MALINGERED MENTAL HEALTH: LEGAL REVIEW AND CLINICAL CHALLENGES IN ENGLISH AND WELSH LAW

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ABSTRACT

Malingering – the feigning of mental or physical health symptoms for external gain – is a significant problem for clinicians, the courts, and society. For clinicians working in mental health settings, it is a complex task to differentiate malingered presentations from genuine ones, with a range of potential legal and ethical questions facing the clinician who conducts this task. Yet, the malingering of mental health problems has a range of potential impacts. For the courts, malingering presents a significant threat to their basic function by acting as a significant impediment to truth. For society, malingering wastes clinical time, leaves the potential for injustice to occur in response to criminal acts, and has a significant financial burden in unwarranted civil payments. The focus of the present review is therefore to review the issue of malingering from a legal perspective, leading to a consideration of recommendations for a clinician faced with assessing a client suspected of malingering behaviour.

OVERVIEW AND STRUCTURE

The review intends to consider the legal challenges and difficulties for practitioners, including clinicians, who may be faced with the task of working with clients who may be malingering.

Part I addresses the wider clinical and legal context of malingering. To contextualise the basic problem, and the challenges that practitioners might be faced with, the article begins with a summary of two case examples, one drawn from criminal law and one from civil law (Sections B and C). The first, Mr Jones, is a fictitious example within the context of criminal law; the second, Mr A, is a real-world example demonstrating some of the issues that may occur in civil law. After considering these case examples, the article will go on to consider the realities of the assessment of malingering in clinical practice (Section D), as well as summarising the literature that addresses the question of how often malingering might be expected to be observed in various settings (Section E).

Part II then goes on to consider how malingering has been dealt with in relevant law. This review is primarily located in English and Welsh law. This section opens with a review of malingering in military law (Sections A-D), where the only specific offences of malingering in English and Welsh law can be found. Section E then begins to consider the issue of malingering in civil law, with Section F

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considering the more general issue of falsity in civil courts. Section G then begins the review of malingering in relation to criminal law, which includes consideration of key areas where malingering may be relevant in criminal cases. This includes fitness to plead (Section H), the insanity defence (Section I), diminished responsibility (Section J) and sentencing (Section K). A summary is provided in Section L.

Finally, Part III comes full circle, and having reviewed the position in law, considers again the case example of Mr Jones introduced in Part I. The review considers a range of ethical and legal questions that a practitioner working with a potentially malingering client might face, particularly one subject to detention. These include issues around provision of treatment (Section A), informed consent (Section B), the point at which remittal to prison might occur (Section C), how a practitioner might assess capacity (Section D), and to what extent the practitioner is obliged and/or permitted to share professional reports with a court expressing a view about a client who they believe to be malingering (Section E).

Finally, Part IV concludes with an overall review and considerations for the future.

I. INTRODUCTION

A. The problem of malingering

Malingering is by no means a new social, legal or healthcare problem. Indeed, the Bible records the example of the as-yet unanointed King David who, escaping from Saul, 'went to Achisch king of Gath'. Afraid of Achisch's retribution after finding out David was responsible for the deaths of many of his men, David 'pretended to be insane in their presence; and while he was in their hands he acted like a madman, making marks on the doors of the gate and letting saliva run down his beard'.[1] Numerous other examples of malingering have been recorded within history, particularly within the military.[2]

The presentation of malingering, and so the legal challenges it poses, will differ depending on the context in which it is observed and the associated 'external incentive' (see definition, below). One can imagine a range of potential external incentives in the breadth of clinical practice; in forensic psychiatric services, for example, it may present as acute mental health symptoms with a function of avoiding punitive legal sanctions (see case example of Mr Jones; Box 1). In neuropsychiatric services, malingering might present as memory loss or cognitive impairment following a road-traffic accident, where the person seeks to claim compensation from an insurance company. In community health services, malingering might occur in a number of different ways, driven by a

[1] 1 Samuel 21:13 (New International Version).

[2] Ian Palmer, 'Malingering, shirking, and self-inflicted injuries in the military' in Peter Halligan, Christopher Bass, David Oakley (eds), *Malingering and illness Deception* (OUP 2003).

wide variety of external incentives: presentation of feigned psychiatric symptoms in order to obtain admission to hospital and so avoid retribution from a drugs-debt owed; presentation of anxiety or insomnia to obtain medication with potential street value, particularly hypnotics or benzodiazepines; presentation of exaggerated symptoms of trauma to obtain compensation or gain welfare benefit payments.

Clearly, the clinical presentation of malingering is as varied as clinical practice itself, and it must be noted that although the present article is primarily interested in the problem of malingering of mental health problems, it draws upon case law concerning malingering of physical illness also to inform this. It must also be noted that within clinical practice, malingering is just one example of false, exaggerated or distorted responding behaviour more generally (a topic that is itself of much interest, but beyond the specific focus of the present article), and there are many other explanations for distorted or inaccurate clinical responses that are not explained through malingering. To summarise briefly, this can include (but is not limited to) problems such as Factitious Disorder or Factitious Disorder by Proxy (previously known as Munchausen's syndrome and differentiated from malingering primarily through a core 'internal' rather than external incentive); acquiescence, social desirability and other psychological biases; suggestibility; different personality presentations (eg Histrionic personality disorder); effort (which might in turn have another cause such as low mood); other aspects of mental health problems, or even simple practical problems such as uncorrected eyesight or poor hearing. Thus, in defining the behaviour of malingering as the specific focus of the present article, the article uses the American Psychiatric Association's DSM-5 definition:

> [The] intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.[3]

B. Mr Jones

The example of Mr Jones (Box 1) illustrates some of the issues that may be involved in assessment of a client in a clinical forensic context. Although the case is a fictitious one (and so any resemblance to a real-world case coincidental), the issues and questions raised by the case would be familiar to any clinician working in forensic settings. Clinical questions that might arise for the team in reference to this case are detailed in Box 2. These are important to consider, since legal determination of Mr Jones' case will depend heavily on the clinical understanding of his presentation. Prominently, the legal context to the question of malingering in such a case is primarily that in England and Wales a s.37 Mental Health Act 1983 (MHA) disposal puts patients on a discharge pathway that is detached from the Criminal Justice System and means a determinate sentence is not imposed (A s.37 "hospital order" allows a patient,

[3] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, DSM-5* (5th Edition, American Psychiatric Association, 2013).

at the point of sentencing, and following appropriate medical opinion (s.37(2)(a)), to be directed to a specialist mental health hospital instead of serving a custodial sentence. The patient then follows a separate release regime). For a person who has committed a serious violent offence – including manslaughter – this may be an attractive outcome, since there is the potential to be 'released' within a much shorter period – possibly a handful of years - and be detained in the more pleasant surroundings of a psychiatric hospital. In Mr Jones' case, the fact he is charged with murder may lead to other potential incentives during the trial (in particular, the partial defence of diminished responsibility) as well as those open to other defendants (eg the insanity defence). Both of these defences are considered in more detail later in this document.

Box 1: The fictitious case example of Mr Jones

Mr Jones is a 34 year-old man who has just been admitted to Woodvines Medium Secure Unit. Ten weeks ago, he was arrested for the murder of his girlfriend, who was found dead at their home after neighbours reported hearing an argument and distressed noises in Mr Jones' flat. Mr Jones was arrested shortly afterwards after police officers broke down the door to the flat. He was reported to be very angry and agitated and was shouting at police officers when arrested. His girlfriend's body had over 40 stab wounds to various parts of the body and the flat was described as 'carnage'. When in police custody there were no overt signs of mental illness although he had been noted to sometimes appear quite emotionally withdrawn.

He gave a 'no comment' interview to police on the advice of his solicitor except for one point when he clearly became angry or upset and shouted 'I just wanted to teach her a lesson... I never meant to kill her'. Mr Jones was noted to have 'broken down' after this point, and his solicitor quickly requested a break in proceedings.

He was remanded to HMP Ravens Hill and remained there until admission to the secure unit. No concerns regarding his mental health were picked up during the reception interview, but it was noted that he had a history of problematic drug use, although did not require treatment for dependency upon reception. A history of depression was noted but he was not assessed as a suicide risk and was placed in an ordinary location. No unusual behavioural observations were noted by prison officers. Three weeks after his arrival at the prison, however, he requested to see a prison doctor and reported for the first time that at night time he heard a loud voice in the evenings which shouted his name and commanded him to kill. He told the doctor he had been hearing the same voice for over a year but had not told anybody. The doctor arranged for an admission to the healthcare wing of the prison. Upon admission to the healthcare wing, Mr Jones was observed to be frequently shouting (apparently to other people) in his cell and was noted as being aggressive towards nursing staff. Nursing staff describe him as paranoid and suspicious. He is prescribed medication but refuses to take it, shouting at the doctor that he is trying to kill him. Ultimately, he is assessed by psychiatrists and transferred to Brookvale Medium Secure unit under s.48/49 of the MHA.

Box 2: Questions that the clinical team will need to consider following the admission of Mr Jones to their unit

- What accounts for Mr Jones' apparent behavioural disturbance?
- Did Mr Jones have a latent or undetected psychotic presentation prior to the alleged offence?
- If he did, could this have been a partial or complete explanatory factor for his alleged actions in the offence?

- Are the presenting psychotic features genuine? (Or: are they all genuine? If malingering is detected and accounted for, is there any element of genuine mental health problem present?)
- What treatment should be given, potentially against the person's will? How will the response to that treatment be evaluated?
- Does Mr Jones have capacity to make decisions about his healthcare and treatment? (not just those issues of treatment determined under the MHA)
- How can important historical elements of the narrative be verified? (eg behavioural observations from those who knew him prior to the alleged offence)

C. Mr A

The example of Mr A (a real-world case, identified and publicised in the press, but with name removed for the present publication) is perhaps more common and less complex than that of Mr Jones, but would still pose a challenging assessment for any practitioner. The case also illustrates the potential relevance of malingering within civil law. The issues in Mr A's case are by no means unique: one could draw upon many similar stories from the pages of the tabloid press.

Most cases like that of Mr A are dealt with by the lower courts and are not appealed, thus one must rely on journalistic reporting to gain an understanding of events. In Mr A's case the outcomes were published in the Telegraph,[4] Daily Mail,[5] and Daily Star.[6] The reporting details how he claimed £15,000 in Employment Support Allowance and Housing Benefit, reportedly claiming he could not work because he was suffering from a 'split personality disorder'[7] as well as anxiety and depression. He was convicted after pleading guilty to 'four charges of making a false statement to obtain housing benefit and employment support allowance'. The specific statute under which he is convicted is not detailed.

Notably, whilst the journalistic reporting focused on the discrepancy between his claimed illness and photographic evidence reporting him skiing, scuba-diving, and on holiday in front of the Eiffel Tower, the case made by the Department for Work and Pensions seemed to focus on evidence that he had been working in dealing with scrap metal whilst at the same time claiming benefits that required him to be unable to work. This introduces some of the

[4] Ceila Walden, 'Our sympathy for anxiety sufferers is being exploited by the cynical' *Daily Telegraph* (London, 22nd March 2017) <https://www.telegraph.co.uk/women/life/sympathy-anxiety-sufferers-exploited-cynical/> accessed 10th March 2021.

[5] Martin Robinson, 'Around the World… on the taxpayer!' *Daily Mail* (London, 20th March 2017) <http://www.dailymail.co.uk/news/article-4330670/Holiday-snaps-shameless-father-32-benefits.html> accessed 10th March 2021.

[6] Andrew Jameson, 'Benefits cheat who sponged 15k of taxpayers' cash gets caught by posting pics on Facebook' *Daily Star* (London, 20th March 2017) <https://www.dailystar.co.uk/news/latest-news/598458/benefits-cheat-taxpayers-cash-travelling> accessed 10th March 2021.

