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Dilemmas for the criminal justice system in dealing with diagnoses for neuropsychiatrically impaired offenders

Abstract

The challenges for judicial education, for legal representatives representing those with neuropsychiatric impairments such as Autism Spectrum Disorder (ASD), Attention-Deficit/ Hyperactivity Disorder (ADHD), Tourette's Disorder (TD), Obsessive Compulsive Disorder (OCD) and Fetal Alcohol Spectrum Disorder (FASD), or a combination of such disorders, and for mental health expert witnesses are extensive. The potentially criminogenic effects of such conditions are recognised amongst some forensic psychiatrists and psychologists but they are misunderstood within the general community, the disorders are often under-diagnosed by mental health professionals, the conditions frequently exist in what may be a potentiating combination, and their effects on culpability for criminal offending can be subtle. This article outlines the essence of ASD, ADHD, TD, OCD and FASD, reviews their forensic relevance by reference to court judgments, and reflects on the need for enhanced awareness of the disorders within all sectors of the criminal justice system. It argues that these neuropsychiatric disorders constitute an area of specialist expertise for forensic mental health experts, requiring particular and informed awareness of and capacity to communicate the complex ways in which such disorders can impair (in particular offenders in particular contexts) capacity to exercise reasoned judgment, to be aware of choices, to be conscious of the repercussions of conduct, to empathise with the situation of potential victims, and the need to control impulsivity. In addition, the capacity of persons with such disorders, as well as with their comorbidities, to cope in a custodial environment is identified as an important issue deserving of informed analysis to assist humane assessment by sentencing courts.

Keywords: Asperger's syndrome, moral culpability, neuropsychiatric impairments, sentencing, imprisonment, autism spectrum disorder, attention-deficit/ hyperactivity disorder, Tourette's disorder, obsessive compulsive disorder, fetal alcohol spectrum disorder

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Abbreviations: ASD, autism spectrum disorder; ADHD, attention-deficit/hyperactivity disorder; TD, Tourette's disorder; OCD, obsessive compulsive disorder; FASD, fetal alcohol spectrum disorder; HFA, high functioning autism

Introduction

Autism Spectrum Disorder (ASD), especially high functioning ASD (hfASD), formerly known as Asperger's Disorder (AD) or Asperger's Syndrome (AS), Attention-Deficit/Hyperactivity Disorder (ADHD), Tourette's Disorder (TD), Obsessive Compulsive Disorder (OCD) and Fetal Alcohol Spectrum Disorder (FASD) constitute a suite of conditions recognised by orthodox psychiatric nosology and generally accepted as potentially criminogenic. A distinctive feature of each is that it incorporates physical signs or behaviours as well as orthodox features of a mental illness, and that it can be under-diagnosed. Each one has the potential in certain circumstances to have an impact upon evaluation of criminal responsibility. More particularly, though, each can impact upon the voluntariness of admissions or confessions made to investigating officials and each is likely to mitigate (to some extent) criminal culpability as each can constitute a background, context and explanation for why criminal conduct has been engaged in by an impaired offender. In addition, each is a condition that impacts upon the experience of imprisonment for the offender. The disorders, however, exist for any given individual along a spectrum with some offenders experiencing severe symptomatology that is highly relevant to their offending, but others experiencing symptomatology which may be minimally relevant to criminal conduct in which they have engaged.

This article considers the disorders, their interplay one with another, and the scenarios in which mental health practitioner expert evidence about them has the potential to enhance a court's understanding of an offender's criminal responsibility and culpability

The disorders

In the 2013 *Diagnostic and Statistical Manual of Mental Disorders*(DSM-5).[1] Asperger's Disorder was omitted and replaced by ASD, with a recognition that persons with the disorder may vary substantially in their levels of functionality. Fundamental to ASD is the fact that it is a neurodevelopmental psychiatric disorder, characterised by deficits in social communication and interaction across multiple contexts, along with engagement in restricted, fixed interests that are abnormal in intensity and focus.[2] The limited ability of persons with the disorder to develop, maintain and understand relationships with others and to communicate non-verbally with others is also an important feature of the disorder and can lead to misunderstandings, stress and confusion in those with ASD.[3] The diagnostic criteria for ASD prescribe that it must commence in the early developmental period but acknowledge that it may not become fully manifest or be recognised at that stage.

ADHD is also a neurodevelopmental disorder which requires the presence of several of the relevant symptoms prior to a person being 12 years of age.[4] It has at its core a persistent pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development in a variety of ways. It is the hyperactivity/impulsivity aspect of ADHD that tends to be more associated with criminal offending because of the propensity of those with the disorder to give little forethought to what they are doing and to the consequences of their conduct. However, both aspects of the disorder involve problematic levels of capacity to focus and give sustained attention to instructions or tasks, and to result in disorganisation and a tendency to engage in conduct without forethought.

TD is a developmental neuropsychiatric disorder which has peak severity in the pre-pubertal period but in about a third of persons it persists into adulthood.[5] Because of the stigmatising nature of the repetitive movements engaged in by those with the disorder, it tends to result in social isolation, low self-esteem and issues related to social management capacity. As Oliver Sacks[6] observed, no two persons with Tourette's are quite the same: there are forms which are "mild and benign, and others of quite terrible grotesqueness and violence". Equally, he observed, some people can "'take' Tourette's, and accommodate it within a commodious personality, even gaining advantage from the swiftness of thought and association and invention which [go] with it, while others might indeed be 'possessed' and scarcely able to achieve real identity amid the tremendous pressure and chaos of Tourettic impulses."

OCD too is a neuropsychiatric condition which is characterised by obsessions, compulsions or both.[7,8] Obsessions are defined by the *Diagnostic and Statistical Manual of MentalDisorders*[1] as:

1. Recurring and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges or images, or to neutralize them with some other thought or action (ie by performing a compulsion).

Compulsions are defined as:

1. Repetitive behaviors (eg hand washing, ordering, checking) or mental acts (eg praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or preventor are clearly excessive.

OCD can have early onset but is relentless and can be highly debilitating, as well as stigmatising.[7,8]

FASD is a neurodevelopmental disorder (ND-PAE) and is defined by DSM-5[1] as a condition characterised by a range of developmental disabilities following exposure to alcohol in utero. The DSM proposes three categories of impairment for ND-PAE, two cognitive and one adaptive:

a. neurocognitive dysfunction (i.e., one or more impairments in intellectual performance, executive functioning, learning, memory, or visual-spatial reasoning);
b. Self-regulation dysfunction (i.e., one or more impairments in regulation of mood, attention, impulse control, or behaviour, all of which require executive control); and
c. adaptive dysfunction (i.e., two or more impairments in communication, socialization, daily living skills, or motor skills).

