The judge said that "where there simply is no rational or proper basis for departing from uncontradicted and ***J. Crim. L. 447*** unchallenged expert evidence then juries may not do so'. [65] The court substituted manslaughter for the murder conviction. [66] Commenting on the "ultimate issue' was not only admissible but to be encouraged:

Most if not all, of the aspects of the new provisions relate entirely to psychiatric matters. In our view it is both legitimate and helpful, given the structure of the new provisions, for an expert psychiatrist to include in his or her evidence a view on all four stages, including a view as to whether there is "substantial impairment' … [and] if willing … making explicit in evidence his or her opinion on what is called the "ultimate issue'. [67]

Brennan made explicit that the "impairment of ability is a purely psychiatric question' [68] and cautioned the jury into entering "into an essentially psychiatric domain'. [69]

In *Golds,* there was a strong emphasis on an expert commenting on the ultimate issue:

Although it is for the jury, and not for the doctors, to determine whether the partial defence is made out … it is inevitable that they may express an opinion as to whether the impairment was or was not substantial. [70]

In *R* v *Squelch* [71] there was a more nuanced approach. Commenting on the ultimate issue will depend on the circumstances and it may not always be appropriate. [72] Nevertheless "all elements involve to a greater or lesser extent considerations of psychiatry and some … do so exclusively'. [73]

In the New South Wales Diminished Responsibility plea, which bears close resemblance to the 2009 Act, medical opinion that an impairment was substantial, is not admissible [74] because it bears directly on the ultimate issue. This is in direct contrast to the position in England and Wales where psychiatric experts are encouraged to comment on the ultimate issue. *Brennan, Golds* and *Squelch* have added to the role confusion which Wake argues was always inherent in the 1957 Act. [75] Although the ultimate issue is still theoretically decided by the jury, in practice, psychiatric evidence threatens to tread on the jury's domain and treat Diminished Responsibility as purely a psychiatric issue.

The Abnormality of Mental Functioning

The 2009 Act introduced the term "abnormality of mental functioning'. [76] The government wanted to "encourage defences to be grounded in a valid medical diagnosis … [and] recognised physical, psychiatric and psychological conditions'. [77] Having the concept of a recognised medical condition would "encourage better standards of expert evidence'. [78] However, what constitutes a recognised medical condition for the purposes of the new Diminished Responsibility is a question of law, not of psychiatry. As cautioned in *R* v *Wilcocks,* [79] "care is needed before the classifications are used in a forensic ***J. Crim. L. 448*** context'. [80] This is shown by the difficulties arising from alcohol intoxication and drug-induced psychosis and demonstrates that even these aspects are not purely psychiatric matters.

In *Dowds,* [81] the new Diminished Responsibility was considered in light of the fact that "acute intoxication' is a recognised medical condition. [82] Lord Justice Hughes refused to accept voluntary intoxication for the purposes of the new defence because parliament had clearly not intended to "reverse the well established rule that voluntary acute intoxication is not capable of being relied upon … a "recognised medical condition" is a necessary but not sufficient, condition'. [83] He acknowledged, however, that there were many unanswered questions as to other conditions [84] and that both alcohol dependency [85] and temporary conditions [86] could in principle be recognised.

In *Joyce,* [87] a defendant who had both schizophrenia and alcohol intoxication had a murder conviction substituted by manslaughter on the grounds of Diminished Responsibility. Although voluntary intoxication cannot relieve responsibility for murder, "the law does not debar someone suffering from schizophrenia from relying on … diminished responsibility where voluntary intoxication has triggered the psychotic state'. [88] In contrast, in *Lindo,* [89] the defendant had a psychotic episode triggered by illicit drug use. Even if the psychosis was to later develop into schizophrenia, the court ruled that drug-induced psychosis within a prodromal state was not sufficient for the defence. [90] Although the psychotic episode was considered to be a "recognised medical condition', it was insufficient because of the voluntarily nature of illicit drug use. [91]

Lindo and *Joyce* had opposite outcomes despite the fact that both had voluntary intoxication leading to a psychotic state. The only difference appears to be the pre-existence of schizophrenia in *Joyce.* Although *Lindo* is the logical conclusion of *Dowds,* it is not clear where the courts will allow voluntary intoxication to trigger a pre-existing recognised mental condition and where the effects of the voluntary intoxication will be disregarded entirely. Ormerod and Laird argue that the courts will interpret this distinction on a case-by-case basis. [92] Given that what constitutes a recognised medical condition is a question of law and may exclude some psychiatric diagnoses, the assertion that the new Diminished Responsibility defence is entirely a matter for psychiatry is misplaced.

