Criminal intent and psychiatric evidence

ARTICLE

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SUMMARY

Although forensic psychiatrists are often asked to comment on a defendant's capacity to form the necessary *mens rea* for their alleged offence, little has been written on how mental disorders map onto legal concepts of *mens rea*, particularly those of intention. In this article we explore legal concepts of *mens rea* and the relevance of mental disorders and alcohol intoxication. We briefly consider philosophical approaches to intentional action and a variety of common mental disorders. We conclude that despite the presence of significant psychopathology it is rare for mental disorders to cause a defendant to lack the ability to form *mens rea*. Experts should therefore be cautious about coming to the conclusion that they do lead to a lack of capacity to form *mens rea* and should make clear the limits of their expertise, given the difficulty of translating clinical mental states into legal concepts of liability.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the legal concept of *mens rea* and how it differs depending on the type of offence
- understand that mental disorders and abnormal mental states may lead to a lack of capacity to form *mens rea* but that this will be relatively rare
- understand when expert evidence is admissible in court and appreciate the difficulty of mapping clinical concepts onto legal concepts.

KEYWORDS

Forensic psychiatrists; psychiatric evidence; criminal Intent; capacity to form *mens rea*; mental disorders.

Forensic psychiatrists in England and Wales are often asked to prepare reports on unfitness to plead, insanity and/or capacity to form *mens rea*. Although there is a substantial body of literature in both legal and clinical journals on the role of expert evidence in determining unfitness to plead and insanity, surprisingly little attention has been paid to the relevance of mental disorder to *mens rea* concepts (such as intention) and the extent to which psychiatric evidence may properly be admitted on this issue. Like insanity and unfitness, *mens rea* terms have specific legal meanings that may not always be appreciated by clinicians. *Mens rea* is not directly concerned with capacity as defined in the Mental Capacity Act 1983 but, rather, with the defendant's state of mind at the time of the alleged criminal conduct and there is a lack of clinical and legal literature relating to how such legal concepts map onto mental states or clinical diagnoses.

Unlike in some other jurisdictions, there is no general defence of diminished capacity in English law. Although it remains possible that a defendant may fail to form *mens rea* owing to a mental disorder, there are few examples of cases in which jurors or appellate courts have found this to be the case. The lack of case law may, in part, reflect the existence of diversionary measures for mentally disordered offenders, but it may also be a consequence of a broad approach to defining *mens rea*, which limits the relevance of mental disorder.

In this article we explore these issues, beginning with the concept of *mens rea* itself.

Mens rea

It is a fundamental principle of Anglo-American criminal law that liability depends on proof that the defendant (D, by convention male) committed the external element(s) of the alleged offence (*actus reus*) with any required fault element (*mens rea*) (*Woolmington v DPP* [1935]). *Mens rea* is about legal culpability, not moral blameworthiness, though the latter may be relevant at the sentencing stage if D is convicted. Not all offences have a *mens rea* component (Box 1), but where they do the *mens rea* may include: intention as to a consequence; knowledge or belief as to a present or future fact or circumstance; recklessness as to whether a result may occur; dishonesty; and/or even mere suspicion. Of these, intention and recklessness are the most commonly encountered. Although most serious offences require proof of intention as to the proscribed result, for some offences proof of either intention or recklessness will suffice. For example, to prove an offence of criminal damage contrary to the Criminal Damage Act 1971, section 1(1), the prosecution must make the

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BOX 1 Offences of strict/absolute liability

Strict liability offences do not require proof of *mens rea* in respect of at least one element of the offence, whereas offences of absolute liability do not have any *mens rea* component. For example, the offence of driving a motor vehicle on a restricted road in excess of the speed limit contrary to the Road Traffic Regulation Act 1984, section 81(1) is committed whenever a person drives a vehicle above the proscribed limit, regardless of whether they know they are exceeding the speed limit, know it is a restricted road or even if they do not realise they are driving.

jury sure that D intended to destroy or damage property belonging to another person *or* that D was reckless as to whether he would destroy or damage any such property.

Somewhat confusingly, legal terms do not always bear their ordinary meanings. For example, the *mens rea* of murder is 'malice aforethought', which means intention to kill or to cause really serious harm (*R v Moloney* [1984]). Some offences use the term 'maliciously', which denotes intention to cause some harm or recklessness as to whether some harm might be caused (*R v Cunningham* [1957]). The terms 'intention', 'recklessness', 'dishonesty', etc. also bear specific legal meanings. Although a non-lawyer might assume that 'reckless' means indifference to the consequences of one's actions, reckless in law is a subjective concept: D is reckless if he takes an unjustified risk that a particular consequence will occur and he is aware of the risk (*R v G* [2003]). Certain other offences require an objective assessment of fault as to certain of their external elements. For example, the offence of rape contrary to the Sexual Offences Act 2003, s.1, requires proof that D intentionally penetrated the complainant (alleged victim, V) with his penis when V did not consent *and* that D did not reasonably believe V was consenting. Accordingly, if V was not consenting but the jury thinks D may have believed V was, they must consider whether such a belief was objectively reasonable. Whenever an expert is invited to express an opinion as to D's capacity to form *mens rea* at the time of the offence, they should therefore consider the following aspects: (a) what is/are the mental element(s) of the offence; and (b) what do these terms mean in law? Further detail may be sought from the party who has requested the report if these matters are not set out in the expert's instructions.