FASD has distinctive physical indicia in many, but not all, persons with the condition, and is often associated with impaired executive function, giving rise to impulsive and reactive conduct associated with poor appreciation of the repercussions of choices made and actions engaged in.[9]

There is a very high rate of comorbidity in each of the disorders with the other disorders as well as with depressive and anxiety disorders. For instance, the Centers for Disease Control[10] has identified that:

among children diagnosed with TD, 86% also have been diagnosed with at least one additional mental, behavioural, or developmental disorder, such as:

- 63% had ADHD.
- 26% had behavioral problems, such as oppositional defiant disorder (ODD) or conduct disorder (CD).
- 49% had anxiety problems.
- 25% had depression.
- 35% had autism spectrum disorder.
- 47% had learning disabilities.
- 29% had speech or language problems.
- 30% had developmental delays.
- 12% had intellectual disabilities.

Similarly in a study of 2,881 children and adolescents (aged 5–17 years), 67% met the diagnostic criteria for ADHD; 650 (34%) had only ADHD, and 1269 (66%) had at least one comorbid psychiatric disorder (learning disorders: 56%; sleep disorders: 23%; oppositional defiant disorder: 20%; anxiety disorders: 12%).[11,12]

In a 2010 analysis it was found that 90% of respondents with lifetime DSM-IV/CIDI OCD met criteria for another lifetime DSM-IV/CIDI disorder. The most common comorbid conditions were anxiety disorders (75.8%), followed by mood disorders (63.3%), impulse-control disorders (55.9%), and substance use disorders (38.6%).[13] This extent of OCD comorbidity led Accordino et al to observe that "it is crucial that clinicians assessing individuals presenting with OCD-relevant behaviour be equipped with a strong knowledge of the clinical correlates of ASD and potential overlap with OCD."[14]

Vulnerability at interview

The 2015 decision of the Privy Council in *Pora v The Queen,*[15,16] highlights the vulnerability of a number of categories of neuropsychiatrically impaired offenders to confabulation at police interview. Pora had FASD and engaged in multiple sessions of police questioning in relation to the rape and murder of a woman in New Zealand. After a very lengthy series of trials and appeals the Privy Council concluded that there had been a miscarriage of justice in the second of Pora's trials because of the risk that he had confabulated to police during the admissions he made during his interviews:

> Any court must … be astute to examine the reliability of seemingly straightforward confession of guilt where that comes under later challenge. In the present case it is clear that none of the police officers exerted pressure on Pora. Indeed, they were, if anything, fastidiously correct in their treatment of him. The natural inclination therefore is to assume that his confession (which was certainly not the product of any form of coercion) must be true. But it is precisely because of the experience that people confess to crimes that they did not commit that one should be vigilant to examine possible reasons that confessions may be false. … In light of that entirely natural and to-be-expected reaction, careful attention should be paid after the confession has been made to reasons given that it was in fact untrue. Indeed, such is the potential potency of confession evidence that particular care is required in examining whether it reflects the true state of affairs.
>
> The combination of Pora's frequently contradictory and often implausible confessions and the recent diagnosis of his FASD leads to only one possible conclusion and that is that reliance on his confessions gives rise to a risk of a miscarriage of justice. On that account, his convictions must be quashed. (*Pora v The Queen, 2015,* at [57]-[58]).

Erroneous inferences from demeanour

There is always the potential for erroneous inferences to be drawn from demeanour[17] but the risks are exacerbated significantly for persons with each of the disorders discussed in this article. This is especially so with persons with ASD,[18] OCD and FASD. Accused persons may say things that are odd or anomalously expressed; they may interpret questions literally and omit important details in their answers, giving rise to suspicions that they are trying to hide their guilt.[16] They may display a preoccupation with detail or have difficulty answering questions which are imprecisely asked, resulting in their appearing distressed, confused or anxious, all of which reactions may give rise to inappropriate inferences that they are guilty. Persons with ASD often do not make ready eye contact, persons with ADHD are fidgety and restless, indicators in popular expectation of untrustworthiness.[18–20] In addition, those with ASD and FASD may have difficulty experiencing, or at least expressing empathy, which has the potential not just to be alienating but to be confused with indifference or an anti-social personality or orientation. Concentration issues can also be problematic for persons with ADHD, ASD, OCD, TD and FAS, which can manifest in the appearance of distractedness or indifference. A person with TD could give the impression of rudeness and might use obscene language.In addition "stimming", odd, unusual repetitive behaviours, also known as "self-stimulation", often displayed by persons with ASD and OCD, can be distracting and alienating in a courtroom environment.[21–23]

A number of judicial decisions in diverse jurisdictions have grappled with the problems posed by unusual conduct engaged in by persons with ASD and the risk that problematic inferences might be drawn from it, in particular by jurors.

In *Sultan v The Queen* (2008),[24] for instance, the Court of Appeal of England and Wales observed that Tipu Sultan's defence had not been assisted by his "strange behaviour in court, such as reading a book" while his estranged wife/the complainant in a rape trial was giving her evidence. New evidence adduced before the Court of Appeal suggested that Sultan had AS. Ultimately the Court of Appeal quashed Sultan's conviction and ordered a new trial, on the basis that the new evidence could have affected his trial in three ways:

> First, it would have enabled a defence for the first time to be based on the requirements of mens rea. Secondly, it would have enabled the jury to view the defendant before them not solely on the basis of whether what he said happened was at all credible, but more importantly on the basis of whether he was honest about what he believed to have been the situation, even if the facts were otherwise as [his wife] said them to be. Thirdly, *it might have gone some way to explain to the jury why the appellant was behaving so oddly at trial, such as reading a book during [his wife's] evidence*.[emphasis added] (*Sultan v The Queen*, 2008, at [34])

In *McGraddie v McGraddie* (2009),[25] a Scottish case about a commercial dispute, Lord Brodie accepted that there were aspects of the first defender's presentation

> which would be consistent with him having difficulty in communication and in comprehension of context and having difficulty in sustaining a conversational interchange in which there is reciprocal responsiveness to the communication of the other person. … If this is so in court it is presumably also so in other social contexts. Asperger's syndrome may be the explanation for the way in which the first defender gave his evidence. It may not. However, whatever the reason for the first defender responding to questions in the way that he did, taking his responses as a whole I have felt bound to conclude that he was not a witness upon whom I could rely. This is particularly so when it came to his accounts of interactions with other people and the inferences to be drawn from these interactions. To an extent this case is about the reasonable interpretation of what was said and done in a particular social context. I have no confidence in the first defender's ability to come to such a reasonable interpretation. (*McGraddie v McGraddie* (2009) at [13])

He noted that the first defender was casual in his presentation, even when speaking about his mother's terminal illness, referred to his father by his full name, was abrupt and "gave the impression of being wearily exasperated at the questions he was being asked. Perhaps to his credit, he did not seem overly concerned to present himself in a favourable light."(*McGraddie v McGraddie* (2009) at [13]) Problematically for the informedness of the court's capacity to draw inferences in respect of the significance of the first defender's AS, though, an expert report was not adduced, or required by the court, on the issue.