Substantial Impairment 實質性損害

The 2009 Act requires a substantial impairment in the defendant's ability to understand the nature of D's conduct, form a rational judgment or exercise self-control. [93] The Law Commission's original proposals included the view that substantial impairment is ultimately a question for the jury. [94] Nevertheless, because the impairment now relates to abilities which are claimed to be purely psychiatric, it could be argued that the jury are unable to decide whether an impairment is substantial, especially if there is uncontested medical evidence, as in *Brennan.*

J. Crim. L. 449 In *Golds,* the definition of substantial was explored at length. It was held to be the same definition as in the 1957 Act but now related to abilities rather than responsibility. [95] This has arguably changed the significance of the term even if it has the same theoretical meaning. The jury had convicted the defendant of murder despite hearing uncontradicted psychiatric evidence that he had an abnormality of mental functioning. On appeal, he argued that the trial judge ought to have defined "substantially impaired' as "more than merely trivial'. The Court of Appeal dismissed his appeal but asked the Supreme Court for further guidance. Lord Hughes clarified that substantial was an ordinary English word which was not the same as "more than merely trivial'. [96] It meant important or weighty like a substantial meal or a substantial salary [97] and could mean "significant and appreciable' or "considerable'. [98] As a result, *Golds* has added further confusion to the meaning of substantial. Gibson [99] and Ormerod and Laird [100] argue that this has made the defence more difficult to plead.

Lord Hughes accepted that even under the new Diminished Responsibility, both the question of abilities and the causative link between the behaviour and the killing were "of course relevant to moral culpability'. [101] This adds further weight to the view that despite the medical terminology used, the new defence continues to involve questions of moral responsibility which psychiatry cannot answer.

In terms of clarifying to what extent "substantial' was a psychiatric issue Lord Hughes said:

So long as the expert understands the sense in which "substantially' is used in the statute … and that the decision … is for the jury rather than for them, it is a matter of individual judgment whether they offer their own opinion on whether the impairment will have been substantial. [102]

This is highly problematic. It leaves the extent to which psychiatric opinion should influence the term "substantial', a matter of individual judgment. As Wake has pointed out, "medical experts continue to express an opinion on the meaning of the term "substantial impairment"' [103] despite the fact that this has traditionally been a question for the jury.

Squelch [104] adds to the confusion in potentially defining substantial as partial. Despite the ruling in *Golds,* the Court of Appeal in *Squelch* approved of the trial judge's definition of substantial as "less than total and more than trivial. Where you, the jury, draw the line is a matter for your collective judgment'. [105] Lord Justice Davis made it clear that partial impairment is not the same as substantial impairment, although in one sense a partial impairment could be substantial because it does not have to be total. [106] This can easily be misinterpreted. Gibson argues that *Squelch* means that a jury will consider "partial impairment' to fulfil the substantial impairment test [107] even though this is not what the court in *Squelch* intended. Both the definition of substantial and the extent to which psychiatrists should comment on it are unclear. What is clear, however, is that it cannot be an entirely psychiatric matter but is predominantly a question for the jury.

Understanding the Nature of D's Conduct

The new Diminished Responsibility requires a substantial impairment in one or more of three abilities: to understand the nature of D's conduct, to rationally form a judgment and to exercise self-control. [108] These are all claimed to relate entirely to psychiatric issues. However, they are difficult to define. In relation to the first limb, it is not clear what aspect of the "nature' of one's conduct is in view. Fortson has described defining this as a "judicial nightmare'. [109]