[7] On this one must point out that 'split personality disorder' is not a recognised or established disorder in any contemporary nosology or classification of mental illness. Whether this was indeed the term used by any clinicians who may have assessed Mr A is of course unknown.

difficulties in other civil cases where demonstrating malingering, particularly of apparent mental health impairment, is legally difficult: impairment that might prevent someone working may not prevent someone from taking a holiday; a demonstration that somebody has been working whilst claiming not to be able to is a much easier contradiction to prove.

D. How is malingering assessed in Clinical Practice?

Although the present article is primarily concerned with the legal aspects of malingering, it is important to summarise at the outset the context of malingering from the position of a clinician potentially dealing with the issue. The clinical context is important as it will inevitably influence the way such evidence might be brought to bear in the courtroom.

In most cases of healthcare provision there is a common fundamental aim: identify the problem (clinicians might use frameworks such as 'diagnosis' or 'formulation' to achieve this), and provide appropriate treatment or intervention.[8] Typically, the treatment that follows rests on the way in which the underlying problem is understood. The medical law that has built up over the years assumes that medicine, and clinical practice more generally, follows this same basic pattern. Malingering violates this fundamental assumption: the person seeking help aims to emulate the symptoms of a problem; not to gain treatment or intervention for a disorder, but for some other external reason. This fundamental shift changes the legal landscape in which the clinician operates, turning the clinician's task from that of identifying the nature of a genuine complaint, to that of identifying whether or not the complaint is itself genuine.

Regardless of whether the law requires the presence of malingering to be demonstrated on the balance of probabilities, or to the criminal standard (which will depend on the nature of the proceedings themselves), the consideration or acceptance of malingering by a court requires evidence of its presence. To accuse somebody of malingering is to accuse them of lying. Whilst clinical assessment can incorporate a number of strategies to assess malingering (or indeed other forms of false responding), conclusions about this complex behaviour are rarely given in black and white terms. As will be seen, the assessment of malingering raises ethical and potentially legal questions for the clinician. This is highlighted by considering the regulations that govern the more concrete use of video surveillance (which as will be seen, is commonly used within the civil courts). Here, there is a requirement on professional investigators to be registered with the SIA (Security Industry Authority),[9] and

[8] Academy of Medical Royal Colleges, 'Common Competencies Framework for Doctors' (2010) <https://www.aomrc.org.uk/reports-guidance/common-competences-framework-doctors/> (accessed 10th March 2021); British Psychological Society, 'Good Practice Guidelines on the Use of Psychological Formulation' (2011) <https://shop.bps.org.uk/good-practice-guidelines-on-the-use-of-psychological-formulation> (accessed 10th March 2021).
[9] Private Security Industry Act 2001, s.3, Schedule 2.

the Association of British Insurers publishes guidance[10] to insurance companies to ensure their activities do not lead to legal challenge (eg by contravening the Data Protection Act,[11] or coming within the scope of the Regulation of Investigatory Powers Act).[12] Accusing somebody of lying in a legal context is never done lightly.

In this regard, one must note the process of clinical assessment in a case of potential malingering. Malingering is a 'diagnosis of exclusion', thus other clinical considerations and explanations must be considered first, and a clinician would be much more likely to focus an assessment in understanding a problem more widely, than asking, from the outset, whether a presentation is malingered or not. The process of clinical assessment of a client who may be suspected of malingering typically requires a full clinical assessment including taking a full clinical and developmental history, review of relevant records, and extensive discussions about the nature of the person's beliefs, reasoning and view of the world. If unreliable reporting is identified, the clinician may use strategies to try to understand the nature of the unreliability further, for instance by changing the order or nature of questions asked and repeating these questions at different times, asking about unlikely, unusual or extreme patterns of symptoms,[13] exploring inconsistencies within and between self-report, the report of others, and the person's behaviour, and looking for mismatches between the apparent patient's reported symptoms and those that might more typically occur.[14] In addition, clinical psychologists may well administer specific psychological tests which are either designed in their methodology to identify

[10] Association of British Insurers, 'Guidelines on the instruction and use of Private Investigators' (2014) <https://www.abi.org.uk/globalassets/sitecore/files/documents/publications/public/2014/crime/guidelines-on-the-instruction-and-use-of-private-investigators-and-tracing-agents.pdf> (accessed 10th March 2021).

[11] Data Protection Act 1998, s.55.

[12] Regulation of Investigatory Powers Act 2000, s.26-27.

[13] For instance, it is known that most people who experience visual hallucinations typically do so in colour; asking somebody who is malingering but reporting visual hallucinations whether their experience is in colour or black and white will force the person to make a choice that may reveal an unlikely pattern of experience (Philip Resnick and James Knoll, 'Faking It: How to Detect Malingered Psychosis' (2005) 4 Current Psychiatry 11). A response indicating visual hallucinations were in black and white would be unusual in genuine psychosis. However, in this case, an experienced clinician would also be aware that black and white hallucinations might occur in some cases of more organically driven psychosis (eg Charles Bonnet Syndrome, where apparent psychotic symptoms are linked to ocular impairment).

[14] Richard Rogers, *The Clinical Assessment of Malingering and Deception* (3rd Edition, The Guildford Press, 2008); Grant Iverson and Laurence Binder, 'Detecting Exaggeration and Malingering in Neuropsychological Assessment' (2000) 15 Journal of Head Trauma Rehabilitation 2; Anne Mason, Rebecca Cardell and Merry Armstrong, 'Malingering Psychosis: Guidelines for Assessment and Management' (2013) 50 Perspectives in Psychiatric Care 1; L Paul Chesterman, S Terbeck and F Vaughan, 'Malingered Psychosis' (2008) 19 The Journal of Forensic Psychiatry and Psychology 3.

malingered and other factitious presentations,[15] or which have within them scales that identify distortion, inconsistency or over-reporting of symptoms (alongside other scales that may help identify the presence of different types of mental health problems or personality types).[16] Although most clinicians would likely resist such a definition on the grounds that such tests can never assess the incentive behind detected patterns of exaggeration or distortion, these assessments are probably the closest thing to a 'malingering test'; but they are by no means infallible, and must be interpreted by a skilled clinician in the context of all the available assessment data. A particular ethical issue for clinicians who use such instruments, not directly considered in the present paper, is the challenge of protecting the validity and methodology of such assessments from being exposed in the face of requirements from courts to explain methods of assessment and, of course, the internet. This is an increasing challenge as test materials and methodologies are increasingly published, cited or reprinted in some form in publicly accessible journals.

There is very little, however, to ensure that clinicians do follow all these lines of enquiry, and very little research to suggest how successful clinicians are, in practice, in detecting malingered presentations. One risk in this regard is the fact there is surprisingly little evidence of structured quality appraisal of any clinical assessments (regardless of whether malingering is considered) that are presented to the courts.[17] Clearly, however, the situation does cause problems. One might look to the case of *BN v Secretary of State for the Home Department*[18] for an example where a psychiatrist, who did not address directly concerns that that the appellant was malingering, was subject to some judicial criticism (although this was significantly tempered from the criticism provided in the original judgment):

> [I]t was Professor Prasher who pointed out that there were three possible explanations, alone or in combination for the symptoms described and seen: medication, malingering, and genuine illness. He took steps to eliminate the first. But he never returned to the second in either report, whether to say that no view could be formed or that he had concluded, and if so why, that the symptoms were or might be genuine or not. That is

[15] For example: HA Miller, *Miller Assessment of Symptoms Test: M-FAST; Professional Manual* (PAR, 2001); Richard Rogers, K Sewell and N Gillard, *SIRS-2: Structured Interview of Reported Symptoms* (PAR, 2010); T Tombaugh, *Test of Memory Malingering: TOMM* (Pearson Clinical, 1996).

[16] For example: Theodore Millon, C Millon, R Davis and Seth Grossman, *Millon Clinical Multiaxial Inventory (MCMI-III) Manual* (Pearson/Psychcorp, 2009); L C Morey, *Personality Assessment Inventory* (PAR, 1996); J Butcher, W Dahlstrom, J Graham, A Tellegen and B Kaemmer, *Minnesota Multiphasic Personality Inventory (MMPI-II) Manual for administration and Scoring* (Minnesota University Press, 1989).

[17] One might remark that this is a much wider problem relating to all clinical assessments conducted for the courts (see for example Cathryn Rodway, Victoria Norrington-Moore, Louis Appelby and Jenny Shaw 'An examination of the quality of psychiatric reports for juvenile perpetrators of homicide' (2011) 22 The Journal of Forensic Psychiatry and Psychology 895, or EP Larkin and PJ Collins, 'Fitness to Plead and Psychiatric Reports' (1989) 29 Medicine, Science and the Law 26.

[18] *BN v Secretary of State for the Home Department* [2010] UKUT 279 (IAC).

not satisfactory.[19]

Psychologists, too, have been subject to such criticism. Simon McCarthy-Jones and Philip Resnick's 2014 article[20] raises serious concerns about practice in relation to assessment of auditory hallucinations. The article is a substantive review of the phenomenology of auditory hallucinations as expressed by people with genuine psychosis and those who are malingering. Worryingly, it cites as an example the US case of *People v Jefferson*[21] in which a court-appointed psychologist doubted the validity of the defendant's symptoms on the basis that 'schizophrenics typically described voices 'as coming from inside their head and being of either famous people or strangers or groups of people'', which was inconsistent with the defendant's reported experience. The paper points out that the assumption on which this assessment rested is countered by evidence that people with genuine psychosis do not always report the symptoms coming from inside their head, and clearly people with psychosis do hear voices of people who are known to them. Clearly there is a significant risk to justice if clinicians themselves do not have adequate knowledge of the apparent disorder they are assessing.

As can be seen, malingering is a challenging focus of any clinical assessment. However, clinical assessment is often the only option for detecting malingering in the case of fabricated mental health symptoms. Clinical assessment, too, is much more able to speak to the wider context of, and motivations behind the malingering act than other techniques such as video surveillance, which can by definition only provide an account of behaviour. This might lead to a reasonable expectation that in different court settings, where different clinical-legal questions were asked of mental health experts, there was a rigorous process of quality assurance for clinical assessments presented to the court, and perhaps some process outlining minimum standards and expectations for a clinical assessment. However, this is in general the exception rather than the norm, and clinicians typically have latitude to determine the way in which a clinical assessment should answer a legal set of instructions.

E. How common is malingering?

This is undoubtedly a difficult question to answer. In addition to the usual issues in determining the frequency of any particular index behaviour (for instance, it will depend on how the behaviour is defined and measured, and on the population considered), malingering presents the additional problem that it is logically impossible to know how many people are 'successful' in any given context.

Nonetheless, various pieces of clinical research indicate that malingering – or at

[19] ibid [44].

[20] Simon McCarthy-Jones and Philip Resnick, 'Listening to Voices: The use of phenomenology to differentiate malingered from genuine auditory verbal hallucinations' (2014) 37 International Journal of Law and Psychiatry 183.

[21] *People v Jefferson* (2004) 119 Cal App 4th, 508.

least the broader concepts of false or distorted symptom responding – is more common in clinical practice than would commonly be assumed. A brief review of some of the primary authorities in the clinical literature is summarised in Table 1, though it is acknowledged that a fuller systematic review of these authorities would be warranted. Nonetheless, if these estimates are even close to representing the true frequency of malingering within people presenting with clinical problems in the English and Welsh court system, it can clearly be concluded that the problem is under-recognised and given insufficient attention. This conclusion seems to stand in contrast with a conclusion from Jill Peay's[22] recent review of 'legal malingering' that 'the fear of legal malingering may be more powerful than its occurrence'.