A similar problem occurred in the Western Australian criminal case of *Western Australia v Mack* (2012).[26] Justice McKechnie accepted that Mack faced significant difficulties due to pervasive autism but permitted him to stand trial in a judge-alone matter and allowed him to attend via video-link after counsel for Mack raised the concern that "the accused's unusual personal characteristics may cause him some prejudice in that the jury are distracted by his behaviour or draw adverse inferences against him as a result of such behaviour (*Western Australia v Mack* (2012) at [44]).

However, an example of a more neuropsychiatrically informed decision is the judgment of Lyons J in *R v BCM* (2015).[27] Her Honour noted that a paediatrician diagnosed in a 15 year old child charged with attempted murder of a fellow student "a Pervasive Developmental

Disorder which is variously called Autism Spectrum Disorder or Asperger's Syndrome", along with depression. This contributed to her decision to order a judge-alone trial. Her Honour stated that her "very real concern" was that a jury may misconstrue evidence given by BCM due to his communication difficulties:

> I am satisfied that because of the operation of the applicant's Pervasive Developmental Disorder, he would have difficulties in appropriately giving his evidence before a jury. I am concerned that they may misconstrue his evidence given his unusual communication style. Ultimately, I have been persuaded by Dr Harden's view that lay people often misinterpret the communicative behaviour of young people with Asperger's particularly as it is likely the applicant will act inappropriately in the expression of emotion. There is a real danger in my view that a jury may consider that he is arrogant and detached from the proceedings. I also consider that it is highly likely that in giving his evidence he will act inappropriately by over or under reacting to various matters. In particular, it would seem that he has a tendency to laugh inappropriately in relation to highly serious matters, or become inappropriately upset and angry over what appear to be trivial issues. Those reactions are all due to his developmental disorder. I am satisfied that a jury may have great difficulty in interpreting his evidence because of his behavioural difficulties.
>
> I also consider that the applicant is likely to be disadvantaged as a witness and would have difficulty with cross-examination particularly in a court room given that the applicant would be prone to increased anxiety associated with interpersonal interactions. Whilst that anxiety will exist whether the trial is conducted before a judge and jury or a judge alone, it would seem to me that the anxiety would necessarily be greater before a jury.
>
> There is also a concern that the jury may inappropriately take into account the applicant's demeanour or behaviour whilst giving evidence or during the trial. Because of those factors, there is a possibility that the applicant may not receive a fair trial. (*R v BCM*, 2015, at [36]-[38].

Justice Lyons observed too that a judge-alone trial would provide greater flexibility in relation to instituting strategies to allow BCM to "give evidence in a way which reduces the stress to him in giving evidence due to his recognised communication difficulties. I also consider that a trial before a judge alone can proceed at a more leisurely pace with frequent breaks to allow the applicant to confer with counsel."(*R v BCM*, 2015), at [38])

Sentencing issues: culpability for offending and the burden of imprisonment

There are instances in which neuropsychiatric disorders should be viewed as significantly detracting from persons' culpability for the criminal offences which they have committed. However, this depends upon factors such as the nature of the disorder, the severity of its symptomatology and the extent to which the symptoms experienced at the time of the offending impacted upon the offending. However, this depends also upon levels of neuropsychiatric informedness in the judiciary and on the quality of expert evidence that is adduced.

A survey of 21 United States judges for the California Superior Court by Berryessa[28] in relation to the sentencing of offenders with high functioning autism (HFA) is revealing. Berryessa developed a semi-structured 20-question interview protocol. 15 of the 21 judges reported that when making sentencing decisions a defendant's HFA diagnosis was an important consideration and that information regarding a defendant's diagnosis of HFA may be useful for judges and jurors in helping them to understand how HFA features or symptomology may have been a contributory factor in the individual's offending behaviour. Twelve of the judges reported considering a diagnosis of HFA to be a mitigating or an aggravating factor. A diagnosis of HFA was reported by nine judges as being a potentially mitigating factor but, significantly, three viewed HFA as being a potentially aggravating factor, apparently on the basis that difficulties with impulse control associated with HFA are likely to result in recidivism and thus an ongoing risk against which the community needs to be protected.

Roach et al.,[29] see too,[30,31] summed up the challenge well in the context of HFA:

> The determination of an appropriate sentence for the HFA offender is a challenging task for courts. Although it is increasingly recognized that FASD is a disability that can have a profound impact on the level of an offender's moral culpability, the mitigation that this consideration would normally have on the length of a sentence is frequently tempered by the practical need to protect the community. [Yet often] the programming available to an FASD-affected offender is inadequate and the resources to support and monitor such an individual in the community are severely lacking.

To similar effect the Alberta Court of Appeal in *R v Ramsay*[32] (2012) at [16] conceded that:

> Crafting a fit sentence for an offender with the cognitive deficits associated with FASD presents at least two identifiable challenges; accurately assessing the moral blameworthiness of the offender in light of the adverse cognitive effects of FASD; and balancing protection of the public against the feasibility of reintegrating the offender into the community through a structured program under adequate supervision. Medical reports assessing the prospect of the offender's rehabilitation and reintegration into the community are essential to the task and must be carefully analysed.

In *R v Harper*[33] (2009, at [38]-[39]) Judge Lilles of the Yukon Youth Court commented of an offender with FASD that society is failed because a sentence calculated for a "normal" offender cannot serve the same ends when imposed on an offender with FASD: "it will not contribute to respect for the law, and neither will it contribute to the maintenance of a just, peaceful and safe society. The calculus of sentencing the average offender simply does not apply to an offender with FASD. Not only can traditionally calculated sentences be hopelessly ineffective when applied to FASD offenders, but the punishment itself, calibrated for a non-disabled individual, can have a substantially more severe effect on someone with the impairments associated with FASD."

There is another relevant sentencing factor. The experience of incarceration for offenders with neuropsychiatric conditions is likely to be particularly burdensome. They are likely to be highly vulnerable to being victimised in a custodial environment.[34] In addition, there is the risk that their condition will make the period of incarceration significantly more oppressive than it would be for other prisoners and there is also the danger that the symptoms of their condition will be aggravated by the pressures of the penitential environment. These are all factors which should bear upon judicial assessment of the

appropriateness of the imposition of a custodial sentence, as well as its duration if imprisonment is the sentence selected by a court.[35]

The decision of the Court of Appeal in *R v Balogh* (2015)[36] is illustrative of the potentially mitigating effects of neuropsychiatric disorders. It was an appeal by the United Kingdom Attorney-General against the leniency of a sentence of two years' imprisonment, with a supervision requirement for the same period, imposed on Balogh for rape. In effect this was a suspended sentence with treatment conditions.

Balogh was aged 28 and suffered from Tourette's syndrome, OCD, ADHD, anxiety and depression. He was prescribed medication to alleviate the depression and anxiety and anti-psychotic medication to suppress his Tourette's tics. After a party the complainant had invited Balogh to share her bed but he knew this was not an invitation for sexual activity, as they had shared a bed before, purely to sleep. She awoke to find him initiating sexual activity with her which evolved into sexual penetration against her will. The complainant struggled and cried out, but Balogh placed his hand over her mouth and commenced sexual intercourse with her. During the course of sexual intercourse Balogh "came to his senses" and desisted. He spent time immediately afterwards apologising profusely to her and punched himself while doing so. The complainant made it clear that their friendship was ruined. Balogh took his clothes from the bedroom, dressed, awoke a friend and left. He told his friend that he had "tried it on" with the complainant.