In their original proposals which led to the 2009 Act, the Law Commission used an example of a 10-year-old boy who had been playing violent video games and killed another child, thinking that they could later be revived. [110] This, they argued, was him not understanding the nature of his conduct. [111] Yet it is unclear whether it was his lack of moral appreciation or his understanding of death, which is in view here. In their more recent proposals of "not criminally responsibility by reason of recognised medical condition', [112] they suggest that the "understanding' limb which mirrors the new Diminished Responsibility defence should include a capacity to appreciate wrongfulness: "appreciation of the nature of an act surely includes appreciation of its moral qualities'. [113] This could imply that the new Diminished Responsibility defence included an appreciation of wrongfulness, as Fortson has argued. [114]

第一個經常被比作精神錯亂的防禦

This first limb has frequently been compared to the insanity defence. [115] Mackay described it as "more like a partial insanity plea than one of diminished responsibility'. [116] Although analysis of the insanity defence and the role of psychiatric evidence in it are beyond the scope of this article, its similarity to this first limb of the Diminished Responsibility defence is relevant to whether it is purely a matter for psychiatry. The McNaughten rules [117] define insanity as "labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong'. [118] Although *R* v *Johnson* [119] has clarified that wrong means legally rather than morally wrong, in practice, the legal/moral distinction is often blurred. [120]

Both the insanity defence and arguably the first limb of the new Diminished Responsibility are concerned with moral knowledge. In practice, this first limb is seldom used exclusively, [121] perhaps because a defendant could rely on the insanity defence instead,

which is a complete defence. Although psychiatrists are often asked to give evidence relating to the insanity defence, [122] this is rightly a matter for the jury to decide because of the question of moral knowledge. Given the similarity with the first limb of the Diminished Responsibility, this should also be decided by the jury.

*J. Crim. L. 451 *Forming a Rational Judgment*

The second limb requires a substantial impairment in the defendant's ability "to form a rational judgment'. [123] This too is ambiguous. In their original proposals, the Law Commission gives several illustrations: A woman with post-traumatic stress disorder believes that only burning her husband to death will rid the world of his sins. [124] A mentally subnormal boy follows his brother's instructions to kill believing that he would never tell him to do something if it was wrong. [125] A depressed man kills his terminally ill spouse after her repeated requests left him feeling that he would never think straight again if he did not. [126] These three examples confusingly conflate rationality with moral judgment despite the Law Commission deliberately omitting the phrase "judge whether his actions were right or wrong' which was their initial suggestion. [127] Ironically, all three examples could be considered rational since they all flow logically from certain premises: religious beliefs about sin, trusting one's older brother's judgment and having a positive view of euthanasia, respectively. Using these as examples, the Law Commission mistakenly gives the impression that it is the wrongfulness of these acts rather than their potential irrationality which matters.

The Law Commission's more recent proposals [128] include the concept of rationally forming a judgment. They define rationality as how a person reaches a decision, not whether the decision itself may be judged to be rational. [129] When examined further, [130] rationality is conceptualised as the capacity to reason intelligently leading to action or to respond to reasons. If this is what rationality means, then the three examples that the Law Commission gave above in their original proposals are rational because they are all based on reasons to do with religious beliefs, trusting an older brother's judgment and beliefs about euthanasia. The Law Commission's illustrations of what constitutes a rational judgment are at best ambiguous and at worst incoherent.

The word "rational' is not a psychiatric term. It is not ultimately a question that psychiatry can answer. Although mental disorder can have an affect on reasoning, rationality has philosophical and social dimensions. Pols argues that there is "no valid scientific theory of (ir)rationality' [131] and that even delusions are problematic because most people have beliefs that appear irrational. [132] She argues that rationality is not the domain of science but rather of culture. [133] Wartofsky agrees that rationality is culturally defined because "it is the norm of rationality which determines sanity in psychiatry and culpability in law'. [134] According to Craigie and Coram, practical rationality consists of procedural rationality (how you reach a decision) and substansive rationality (having rational ends or goals). [135] They argue that capacity, rationality and culpability are closely linked and that incapacity is fundamentally about procedural irrationality. [136] Irrationality is really about illogical processing of information, rather than the choice that is eventually made. [137] The problem with this, as Howard points out, is that if *J. Crim. L. 452 logic is the only criterion for rationality, then "the person who kills his wife thinking that she has been possessed by aliens, is also rational'. [138]

Conroy [139] and *Blackman* [140] confirm the ambiguity in the statutory language of forming a rational judgment. They support the idea that rationality is not a purely psychiatric issue because of the moral dimensions involved and the weight given to circumstantial rather than medical evidence.