Despite this, there is evidence to suggest that clinicians instructed in cases, even in settings where rates of malingering may be elevated, may only infrequently address the issue directly within their clinical assessment. Matthew Large and Olav Nielssen,[23] for instance, conducted an audit of medico-legal reports in Australian personal injury cases. The extent to which 'veracity and corroboration' was considered within each report varied depending on the position of the clinician: treating clinicians only considered the issue 21% of the time; clinicians instructed by the plaintiff considered the issue 35% of the time; clinicians instructed by the defendant considered the issue 55% of the time. Perhaps of more concern, Tess Neal and Thomas Grisso,[24] although not addressing the issue of malingering directly, asked a large sample of clinicians who had completed the court reports to provide details on specific structured assessments used in their two most recently submitted court reports. Whilst a specific assessment of memory malingering and a specific assessment of malingered mental health symptoms did feature in the 'top 10' most frequently used assessments, they were only used, on average in 3.2% and 2.8% of reports respectively.

Table 1: Summary of studies aiming to estimate prevalence of malingering or false symptom responding in various clinical samples

Author and reference	**Sample**	**Conclusions**
W Mittenberg and others 2002[25]	33,531 cases referred for neuropsychological evaluation: 6371 personal injury; 3688 disability; 1341 criminal; 22,131 medical cases	'Diagnostic impressions of probable malingering' in: 29% personal injury; 30% disability; 19% criminal; 8% medical cases

[22] Jill Peay 'Legal Malingering: a vortex of uncertainty' (2019) LSE Law, Society and Economy Working Papers 10/2019, <http://ssrn.com/abstract=3406572> accessed 11th March 2021.

[23] Matthew Large and Olav Nielsen 'An Audit of medico-legal reports prepared for claims of psychiatric injury following motor vehicle accidents' (2001) 35 Australian and New Zealand Journal of Psychiatry 535.

[24] Tess Neal and Thomas Grisso, 'Assessment Practices and Expert Judgement Methods in Forensic Psychology and Psychiatry' (2014) 41 Criminal Justice and Behaviour 12.

[25] Wiley Mittenberg and others, 'Base rates of malingering and symptom exaggeration' (2002) 24 Journal of Clinical and Experimental Neuropsychology 1094.

B Ardolf, R Denney and C Houston, 2007[26]	105 criminal defendants for neuropsychological assessment	'The combined rate of probable and definite MND was 54.3%'
D Clifford, M Byrne and C Allan, 2011[27]	154 referrals to forensic psychologists, involved in litigation.	31% of scores above cut-off on psychometric test (MMPI-II) known to be associated with malingered presentations
JL Lewis, AM Simcox and D Berry, 2002[28]	55 men undergoing pre-trial evaluations for competency to stand trial/criminal responsibility	44% scored above cut-off on measures designed to detect malingered symptoms
P Gold and C Freuh, 1999[29]	119 veterans referred for assessment of PTSD	14-22% classified as 'extreme exaggerators'
KW Greve, JS Ord, KJ Bianchini and KL Curtis, 2009[30]	508 patients referred for evaluations of chronic pain (where financial incentive is present)	20-50% depending on definition and assessments used
J Denning and R Shura, 2017[31]	74 veterans assessed for compensation in relation to mild Traumatic Brain Injury (mTBI)	33-52% of sample found to be malingering. Estimated national costs to US treasury based on malingering of mTBI symptoms of $136-$235 million/year.

Worryingly, there is evidence that the judiciary may also underestimate the frequency of malingering, and further, may overestimate the degree to which clinicians can successfully identify malingering without specific assessment.[32] One struggles to find English or Welsh authorities that have given an indication as to the judiciary's beliefs on this matter, but the Canadian authority of *Chaulk and another v R*[33] highlights this problem. Part of this judgment reviews

[26] Barry Ardolf, Robert Denney and Christi Houston, 'Base Rates of Negative Response Bias and Malingered Neurocognitive Dysfunction among Criminal Defendants Referred for Neuropsychological Evaluation' (2007) 21 The Clinical Neuropsychologist 899.

[27] Danielle Clifford, Mitchell Byrne and Chris Allan, 'Getting Caught in Court: Base Rates for Malingering in Australian Litigants' (2011) 11 Psychiatry, Psychology and Law 197.

[28] J L Lewis, A M Simcox and D T Berry, 'Screening for feigned psychiatric symptoms in a forensic sample by using the MMPI-2 and the Structured Inventory of Malingered Symptomatology' (2002) 14 Psychological Assessment 170.

[29] Paul Gold and Christoper Freuh, 'Compensation-Seeking and Extreme Exaggeration of Psychopathology Among Combat Veterans Evaluated for Posttraumatic Stress Disorder' (1999) 187 Journal of Nervous and Mental Disease 680.

[30] K W Greve, J S Ord, K J Bianchini and K L Curtis, 'Prevalence of Malingering in Patients With Chronic Pain Referred for Psychological Evaluation in a Medico-Legal Context' (2009) 90 Archives of Physical Medicine and Rehabilitation 1117.

[31] John Dennins and Robert Shura, 'Cost of malingering mild traumatic brain injury-related cognitive deficits during compensation and pension evaluations in the veterans benefits administration' (2017) 15 Applied Neuropsychology 1.

[32] Malingering is not necessarily the only area where this is so. See for instance, Joseph Cocozza and Henry Steadman 'Prediction in Psychiatry: An Example of Misplaced Confidence in Experts' (1978) 25 Social Problems 265, for a review of the issues in regards to assessment of 'dangerousness'.

[33] *Chaulk and Another v R* [1991] LRC (Crim) 485.

specifically the likelihood of somebody feigning mental illness gaining an insanity verdict. Drawing from other case law including *Davis v United States,*[34] the judgment of Wilson J concludes that:

> The argument is sometimes advanced that feigning insanity is easy but in fact it appears that nothing is further from the truth. As the body of scientific and diagnostic knowledge about mental illness develops and is consolidated by interdisciplinary research, the disease becomes more and more clearly defined.

From a clinical perspective, one might reasonably argue that the very opposite is true. Increasing knowledge about the complexity of mental health problems has meant, for instance, that the diagnostic frameworks which developed out of biomedical psychiatry in the 1960s are now seen as increasingly limited.[35] They may also, themselves, be a source of stigma.[36] The idea that mental health problems can be understood through a 'disease' paradigm is considered outdated.[37] The recognition of a complex interplay of biological, social and psychological factors in causation and maintenance of mental health problems is recognised in the 'biopsychosocial' paradigm. Yet, the scientific understanding of the complex web of interactions between biological factors such as genetics and life experiences (particularly early and developmental experiences) remains embryonic.[38]

In sum, the picture of malingering as being a not infrequent behaviour, particularly in groups of people who have 'something to gain', combined with the lack of explicit attention given to the issue within both legal judgments and clinical assessment, and the potential over-estimation by the judiciary and clinicians themselves of the ability to reliably detect malingering, is a toxic combination of factors, and provides impetus for the present review.

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[34] *Davis v United States*, 160 US 469 (1895).

[35] Steven Hyman, 'The Diagnosis of Mental Disorders: The Problem of Reification' (2010) 6 Annual Review of Clinical Psychology 155; S Guloksuz and J Van Os, 'The slow death of the concept of schizophrenia and the painful birth of the psychosis spectrum' (2017) 48 Psychological Medicine 229; Lee Anna Clark, W John Livesley and Leslie Morey, 'Special Feature: Personality Disorder Assessment: The Challenge of Construct Validity' (2011) 11 Journal of Personality Disorders.

[36] John Read, N Haslam, L Sayce and E Davies, 'Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach' 114 Acta Psychiatrica Scandinavica 303.

[37] Donald J Kiesley, *Beyond the Disease Model of Mental Disorders* (Praeger 1999); British Psychological Society, 'Division of Clinical Psychology Position Statement on the Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses: Time for a Paradigm Shift' (Division of Clinical Psychology 2013) <https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Classification%20of%20behaviour%20and%20experience%20in%20relation%20to%20functional%20psychiatric%20diagnoses.pdf> accessed 11th March 2021.

[38] Michael Rutter, 'The Interplay of Nature, Nurture, and Developmental Influences - The Challenge Ahead for Mental Health' (2002) 59 Archives of General Psychiatry 996; Kathryn A Becker-Blease, 'As the world becomes trauma–informed, work to do' (2018) 18 Journal of Trauma and Dissociation 131.

II. MALINGERING: A LEGAL REVIEW

A. Malingering as a specific Military Offence

Perhaps the most straightforward examples of malingering in law relate to the Acts of Parliament concerning members of the Armed Forces. The reasons are obvious: a government requires an effective military force to enter dangerous situations which their human instincts will drive them to avoid. Injuries which render a soldier unfit for service may in desperate times be seen as a logical option to avoid combat.

B. Historical context of Malingering in the Armed Forces

The Mutiny Acts were annually reviewed Acts first implemented in 1689, and provide some of the earliest examples in which malingering received legal attention. L White & W Hussey state the primary purpose of the Mutiny Acts 'was to legalise the existence of a standing army and the enforcement of military law by court martial with appropriate punishments for mutiny, sedition and desertion, but no other offences'.[39] However, by the time of the Marine Mutiny Act of 1830, their scope had widened, and there is a concrete example of the term 'malingering' being used in statute in the United Kingdom, perhaps for the first time. This provides that a court martial may place a custodial sentence 'with or without hard Labour... or to Corporal Punishment, not extending to life and limb' for

> [D]isgraceful Conduct in wilfully maiming or injuring himself, or any other Marine at the Instance of such Marine, with Intent to render himself or such other Marine unfit for the Service; in tampering with his Eyes; in malingering, feigning Disease, absenting himself from Hospital while under Medical Care, or other gross Violation of the Rules of any Hospital, thereby wilfully producing or aggravating Disease or Infirmity, or wilfully protracting his Cure.[40]

The context of these legal developments is noteworthy as, rather than stemming primarily from the specific need of the military to act as an effective defensive force, the need to focus on malingering actually bears striking similarity to contemporary concerns about the use of malingering within wider society in claims of fraudulent welfare payments,[41] in the form of disability pensions.[42]

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[39] L W White and W D Hussey, *Government in Great Britain, The Empire and the Commonwealth* (Cambridge University Press, 1958) 146.

[40] Marine Mutiny Act 1830, s.XI.

[41] (n 4-6).

[42] Roger Cooter, 'War and Modern Medicine' in WF Bynum and Roy Porter (eds), Companion Encyclopaedia of The History of Medicine (Volume 2, Routledge, 1993) 1536. 'During the Napoleonic Wars, it became apparent that alarming numbers of soldiers and sailors were obtaining disability pensions; indeed, in the aftermath of those wars, to the horror of the treasury, it was claimed that there were nearly as many men on such pensions as there were *in* the armed forces... Partly in response to the treasury's concerns, and partly from an interest in improving job prospects in an overcrowded profession, civilian practitioners in Britain staked

The methods used by these medical practitioners to detect malingering are worth a brief detour to consider, if only to highlight that some of the most obvious methods of detection of malingering would be highly problematic from a legal and ethical perspective today. Samuel Gross' 1861 'Manual of Military Surgery' for instance, highlights that:

> contraction of the joints, a not unfrequent source of imposition, is easily detected by the use of anaesthetics, or simply by pricking the parts suddenly with a needle, when the patient is off his guard.[43]

Similarly, the text suggests crude methodologies for detecting malingering:

> paralysis is frequently imitated, but is generally easily detected, simply by watching the patient, tickling his feet when he is asleep, or threatening him with the hot iron.[44]

The manual, unsurprisingly, does not make reference to the potential of malingering to encompass mental health problems, arguably reflecting the fact that malingered presentations will necessarily reflect the contemporary nosology of 'accepted' illness.