Balogh's behaviour caused him significant ongoing distress and an enduring sense of guilt. Two years after his conduct he tried unsuccessfully to make contact with the complainant. After making several telephone calls to the police, he then attended a police station, taking with him some of his medical records. He was in a state of considerable anxiety. He told the police that he wanted to confess to sexual assault; he thought he needed help. He was arrested, booked into the police station and prescribed tranquillisers. The complainant was then approached by the police and she confirmed that she had been raped by Balogh. She said nothing about her invitation to Balogh to share her bed. The following day Balogh was assessed under the Mental Health Act and judged fit to be interviewed. He pleaded guilty to the offence.

At the sentencing hearing two psychiatrists provided reports. The first, Professor Greenberg, found Balogh to be within the normal range of intelligence but suffering obvious motor and verbal tics. His vocabulary was good but on occasion he had a stutter. He was angered and frustrated by his condition, had mood changes and believed himself to be evil and horrible. He had himself been abused by a 15-year-old male when he was aged six or seven years. He claimed to have had no intention to harm anyone but was worried that he might. In Professor Greenberg's view Balogh's thoughts about women were egodystonic; in other words, he was aware of his thoughts and did not want them, a characteristic found in many of those with OCD. Balogh was a compulsive list-maker and cleaner. His failure to complete his self-allotted tasks caused high levels of anxiety that significantly impaired his quality of life. Professor Greenberg confirmed that Balogh suffered Tourette's syndrome, OCD and depression and observed that one of the accompanying symptoms for some sufferers, including Balogh, was poor impulse control.

Professor Greenberg described the likely presentation of Balogh under the stress of giving evidence at court: he would have jerking movements in his limbs, neck and body and was liable to blurt out words impulsively and without thought. He could give the impression of rudeness and might use obscene language.

In Professor Greenberg's view, the Crown Court's judgment upon the conflicting accounts of the complainant and Balogh might have a material bearing upon an assessment of the contribution made by Balogh's disorder to the commission of the offence. If Balogh's account (that sexual activity was consensual until a few moments after penetration had occurred) was preferred, Balogh's mental health problems would have made a significant contribution to his failure to cease intercourse when the complainant told him to stop. On the other hand, if the complainant's evidence was preferred, the nature and duration of the incident seemed to preclude lack of impulse control as the cause of the offence, although Balogh's poor mental health might be viewed as mitigation.

Professor Greenberg observed that Balogh had what Professor Greenberg described as a "terrible quality of life". He was of the view that Balogh should be assessed by a neurologist or psychiatric expert in Tourette's and should receive psychological counselling to help him "come to terms" with the long-term nature of his problems. He noted that Balogh also had a history of self-harm and that a custodial sentence would cause a deterioration of his mental health at least in the early stages of the sentence.

The second psychiatrist, Dr Bowers, agreed with Professor Greenberg's diagnosis of Balogh's condition and expressed the view that residential treatment was not appropriate for him. Balogh told Dr Bowers that the week before the party he had watched "A Clockwork Orange" in which one scene depicted a male preparing for a sexual assault on a female. Balogh had been obsessing about the costume he would wear to the party. In Dr Bowers' opinion, a number of factors may have contributed to Balogh's offending. First was his obsessive objectification of women. Second, he was disinhibited by alcohol. Third, he had poor impulse control. Dr Bowers warned that a custodial sentence would result in a worsening of Balogh's mental state: it was likely that he would self-harm or worse. A tranquilliser would be required and his mental disorder would need to be managed. Dr Bowers agreed with Professor Greenberg that a multi-disciplinary approach was required: Balogh's medication should be reviewed to reduce his motor tics and specialist psychological counselling was needed to focus on both his obsessive behaviour and impulse control. In Dr Bowers' view the principal risk was for further sexual touching rather than rape.

The Court of Appeal found that the recorder at his trial had been correct to find that Balogh's mental disorder had had a bearing on the commission of the offence. It commented that:

> There were several contributory factors including the offender's thoughts about women, his regard for and physical proximity to the complainant, his consumption of alcohol and his poor impulse control. In part, these were common environmental factors; in part, they were a product of his disordered mental functioning. We accept, however, that the offender retained primary mental responsibility for his conduct. (*R v Balogh*, 2015, at [35])

It concluded that the most significant of the factors that mitigated the offence was Balogh's immediate and distraught reaction to his behaviour:

> No doubt this contributed to the complainant's decision to end the relationship of friendship but not to report the offence to the

> police. There is little doubt that the investigation would never have taken place but for the offender's inability to live with his guilt. It was his report to the police that brought the incident to the forefront of the complainant's mind and caused a renewal of her distress. (*R v Balogh*, 2015, at [34])

The recorder at Balogh's sentencing had concluded that Balogh should receive no credit for his plea of guilty. The Court of Appeal regarded this as "a harsh conclusion" in a case in which the act of non-consensual intercourse had been admitted from the outset: "A discount of about 20% would, we consider, have been appropriate in the circumstances of this exceptional case". (*R v Balogh*, 2015, at [34])

The Court of Appeal commented that:

> What sets this case apart is the distress the offender himself suffers from unwelcome thoughts, his feelings of guilt and fear of catastrophe, and his almost inevitable mental deterioration if required to serve a sentence of imprisonment. In our view, … the recorder would have been justified in concluding that the interests of justice demanded a sentence outside the offence range. While a sentence of 2 years imprisonment (after 20% credit for his guilty plea) might be regarded as somewhat lenient we do not conclude that it is unduly lenient. (*R v Balogh*, 2015, at [35])

The Court of Appeal found that there were grounds for suspending this sentence of imprisonment but found that it was doubtful whether they were adequate to justify suspension; notwithstanding the mitigating factors, a serious sexual offence for which a custodial sentence was required: "It seems to us that the offender himself was aware of the grave wrong he had done and was prepared for the consequences". However, by the time of the hearing before the Court of Appeal (12 weeks later) events had moved on and the Court concluded that it would not be appropriate by that stage to require Balogh to serve an immediate custodial sentence:

> The offender has made a fully committed start to the suspended sentence order. It seems to this court that a rupture of current arrangements could only make more certain serious deterioration in the offender's condition and put at risk a successful outcome on his release from custody. We accept the opinion … that the offender has proved himself to be highly and genuinely motivated to make progress. This is, we conclude, the best possible means of reducing risk further.(*R v Balogh*, 2015, at [41])

The Court of Appeal determined that it was not in the public interest that the sentence should be disturbed so it dismissed the Attorney-General's appeal. The Court of Appeal judgment, as well as that at first instance, constitute an affirmation that neuropsychiatric symptomatology in some circumstances can significantly mitigate blameworthiness for criminal conduct. The extent of Balogh's obsessive contrition was highly relevant. It also highlights the vulnerability of persons with Tourette's and OCD, including within a custodial environment and the potential for a custodial sentence to exacerbate his symptomatology.