Many academics, judges and law reform bodies have noted that legal and clinical terminology often diverges and that 'the law requires definitive statements, to which psychiatric assessment does not always lend itself' (Law Commission 2013, para 1.58). Psychiatrists are likely to be more comfortable with assessing capacity under the Mental Capacity Act 2005, but this is not the same as capacity to form *mens rea*. The question for the tribunal of fact is whether D in fact formed the relevant *mens rea* at the material time. Psychiatrists will therefore need to consider how clinical concepts of psychopathology and mental state can assist in answering the narrower question of *mens rea*, having regard to the definition of the relevant fault term(s). Psychiatrists may be reluctant to express an opinion on D's exact state of mind at the material time and they should not violate the ultimate issue rule (which we consider in more detail below, after exploring the key concepts of intention and recklessness).

Offences requiring proof of intention

The intersection between the concepts of intention, purpose and motive is illustrated by the Court of Appeal's recent judgment in *R v Casserly* [2024] (Box 2). However, the 'golden rule' is that intent is an ordinary, everyday English word and judges should 'avoid any elaboration or paraphrase' (*R v Moloney* [1984]). If further explanation is required, the jury may be told that a person intends a consequence 'if s/he acts in order to bring it about' and that, in such circumstances, 'it is immaterial that D's chances of success are small' (Judicial College 2023: para. 8-1). This is known as direct intent. However, in certain circumstances, a jury may be entitled to infer intent even though the result was not D's aim or purpose. As the Court of Appeal noted in *R v Nedrick* [1986], 'where [D] realises that it is for all practical purposes inevitable that his actions will result in death or serious harm, the inference may be irresistible that he intended that result, however little he may have desired or wished it to happen'. An example is *R v Woollin* [1999], in which the appellant killed his 3-month-old son by throwing him onto a hard surface. It was accepted that D did want to kill or seriously

BOX 2 Purpose versus intention

In *R v Casserly* [2024], D appealed against his conviction for sending an indecent or grossly offensive electronic communication, contrary to section 1 of the Malicious Communications Act 1988. This offence requires proof that D's 'purpose' was to cause distress or anxiety to the recipient. Quashing D's conviction, the court held that, 'the word "'purpose" connotes something that is a motivating objective', whereas intention is not synonymous with motive.

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harm his son but the prosecution contended that he must have appreciated that serious harm was virtually certain to result from his actions. The House of Lords held that in such cases the jury should be directed that 'they are not entitled to infer the necessary intention, unless they feel sure that death or serious bodily harm was a virtual certainty […] as a result of the defendant's actions and that the defendant appreciated that such was the case'. This is known as oblique intention and is a rule of evidence rather than a rule of law, as foresight of death or serious harm as a virtual certainty is merely evidence from which the jury *may* find that D acted with intent to bring the relevant consequence about (*R v Matthews & Alleyne* [2003]).

Although psychiatrists may be asked to express an opinion as to whether a defendant had the capacity to form intent, as a general rule expert evidence will not be relevant to this issue (*R v BRM* [2022]). A potential role for psychiatric evidence may also arise in the context of a defendant who was intoxicated at the time of the alleged offence. The approach of the common law to the relevance of intoxication is based on public policy considerations, as many crimes, particularly crimes of violence, are committed when offenders are intoxicated. Accordingly, in *DPP v Majewski* [1977], the House of Lords laid down a rule that a defendant who lacked *mens rea* owing to intoxication must be acquitted of a crime of specific intent but remains liable for a crime of basic intent.

Generally speaking, specific intent crimes are those that can only be committed intentionally, such as murder or wounding with intent to do grievous bodily harm (Offences Against the Person Act 1861, s.18), whereas basic intent crimes can be committed with a lesser *mens rea* (typically, recklessness), such as manslaughter or malicious wounding (Offences Against the Person Act 1861, s.20). The terms 'specific intent' and 'basic intent' do not refer to different types of intent but, rather, they are labels used to divide offences into two categories: those for which intoxication may operate as a defence (crimes of specific intent) and those for which it will not (crimes of basic intent).

Care is needed when psychiatrists are instructed to provide an expert report on the issue of capacity to form *mens rea* owing to intoxication, for three reasons. First, although the question is rightly put as one of *capacity* to form intent, the real question is whether D *in fact* formed the requisite intent, and 'a drunken intent is nevertheless an intent' (*R v Sheehan* [1975], and see further, below). Second, although it was suggested by the House of Lords in *DPP v Majewski* [1977] that consuming intoxicants is sufficient to satisfy the element of recklessness for the purposes of a crime of basic intent, a more refined approach has subsequently developed, under which the question for the jury is whether D would have appreciated the relevant risk if he had been sober (*R v Richardson and Irwin* [1999]). Third, some crimes requiring proof of intent are nevertheless crimes of basic intent. Sexual assault, for example, requires proof of an intentional sexual touching but has been categorised as a crime of basic intent and therefore intoxication is no defence (*R v Heard* [2007]).