C. The contemporary legal position of malingering in the Armed Forces

The prohibition in military law against malingering has persisted since this time, up until the most recent Armed Forces Act 2006[45] (AFA 2006) as well as its precursor legislation (Army Act 1955,[46] Air Force Act 1955[47] and Naval Discipline Act 1957).[48] This specific statue is a broad one regulating most aspects of British military law in the Armed Forces, of which the consideration of malingering forms only a small part; the inclusion of malingering is one small part of the much bigger legislation.

The definition used in the AFA 2006 to determine whether an offence of malingering has occurred does not fully overlap with the clinical definition of malingering in DSM-5.[49] This would be an important point to note for any clinician faced with assessing malingering in the context of military law. Table 2 shows some of the main differences.[50]

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claims to expertise in the detection of malingering. Ever after, suspected malingers ('skulkers' in navy talk) were required to pit their wits against medical officers intent on their unmasking.'

[43] Samuel D Gross, *A Manual of Military Surgery* (first published 1861, Norman Publishing 1988) 162.

[44] ibid, 160.

[45] Armed Forces Act 2006, s.16 & s.345. The former section provides for an offence for the act of Malingering itself. The latter section provides for an offence of 'aiding and abetting malingering'.

[46] Army Act 1955, s.42.

[47] Air Force Act 1955, s.42.

[48] Naval Discipline Act 1957, s.27.

[49] (n 3).

[50] In addition to these differences, the definition in AFA 2006 also includes the concept of the person causing themselves an injury leading to genuine physical symptoms (Armed Forces Act

It is noteworthy, however, that the AFA 2006 explicitly includes mental health problems within the scope of potential malingered behaviour, with s.16(3) defining the scope as 'any impairment of a person's physical or mental condition'. The term 'mental condition' is not defined further, but does not appear to be the same definition of Mental Disorder as used in either the MHA,[51] or the definition of Mental Impairment used in the Mental Capacity Act.[52] Rather, the phrase echoes that used within other earlier legislation, for instance in the Law Reform (Personal Injuries) Act 1948[53] and the County Courts Act 1984.[54]

Table 2: Comparison of clinical definition of malingering in DSM-5 with that found in AFA 2006

DSM-5 definition component	**Offence in Armed Forces Act 2006, s.16**
intentional production	No mention of intentionality
false or grossly exaggerated	'False' – 'Pretends to have an injury' (s.16(1)(a)) 'Grossly Exaggerated' – not considered
Physical or psychological symptoms	s.16(3): 'any impairment of a person's physical or mental condition'
motivated by external incentives	Must be motivated by a desire 'to avoid service' (s.16(1))

D. Convictions for Malingering under the AFA 2006

A review of cases of offences of malingering under the AFA 2006 suggests that such behaviour has been rare, with three offences of malingering mentioned in

2006, s.1(b)) which is not considered within DSM-5 (at face value this might be covered within the DSM-5 concept of factitious disorder, but this requires the incentive for the malingering to be 'internal'), prolonging an injury through an 'act or omission', (Armed Forces Act 2006, s.1(c)) and 'causing another person to injure him'. (Armed Forces Act 2006, s.1(d)) All of these points seem to be relevant to feigned or induced physical illnesses/injuries, but fall outside a literal interpretation of DSM-5.

[51] Mental Health Act 1983, s.1(2).

[52] Mental Capacity Act 2005, s.2(1).

[53] Law Reform (Personal Injuries) Act 1948, s.3(1).

[54] County Courts Act 1984, s.51(5). Interestingly, but perhaps somewhat divergently to the main issue at hand, when this phrase has been interpreted within the instance of personal injury law, case-law has interpreted this phrase as seemingly requiring there to be a formal diagnostic threshold to be crossed, for instance in *Cartledge v E Jopling & Sons Ltd* [1963] AC 758, the damage had to reach a threshold 'beyond the minimal', and in *Johnston vs NEI International Combustion Limited* [2007] UKHL 39, [2008] PIQR P6, the judge, referencing *Lynch v Knight* [1861] 9 HLC 577, 598, held that 'it is accepted that a state of anxiety produced by some negligent act or omission but falling short of a clinically recognisable psychiatric illness does not constitute damage sufficient to complete a tortious cause of action'. This potentially leaves open a rather circular argument as to how attempts to identify malingered mental illness that didn't cross the artificial diagnostic threshold might be defined using this phrase, since, clearly, malingering must require the active lack of diagnosis of a genuine mental illness (or at least the lack of diagnosis of the mental illness supposedly being presented).

the court martial records of military courts between 2010-2018.[55] The first two of these cases appear to have been appealed (the most recent case, in 2018, does not, at least at the time of writing), with the appeal judgments indicating that both cases concerned acts of physical malingering (asking a friend to run over his leg;[56] asking contemporaries to break the person's arm[57]) to avoid returning to combat. In the second case, it is noted that the defendant would not have been returned to active service anyway as she 'needed to be downgraded on grounds of emotional pressure'.

Both cases brought to appeal highlight the difficulties that the courts face in dealing with malingering behaviour which is itself connected to emotional vulnerability. The second case in particular highlights the possibility that existing emotional vulnerabilities may well mean it is more likely that those in the military will look for viable options to escape military service, and hence consider malingering; or perhaps it simply highlights that more desperate attempts to avoid service are associated with less convincing attempts to malinger.

It is probable that these cases are an underestimation of the extent of malingering as a wider problem in the military. There is of course no way of determining how many people might successfully avoid combat because of malingering, but data from military healthcare records in America seems to suggest that this is a relatively common problem.[58] This might be for several reasons, but perhaps significantly because attempts to malinger are unlikely to always be dealt with by court martial in the first instance; the Commanding Officer has significant powers to deal with most aspects of military discipline, including malingering, as the need arises.

In sum, whilst the military law provides the only example of a specific offence of malingering, the contemporary application of this law provides very little in the way of guidance as to how the issue might be addressed by both legal professionals and clinicians dealing with criminal or civil cases. It does, perhaps, raise the prospect that mental health problems, or at least emotional vulnerability, may be at times causally related to somebody's decision to carry out, at least, an act of physical malingering. A wider potential overlap between genuine mental health symptoms and malingering is extraordinarily complex and under-researched. At one level one might imagine that experiential knowledge of mental health problems might in some cases provide a template

[55] HM Government (Military Court Service), 'Guidance: Court martial results from the military court centres' (*Ministry of Defence*, 8.7.2020) <https://www.gov.uk/government/publications/court-martial-results-from-the-military-court-centres> accessed 10th March 2021. The review published by the Ministry of Defence covers the period January 2010-December 2019. The relevance provisions of the Armed Forces Act 2006 came into force on 28th March 2009 (The Armed Forces Act 2006 (Commencement No. 4) Order 2009) so any cases that occurred in the latter part of 2009 would not be recorded.

[56] *R v Danny Cross* [2010] EWCA Crim 3273.

[57] *R v Kirsty Louise Capill* [2011] EWCA Crim 1472.

[58] R. Gregory Lande and Lisa Banks Williams, 'Prevalence and Characteristics of Military Malingering' [2013] 178 Military Medicine 50.

on which a client may base later malingered behaviour (though this would imply, at least some post-hoc 'insight' into the original mental health problem, since presumably one could only do this if one accepted and understood one's original experiences as being caused by a mental health difficulty). Alternatively, one might imagine a range of other potential functional links; for instance, a person with post-traumatic stress symptoms (PTSD) malingering psychotic symptoms to avoid military service, or a person with paranoia malingering hallucinations to avoid feared individuals.

E. Malingering in Civil Law: Why does it matter?

Unlike military law, the civil courts do not deal with malingering as a specific offence or legal issue. Rather, malingering in this context is primarily of concern because of its potential impact on the veracity of evidence relevant to a civil claim. In considering the seriousness by which the law views malingering, one might take as a starting point the judgment given by Moses J in *South Wales Fire and Rescue Service v Smith:*[59]

> Our system of adversarial justice depends upon openness, upon transparency and above all upon honesty. The system is seriously damaged by lying claims. It is in those circumstances that the courts have on numerous occasions sought to emphasise how serious it is for someone to make a false claim… Those who make such false claims if caught should expect to go to prison. There is no other way to underline the gravity of the conduct.[60]

A similar stance was taken by Laws LJ in the 2001 case of *Molloy v Shell UK.*[61] In agreeing to a 100% costs order against the claimant (instead of 75% allowed in the prior judgment) Laws LJ hinted he might well have liked to have gone further:

> I entertain considerable qualms as to whether, faced with manipulation of the civil justice system on so grand a scale, the court should once it knows the facts entertain the case at all save to make the dishonest claimant pay the defendant's costs.[62]

One might further this point by reflecting on the various processes of the court which aim to guard more generally against falsity. Even given the adversarial rather than inquisitorial nature of the English and Welsh legal system, truth is vital to the process of seeking 'justice' (or perhaps, more accurately, falsity is an impediment to seeking justice). For instance, one need only to consider the processes of cross-examination, taking the oath and the need for signed statements of truth in documents and statements, all of which are intended to ensure the veracity of the information presented. Malingering, where it forms part of the legal issue at hand, is therefore a direct threat to the task of any court.

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[59] *South Wales Fire and Rescue Service v Smith* [2011] EWHC 1749 (Admin), [2011] All ER (D) 39 (Oct).
[60] ibid [4]-[5].
[61] *Molloy v Shell UK Limited* [2001] EWCA Civ 1272, [2002] PIQR P7.
[62] ibid [18].

However, as will be demonstrated, a relatively uncompromising stance to malingering does not always occur in practice. For instance, one might look to the authority of *Painting v University of Oxford,*[63] in which a slightly softer stance was taken by the judge:

> Here, Mr Farmer was constrained to accept that Mrs Painting had been deliberately misleading in the course of the claim, and the fact that the exaggeration is intended and fraudulent is, to my mind, a very important element which needs to be addressed in any assessment of costs.[64]

F. Dealing with falsity, and malingering, in the civil courts

In theory, civil courts could deal with false claims, including malingering, in two broad ways: dismissal of the proceedings in part or entirety; or committal to prison for contempt of court. Furthermore, a person who malingers in any court setting in England and Wales potentially risks prosecution for perjury.[65] However, it is arguably the case that the reality of the civil court process is that very few people receive any legal sanction following malingering being detected; that claimants who do present with symptoms where malingering is questioned are generally given the benefit of the doubt; and that, in reality, there is little in law to discourage claimants from pursuing claims based on malingered symptoms. The following discussion will draw out this argument based on a review of relevant case law.

In regard to the process for striking out a case, whilst a judge in a civil case has jurisdiction to decide to strike out a case or a statement of a case either through the Civil Procedure Rules[66] or the court's inherent jurisdiction, this position was heavily restricted through the Supreme Court judgment in *Summers v Fairclough Homes Ltd.*[67] The original case, as outlined in the appeal judgment,[68] had seen the claimant bring a claim for damages of over £800,000, subsequently reduced to approximately £90,000 because undercover surveillance had demonstrated incompatibility between his claimed injury and observed physical abilities. These were separated by the original judge from some limited psychiatric injury which was felt to be genuine, and some physical injury which was accepted as genuine. Those acting for the employer claimed that the fact that the claimant had lied so significantly, demonstrated that the

[63] *Painting v University of Oxford* [2005] EWCA Civ 161, [2005] PIQR Q5.

[64] It is noted that even in this case, which solely concerned an appeal as to costs (previously the employer had been ordered to bear all of the employee's costs), and where an element of exaggeration was agreed, the judgment made an order splitting costs between the employer and employee – supporting the idea that the courts tend to prioritise evidence of any genuine component of the presentation over evidence of at least partial exaggeration of fabrication. (see also Andrew Gillett, '*Lying for Free*' (2010) 2 Fraud Intelligence 8 and Jonathan Upton, '*Lying litigants beware!*' (2010)160 New Law Journal 418).