In *R v Friend* (2004)[37] the Criminal Cases Review Commission (CRCC) referred to the Court of Appeal of England and Wales the conviction of Billy Joe Friend for murder and his sentence to detention at Her Majesty's Pleasure. Friend did not give evidence at his trial. At the time of his conduct he was aged 14 and at trial he was 15. During the initial hearing in 1996 before the Central Criminal Court Dr (later Professor) Gudjonsson gave evidence on a voir dire about the mental state of Friend and his ability to give evidence in his own defence. It was argued on Friend's behalf that no adverse inference should have been drawn from his having failed to give evidence.

According to Dr Gudjonsson, if Friend was allowed plenty of time and if he could be induced to settle down and concentrate, he was capable of providing a coherent account although he would find it more difficult to listen to questions and to concentrate if he was under stress. Dr Gudjonsson expressed concern about whether Friend could do justice to himself. His distractibility would be a concern. He would not have the same intellectual resources as others. He contended that it was necessary to take an overall view of Friend's ability to concentrate.

However, the trial judge said that it appeared to him that Friend had given a very coherent, even though in certain respects not true, account of what had happened in answers in an interview with police. He took into account that Dr Gudjonsson had said that he was not a very suggestible young man. At the time the power to draw inferences in relation to a failure to give evidence applied only to those of 14 or over, but the judge took the view that that applied to calendar age and not to mental age. The trial judge concluded that on balance Friend's mental condition was not such as to make it undesirable for him to give evidence. He based his conclusion, amongst other things, on the explanation given by Friend in interview, as well as to Dr Gudjonsson when seen by him, and on the powers of the court to ensure a witness was not put under any undue pressure.

Before the Court of Appeal Friend placed reliance upon reports from an expert in adolescent psychology, Dr Susan Bailey, obtained by the CRCC, and a report obtained subsequently by the Crown from Dr Susan Young of the Maudsley. Dr Bailey expressed the view that Friend had features of ADHD. She expressed the opinion that, although he had been adjudged by a small margin as fit to plead, Friend did not have the cognitive or psychological function or capacity to participate effectively in the trial as a result of, firstly, his level of mental impairment; secondly, inattentiveness and lack of ability to concentrate; and thirdly, his emotional state. Thus, it had been undesirable for him to give evidence. Further, she expressed the view that in any event a less emotive setting could have been arranged, such as involving a separate trial or a video link. She said Friend's functional capacities were such that he could only have comprehended simple questions with one concept within a question and that he would have been unlikely to remember earlier answers while giving evidence at trial.

When contacted in relation to the report of Dr Bailey, Dr Gudjonsson said he observed that he had not specifically stated originally that it would be undesirable for Friend to give evidence because he thought that that was an (ultimate) issue for the court to determine. He conceded that if Friend met the criteria for ADHD at the time of his trial then this might have strengthened the arguments that it had been undesirable for adverse inferences to be drawn due to his not giving evidence at his trial. Dr Bailey then saw Friend and after reviewing Friend's account of his early life, his understanding of the offences, the trial process, sentencing and life at Glenthorne Youth Treatment Centre which he had attended, she expressed the view that the information obtained confirmed her prior opinions that he could not effectively have participated in the trial.

Before the Court of Appeal the evidence from Dr Young was important. She identified as the core symptoms of ADHD inattention, impulsiveness and hyperactivity. She estimated that:

> 3-5% of the childhood population has ADHD and symptoms generally gradually remit as they mature. Nevertheless, up to two-thirds of ADHD children will continue to have residual symptoms in young adulthood and it is estimated the disorder is present in about 1-3% of adults or one in every 35 people. Some adults continue to be symptomatic in their 40s or even 50s. (*R v Friend*, 2004 at [25])

She noted that:

> ADHD is a strongly associated with specific learning problems, problems in employment and instability in relationships. Around one-third of ADHD children are subject to a Statement of Special Educational Needs and either receive additional support to cope in mainstream education or referred to special school due to their learning and/or behaviour problems. Comorbid problems are commonly reported including conduct disorder (50%), depression (70%), anxiety (25%) and personality disorder (30%). … a sizeable subgroup misuse drugs and engage in criminal behaviour. (*R v Friend*, 2004 at [25])

Dr Bailey emphasised that:

> Because of their cognitive deficits, individuals [with ADHD] are predisposed towards poor impulse control, an attention deficit and a desire for immediate gratification without consideration for the consequences. There is a significant risk for anti-social outcomes, including criminal behaviour, disinhibited and aggressive behaviour. In addition to these behavioural problems, they suffer a range of neurocognitive impairments, including attentional, executive (ie poor planning, sequencing and organisational ability) and memory dysfunction. Although these deficits appear widespread, it is thought that their neuropsychological basis involves dysfunction in working memory, the self regulation of cognition and future directed behaviour. (*R v Friend*, 2004 at [25])

She concluded that the later residual symptoms of inattention and impulsivity fell within a level of significant impairment and at the time of his trial would have been "considerably more prevalent and severe." She also concluded that his scores for intellectual deficit would have been accentuated by his inability to concentrate consequent upon his ADHD and his anxiety. She expressed the view that the implication of having ADHD and significant cognitive impairments of this type meant that Mr Friend would have had difficulty sustaining attention over a prolonged period, he would have become easily distracted and his mind may have wandered onto different and/or irrelevant topics. In addition, his verbal deficits meant that he was disadvantaged in terms of his understanding of what was being said (ie not understanding the meaning of some of the words used) but his ADHD cognitive deficits meant that he may have completely missed some parts of the process (eg by going off task, ie not listening or 'tuning out'). She commented that: "aside from concentration problems in the witness box causing him to lose his train of thought, Mr Friend may have blurted out the first thing that came to mind. He may have been inconsistent and given conflicting evidence. People with ADHD often speak and act without thinking of the consequences. He may have become emotionally labile, distressed and/or angry when giving evidence. He may not have been able to inhibit a verbally aggressive response. These vulnerabilities are likely to be misinterpreted by a jury. (*R v Friend*, 2004 at [25])

Her opinion was that at the time of his trial Friend was hampered by:

a. severe cognitive deficits associated with ADHD in inattention and impulsivity);
b. poor behavioural controls (hyperactivity, restlessness, emotional liability);
c. verbal intellectual deficits;
d. deficits in short-term verbal memory;
e. anxiety;
f. his young age; and
g. no concessions made at trial.