A drunken intent is nevertheless an intent

In *R v Sheehan* [1975], Lord Justice Lane made clear that, where the possible effect of intoxication on D's *mens rea* is in issue, the question for the jury is 'having regard to all the evidence, including that relating to drink […] whether they feel sure that at the material time the defendant had the requisite intent'. The '*Sheehan* direction' has been repeated or paraphrased many times in the appellate courts and was extended to cases involving involuntary intoxication in *R v Kingston* [1995]. However, a *Sheehan* direction is not a prerequisite in every criminal trial where the accused might have been intoxicated. This is especially, but not exclusively, the case where D puts forward a defence other than intoxication at trial and a *Sheehan* direction might contradict or undermine that defence. For example, in *R v Groark* [1999], the defendant unsuccessfully relied on self-defence at his trial for wounding with intent. The Court of Appeal rejected his contention that the trial judge should have given a *Sheehan* direction, noting that this 'was a case in which [D] was in no way asserting that he was incapable of forming an intention'.

Recklessness

Another commonly encountered form of *mens rea* is recklessness. Prior to 2004, D was reckless if he did an act that created an obvious risk and, at the time of doing so, either he gave no thought to the possibility of there being any such risk or recognised there was some risk involved but nonetheless went on to take it (*R v Caldwell* [1982]). However, in a series of cases in which mentally disordered and/or young defendants were convicted of criminal damage, the doctrine of objective recklessness was criticised as being a harsh test. One such case was *Elliott v C* [1983] (Box 3).

The leading case of *R v G* [2003] involved two boys (aged 11 and 12) who were convicted of arson after lighting pieces of newspaper and throwing them under a bin, which caused a fire that spread to an adjacent shop. They were convicted on the basis that there was an obvious risk that the fire might spread. Their appeals against conviction reached the House of Lords, which took the opportunity to review the law of recklessness and

BOX 3 Recklessness: *Elliott v C (A Minor)* [1983]

The defendant was a 14-year-old girl described as being 'of low intelligence' who had entered a shed, poured white spirit on the floor and set it alight. The magistrates found that she had given no thought to the possibility that the shed and its contents would be destroyed, but convicted her because the risk would have been obvious to a reasonable person.

reinstate a subjective test. It is now the law that, where an office requires proof of recklessness, D acts with the requisite fault if he is aware of a risk that the relevant consequence (e.g. damage) will occur and it is, in the circumstances known to him, unreasonable to take the risk. *R v Cooper* [2004] is a further example of the operation of the subjective test (Box 4).

Knowledge or belief

Some offences (and some defences) require knowledge of a particular fact or circumstance, or a belief that the relevant fact or circumstance exists (or would exist). In the context of rape (discussed above), the prosecution must prove both that V did not consent and that D did not reasonably believe that circumstance (i.e. V's consent) existed. In *R v Grewal* [2010], the Court of Appeal held that voluntary intoxication cannot be taken into account when determining whether D's belief in consent may have been objectively reasonable: 'one has to look at the matter as if [D] were sober'. Similarly, evidence concerning D's mental disorder is irrelevant when the jury are considering whether a delusional belief in consent was reasonable (Box 5).

BOX 4 Recklessness: *R v Cooper* [2004]

The defendant, who lived in supported accommodation, set fire to his mattress and bedding. When asked whether he had given any thought to whether people might be hurt, he replied '[…] it did cross my mind a bit but nobody would have got hurt'. He was charged with aggravated arson, the prosecution alleging that he was reckless as to whether life would be endangered by the damage he caused. D was convicted after the trial judge directed the jury that recklessness fell to be determined objectively. By the time of his appeal, the case of *R v G* [2003] had been decided in the House of Lords and D's appeal was allowed. Lord Justice Rose emphasised that the question now is whether 'the risk of danger to life was obvious and significant *to the defendant*. In other words, a subjective element is essential before the jury can convict of this offence' (emphasis added).

Mens rea and insanity/automatism

To successfully plead insanity D must prove that he was suffering from a 'defect of reason' from a 'disease of the mind' such that either: (a) he did not know the nature and quality of the act; or (b) if he did know it, he did not know that what he was doing was wrong (*M'Naghten's Case* (1843)). 'Wrong' in this context means both morally wrong and legally wrong (*R v Keal* [2022]). Thus, insanity does not necessarily operate by negating *mens rea* (*Loake v DPP* [2017]). Although lack of knowledge of the nature and quality of an act will usually mean the defendant lacked the fault element of the offence, the alternative wrongfulness limb of the M'Naghten test does not depend on lack of *mens rea*. In either case, a successful plea will result in the jury returning a special verdict of not guilty by reason of insanity, which requires the court to make a hospital order, a supervision order or an absolute discharge as per the Criminal Procedure (Insanity) Act 1964. In ensuring that, although not convicted, an 'insane' accused may be detained in hospital for treatment, the special verdict seeks to balance the fair treatment of mentally disordered defendants against the need to protect the public.