[65] Perjury Act 1911.

[66] CPR 3A.

[67] *Summers v Fairclough Homes Ltd* [2012] UKSC 26, [2012] 1 WLR 2004.

[68] *Summers v Fairclough Homes Ltd* [2010] EWCA Civ 1300.

claim was an abuse of process, and the claim should have been struck out in its entirety. The Supreme Court agreed with the original judge and appeal judge, stating that whilst the court did have power under the Civil Procedure Rules to strike out a claim for abuse of process, this was something that should only be done in exceptional circumstances, which did not apply in the present case. This leaves a situation where on one hand, the law suggests that those who are 'caught' malingering should expect a custodial sentence, but on the other, could still receive at least partial compensation in a claim, at least in all but the most exceptional circumstances.[69]

Not all jurisdictions have taken the same approach. For instance, the Irish legislators have introduced much stricter measures in s.26(1) of the Civil Liability and Courts Act 2004.[70] This provides that a case will be dismissed if a 'plaintiff in a personal injuries action gives or adduces... evidence that (a) is false or misleading in any respect, and (b) he or she knows to be false or misleading'. Note that the wording implies an imperative to strike out a case if this test is met, with an exception being made only if 'the dismissal of the action would result in injustice being done'. This seems a reverse of the English and Welsh situation where the exception created is for striking out. Whilst a full analysis of the Irish legal situation in regard to this issue is outwith the scope of this the present article, it is important to note that this statutory provision does seem to have resulted in a practical legal position that is much less friendly to the part-malingering claimant. *Salako v O'Carroll,*[71] a case in the Irish Court of Appeal, is one instance in which the judge summarises the position at law that:

> [w]hile the defendant has pointed to a great number of occasions on which it is alleged that a false or exaggerated account and presentation of symptoms and complaints was given to consultants, it suffices in my view for her to be shown to have done so even once, since even that one occasion is sufficient to trigger the section and mandate a dismissal of the entire case.[72]

Arguably, the English and Welsh approach leads to a situation where anything less than a definitive view that all features of the apparent disorder are false leads to a judgment that gives the claimant the benefit of the doubt. This is problematic because the task of identifying malingering, or even false responding, is complicated *per se* and clinicians are unlikely to draw definitive conclusions in all but the most clear-cut cases (which, of course, are unlikely to progress far in the court system anyway).

Two cases illustrate the complexity of such issues, particularly in regard to the question of determining whether false responding is motivated by external gain (as required to demonstrate malingering). First, *Fletcher v Keatley*[73] considered

[69] David Sawtell, 'My Big Fat Fraudulent Claim' [2011] 7463 New Law Journal. This article provides a similar perspective including reviewing the *Summers v Fairclough Homes* judgment within the context of other contemporary case-law.
[70] Civil Liability and Courts Act 2004, s.26(1) (Republic of Ireland).
[71] *Salako v O'Carroll* [2013] IEHC 17.
[72] ibid [2].
[73] *Fletcher v Keatley* [2017] EWCA Civ 1540.

the problems in identifying differences between a person who presents with deliberate and unconscious reasons for exaggerated or distorted symptoms. In this case there was a difference in expert views. The appeal concerned the question of whether the original judge had been correct to only apply a partial reduction in damages (of 50%) to reflect the respondent's deliberate behaviour. The appeal was dismissed (with the appeal judges agreeing that the original decision to apply a partial reduction in damages had indeed properly accounted for the uncertainty in determining which elements of the presentation were genuine and which were exaggerated), leaving the respondent with a successful 50% claim for damages.

Second, one might consider *Ford v GKR Construction,*[74] which concerns an appeal brought against damages. This case illustrates how the introduction of an 'internal' explanation for the person's false reporting can lead to a somewhat tautological argument that becomes virtually unfalsifiable. Specifically, the original judge had been careful not to conclude that the person was malingering but that observed discrepancies between the claimant's stated injuries and her observed performance on video surveillance arranged by the defendants were due to 'by implication at least… a manifestation of the mental state to which she had been reduced as a result of her injuries'. The appeal judge considered that had the first judge concluded otherwise:

> I have little doubt that he would have taken the view that… the claimant should not be permitted to escape the consequences of the revelation… of her attempted fraud.

Courts that reason that a claimant's decision to feign or exaggerate symptoms was itself caused by the person's own vulnerability are essentially forced to find in favour of the claimant. This is problematic. Whilst one can conceptually see a clear link between malingering and underlying vulnerability in the cases of malingering in the armed forces[75] (the person is motivated by an external incentive of avoiding harm to themselves, potentially influenced by their own feelings of vulnerability or inability to cope with such potential harm), there may be a less direct or obvious relationship between vulnerability and a motive to seek financial compensation.

However, this tendency of the court to resolve a dispute in favour of the claimant where there is anything less than a unanimous and definitive view that malingering is present, is not just limited to situations where external/internal motives are in doubt. The issue arises also where an external motive may be present alongside an internal one, as well as situations where fabrication of symptoms is at least a partial explanation for the person's presentation. Three cases, which seem to highlight a potential specific difficulty in cases involving potentially malingered mental health symptoms, are highlighted presently:

First, *AXD v The Home Office.*[76] This was a case considering a claim for damages

[74] *Ford v GKR Construction* [1999] EWCA Civ 3030, [2000] 1 WLR 1397.
[75] See paragraph 9.2 onwards.
[76] *AXD v The Home Office* [2016] EWHC 1133 (QB).

as a result of unlawful detention and breach of Article 3 and Article 8 ECHR rights. A significant component of the case rested on whether or not the claimant should have been diagnosed with paranoid schizophrenia, or whether the symptoms were malingered. On this point psychiatrists gave divergent opinions. In considering a claim for breach of ECHR rights, the judge had to apply the criminal burden of proof, and concluded that he could not be satisfied beyond reasonable doubt that the client had paranoid schizophrenia. However, in considering the claim for unlawful detention at common law, the judge considered the same question on the balance of probabilities, concluding that the claimant probably did have paranoid schizophrenia, and allowing a subsequent claim to be made for substantial damages.[77] Five psychiatrists completed assessments of the claimant, with the judge's difficulty in being able to reach a definitive conclusion about the presence of mental health difficulties highlighting the difficulty in resolving such differences of opinion in practice. Notably, in this case, the psychiatric opinion was not supplemented by any psychological testing which might have provided greater clarity as to the validity of symptoms expressed.

Second, *Ali v Catton*[78] is a complex case in which the issue of quantum of compensation, following brain injuries received in a motor vehicle accident, is considered. The case considers evidence from a number of experts in relation to the injuries suffered and, for instance, the client's need for support with self-care. Concerns were expressed that the client's father had assisted the client in presenting a more exaggerated level of impairment than was the case. Alongside this evidence was the evidence of two neuropsychologists, who both conducted symptom validity tests as well as tests of cognitive impairment. There was a divergence in views as to whether the impairment observed was genuine. The judge preferred the evidence of the neuropsychologist who thought the impairment was genuine, making some criticism of the other expert witness for sticking doggedly to views that did not change in light of new evidence. However, the judge did find examples where both the claimant and the father had exaggerated disability.[79] The claimant received substantial damages. The judgment was appealed and upheld.[80]

Third, as a demonstration of a similar approach taken within the lower courts, *Maguire v Carillion Services Ltd*[81] is a noteworthy case. The claimant had experienced an occupational injury whilst at work, sustained whilst riding a glass lift. The judgment notes that a steel-framed window had somehow been opened into the inside of the lift-shaft. As the lift moved it pushed against this window causing the glass to shatter. The claimant had not suffered any gross physical injury but was ultimately admitted to the local hospital with 'shock' and diagnosed with soft-tissue injury. However, over subsequent months she gained

[77] *AXD v The Home Office* [2016] EWHC 1617 (QB).
[78] *Ali v Catton* [2013] EWHC 1730 (QB).
[79] ibid [246].
[80] *Ali v Catton* [2014] EWCA Civ 1313, [2015] PIQR Q1.
[81] *Maguire v Carillion Services Limited* (Manchester County Court, 31st March 2017).

additional diagnoses of Post-Traumatic Stress Disorder (PTSD) and Fibromyalgia. The insurance company demonstrated some apparent incompatibility between her claimed illness and her behaviour in video evidence. Expert evidence suggested that stated memory impairments (often a feature of PTSD) were exaggerated. The judge concluded that there had been 'an element of conscious subjective exaggeration', but chose not to strike out the case, citing specifically the judgment of *Fairclough Homes.*[82] An award of £133,000 was made (the original claim for damages had been for £560,000).

The one case that seems to provide an exception to this approach is the more recent case of *Pinkus v Direct Line*[83] which considered a claim for loss of earnings, and other damages, after claimed Post-Traumatic Stress Disorder following a road traffic accident. Despite there being some disagreement amongst the expert witnesses, the judge preferred the evidence of the majority view of the experts, finding that the claimant did not have Post-Traumatic Disorder, and dismissing the entire claim, including the small element of the claim that the judge noted had merit, because of fundamental dishonesty.[84] Whilst this dishonesty was significantly about the account of mental health symptoms, the judge noted a much wider pattern of dishonesty which presumably assisted in forming this view.

It must be stated that it does not seem to be the case that the courts are unable or unwilling to deliver robust judgments in responding to false reporting; as will be shown shortly, the position taken in *South Wales Fire and Rescue Service*[85] has been used in several subsequent cases as the basis for a committal proceeding to succeed. Indeed, an analysis of relevant case-law finds plenty of examples where committal to prison (or a suspended sentence) has occurred in relation to factitious *physical* health problems, typically after video evidence or objective evidence demonstrating a clear inconsistency is presented (eg. evidence the person is working when they claimed they were unable to work). These include the cases of *Homes for Haringey v Fari,*[86] *Nield v Loveday,*[87] *Kirk v Walton,*[88] *Calderdale and Huddersfield NHS Trust v Sandip Singh Atwal,*[89] and *Ajaj v Metroline West Limited.*[90]

In addition to these cases, one might note as well a number of cases where the actual accident is contrived. In such cases there is also usually feigned physical injury, which provides a basis for a fraudulent claim. These cases include *Aviva*

[82] (n 67).
[83] *Pinkus v Direct Line* [2018] EWHC 1671 (QB), [2018] PIQR P20.
[84] Criminal Justice and Courts Act 2015, s.57.
[85] (n 59).
[86] *Homes for Haringey v Fari [*2013] EWHC 757 (QB).
[87] *Nield v Loveday* [2011] EWHC 2324 (Admin), [2012] 123 BMLR 132.
[88] *Kirk v Walton* [2008] EWHC 1780 (QB), [2009] 1 All ER 257.
[89] *Calderdale and Huddersfield NHS Trust v Sandip Singh Atwal* [2018] EWHC 961 (QB).
[90] *Ajaj v Metroline West Limited* [2015] (UKEAT, 3rd December 2015).

Insurance Ltd v Ahmed,[91] *Liverpool Victoria Insurance Co v Bashir,*[92] *AIG Europe Limited v Parmar,*[93] *Amlin Insurance Ltd v Kapoor, EUI Limited v Damian Hawkins & Samantha Presedee-Hughes*[94] and *Havering Borough Council v Bowyer, Jones & Bowyer.*[95]

This brief review emphasises the seriousness with which the law treats false statements in the courtroom. Malingering of mental health problems is no different in its toxicity to the justice system than malingering of physical symptoms, or false claims entirely, but is clearly harder to prove. The types of evidence to do so are also limited; for instance, compared to claimed physical impairments, video evidence is inherently less *able* to demonstrate a conflict between claimed disability and observed behaviour in the case of claimed mental health impairments; one cannot demonstrate that somebody is not depressed by showing one – or several – examples of them appearing cheerful. Further, in several cases, evidence given by clinicians often seems to be in conflict. Apart from this, one might also note that in regard to contempt of court proceedings, the burden of proof is to the criminal – not the civil – standard,[96] and the proceedings must be shown to be in the public interest (for instance see *Royal & Sun Alliance v Kosky*[97] and related commentary by West[98]). Given this high bar, and the potential consequences of a judge incorrectly accusing a claimant of malingering, it is perhaps unsurprising that they shy away from doing so.