The Court of Appeal unanimously permitted the fresh evidence and concluded that Friend's conviction could no longer be regarded as safe:

> It is clear that the judge would not have ruled in favour of drawing any adverse inference, certainly in respect of the failure to give evidence, and we think probably also in respect of the interview or silence at the first interview in so far as he did direct the jury that they might do so. Indeed, the Crown has conceded that it would not even have invited any adverse inference as regards the failure to give evidence.
>
> Even if there had been any direction regarding an adverse inference, the judge would still have had to direct the jury with reference to the new evidence and in any event, and quite apart from these points, he would in the light of the new evidence certainly have directed the jury in quite different terms as regards any inference from silence or lies told in interviews. (*R v Friend*, 2004 at [30]-[31])

The Court allowed the appeal and quashed Friend's conviction. The decision is a significant precedent in relation to the potential for ADHD to constitute a mitigating factor for offending by persons with ADHD. [4]

Courts have been variable in their receptiveness to OCD as a mitigating factor for offences involving the possession of child exploitation material. Much has depended on the forensic mental health practitioner expert evidence.

In *R v Grehan* (2010),[38] Holmes, Muir and Chesterman JJA of the Queensland Court of Appeal heard an appeal from the imposition of a sentence of imprisonment of three years and one day, with 18 months to serve, for possessing over 44,000 images of child exploitation material, 36 videos and 36 cartoon images. Most of the images depicted pre-pubescent children. When interviewed about his conduct, Grehan told police he had been collecting the material for five or six years and had paid to download some of it. He said that he had tried to stop viewing and collecting about two years earlier and had erased material from the hard drive of the computers, but felt compelled to renew his activity, and did so.

Expert evidence was adduced at sentencing that Grehan had OCD that had existed since he was a child, as well as marked depression and anxiety. A psychologist's report asserted of Grehan that:

> He appeared to be overwhelmingly preoccupied with details and routines. He is unable to curtail repeated obsessional

> thoughts and compulsive behaviours... (He) presented with depressogenic and catastrophic cognitions, extremely low self esteem and depressed mood. He possesses low self confidence, ineffective coping strategies and a sense of lifelong personal failure.
>
> ... (the applicant's) offending behaviour was maintained by his obsessiveness and ritualistic behaviours. He did not attribute his offending behaviours to his mental illness although the act of collecting and masturbation were perpetuated by the clinical features of obsessive compulsive disorder. Moreover, he possessed erroneous cognitions about his own sexuality and experienced persistent feelings of inadequacy and depression in response to sexual dysfunction and abnormal socio-sexual development.

The psychologist contended that Grehan presented with insight into the seriousness of his actions and appeared motivated to continue to address his deviant behaviour and thought processes. The Court of Appeal observed that:

> It is a common feature in cases of possessing CE material that the offender has much the same defects in personality as this applicant has. The inability to make and sustain normal adult relationships, particularly intimate relationships, lack of self confidence, low self esteem, anxiety, depression and isolation seem to be attributes associated with this particular offence. What distinguishes the applicant from such similar cases is the fact that he has a psychiatric disorder of such severity as to amount to a mental illness.…
>
> The number of images collected and stored by the applicant is vast. Moreover they were collected over a period of about three years. There was, to that extent, some persistence in the offending. On the other hand there can be no doubt that it was the compulsive obsessive psychiatric disorder which led to the persistence in the collection over that time. The images were, it will be remembered, not looked at after their initial collection and storage. (*R v Grehan*(2010) at [28], [37])

The Court determined the sentence imposed to be excessive, observing that: "It must be remembered that the scale of offending was the product, at least in part, of the applicant's mental illness." (*R v Grehan* (2010) at [38]) The Court also noted that:

> Moreover the applicant had already made a commitment to psychiatric treatment and psychological counselling to address his disorders and shortcomings. The need for parole supervision was not, therefore, obvious. The applicant had formed what appears to have been a stable and supportive relationship with a woman in recent years and had taken up residence with her. This appears a positive aspect of rehabilitation, given the applicant's past isolation, and what it led to.
>
> It is also a relevant consideration that the applicant's psychiatric illness and personality inadequacies will make prison for him considerably more difficult than for the ordinary prisoner. This is not a factor which received any recognition, as it should have. (*R v Grehan* (2010) at [38])

This combination of factors led the Court of Appeal to reduce the sentence imposed.

However, the difficulties with the contention that a neuropsychiatric condition has reduced the culpability of offending are exemplified by three Australian decisions.

In *DPP v HPW* (2011)[39] the Victorian Court of Appeal heard an appeal brought by the prosecution contending that the sentencing judge at first instance had wrongly found a causal connection between HPW's AD and his sexual offending, had erred in imposing a manifestly inadequate sentence and had inadequately cumulated the penalties he imposed for a significant number of sex offences committed by HPW.

HPW was found guilty by a jury in the Victorian County Court of eight charges, three of which were representative of many instances of offending, committed against his biological daughter during a time when she was aged 11 and 12. They involved multiple instances of oral, digital and anal penetration as well as instances of masturbation and of encouraging the family dog to lick his daughter's vagina.

When interviewed by the police, HPW admitted sodomising his daughter and explained that it was "just as an experiment". He said by way of explanation that "it was just sexual gratification for myself" and commented that he was "probably a psycho". HPW was aged 47 at the time of sentencing and without prior convictions. He had served a lengthy period of time in the army until he was discharged in 2007 for not handing back grenades. He had two children from a marriage that lasted over a decade, after which he formed a relationship that involved bestiality and anal sex with another woman. A psychologist who examined him concluded that the offending with his daughter finished when "he realised what he was doing".

As commonly occurs, HPW's AD went undiagnosed until after the criminal charges were laid. A psychologist, Dr Goode, who assessed him concluded *(DPP v HPW*, 2011, at [37]) that he had "significant deficits in social interaction; restricted behaviour, interests and activities; clinically significant impairment in social or other important areas of functioning; no apparent language impairment; and no apparent cognitive impairment. He is somewhat atypical in his awareness of his deficiencies in empathy and friendship skills."

Dr Kennedy, a psychologist whose report was tendered at the plea hearing, stated:

> In this case, victim empathy should be commented on for specific reasons, particularly in relation to [HPW]'s cognitive distortion associated with the offences. In this matter, he has reported that while carrying out the sexual offences he considered that [his daughter] *was experiencing the sexual abuse in a matter-of-fact way* as if the activities were normal, and nothing more than her daily activities.
>
> Discussion of this issue occurred at some length. I should note that [HPW] did not appear to be attempting to minimise this behaviour in this [sic], but *was attempting to explain how he saw [his daughter's] response to the sexual abuse*. He thought at the time for her, it was "something to do ... as if it was an activity such as playing cards or watching TV" that *had no impact on her at an emotional level*. When asked about his understanding of the effects of the sexual abuse on [his daughter], he reported in a very distinct way that the impact has been "huge ... I think I've ruined her ... she'll never be able to see me in the same light ... it will be very difficult for her with partners in the future". (*DPP v HPW*, 2011, at [47])

He added that:

> [There is a] focus on deficient empathy, which is clearly relevant in this case, interpersonal naivety which appears to be the case in this matter, sexual frustration which is clearly relevant in this

> case, and immediate confession, which from my understanding, is also present. Additionally, there are sexual preoccupations, which do appear relevant in this case.(*DPP vHPW*, 2011, at [50])

Dr Kennedy expressed the view that at the time of his offending HPW was unaware of the distress he was causing to his daughter but contended that since that time he had acquired genuine empathy and remorse. He observed that there had been no grooming process, as is often seen in six cases.