There is a related defence of automatism, the essence of which is an inability to control physical actions, either because the 'act is done by the muscles without any control by the mind' or because it is 'done by a person who is not conscious of what he is doing' (*Bratty v Attorney General for Northern Ireland* [1963]). There are two forms of automatism, namely insane automatism and non-insane automatism. The former is a species of insanity and examples include defendants acting during epileptic seizures, hyperglycaemic episodes or while sleepwalking. The hallmark of insane automatism is the absence of an external cause for the defendant's condition. In contrast, where D's state of automatism is caused by an external factor, such as a blow to the head or taking insulin (*R v Quick* [1973]), the defence of non-insane automatism (sometimes known as 'sane automatism') is

BOX 5 Relevance of delusional beliefs in the context of sexual offences

In *R v B (MA)* [2013], D held a delusional belief that he had sexual healing powers and that intercourse would be good for his partner. His mental disorder was irrelevant to whether his belief in consent was reasonable, as a delusional belief is necessarily irrational and unreasonable.

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BOX 6 Where mental disorder not amounting to insanity negated *mens rea*: *R v Clarke* [1972]

Here, the defendant's conviction of theft was quashed on the basis that she lacked the requisite *mens rea* (a dishonest intention to permanently deprive) because of depression. The Court of Appeal explained that her mental disorder fell short of the insanity threshold but did negate *mens rea*. In some jurisdictions, this situation has attracted the status of a separate defence, known as diminished capacity.

BOX 7 Diminished capacity: the Canadian case of *R v Walle* [2012]

D shot V through the heart from a distance of five feet using a rifle that D knew was loaded. He was charged with second degree murder but claimed lack of *mens rea*, i.e. diminished capacity. This was dismissed as 'incredible' by the trial judge and D was convicted. Before the Supreme Court of Canada, D sought to adduce fresh evidence of a number of disorders said to have impaired his ability to form the specific intent required for second degree murder. Dismissing this ground of appeal, Justice Moldaver noted that 'at trial there was no forensic evidence relating to these disorders that could realistically have impacted on the issue of [D's] mental state at the time of the shooting'. The proposed fresh evidence did not suggest that D may not have been aware of the consequences that were likely to follow on shooting someone in the chest at close range.

available. If successfully pleaded, non-insane automatism results in a complete acquittal rather than the special verdict. In addition, whereas a defendant bears the burden of proving insanity (or insane automatism), they bear only an evidential burden of adducing some evidence of non-insane automatism and it is then for the prosecution to make the jury sure that the defence does not apply.

Thus, for all crimes (save for offences of strict/absolute liability), unless insanity is successfully pleaded or the accused is unfit to plead, the prosecution must prove that D committed the *actus reus* of the offence with the required *mens rea*. Accordingly, a mental disorder that does not amount to insanity may theoretically negate *mens rea*. Examples in English law are rare but one striking example is *R v Clarke* [1972] (Box 6).

Diminished capacity in Canadian law

Although impaired or reduced capacity falling short of insanity or automatism is not a defence in English law, a partial defence of diminished capacity is available in some other jurisdictions. In Canada, for example, this defence has long been recognised at common law. As Justice Moldaver explained giving the unanimous judgment of the Supreme Court of Canada in *R v Walle* [2012], a case of second-degree murder:

> 'In the end, what is critical is that the jury be made to understand, in clear terms, that in assessing the specific intent required for murder, it should consider the whole of the evidence that could realistically bear on [D's] mental state at the time of the alleged offence'.

The defence operates in identical fashion to that of intoxication (both in Canadian and English law), i.e. it is available as a means of denying 'specific' intent but not 'basic' or 'general' intent. Hence, it can – in principle – be used to deny the *mens rea* required in, for example, first degree murder (planning and deliberation), second degree murder (intent) and attempted murder (intent). However, it cannot be used to deny *mens rea* for 'general intent' crimes such as manslaughter or aggravated assault.

In the same way that defendants in English courts must adduce evidence of intoxication for that defence to be left to the jury (*R v Groark* [1999]), defendants in Canadian courts must adduce medical evidence to make diminished capacity a live issue (*R v McKinnon* [1989]). In *McKinnon*, the Ontario Court of Appeal stated: This is an evidentiary burden […] It is not the responsibility of the trial judge to conjure up defences which have no basis in fact in the evidence'. For this reason the defence was rejected in *Walle* (Box 7).