G. Malingering and Criminal Law

As noted, the act of malingering requires a specific external incentive, which in the context of criminal law is likely to relate broadly to the potential to avoid a conviction (or gain a lesser conviction) for an alleged offence, or indeed to gain a lesser or more favourable sentence post-conviction. Of course, any act of malingering is likely to be targeted to specific legal issues only as far as the malingerer is aware of those legal issues, and it is quite likely that malingering may be pursued by a defendant with a general aim of 'getting off' or 'getting a better sentence' without specific knowledge of the most effective way to go about achieving this. Nonetheless, one might broadly observe that some of the most obvious legal issues which may give rise to an 'external incentive' may include the following legal questions:

- Whether a defendant is unfit to plead

[91] *Aviva Insurance Ltd v Ahmed* [2017] EWHC 3276 (QB).
[92] *Liverpool Victoria Insurance Co v Bashir* [2012] EWHC 895 (Admin), [2012] ACD 69.
[93] *AIG Europe v Bernard Parmar* [2016] EWHC B23 (QB).
[94] *EUI Limited v Damian Hawkins & Samantha Presedee-Hughes* [2015] (Cardiff County Court, 16th June 2015).
[95] *Havering Borough Council v Bowyer, Jones & Bowyer* [2012] EWHC 2237 (Admin).
[96] *Dean v Dean* [1987] 1 FLR 517 (EWCA); *Re Bramblevale* [1970] 3 WLR 699 (EWCA).
[97] *Royal and Sun Alliance Insurance Plc vs Shirley Kosky,* [2013] EWHC 835 (QB).
[98] Richard West, 'Royal & Sun Alliance Insurance Plc v Kosky: personal injury - road traffic - civil procedure' (2013) 3 Journal of Personal Injury Law C171.

- Whether a defendant has access to the insanity defence
- Whether a defendant has access to the special partial defence of diminished responsibility in response to a charge of Murder
- When a defendant is convicted of an offence and a potential alternative sentence route is available that is more appealing to the defendant (eg a s.37/41 disposal under the MHA as opposed to a custodial sentence). Presumably this would also include situations where a community sentence (eg with a Mental Health Treatment Requirement) was considered in preference to a custodial sentence.

Of course, there are many other possibilities; malingering may be an issue that raises itself during an initial trial, or indeed it may 'develop' after the trial, potentially leading to the basis for an appeal (ie that the symptoms which the person is supposed to experience were in fact present, but not detected, during the original trial). Malingering of course may even be an issue prior to the trial, in that apparent mental health symptoms may lead a prosecutor to decide the case is not in the public interest (eg by reducing culpability).[99]

In order to consider relevant case-law, the present discussion will briefly lay out the main points of law relevant to each of these potential issues, considering the ways in which this is relevant for a malingered presentation, and will then summarise relevant cases and discuss how these issues have been resolved in practice in the courts.

H. Criminal Law: Fitness to Plead and Malingering

The current law in regard to fitness to plead has undergone review by the Law Commission,[100] which still awaits the government's response in relation to its findings.[101] This is important as any changes to the process, particularly if they lead to a claim of unfitness to plead that is easier to access, may increase the potential for malingered presentations to appear in this context.

The case law underpinning the determination of fitness to plead is found in *R v Pritchard*[102], emphasised in *R v Walls*[103] and revised in *R v M (John).*[104] At first blush, fitness to plead may appear an attractive option for a potentially malingering defendant, particularly since the outcome of this process means by default that a custodial sentence is avoided (a finding of unfitness to plead means that the defendant is subject to a 'trial of the facts',[105] with the *mens rea*

[99] Crown Prosecution Service, 'The Code for Crown Prosecutors' (CPS, October 2018), <https://www.cps.gov.uk/publication/code-crown-prosecutors)> accessed 10th March 2021, 4.14b.
[100] Law Commission, *Unfitness to Plead* (Law Com No 364).
[101] Law Commission, 'Unfitness to Plead' (Law Commission, 30th June 2016). <https://www.lawcom.gov.uk/project/unfitness-to-plead/> accessed 10th March 2021.
[102] *R v Pritchard* [1836] 7 C & P 303.
[103] *R v Walls* [2011] EWCA Crim 443, [2011] 2 Cr App R 61.
[104] *R v M (John)* [2003] EWCA Crim 3452, [2003] All ER (D) 199.
[105] Criminal Procedure (Insanity) Act (1964), s.4A.

component of the offence not being tried.[106] The only possible options following a conviction are a hospital order (with or without restrictions), a supervision order, or an absolute discharge).[107] In practice, however, it is so infrequently successfully made out[108] that it is unlikely to be a successful avenue for *any* defendant (recent estimates are that about 30 defendants are found unfit per year[109] – a tiny fraction of criminal cases where mental illness is a prominent issue).

Despite this, questions of factitious presentations, including potentially malingering, have made several appearances within case law. In all cases identified, doubt was resolved against a finding of unfitness to plead. In *R v Marcantonio*[110] the doubt related to divergence in professional views about the nature and extent of cognitive impairment. There had been some suggestion by one psychiatrist that exaggeration had occurred. In *R (Boujetiff) v Public Prosecutor's Office of Court of Appeal, Brussels, Belgium*,[111] the doubt again revolved around professional differences of opinion, with the judge preferring evidence suggesting a defendant was faking psychiatric symptoms, concluding there had been no unfitness to plead at the original trial, and dismissing the appeal. Finally, in *R v Borkan*,[112] malingering is not explicitly considered but a judge accepted psychiatric evidence 'that Mr B. was emphasising his psychological problems in the hope that he might be transferred to a psychiatric hospital'. The judge dismissed the appeal.

Given it seems unlikely that malingering behaviour will often interact with the question of fitness to plead, this therefore may be a particular subject that needs to be given explicit attention if the Law Commission's recommendations for change are adopted. Three considerations seem relevant in the context of the present discussion. First, the question of whether the test for determining fitness should be applied to the criminal or civil standard, and under which circumstances, is of relevance given the experience within the civil courts of judges giving malingering claimants the benefit of the doubt. Second, a doctoral dissertation appears to cast doubt on the validity of one of the Law Commission's published tools for assessing fitness to plead when applied to

[106] *R v M (John)* [2003] EWCA Crim 3452, [2003] All ER (D) 199; *R v Wells* [2015] EWCA Crim 2, [2015] 1 WLR 2797.

[107] Criminal Procedure (Insanity) Act, (1964), s.5(2).

[108] Indeed, rather than being an 'open target' for malingers, it is noteworthy that the current narrative around these criteria is that they lead to a situation where too few people with genuine mental illness are able to access the defence; indeed this has provided impetus for the Law Commission's review of the law (n 98), 2.60.

[109] Law Commission, 'Insanity and Automatism' (23rd July 2013) <https://www.lawcom.gov.uk/project/insanity-and-automatism/> accessed 10th March 2021; note also that this view is supported by Jill Peay in her recent article (n 22).

[110] *R v Marcantonio* [2016] EWCA Crim 14, [2016] MHLO 9.

[111] *The Queen on the Application of Boujetiff v Public Prosecutor's Office of Court of Appeal, Brussels, Belgium* [2014] EWHC 2658(Admin).

[112] *R v Borkan* [2004] EWCA Crim 1642, [2004] MHLR 216.

cases of simulated malingering.[113] Third, the case of *R v Omara*[114] provides some authority that once unfitness has been found, even if the defendant is subsequently found to be fit, there is no process by which the trial of facts and subsequent process may be avoided. Given the 'high stakes' involved in fitness to plead cases, this needs careful consideration bearing in mind the inherent fallibility within the clinical assessment process.

I. The Insanity Defence and Malingering

If a person is fit to plead and the case proceeds to trial, an insanity defence may be the next possibility for a malingering defendant to attempt to gain a more favourable outcome. The insanity defence would have particular appeal in this regard as it provides a complete defence in regard to the alleged offence. The court's disposal options are the same as for a finding of unfitness to plead.[115] The relevant two-part test drawn from the case of Daniel M'Naughten,[116] is well known, as is the more contemporary version found in *R v Sullivan.*[117]

Of relevance to the present discussion, the first part of this test focuses not on whether there is mental illness from a broad clinical perspective (though of course may be informed by this), but whether the defendant was suffering from a 'disease of the mind'. This has led to cases where a clear clinical impression of mental illness has not been viewed as meeting this limb of the test,[118] and cases where a physical disorder only, which psychiatrists have viewed as not being a mental disorder, has been viewed as meeting this limb of the test.[119] This problem has long been recognised.[120]

The second part of the test means the defendant must either not know 'the nature and quality of the act' or 'not know what he was doing was wrong'. In regard to the latter, this is to be interpreted in terms of whether the defendant was aware the act was legally wrong.[121] This part of the test may or may not be a problem for a malingering defendant, depending on the nature of presentation they feign. A person feigning a psychotic-type presentation may, for instance, make an argument that they knew the act was wrong, but believed

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[113] Maeve Wallis 'Establishing the Accuracy of the 'FTP' tool in identifying malingering' (Doctorate in Clinical Psychology Thesis, Royal Holloway, University of London, June 2016).
[114] *R v Omara* [2004] EWCA Crim 431, [2004] All ER (D) 31.
[115] Criminal Procedure (Insanity) Act 1964, s.5(2).
[116] *R v M'Naghten* [1843] 8 ER 718 (HL).
[117] *R v Sullivan* [1984] AC 156 (HL).
[118] *R v C* [2001] EWCA Crim 1251, [2001] MHLR 91; *R v MAB* [2013] EWCA Crim 3, [2013] 1 Cr App R 36; *R v Johnson* [2007] EWCA Crim 1978, [2008] Crim LR 132.
[119] *R v Hennessey* [1989] 1 WLR 287 (CA); *R v Burgess* [1991] 2 QB 92 (CA); *R v Kemp* [1957] 1 QB 399, [1956] 3 WLR 724; *Bratty v Attorney General of Northern Ireland* [1963] AC 386, [1961] 3 WLR 965.
[120] W Lindesay Neustatter, 'Psychiatric Aspects of Diminished Responsibility in Murder' (1960) 28 Medico-Legal Journal 92.
[121] *R v Windle* [1952] 2 QB 826; *R v Johnson* [2007] EWCA Crim 1978, [2008] Crim LR 132.

it was justified because of some misplaced expectation of harm.

Given its ability to provide a complete defence, the insanity defence as it stands in England and Wales may seem an attractive opportunity for a would-be malingerer; the concept of impairment as a 'disease of the mind' may well allow a more confusing or 'less perfect' picture of mental disorder to 'pass' for this part of the test. Further, although the question of insanity is determined by a judge, it must be proven only on the balance of probabilities.[122] However, in practice it seems unlikely to be a frequent opportunity for malingering, at least in its current form. The defence is rarely used, even in cases where mental illness is present,[123] and judgments have tended to take quite black and white approaches to the second limb of the test where any evidence of knowing right from wrong, or awareness of what the person was doing, means the test fails (*R v Windle*[124]; *R v Codere*[125]).