The Court of Appeal found emphatically, though, that the evidence of the expert gave no support for the foundation of the plea made on HPW's behalf, and which was (wrongly) accepted by the sentencing judge that HPW misread his daughter's behaviour as providing encouragement to him by hints or signals, to engage in the sexual offending. Tate JA found that the psychologist's opinion:

> suggested that the sexual offending occurred in a context in which (1) the respondent had sexual preoccupations with his daughter, fantasising about her in a manner reflective of his previous unusual sexual relationship with an earlier partner of whom his daughter reminded him; (2) he was sexually frustrated with his current partner; (3) his level of alcohol abuse led to disinhibition; and (4) his deficient empathy meant that he believed that his sexual offending was having no emotional impact on his daughter. Dr Kennedy's opinion did not provide a proper evidentiary base supporting the finding of the sentencing judge that the respondent 'may have misinterpreted [his] daughter's cues'. (*DPP v HPW*, 2011, at [53])

She found that the plea by counsel misrepresented the expert report. To the extent that Dr Kennedy had commented "it is highly likely that [HPW's] behaviour is best explained by the presence of an Autism Spectrum Disorder", Tate JA found that it could not support the proposition that there was a causal connection between his conduct and his misreading of his daughter's behavioural cues. This led Tate JA (with Neave and Mandie JJA agreeing) to find a sentencing error. They also found that HPW's AD should not have led to a significant moderation in the sentence imposed upon him, and that his sentence was not sufficiently cumulated to reflect the "debased and humiliating nature of the offending, the core breach of trust, or the effect of the offending upon [HPW's] daughter" (at [82]).

While the Court did not generally find that HPW's Asperger's reduced his moral culpability for the purposes of sentencing, it did accept that it was appropriate to view his disorder as a mitigating factor to the extent that it was likely to make his serving of the sentence in prison more burdensome. However, ultimately it ordered his sentence to be increased from seven and a half years' imprisonment with a non-parole period of five years and six months to nine years and six months' imprisonment with a non-parole period of six years and six months. The decision is a powerful reminder of the fact that, unless a connection is established by expert evidence between anti-social conduct and ASD, the fact that an accused person suffered from ASD should only exercise a moderate impact, at most, on the sentence imposed by a criminal court. If the argument is advanced on behalf of a person accused of sexual impropriety that their ASD caused them to misinterpret cues, a plausible basis will need to be laid, including by expert evidence about their propensity to draw such incorrect inferences; otherwise, the ASD will not be found to have precluded the person's appreciation of the unacceptability of their conduct. In addition, the fact that a person has the propensity to draw such inferences or to fail to respond properly to expressions of disinterest or repudiation of advances serves to underline their ongoing dangerousness. It is prudent for such expert evidence to be coupled, if possible, with evidence that with the benefit of psychosexual education the person has acquired skills at better responsiveness to such communications.

The subsequent decision of the Victorian Court of Appeal in *Gray (a Pseudonym) v The Queen* (2018)[40] took a similar approach. Tom Gray had pleaded guilty in the Victorian County Court to abduction, false imprisonment, two charges of rape, rape by compelling sexual penetration, four charges of sexual assault, sexual assault by compelling sexual touching, five charges of common assault and a summary charge of threatening to distribute an intimate image. Gray was a man of superior intelligence and held a doctoral degree in quantum physics. He was sentenced to 19 years' imprisonment with a non-parole period of 15 years.

On the plea, evidence was called on behalf of Gray from Associate Professor Andrew Carroll, a consultant forensic psychiatrist, who expressed the view that Gray met the criteria for a diagnosis of ASD. He said that Gray had profound impairments in vocational and interpersonal functioning, commenting that "a significant core problem in Asperger's disorder is impaired capacity to empathise with the thoughts and feelings of other people", so that it was "possible" that Gray "was unable to appreciate the full extent of the impact of his behaviours upon the victim". (*Gray (a Pseudonym) v The Queen* (2018) at [29]) The tentative wording that Associate Professor Carroll utilised in this respect ended up being important.

A consultant clinical neuropsychologist, Professor Warwick Brewer, agreed with Associate Professor Carroll, observing that a key feature of AD is the compromised ability of sufferers to relate to another person emotionally. His view on balance was that Gray's AD did not cause his offending but was a "significant contribution to the offending and the nature of the offending." As the offending continued on the second day of Gray's infliction of sexual assaults upon his victim, Gray's anxiety and distress "had continued to compound", and "his ability to formulate rational and reasoned behaviour, or to even respond to what the victim was expressing in terms of distress ... was becoming further [and] more significantly reduced as his distress exacerbated". With respect to Gray's level of executive functioning throughout the offending, Associate Professor Brewer thought that Gray did have "analytical skills" to plan and organise, but his "socioemotional executive function" was subject to a "significant developmental delay, if not arrest, of those features of socioemotional self". As a consequence, Gray's socioemotional executive functioning was "significantly compromised"; put another way, he had "lost the capacity for that normal ability in his cognitive executive function to regulate his socioemotional executive function." (*Gray (a Pseudonym) v The Queen* (2018) at [33])

The trial judge accepted that at times during the period when Gray offended his Asperger symptoms facilitated his regression into a fantasy world and that his mental state was further compromised by insomnia and depression to some degree in the aftermath of a relationship break-up. She concluded that his deficits that facilitated his remaining were wilfully egocentric as regards his desires, and in that sense inhibited his ability to think clearly and exercise appropriate judgement: "The nature of your illness, and to a lesser extent your depression, facilitated you viewing what you were engaged in only within the confines of your desires." (*Gray (a Pseudonym) v The Queen* (2018) at [44]) However, she rejected the proposition that Gray's deficits were causally related to his offending at all times:

> There are clear examples of your cognition engaging and dominating such as to protect your identity, to consider leverage into the future, to deal with issues arising from the mobile phone, to discuss what should be said if the police attended, you lying to police when intercepted. … There is no dispute that you retained your cognitive ability to come to your senses. This was indeed the evidence of Associate Professor Brewer and I think it is clear that at times you chose not to allow reason, or what you knew to be wrong, to stand in the way. You were simply intent upon achieving the gratification you desired, at times conscious as to the effect of victim [sic.] in terms of physical pain and the disgusting nature of the acts … (*Gray (a Pseudonym) v The Queen* (2018) at [44])

The Court of Appeal found this analysis "beyond any legitimate criticism." It observed, without criticism, that the trial judge concluded that Gray was not incapable of appreciating the victim's emotional perspective, but "rather sought to exploit it so as to prevent his crimes coming to light (for example, by use of the video recording), whilst obtaining twisted gratification from her suffering. Importantly, the judge found that the applicant was conscious of the effect of his depredations on the hapless victim 'in terms of physical pain and the disgusting nature of the acts.'" *Gray (a Pseudonym) v The Queen* (2018) (at [46]) In short, therefore, while there was some measure of acceptance by the sentencing judge, and on appeal, that the socio-emotional functioning of Gray was compromised by ASD, he was found to have sufficient awareness of the harm that he was inflicting for his condition not to mitigate his culpability.