In *Conroy,* the defendant who had autism spectrum disorder had strangled his victim in order to have sex with her. He argued that his ability to form a rational judgment was substantially impaired. A plea of Diminished Responsibility was rejected on appeal. One psychiatrist stated that a rational judgment involved being able to "appraise the social, emotional and intellectual dimensions of an action … [his] desire was to have sex and he was unable to form a rational judgment as to how to go about that, in the right way'. [141] Another psychiatrist, however, said that "he was able to think rationally … it was a planned, thought out and instrumental assault'. [142] Lord Justice Davis said that "the fact that the decision was bad or immoral does not make it irrational' [143] and that "many killings as an outcome, although obviously "wrong", are all too "rational"'. [144]

Lord Justice David explicitly addressed the difficulty with the statutory language:

The expression "rational judgment' has not been defined by the Act of Parliament … nor is it an expression used by psychiatrists. Accordingly [the jury] should apply the English language definition of the expression, namely "a considered decision based on reason'.

Nevertheless, he accepted that there could be cases "where an entirely "irrational" decision may be taken … to kill one's neighbour because of a fixed belief that he is an alien from Mars … but that decision [may be] ostensibly logical and rational'. [145] Although the jury must "concentrate on the process and not the outcome of that process', [146] separating them is not always possible. [147]

Significant weight was put on non-medical evidence. A jury should consider "all relevant circumstances preceding … the killing as well as any relevant circumstances following the killing'. [148] Gibson argues that *Conroy* slightly de-medicalises this limb because it includes "relevant circumstances' including personal characteristics which may relate to moral culpability. [149] *Conroy* emphasises that forming a rational judgment is about procedural logic and less to do with psychiatric evidence or the presence of delusions.

In *Blackman,* a marine serving in Afghanistan had originally been found guilty of murder by a court martial. On appeal, he was found to have Diminished Responsibility due to a substantial impairment of forming a rational judgment and exercising self-control [150] due to an adjustment disorder. [151] Video evidence showed what seemed to be a purposeful and deliberate shooting of an injured insurgent [152] which looked like a "cold-blooded execution' [153] to one psychiatrist. Nevertheless, the court concluded ***J. Crim. L. 453*** that his ability to form a rational judgment had been impaired in relation to the need to adhere to the moral compass as set by the Armed Forces. [154] This decision appears to veer toward defining rationality from a moral rather than a logical perspective. Gibson argues that *Blackman* dilutes the concepts of rationality and self-control [155] and makes it more of a moral question. Stuart-Cole shares Gibson's concern and suggests that psychiatric testimony may be manipulated to fit with the Diminished Responsibility requirements. [156] The moral emphasis in *Blackman* appears at odds with the concept of procedural rationality in *Conroy.* Yet either way, they demonstrate that many of the real issues are not psychiatric.

Exercising Self-Control

The third limb requires a substantial impairment in the defendant's ability "to exercise self-control'. [157] In the Law Commission's original proposals, they give the example of a man who believes that the devil takes control of him and implants in him a desire to kill which must be acted on before the devil will leave him. [158] This is a strange example to choose because it appears to be more about delusional beliefs than about impulsivity. Presumably part of exercising self-control is the extent to which desires can be resisted, in this case desires to kill. Fortson argues that it is almost impossible to distinguish between being unable to resist and choosing not to resist, [159] a point recently made by the Law Commission [160] and as long ago as in the case of *R* v *Byrne* [161] under the old Diminished Responsibility. If an impairment of self-control is difficult to prove scientifically, it is less of a psychiatric issue and more a question for the jury.

The Law Commission more recently stated that if "a person cannot choose between right and wrong or … has no power to act on that knowledge, then it is not fair to hold that person criminally responsible'. [162] This blurs the line between having moral knowledge and exercising self-control in acting on that knowledge. In *Blackman,* this distinction between moral appreciation and self-control was also blurred. The court argued that since the defendant had been able to control his emotions previously, his decision to kill must have been impulsive. [163] While this is possible, it could equally be the case that he chose not to control his emotions. If moral knowledge is part of self-control, there is even greater reason to consider it less of a psychiatric issue.