Given this, it is noted that it has not been possible to identify any cases concerning the insanity defence where malingering or exaggeration of impairment has been an explicit concern. However, again, this may become more of an issue if access to the insanity defence is widened, and may need to be balanced alongside the real potential benefits for people with mental health problems that might be obtained through widening access

J. Diminished Responsibility and Malingering

The law around diminished responsibility is a complex area outside the scope of discussion in the present text. Its relevance to the topic at hand is in the fact that somebody convicted of murder must be given a life sentence.[126]. Diminished responsibility is a special partial defence to murder, and if pleaded successfully, allows the courts the same sentencing options as if the defendant had been convicted of manslaughter. It only applies in cases where the defendant is charged with murder, however in such cases can be seen as being a potential attractive 'external incentive' for a defendant

The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness[127] provides relevant data as to how often the diminished responsibility defence is successfully argued. This suggests that of 662 'patient

[122] *Woolmington v DPP* [1935] AC 462, 481.

[123] Janet Meehan and others, 'Perpetrators of Homicide with Schizophrenia: A national Criminal Survey in England and Wales' (2006) 57 Psychiatric Services 1648. This paper reviews all homicides committed within a three-year period between April 1996 and April 1996 in England and Wales. Of the 1,594 perpetrators of homicide, 85 were reported to have schizophrenia. Of this sample 13 were found unfit to plead or not guilty by reason of insanity.

[124] *R v Windle* [1952] 2 QB 826.

[125] *R v Codere* [1916] 12 Cr App R 21.

[126] Murder (Abolition of Death Penalty) Act 1965, s.1(1).

[127] University of Manchester, 'The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review' (University of Manchester, October 2016).

homicides'[128] committed in England over a ten-year period (2004-2014), 16% ended with a disposal of manslaughter by diminished responsibility. This is in the context of 6,241 total homicide convictions (murder, manslaughter, infanticide) over the same period. Thus, perhaps 1-2% of homicides end in a disposal of manslaughter by diminished responsibility. Clearly, a lot of people with mental illness will not get access to the diminished responsibility defence. Could people without mental illness do so?

The test for diminished responsibility is laid out in s.2 of the Homicide Act 1957. This is a three-part test, requiring the defendant to suffer from an:

> [A]bnormality of mental functioning which (a) arose from a recognised medical condition; (b) substantially impaired D's ability to either understand the nature of D's conduct, form a rational judgment, or to exercise self-control; (c) provides an explanation for D's acts and omissions in doing so or being a party to the killing[129]

R v Golds[130] is important recent case-law from the Supreme Court clarifying that 'substantial impairment' means substantial in the sense 'impairment of some importance'.

A review of appeal cases concerning diminished responsibility and malingering suggests that where the issue of false reporting is raised, even equivocally, at trial, the courts tend to dismiss claims for diminished responsibility made out on appeal. To illustrate this, one might briefly reference the appeal cases of *R v Fathi,*[131] *R v Shetty,*[132] *R v Clemens,*[133] *R v Sharp,*[134] *and Yazdanparast v HM Advocate*[135] – all were rejected appeal cases where a query of false reporting had been made at the original trial.

R v Shetty[136] is worthy of specific comment to highlight somewhat curious reasoning within one of the psychiatric opinions that 'what was diagnosed as the claimant's malingering 'could well be a harbinger of future genuine mental illness".[137] This statement seems hard to understand, but perhaps was a way of conveying a concern about mental illness whilst also stressing exaggerated or theatrical components of the defendant's presentation. This may highlight, again, either the aversion of clinicians in reaching black and white conclusions about malingering, or their inability to do so based on a limited approach to the clinical assessment taken.

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[128] A patient here is defined as somebody who has had contact with Mental Health services in the preceding 12 months.
[129] Homicide Act 1957, s.2(1-1A).
[130] *R v Golds* [2016] UKSC 61, [2016] 1 WLR 5231.
[131] *R v Fathi* [2001] EWCA Crim 1028.
[132] *R v Shetty (Responsible Medical Officer) and another* [2003] EWHC 3152 (Admin), [2004] MHLR 131.
[133] *R v Clemens* [2003] EWCA Crim 2385.
[134] *R v Sharp* [2003] EWCA Crim 3870, [2004] All ER (D) 119 (Feb).
[135] *Yazdanparast v HM Advocate* [2015] HCJAC 82.
[136] (n 127).
[137] ibid [3].

Whilst appeal cases are useful in giving a flavour of how the courts deal with issues of diminished responsibility in the face of questionable mental illness, to give the issue proper discussion one has to consider first instance decisions. As an example, one might highlight one case reported in the press; *R v Kalejaiye.*[138] Initially, local journalistic reporting highlighted that the defendant had successfully convinced a jury that he had killed his mother by reason of diminished responsibility.[139] However, on sentencing almost a year later, reports from mental health professionals who had assessed the defendant in hospital, were conflicted about the validity of the symptoms being expressed.[140] The judge sentenced for manslaughter,[141] passing a custodial sentence (for life) and 'Hybrid Order' under s.45A of the MHA, noting the possibility of long-term hospital treatment being beneficial.[142] As with insanity findings, the case highlights a potential difficulty of 'undoing' a finding of diminished responsibility if subsequent evidence comes to light questioning the veracity of a defendant's presentation.[143]

On the other hand, the unreported case of *R v Fraser*[144] is notable. Reporting in the national media[145] highlighted that the defendant, who killed a sex worker, was able to successfully access a defence of diminished responsibility at trial based on clear evidence of psychosis. However, the report highlights that prior to this, he had not received psychiatric help because the local psychiatric hospital had believed he was malingering to gain accommodation. Clearly, 'getting it wrong' has the potential for serious implications, whichever way the error occurs.

K. Malingering and sentencing

Out of all of the ways in which malingering may be of use to a defendant in a criminal trial, the sentencing process is perhaps the most obvious and most likely to be successful. s.157 of the Criminal Justice Act 2003 requires that 'in

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[138] *R v Kelajaiye* (Chelmsford Crown Court, 15th April 2015).

[139] Basildon Echo, 'Man Found Guilty of Killing his Mum' *Basildon Echo* (Essex, 18th April 2014) <http://www.echo-news.co.uk/news/11157637.Man_found_guilty_of_killing_his_mum/> accessed 10th March 2021.

[140] Basildon Echo, 'Conflicting Views of Mental State of Son who killed his mum' (Essex, 15 April 2015) <http://www.echo-news.co.uk/news/12889108.Conflicting_views_on_mental_state_of_son_who_killed_his_mum/> accessed 10th March 2021.

[141] Basildon Echo, 'Wickford Man Starts Life Sentence for Killing His Mum' (Essex, 19th June 2015) <http://www.echo-news.co.uk/news/13343629.Wickford_man_starts_life_sentence_for_killing_his_mum/> accessed 10th March 2021.

[142] Mental Health Act 1983, s.45A.

[143] Although in this case at least there was little practical difference in outcome following the successful diminished responsibility finding; the defendant still received a life sentence.

[144] *R v Fraser* (Central Criminal Court, 19th December 2014).

[145] BBC News, `*Robert Fraser Detained over Sex Workers Death'* <http://www.bbc.co.uk/news/uk-england-london-30553670> accessed 10th March 2021.

any case where the offender is or appears to be mentally disordered, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law'.[146] The court is then required to consider the contents of such a report including 'the likely effect of such a sentence on that condition and on any treatment that may be available for it'.[147] This process provides a significant opportunity for a malingering defendant.

As noted earlier, one of the most obvious 'external incentives' for malingering might be to gain a Hospital Order disposal[148] instead of a custodial sentence. The ability to gain a Hospital Order, has, however, been reduced somewhat by the judgment in *R v Vowles*[149] which has required clinicians and judges to take a more rigorous approach to assessing the links between the mental disorder and offending behaviour.[150] Nonetheless, several cases can be drawn upon to illustrate the issues the courts have faced when considering the issue of malingering in this context:

R v Ahmed[151] was an appeal against sentence following claims that the defendant had been suffering from schizophrenia at the time of sentencing, and so should have received a Hospital Order disposal rather than an indeterminate custodial sentence. Psychiatric opinion from the hospital which had treated him under s.47 of the MHA broadly supported the appropriateness of a Hospital Order, suggesting the Mental Illness was genuine. An independent psychiatrist, however, provided evidence suggesting the defendant was malingering. The results of psychological testing, conducted by the hospital, and which supported this conclusion, were relied upon both by the psychiatrist, and by the judge in their rejection of the appeal.

R v Hussain[152] is a first-instance judgment following conviction for terrorism offences. The judge's sentencing remarks make clear he had deep suspicions about the validity of the defendant's claimed mental health experiences. In terms of the psychiatric evidence, the judge noted that during the commissioning of the offences the defendant had written to his GP claiming to suffer from a range of mental health issues including social anxiety and paranoia. The defendant had been referred to a psychiatrist but did not attend the appointments. After being arrested, the defendant revealed wide-ranging symptoms of apparent psychosis including paranoid beliefs and a need for protection through bomb-making. The defendant was admitted to hospital on remand. Whilst there he was assessed by three hospital psychiatrists and one

[146] Criminal Justice Act 2003, s.157(1).
[147] Criminal Justice Act 2003, s.157(3)(b).
[148] Mental Health Act 1983, s.37.
[149] *R v Vowles* [2015] EWCA Crim 45, [2015] WLR(D) 52.
[150] Andrew Ashworth and Ronnie Mackay, 'Case Comment - R. v Vowles (Lucinda); R. v Barnes (Carl); R. v Coleman (Danielle); R. v Odiowei (Justin Obuza); R. v Irving (David Stuart); R. v McDougall (Gordon): sentencing - guidance where an element of mental disorder exists' (2015) 7 Criminal Law Review 542.
[151] *R v Ahmed* [2013] EWCA Crim 1393, [2014] MHLR 58.
[152] *R v Zahid Hussain* (Winchester Crown Court, 9th October 2017).

independent psychiatrist. The hospital psychiatrists concluded the defendant was psychotic and recommended a hospital order. The concerns about the potential for making the wrong decision (ie providing a Hospital Order disposal to somebody malingering mental illness) are illuminated in the following excerpt summarising the position of the independent psychiatrist, Dr Joseph:

> Dr Joseph invited consideration of the fact that you were considering who to talk to on the basis that you would only engage with psychiatrists who you considered would support a hospital disposal, and that you were likely to be manipulating Dr Cumming. He expressed concern that three psychiatrists were recommending a s.37/41 disposal in the face of what may well be a malingered mental illness, but concluded that if the court is satisfied that you are currently suffering from a mental disorder the appropriate disposal is by a Direction under s.45A as the risk is too great that if you are made the subject of a s.37/41 disposal you will make a swift "recovery" so that a First Tier Tribunal has no option but to conditionally discharge you.

Ultimately, the judge, who also expressed his doubts about the genuineness of the defendant's mental health symptoms, imposed a sentence of life imprisonment (minimum term of 15 years) and concurrently a Hospital Order direction under s.45A of the MHA.

Outside of hospital orders, malingering may be an issue for sentencing in other ways. Two cases are highlighted. *R v Ali*[153] is a particularly interesting judgment, with a potential unusual function of malingering. Here, the defendant had failed to comply with an enforcement notice made under the Town and Country Planning Act 1990,[154] following his decision to partition – without permission – a single dwelling house into 12 distinct flats. A confiscation order had been made in the absence of the defendant. The defendant was in hospital at the time of the confiscation hearing, reporting that he had suffered from mental health problems. The court had unsuccessfully tried to obtain information from the hospital as to the basis of the patient's admission. The judge attached significance, however, to the fact that they had ascertained it was a voluntary readmission, not one under the MHA, and concluded that 'this was not a case where the appellant was involuntarily absent so as to make it just for the court to step in and stop proceedings'. Two of the three psychiatrists involved, including the treating psychiatrist, had felt there was an element of malingering. The appeal found the judge had not erred in the decision to make the confiscation order.