The admissibility of psychiatric evidence

The general rule in criminal proceedings is that witnesses are not permitted to give evidence of opinion, save as a means of conveying facts personally perceived. Special rules apply to experts, who may provide the jury with opinion evidence on matters within their area of expertise. They may even be permitted to give their opinion as to the ultimate issue the jury has to determine in a diminished responsibility case but should be wary of commenting on the ultimate issue in other areas (*Pora v R* [2015]). As the Criminal Practice Directions 2023 make clear, expert evidence is only admissible if the following four criteria are satisfied: (a) it is relevant to a matter in issue in the proceedings; (b) it is necessary to provide the jury with information likely to be outside their own knowledge and experience; (c) the expert is competent; and (d) the evidence is sufficiently reliable to be admitted. Some of the appellate decisions discussed above involved experts whose opinions were not sufficiently tethered to the evidence in the case to make

BOX 8 The admissibility of expert psychiatric evidence: *R v Jacobs* [2023]

The defendant appealed against his conviction for rape, relying on fresh evidence as to the effect of autism spectrum disorder. He contended that his inability to understand verbal and non-verbal cues had caused him to mistakenly believe that V was consenting and that this was a reasonable belief for him to hold. The experts at trial and on appeal raised theoretical possibilities in their reports about the effect of autism, but their evidence was not tethered to the circumstances of the incident. Upholding D's conviction, the Court of Appeal held that evidence of autism was *capable* of being relevant but it was not sufficient to merely make 'generalised statements about people who have autism'. The expert must relate their opinion to the facts of the alleged offence and to the defendant's previous experiences in the context of any pre-existing relationship with the complainant and/or with others, if applicable.

their evidence either relevant or capable of assisting the jury (Box 8).

Although psychiatric evidence is routinely admitted in support of defences such as automatism, insanity and diminished responsibility, it is unusual for it to be admitted on the question of *mens rea*, which is typically regarded as an issue on which the jury can form its own conclusions without assistance. For example, in *R v Chard* (1972), the defence were not permitted to adduce the opinion of a psychologist as to whether D, an 'entirely normal' man charged with murder, had acted with intent to kill or to cause grievous bodily harm. For the same reason, expert evidence relating to the ability of defendants with intellectual disabilities (also known as learning disabilities) to form *mens rea* is routinely excluded unless their IQ is below 70.

The Criminal Procedure Rules/Criminal Practice Directions

The Criminal Procedure Rules 2020 (CrimPR) and Criminal Practice Directions 2023 (CPD) set out an expert's duties (www.gov.uk/guidance/rules-and-practice-directions-2020). Experts are under an obligation *inter alia* to draw the court's attention to any question the answer to which would be outside their area of expertise (CrimPR 19.3(b)) and, where there is a range of expert opinion, to explain where within the range their own opinion lies and why (CrimPR 19.3(f); CPD, 7.1.2(h)). Failure to do so may be relevant when the court is determining whether the evidence is sufficiently reliable to be admitted. There may be a range of reasonable psychiatric opinion as to an individual's diagnosis and/or whether their mental disorder supports a defence of insanity or non-insane automatism, but there is perhaps even more scope for varying opinions on capacity to form intent. There is much less scientific literature on the relevance of mental states to criminal intent than, for example, the relationship between psychosis and violence. This is partly because psychiatry is rightly much more interested in explaining behaviour than in determining questions of legal culpability.

When experts address questions of capacity to form intent, they must therefore be careful to make clear the limitations of psychiatric evidence and to focus on *capacity* to form intent, not whether D *in fact* formed such an intent. Although psychopathology may be relevant to capacity to form intent, experts may reasonably differ in their approach to medico-legal mapping. Experts who opine that D did not have capacity to form intent are, if their evidence is accepted, effectively leaving the jury with no option but to conclude that D did not form such an intention (the ultimate issue), leading to an acquittal. Experts should be extremely cautious in coming to this conclusion because of the difficulty of translating clinical mental states into legal concepts. Having considered the legal concept of *mens rea* and the relevance of psychiatric evidence we will now consider a variety of common mental disorders and their relevance to *mens rea*, focusing on the concept of intention.

Psychopathology and intentional action

Humans engage in many unintentional automatic movements, such as a breathing while unconscious or a patella reflex causing a sudden leg extension. Nevertheless, choosing to raise your arm involves desires, volitions or an act of the will (Wittgenstein 1953). Experiments by Libet (1985) and others have questioned the role of conscious intentions in bringing about an action, given that unconscious neural processes are involved. Whether a mental state or event can cause an action is debated. According to Davidson (2001), actions are caused by certain mental states. Agents have intentional explanations and reasons for why they act. The primary reason causing the action is a belief and desire pair: I believe something (if I raise my arm I will get your attention) and have a desire to bring something about (I want to get your attention). Explanation of human action requires justification (whether or not the justification is actually causative); it asks the question 'why', even if people act emotionally or habitually and even if the reason is flawed, illogical or non-existent. This sort of justification may therefore be very 'weak' in the sense that the reasons may be bad reasons but they are reasons nonetheless.