More significant perhaps than the problems with defining self-control is the influence of the concept of loss of control in the new statutory defence of Loss of Control which itself is defined in the 2009 Act. [164] Although analysis of the Loss of Control defence is beyond the scope of this article, it is relevant in relation to the concept of self-control in Diminished Responsibility. This is because the latter assumes that psychiatric evidence is needed to explain loss of self-control to a jury, whereas the former assumes that a jury already understands what loss of self-control is. This exposes a fundamental inconsistency in the legal view of whether loss of self-control is a psychiatric issue.

Like Diminished Responsibility, Loss of Control is a partial defence to murder, leading to manslaughter upon a successful defence.[165] The 2009 Act allows this defence if the killing resulted from a **J. Crim. L. 454* loss of control, if the loss of control had a qualifying trigger and if "a person of D's sex and age, with a normal degree of tolerance and self-restraint and in the circumstances of D, might have reacted in the same or in a similar way to D'.[166] These circumstances can relate to any circumstances other than if they bear on D's general capacity for tolerance or self-restraint.[167] The qualifying triggers include a fear of serious violence[168] or of a thing said or done constituting circumstances of an extremely grave character or causing the defendant to have a justifiable sense of being seriously wronged.[169]

Loss of self-control itself is difficult to define. The Law Commission acknowledged that there was "no statutory definition of loss of self-control'[170] and that "is not a question which a psychiatrist could address as a matter of medical science'.[171] Mitchell argues that it was never clear whether the defendant failed to exercise self-control or was unable to do so.[172] In *R* v *Jewell,*[173] Loss of Control was considered to be "a loss of the ability to act in accordance with considered judgment or a loss of normal powers of reasoning'[174] which sounds more like the impairment of rationality in Diminished Responsibility. In *R* v *Dawes,*[175] it was established that "a reaction to circumstances of extreme gravity may be delayed … loss of control may follow from the cumulative impact of earlier events'.[176] This may be in part due to sympathy toward the so-called "mercy killings'[177] but changes how loss of control is conceptualised. These problems in defining loss of control are also problems for Diminished Responsibility because loss of self-control itself is the same concept whether caused by mental disorder or not.

The difference between loss of self-control in the Diminished Responsibility and Loss of Control defences appears to be the focus of the explanation for the defendant's conduct and the normal/abnormal distinction. As Lord Hughes said in *R* v *Foye,*[178] "Diminished Responsibility depends on the internal mental condition of the defendant. Loss of control depends on an objective judgment of his actions as a reaction to external circumstances'.[179] A further difficulty therefore, arises when a mental disorder potentially affects the way in which someone might react to external circumstances.

Section 54 1(c) of the 2009 Act is often referred to as the "normal person' test because they are treated as if they have a normal degree of tolerance and self-restraint. As a result, evidence of mental disorder, even if part of "circumstances' in Loss of Control, is inadmissible insofar as it affects their tolerance and self-restraint. In *R* v *Mcgory,*[180] evidence that depression affected the defendant's ability to cope with taunting was deemed inadmissible. As Loughnan points out, the law sees a "profound significance of the normal/abnormal distinction'.[181] Loss of Control creates a legal fiction, whereby someone is treated as both normal and abnormal simultaneously.

**J. Crim. L. 455* In *Wilcocks,*[182] psychiatric evidence given in relation to the new Diminished Responsibility was also used for the Loss of Control defence. Evidence of personality disorder was admissible insofar as it was relevant to the "circumstances' in Loss of Control (such as if it resulted in a suicide attempt) but not insofar as it affected one's tolerance and self-restraint.[183] This distinction was later affirmed in *R* v *Rejmanski*[184] where Lady Justice Hallett explicitly said that because of the availability of the Diminished Responsibility defence, "the law does not therefore ignore a mental disorder that … renders him or her unable to exercise the degree of self-control of a "normal" person'.[185] By drawing parallels between the two defences, she implies that the concept itself is the same, but the difference is what has caused the loss of self-control. While psychiatric evidence may demonstrate the existence of a loss of self-control inherent in a particular disorder, a jury do not need a psychiatrist to explain what a loss of self-control is. A loss of self-control is within the experience and understanding of a jury and is, therefore, not a purely psychiatric matter within Diminished Responsibility.