In *R v Sokal*uk (2012)[41,42] Coghlan J of the Victorian Supreme Court presided over a trial of a man diagnosed with ASD and a mild intellectual disability who was convicted of ten counts of arson causing death in a rural location, each offence carrying a maximum term of imprisonment of 25 years. The case is notorious in Australia and the subject of a best-selling book.[39] Sokaluk had been found guilty by a jury of intentionally lighting a fire, not with the intention of killing, but recklessly and with the knowledge that his actions would cause damage to property. A senior forensic psychologist, Professor James Ogloff, observed that Sokaluk was distant from others, including his parents. At the time of his offending he was aged 42 and had no forensic history. Professor Ogloff concluded that Sokaluk met the criteria for a diagnosis of ASD:

> his disorder has affected his social and adaptive functioning all of his life. He does not meet the criteria for a diagnosis of a major mental illness or personality disorder at present, although he has been treated with medication in the community for depression and in prison for lowered mood and anxiety.
>
> Whilst his overall level of intellectual functioning is in the borderline range, his verbal capacity is more limited and, in fact, falls in the intellectually disabled range. Conversely, his perceptual capabilities are much better, falling in the low average range. This suggests that while Mr Sokaluk has been able to hold a job, operate a motor vehicle, and live on his own, his level of intellectual reasoning and verbal comprehension is very impoverished. He has been dependent on his parents for maintaining his finances, cleaning his house, and providing him with meals. It takes him much longer to acquire information or to learn a task than would be the case for most others and his abstract reasoning capacity is very limited. His presentation, reasoning, receptive and expressive language are affected by the confluence of his Autism Spectrum Disorder and decreased level of intellectual functioning. For example, he is a very concrete and literal thinker.(at [55])

Notably, though, Professor Ogloff offered no specific evidence on the extent to which Sokaluk's ASD or intellectual disability would have mitigated his capacity to understand the consequences of his behaviour nor how amenable he might be to behaviour modification of a kind that might thenceforth protect the community. It is highly unlikely that this was an oversight on the part of the expert witness. Nonetheless the absence of such evidence meant that the diagnosis of the two conditions is likely to have had relatively little actual impact upon the sentencing process, save to have removed as a factor the proposition that Sokaluk should be used as a vehicle to deter others from similar conduct.

Professor Ogloff's evidence led Coghlan J to conclude that Sokaluk had a mental impairment and for that reason regarded him as having "reduced moral culpability" and therefore moderated general deterrence as a sentencing factor, rather focussing upon the need for deterring Sokaluk from similar conduct. He sentenced him to 17 years and 9 months' imprisonment, and directed that he serve 14 years of the sentence before becoming eligible for parole.The Director of Public Prosecutions appealed the sentence, contending that it was manifestly inadequate (*DPP v Sokaluk*, 2013).[43] However, the Court of Appeal did not interfere with the sentence imposed by Coghlan J.

Each of these three ASD cases from Australia illustrates the fact that a "mere" diagnosis of a neuropsychiatric condition in an offender will not necessarily be regarded by the courts as mitigating an offender's blameworthiness for their conduct – their moral culpability. More needs to be placed before a court – as it was in *R v Balogh* (2015),[36] *R v Friend* (2004)[37] and *R v Grehan* (2010)[38] to establish the forensic relevance of the diagnosis to the sentencing process.

Conclusion

In 2018 Binnie[44] argued in respect of FASD that:

> It seems apparent … that in dealing with the FASD individual, society has not adequately integrated medical science and the exigencies of the law. Legal theory takes into account the individual circumstances of the offence and the offender up to a point but 'the point' often falls short of what is required to justly accommodate the FASD sufferer. As a result, a person who suffers from FGASD may operate at a morally unacceptable disadvantage in the legal system, particularly in the criminal courts. … The FASD sufferer cannot be blamed for his or her condition. The diminished capacity of the individual suffering FASD to comply with normal expectations is rarely either properly diagnosed or accommodated. That reduced blameworthiness should be better reflected in our legal system. (at p35)

This observation has the potential to be equally pertinent to the diagnosis of other neuropsychiatric conditions, such as ASD, ADHD, TD and OCD.

Much depends upon the neuropsychiatric awareness of the legal representatives appearing for a person with ASD, ADHD, TD, OCD or FASD, or a combination of such disorders, with attendant depression and/or anxiety, as is so often the case. In turn this manifests in the quality of mental health expert evidence about the disorders, as it comes before a court, and the views ultimately formed by judicial officers on the basis of previous judicial education on the issues and

the expert evidence adduced in the case before them, some of which will be educative about the subtleties of the disorders, or a combination of them, and some of which will be counter-intuitive.

The evidence adduced in *Love v Government of the United States* (2018)[45], an English case dealing with the unsuitability of a hacker with ASD for extradition to the United States, is an example of how such highly professional assembling of forensic mental health expert evidence, suitably focused on the issues before the court, can result in suitable imparting of expert insights in a forensic context and a just and neuropsychiatrically informed outcome. In *Love v Government of the United States* (2018) the challenging proposition was advanced that removal of the accused man with ASD, anxiety, depression and eczema, from the United Kingdom to the United States away from all sources of support, would lead to an unacceptable risk of suicide and would constitute an unacceptable interference with his human rights because of the oppression which such a step would constitute. The combination of diverse psychiatric and psychological evidence, together with evidence about the counter-therapeutic and burdensome conditions in United States penitential facilities for a person with such a combination of impairments, ultimately persuaded the High Court of England and Wales that extradition of Love was inappropriate. The case mounted constitutes a template for how, most effectively, expert evidence about a neuropsychiatric impairment can be deployed.[46]

The challenges for judicial education, for legal representatives representing those with ASD, ADHD, TD, OCD or FASD, or a combination of such disorders, and for mental health expert witnesses are extensive. The potentially criminogenic effects of such conditions are recognised amongst some forensic psychiatrists and psychologists but they are misunderstood in the general community, the disorders are often under-diagnosed by mental health professionals, they frequently exist in potentially potentiating combination, and their effects on culpability for criminal offending can be subtle and counter-intuitive. Assessment of the relevance of ASD, ADHD, TD, OCD and FASD for both child and adult criminal offending constitutes an area of specialist expertise, requiring informed awareness of and capacity to communicate the complex ways in which such disorders can impair (in particular offenders in particular contexts) matters such as capacity to exercise reasoned judgment; to be aware of choices; to be conscious of the repercussions of conduct; to empathise with the situation of a potential victim; and the need to control impulsivity. In addition, the capacity of persons with such disorders, as well as with their comorbidities, to cope in a custodial environment is an important issue deserving of informed analysis to assist humane assessment by sentencing courts.

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Conflicts of interest

The author declares there are no conflicts of interest.

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