If intentional action requires agents to have desires and beliefs that form primary justificatory reasons for acting, most mentally unwell individuals, including those who are psychotic, will still be capable of carrying out intentional actions because they have beliefs and desires. Beliefs may be delusional and desires may be due to addiction, but such individuals still act for justificatory reasons: 'because the demons will punish me if I don't obey them' or 'because I want another drink'. This kind of justification is still sensitive to reasons.

There are some medical conditions that involve no intentional action, such as generalised epileptic seizures or sleepwalking. In such cases, a defence of automatism may be raised. Tourette syndrome is also used as an example of non-intentional action in the philosophical literature, but it is often said to be partially suppressible and not strictly involuntary (Leckman 2014). For the majority of other mental disorders, conscious voluntary control and the existence of beliefs, desires and reasons for acting are retained. In these cases, it is difficult to argue that such people are unable to carry out intentional actions. The philosophical concept of intentional action is not the same as the legal concept of intent. Nevertheless, it does provide a reasonable basis for determining the relevance of certain mental states to capacity to form intent. If the ability for intentional action (via beliefs and desires) is a prerequisite for criminal liability where *mens rea* involves intention, most people with mental disorder would have the capacity to form the necessary *mens rea*.

Exploring the mental states of those with mental disorders should be done from both a diagnostic and phenomenological approach (Broome 2012) since this gives a more accurate description of the types of beliefs, desires and reasons an individual may have at the material time. To end this section we examine various mental disorders in relation to their ability to prevent a person from forming beliefs and desires necessary for intentional action. We conclude that most of these disorders will not prevent a person from being able to form the necessary *mens rea* in cases of intent.

Depressive disorder

Depressive disorder includes low mood, anhedonia, decreased energy, reduced concentration and psychomotor agitation or apathy. There may be disturbances in feelings of future possibilities, an altered sense of self, a loss of hope and trust in others, immutable guilt, distortions of time, isolation from others, an impairment of agency or control and a sense of having no will to act (Ratcliffe 2014). Nevertheless, only very severe depression (involving catatonia or requiring electroconvulsive therapy) may prevent a person from having desires and beliefs as a justification for intentional action. They may believe that the future is hopeless and may desire to die (leading to tragic cases of suicide pacts) but they are able to form intentions nonetheless. It will therefore be rare for those with depression to lack capacity to form the necessary intent.

Psychotic disorders

Psychotic disorders, including schizophrenia, may involve auditory hallucinations, paranoid delusions, thought disorder, passivity experiences, disorganisation, cognitive impairment, apathy, self-neglect and lack of insight. There may be disturbances in consciousness and in one's sense of self and a lack of or altered volition. A person's agency may be so distorted that they experience an action as being done by an external agency (delusions of control), although in reality they are still the one doing the acting. Nevertheless, most people with psychotic symptoms still form beliefs (some of which may be delusional) and desires (even if a result of paranoia or hallucinatory voices) leading to intentional action. Delusional intent is still an intent (*R v Keal* [2022]). Severe disorganisation, thought disorder, altered volition and severe apathy might prevent a person from forming a belief and desire coherently enough to be the reason for acting. In such severe cases, it might be possible for psychotic experiences to result in a lack of capacity to form the relevant intent, but this will be rare.

Depersonalisation

Depersonalisation is a type of dissociative disorder that includes experiencing the self as strange or unreal and feeling detached from one's feelings, thoughts or actions. There may be concurrent derealisation, with experiencing the world or other people as strange or unreal. Reality testing remains intact in the sense that a person is aware of the 'as if' quality of their experience. Nevertheless, they may be in a dream-like state, feel like they are acting in a film, feel that their bodily movements are not their own and feel that they are acting automatically. There may be sensory perception, self-perception and metacognition. There may be a lack of phenomenal depth whereby the range of possible experiences is reduced or flattened. Nevertheless, despite feeling detached from one's actions, their agency remains intact. A person may form beliefs and desires leading to reasons for intentional action. As a result, depersonalised intent is still an intent (Rix 1994) and is unlikely to lead to a lack of capacity to form the necessary intent.

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) develops following an extremely threatening or horrific event and it is characterised by re-experiencing the event (intrusive memories, flashbacks or nightmares), avoidance of thoughts or memories reminiscent of the event, and a heightened threat response (hypervigilance). A person may perceive seemingly neutral stimuli as threatening owing to the triggering of their trauma memories, and they may overreact to these perceived threats. Nevertheless, reality testing remains intact. Intrusive memories have an 'as if' quality to them. A person may form beliefs (albeit distorted perceptions of threat) and desires (such as avoidance of triggering stimuli) sufficient to form reasons for intentional action. They may act in order to escape perceived dangerous situations. As a result, it is unlikely that they will lack capacity to form the necessary intent.