The Causative Link

The 2009 Act requires that the abnormality of mental functioning provides an explanation for D's acts and omissions in relation to the killing if it causes, or is a significant contributory factor in causing, D to carry out that conduct.[186] This requirement is something of an anomaly because no other Diminished Responsibility defence around the world requires this causative link, not even the New South Wales revised plea on which the 2009 Act is modelled.[187] The Ministry of Justice wanted "some connection between the condition and the killing in order for the partial defence to be justified'[188] but both Loughnan[189] and

Mackay [190] dispute the need for a link at all. The Law Commission originally recommended "a significant cause' [191] but was cautious about needing to demonstrate causation on a scientific basis. [192]

During the House of Lords debates, it was said that "it need not be the only cause or even the most important factor in causing the behaviour but it must be more than merely a trivial factor'. [193] The aim was a narrative or explanation without being a necessary or sufficient cause of the killing. [194] On the one hand, it only needs to be "an explanation' but on the other hand, it must have some role in causation. Yet if causation is not necessary or sufficient for the killing, then something that is an almost trivial cause may suffice.

The ambiguity in the statutory wording has led Mackay [195] and Fortson [196] to argue that a link will usually be self-evident and that the threshold is easy to reach. In contrast, Baker argues that demonstrating something to be a significant contributory factor is difficult because of the complexity of criminal behaviour. [197] Research by Mackay and Mitchell found that over 40% of psychiatric reports made no reference to the abnormality of mental functioning being an explanation for the defendant's conduct [198] ***J. Crim. L. 456*** perhaps because this is difficult to demonstrate scientifically. In *Golds,* the issue of causation was "essentially a jury question'. [199] Whatever the exact nature of the link, it is not purely a matter for psychiatry. Although psychiatric evidence may play an important role, demonstrating that a mental disorder had a causative role in the killing will often be an impossible task for anyone.

Conclusion

Although the 2009 Act aimed to "ensure greater equilibrium between the law and medical science', [200] Loughnan and Ward rightly conclude that the "old tensions remain'. [201] As Baroness Murphy said during the House of Lords debates, "Lawyers and psychiatrists … come from different planets'. [202] The mismatch between the thinking of law and psychiatry in homicide cases prior to the 2009 Act [203] has not been resolved. Far from clarifying the role of psychiatric evidence, the medicalisation of the Diminished Responsibility defence merely adds to the role confusion and encourages psychiatrists to comment on the ultimate issue and to tread on the domain of the jury.

Once the statutory language is analysed, it becomes clear that the Diminished Responsibility defence does not relate entirely to psychiatric matters as is often assumed. The question of moral responsibility is not removed but is rather decided in part by psychiatrists under the guise of psychiatric terminology. The abnormality of mental functioning from a recognised medical condition is ultimately a question of law, not of psychiatry. The statutory abilities themselves are not purely psychiatric issues. Although mental disorders may heavily impair the abilities, understanding, rationality and self-control are not psychiatric terms. Rather they have moral, social and philosophical dimensions, which lead to inconsistent interpretation by psychiatrists, juries and the courts. A causative link between the mental disorder and the killing is extremely vague and may not be answerable by anyone. Kennefick rightly concludes that "psychiatrists testifying in relation to responsibility, and juries attempting to decipher complicated psychiatric terminology, results in ambiguity, inconsistency and thus arguably unfair treatment of the mentally disordered offender'. [204]

It is tempting to look to medical science to solve the real problem of moral responsibility, but the result is that psychiatric evidence is given too much authority and is asked questions it cannot answer. In describing the new Diminished Responsibility as "relating entirely to psychiatric matters', the courts have obscured the real issues and have restricted the important role of the jury in deciding the ultimate issue. They have been mistaken in thinking that psychiatry can answer these questions definitively and have encouraged psychiatrists to step outside their area of expertise and usurp the function of the jury.

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