Borderline personality disorder

Personality disorder is a persistent developmental disorder of abnormal behaviour and inner experience characterised by problems in aspects of the self such as self-identity and self-direction. There is impaired interpersonal functioning and difficulty maintaining mutually satisfying relationships. Borderline personality traits (also called emotionally unstable personality traits) include emotional dysregulation, unstable interpersonal relationships, an unstable sense of self, impulsivity, fear of abandonment, threats or acts of self-harm, chronic feelings of emptiness, intense anger, emotional crises and sometimes dissociative or psychotic-like features of high affective arousal, including the experience of hearing voices. There may be negative affectivity and interpersonal instability along with fragmentation of the self and identity confusion. Despite the impairment in their sense of agency, people with borderline personality disorder nevertheless form beliefs ('people let you down') and desires ('I want to get rid of my negative feelings') sufficient for reasons for intentional action. It may be possible that in severe episodes of intense affective arousal, they are so overwhelmed as to be unable to form coherent desires and beliefs, but this will be extremely rare. As a result, it is unlikely that they will lack the capacity to form the necessary intent.

Alcohol intoxication

Alcohol intoxication (as distinguished from alcohol dependence, withdrawal or alcohol-related psychosis) may involve temporary disturbances in consciousness, cognition (impaired attention or judgement), perception, affect, behaviour or coordination and, in severe cases, may include stupor or coma. If disturbances in consciousness are sufficiently severe (including stupor or coma), it is possible that a person is unable to form beliefs, desires and reasons sufficient for intentional action. The severity would have to be high, since moderately intoxicated people still form desires and intentions. Impairments in judgement, perception and coordination are unlikely to be relevant to forming intentions, although beliefs and desires may be influenced by the intoxication itself. Since voluntary intoxication is no defence to crimes of basic intent this suggests that it will be rare for alcohol intoxication to exculpate on the basis of a lack of capacity to form the relevant *mens rea*. Nevertheless, for crimes requiring specific intent this might be possible if the level of impaired consciousness is very high and there are other aspects of disorganisation. In most cases, however, they are likely to be able to form beliefs, desires and intentions sufficient to form the relevant intent.

Intellectual disability

Disorders of intellectual development (also known as intellectual disability or learning disability) are developmental disorders characterised by significant limitations in intellectual functioning. These include perceptual reasoning, working memory, processing speed, verbal comprehension, conceptual skills (reading, writing, calculating, problem-solving and making decisions), communication, social skills, responsibility (including obeying laws) and practical skills (self-care, health and safety, occupational skills, recreation, use of money, travelling and the use of technology). There may be comorbid mental and neurodevelopmental disorders such as autism spectrum disorder. Given the heterogeneity of intellectual disability, there will be a wide variation in deficits. Nevertheless, the vast majority of people will form beliefs and desires that are sufficient for intentional action and they are unlikely to lack the capacity to form the relevant intent. Those with severe or profound intellectual disability may lack the capacity for the relevant intent, although it is unlikely that they would be prosecuted.

Autism spectrum disorder

Autism spectrum disorder (ASD) is a neurodevelopmental disorder characterised by persistent deficits in the ability to initiate and sustain reciprocal social interaction and social communication, and by a range of restricted, repetitive or inflexible patterns of behaviour and interests. Individuals along the spectrum exhibit a full range of intellectual functioning and language abilities. There may also be changes in one's sense of self, in motor, sensory and perceptual experiences and in social interactions.

Although there is considerable heterogeneity, individuals with ASD may struggle to understand others' behaviour or facial expressions, owing to theory of mind deficits. Such deficits may be relevant in offences such as rape as in *R v Jacobs* (Box 7) as to whether it is reasonable to believe that consent had been given. Nevertheless, people with ASD still form desires and beliefs as reasons for intentional actions, even if desires are driven by inflexible or restrictive interests and beliefs are influenced by deficits in social interactions. They are unlikely to lack capacity to form the relevant intent.

Dementia

Dementia is a neurodegenerative disorder which, in the case of Alzheimer's disease, is characterised by impairments in memory, along with impairments in executive function (such as the ability to plan or manage one's affairs), attention, language, social judgement and visuospatial abilities. Mental and behavioural changes include depression, irritability, agitation, confusion and sometimes psychosis. There may be disturbances in one's sense of self and personal identity, particularly in the later stages of dementia. Although a basic self-awareness is preserved, the ability for self-reflection and deeper self-consciousness is impaired.

For those with mild or moderate dementia, the ability to form beliefs, desires and reasons for acting sufficient for intentional action is preserved. In severe cases of dementia, particularly if there is significant disorganisation, comorbid delirium or psychosis, there may be insufficient coherence for intentional actions, but such cases will be rare. Most people with dementia retain the ability to form the relevant intent despite their deficits in memory and executive functioning.

Delirium

Delirium is an acute confusional state characterised by impairments in orientation, consciousness and awareness, attention, memory, language, perception and cognition. There may be fluctuations during the day and reversal of the sleep–wake cycle. There may be psychotic features such as vivid hallucinations and delusions, in addition to insomnia, disorganisation and agitation. Delirium may be caused by a number of factors, including infections, trauma or metabolic changes, along with medications, alcohol (particularly after withdrawal, as in delirium tremens) or illicit drug use. Pre-existing dementia in addition to old age or comorbid psychiatric or medical illness increases the risk of delirium.

The phenomenology of delirium often leads to profound disturbances in self-awareness, altered states of consciousness and a complete loss of touch with reality, particularly if there are severe psychotic features. As a result, a person suffering from delirium is unlikely to form beliefs and desires coherently enough to be the primary reason for acting. The severity of their disorganisation, impairments in consciousness and their awareness of themselves and those around them would usually lead them to lack capacity to form the relevant intent, although owing to the fluctuating nature of delirium this may not always be the case.

Conclusions

Psychiatric evidence is often required to help courts make determinations, including on matters of guilt. Nevertheless, psychiatric experts must only give evidence within their area of expertise and should acknowledge areas of uncertainty or disagreement, particularly in the mapping of mental disorder onto legal concepts. This is extremely important when offering an opinion on a defendant's (D's) ability to form *mens rea*, because of the overriding objective of ensuring that criminal cases are dealt with justly (Criminal Procedure Rules 2020, rule 1.1) and because of the relative lack of scientific or legal literature written on the topic. Experts should ask for clarification from their instructing party as to the meaning of relevant *mens rea* terms depending on the crime in question.

Given the legal meanings attributed to *mens rea* terms, the nature of intentional action and the phenomena of psychopathology, most people with mental disorder or alcohol intoxication will still be capable of forming the required *mens rea*, particularly in cases of intent. In rare cases where experts form the opinion that this capacity is extinguished owing to the severity of D's mental disorder, this should be clearly explained with reference to the nature of their psychopathology and how it affects their ability to form beliefs, desires and reasons for acting.

Psychopathology such as delusions, mania or addiction may significantly contribute to a person's offending behaviour more generally and to their mental state at the time of their alleged offence. Although the finding of *mens rea* is a matter for the court, experts may assist the court by explaining how and why D was more or less likely to have behaved in the way alleged, given D's particular disorder and presentation. Even if the disorder does not exculpate D on the basis of a lack of capacity to form *mens rea*, this allows the court to take such evidence into account in mitigation in sentencing in the event of a conviction.

Psychiatric experts should be cautious in coming to the conclusion that a person's mental disorder caused them to lack capacity to form the relevant *mens rea* at the material time and should bear in mind that there is no defence of diminished capacity

MCQ answers
1 e 2 b 3 d 4 c 5 d

in English law. If it is the expert's view that D would (or may) have been unable to form the required *mens rea*, they should show how the relevant psychopathology would negate such an ability rather than merely highlighting common symptoms of the disorder or its severity in D's case. Experts must carefully consider the facts of each case rather than making generalised statements about particular diagnoses. In the vast majority of cases, defendants with mental disorders will retain the capacity to form the relevant *mens rea*. Whether they did *in fact* form the relevant *mens rea* is a matter for the court to determine based on all the evidence, including the psychiatric evidence.

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MCQs

Select the single best option for each question stem

1 Which of the following statements about *mens rea* is *true*?

a *Mens rea* is the same as intent for all crimes
b All offences have a *mens rea* component
c *Mens rea* is the same as motive
d Crimes of basic intent have no *mens rea* component
e Intoxication with alcohol is a potential defence to crimes of specific intent.

2 Which of the following is *false* in relation to the admissibility of opinion evidence?

a The witness must be competent to give their opinion
b The evidence must be uncontested
c The evidence must be relevant to a matter in issue in the proceedings
d The evidence must be necessary to provide the jury with information likely to be outside their own knowledge and experience
e The evidence must be sufficiently reliable to be admitted.

3 Which of the following is *true* in relation to psychiatric evidence?

a The expert does not need to give a range of reasonable opinion as long as they are convinced that their opinion is the correct one
b The expert can give an opinion on whether the defendant had the relevant *mens rea* at the material time
c Lack of capacity to form *mens rea* owing to mental disorder is the same as legal insanity
d Rather than give general comments about a diagnosis, an expert should explain how a particular diagnosis or mental state affects capacity to form *mens rea*
e Psychiatric evidence is too unreliable to be admitted as evidence.

4 Which of the following is *true*?

a Capacity to form *mens rea* is the same as capacity in the Mental Capacity Act 2005
b Psychosis always leads to a lack of capacity to form *mens rea*
c In severe depression with catatonia a lack of volition may lead to lack of capacity to form *mens rea*
d Defendants with dementia can never form *mens rea*
e Defendants with autism spectrum disorder usually lack capacity to form *mens rea* in sexual offences.

5 Which of the following is *true*?

a Experts should say that a defendant lacked capacity to form *mens rea* if they think the defendant's mental disorder contributed to the commission of the offence
b Experts can give any opinion they want about capacity to form *mens rea*, because there are no significant implications for justice
c Experts should never ask their instructing party if they are unsure what the relevant *mens rea* components are of the alleged offence
d Experts need to make clear the limits of their expertise and the difficulties in assessing the way in which mental disorder may affect capacity to form *mens rea*
e Experts do not need to fear judicial criticism if they offer unsubstantiated psychiatric opinion which is later seen to be speculative or unreliable.