Owda v Greece[155] was a case in which the defendant appealed a decision to extradite him to Greece on charges of people trafficking. The appeal was based in part on a claim that his mental condition 'is such that it would be oppressive to extradite him within the meaning of section 25 of the 2003 Act'.[156] The judge held that although there was evidence of mental health problems (referring to

[153] *R v Ali* [2014] EWCA Crim 1658, [2015] MHLR 446.
[154] Town and Country Planning Act 1990.
[155] *Owda v Greece* [2017] EWHC 1174 (Admin).
[156] ibid [1].

depression and personality disorder as 'relatively mild') there was also evidence of malingering. The judgment indicates that this rested on the fact that the defendant had 'admitted lying to doctors which resulted in a withdrawal of a possible diagnosis of Post-Traumatic Stress Disorder'. The judge ruled the appeal failed because the problems fell 'far short of the establishing that it would be oppressive to extradite him'.[157]

Finally, whilst considering the issue of sentencing, it is worth citing the American case of *US v Geer*[158] and associated commentary.[159] The case highlights the American system which, to act as a deterrent to attempts to malinger, allows a judge to increase a sentence to account for the malingering.

L. Summary of Malingering in Criminal Law

The review of cases of malingering in the criminal courts perhaps most prominently highlights how unusual it is for a judgment to turn on the issue of malingering. Certainly, it is an important issue in some cases, but the issue is far less prominent than might be anticipated given the expected frequency of malingering in these contexts.[160] This leads one to question just how many people are 'successful' at malingering in the criminal courts. It is of course impossible to know the true answer to this question, but one suspects that courts, and clinicians, are perhaps fooled more often than they would like to think. Certainly, journalistic reports exist of people who have 'confessed' to having previously malingered.[161] Such 'admissions' might happen occasionally when the 'external incentive' no longer applies, although of course it is impossible to rule out the 'confession' is itself simply another manifestation of a person's mental illness or challenging personality.

How could the courts improve their chances of detecting malingered presentations? A few suggestions may be made. First, guidance could be produced requiring further structure of clinical assessment to address specifically the issue of malingering in all cases where mental health problems are considered. Directing clinicians to provide opinion on whether malingering or false reporting was likely in a specific case would at least force the issue to be considered by the courts. Second, whilst courts require psychiatric/medical

[157] ibid [14].

[158] *US v Greer*, 158 F 3d 228 (5th Cir 1998).

[159] James Knoll and Philip Resnick, '*US v Geer: Longer Sentences for Malingerers'* (1999) 27 Journal of American Academy of Psychiatry and the Law 621.

[160] see Table 1.

[161] Associated Press, 'Mental Patient Surprised by his Own Escape' (VC Star, November 17th 2017); Les Zaitz, 'He wasn't insane, he says – he faked it to avoid prison' (Pacific Northwest News, March 29th 2017); Anthony DeStefano, 'NY Crime Boss admits he faked mental illness' (The Baltimore Sun, 8th April 2003); Katherine Sayre, 'Mobile judge to consider release of a man accused of Capital murder from mental hospital' (The Times-Picayune, January 15th 2012); Kevin Krause, 'Family Admits to faking mental illness to steal Social Security benefits' (Dallas News, July 3rd 2017); Rha Hae-Sung, ''Schizophrenic' draft-dodger gets caught by IQ test score' (The Korea Times, 9th November 2017).

evidence in all of the above cases, there is no legal requirement for evidence from psychologists, who could provide assessments of claimants using aforementioned psychometric tests. Whilst such assessments might be unlikely to give a 'black and white' conclusion, they may significantly assist the court in reaching a better-informed decision. These changes may be of particular importance if access to any of the partial defences is widened following the Law Commission's recommendations.

Of course, these recommendations need to be seen in the context as being specific to malingering, and it may well be that wider improvement to the quality assurance of expert evidence in mental health cases would, overall, be more valuable. The issues with malingering may be symptomatic of wider issues in the use of clinical assessment and expert evidence in mental health cases. Jill Peay's recent review[162] makes the important point that the relationship between mental health problems and offending is, generally, a very complex one. From a clinician's perspective, the courts could develop a more sophisticated understanding of the relationship between mental health presentations and offending by moving away from a primary interest in the presence or absence of a diagnosis or 'medical condition', and towards a more nuanced focus on the specific symptoms, experiences and psychological characteristics of the defendant, particularly before and during the alleged offence. Some of the suggestions made above in relation to malingering may thus be relevant here also, and could therefore potentially lead to wider improvements in court processes for people who do indeed have very genuine mental health problems.

III. WHAT NEXT FOR MR JONES: HOW SHOULD CLINICIANS RESPOND TO LEGAL AND ETHICAL DILEMMAS IDENTIFIED?

The complexities of the clinician's assessment, and the potential legal issues facing the clinician, are best illustrated by returning to the case of Mr Jones. This is presented as an unfolding narrative with the specific legal questions described at each stage. Although a criminal case, many of the issues would be common to any assessment of malingering.

Upon admission to hospital, Mr Jones presents with acute behavioural disturbance, and is placed within a seclusion facility on the ward. After calming down, Mr Jones describes how he continues to feel worried about the staff on the unit, although feels better than he did in prison. He explains how he came to believe that two prison officers were actually sent by MI5 to spy on him and feed information back to the government about his movements. He gives a vague description of auditory hallucinations experienced in prison. Suddenly, during the interview, Mr Jones shouts 'shut up' and looks to the ceiling, then tells the clinicians he heard the voice again. Mr Jones explains he believes the medication in prison was poisoned intentionally by MI5 with the intent of controlling him.

[162] (n 22).

Legal issue 1: **What next for Mr Jones' treatment?** *At this point a medical decision will be necessary to decide whether to continue prescribing antipsychotic medication. As the patient is subject to Part IV of the MHA, the Responsible Clinician (RC) can do this without the patient's consent for the first three months (if the patient lacks capacity or the other parts in the relevant section apply).*[163] *However, we may imagine the RC has concerns about the validity of Mr Jones' presenting symptoms but has not yet reached a clear opinion. If Mr Jones is malingering, the prescribing clinician risks Mr Jones experiencing serious unnecessary side effects from medication, as well as potentially complicating the subsequent assessment process (medication withdrawal can paradoxically induce a genuine psychotic episode,*[164] *which would risk leading the psychiatrist to falsely conclude that the patient had indeed always had genuine psychosis). If medication is withheld, and the presentation is genuine, there is a risk of deterioration in the person's psychosis. What legal principles should the prescribing clinician draw on in deciding whether or not to prescribe the medication?*

During the same meeting, a psychologist on the ward explains to Mr Jones that they offer all patients a psychological assessment. They explain that the assessment may be used to help the Responsible Clinician understand his clinical needs better. The psychologist explains that they wish to conduct a number of psychometric tests as part of this assessment.

Legal issue 2: Informed Consent in Assessment of Malingering. *In reality, the psychologist shares the Responsible Clinician's doubts about the validity of the patient's symptoms. They do not share these doubts with the patient. Specific symptom validity testing alongside appropriate clinical assessment may help form the clinical opinion. The psychologist decides they cannot expand on the explanation of the purpose of the test beyond the general explanation already given for fear that the patient will alter his presentation to defeat the purposes of the test. How can the psychologist gain informed consent to take the test under these circumstances? Does the psychologist have to do so?*

After three and a half months of assessment, both clinicians have formed the opinion that the patient is malingering psychosis and does not have a genuine mental health condition. Both clinicians have prepared a report to this end, justifying their opinion. Amongst other observations, they highlight behaviours which show significant inconsistencies in his presentation at different time points (apparently depending on whether or not he believed he was being observed), emotional presentations that were incompatible or inconsistent with stated beliefs (eg reporting highly distressing auditory hallucinations but showing no

[163] Mental Health Act 1983, s.58(1)(b).

[164] Joanna Moncrieff, 'Does antipsychotic withdrawal provoke psychosis? Review of the literature on rapid onset psychosis (supersensitivity psychosis) and withdrawal-related relapse' (2006) 114 Acta Psychiatric Scandanavica 3.

signs of distress), and high scores on various measures designed to assess symptom validity.

Legal Issue 3: At what point should the RC transfer Mr Jones back to prison? *Do these conclusions have any implications for Mr Jones' continued status under the MHA? Are the clinicians now duty-bound to initiate a transfer back to prison now that they have formed the opinion that he is malingering?*

Legal Issue 4: How to assess capacity? *At the three-month stage, the Responsible Clinician has to make a decision whether the patient has capacity to consent to their medical treatment. If he does have capacity to consent, the RC is required to certify this. How should the RC assess the patient's capacity to consent to medical treatment given doubts about the veracity of his presentation?*

Legal Issue 5: What considerations should the clinicians have when disclosing their reports to the courts? *Should the clinicians share their reports with Mr Jones? If Mr Jones objects to the contents, can he prevent the reports from being shared with the court?*

A. Legal Issue 1: What next for Mr Jones' treatment?

One might start to answer this question by reviewing the nature of 'medical treatment' as defined in the MHA.[165] This requires that medical treatment must have a 'purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations'. This suggests that if (or in this case, once) the clinician has concluded that there is no 'disorder', it would not be possible to provide 'medical treatment'. This has a potential wider implication in terms of the third question (whether the patient should be remitted to prison) since without medical treatment, presumably there can be no detention (though the wide scope of 'medical treatment' is emphasised). Further, providing treatment to somebody judged to have no genuine disorder may also open the clinician to a range of problematic legal outcomes or challenges, which could become more serious as the risks or side effects of the treatment increased. From a criminal perspective, this might include a criminal assault charge if there is evidence of harm or injury, allegations of professional misconduct, liability for negligence, and potentially other civil charges. Ultimately, it might even be conceived that a claim under the Human Rights Act 1998 for a violation of Article 3 of the European Convention on Human Rights (ECHR),[166] concerned with the prohibition of torture, could be made, as the absence of a genuine mental health problem would make it hard to justify the 'medical necessity' of the proposed treatment.[167] Similarly, it could lead to a violation of Article 15 of the Convention on the Rights of Persons with Disabilities

[165] Mental Health Act 1983, s.145(4)

[166] Council of Europe, 'European Convention on Human Rights' (1950).

[167] *Herczegfalvy v Austria* [1992] 15 EHRR 437; *B v S* [2005] EWHC 1936 (Admin), [2005] HRLR 40.

(CRPD)[168] which prohibits 'medical or scientific experimentation' in the absence of consent. This range of adverse legal outcomes leaves the potential for a very problematic situation for a clinician who continues treatment after concluding that there was no disorder to treat, and potentially even works to lead clinicians to avoid concluding a presentation was malingered (even in the face of near clinical certainty). This leads to a more general question about 'clinician avoidance' of malingering, which is certainly a worthwhile future research topic.

How would a clinician be guided in a situation where their view on the nature of the disorder was uncertain? A fuller answer would depend on a lengthy analysis of medical ethics and decision making more generally. However, this is certainly more familiar clinical territory; clinicians have to make treatment decisions about uncertain presentations in all areas of clinical practice. One might start by exploring the general expectations placed on clinicians in guidance in dealing with clinical uncertainty. For medical doctors, guidance from the General Medical Council suggests this is ultimately a matter of clinical judgement for the doctor:

> The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options.[169]

To do this effectively would likely require the clinician to carry out a balancing act between the advantages and risks of the treatment, considering all the potential explanations for the person's apparent presentation. The response may well be different, also, depending on the level of doubt the clinician has about the veracity of the person's presentation. However, given the serious implications involved in making an incorrect judgment, the clinician would also be well advised to make clear records of their decision-making process, and to remain actively aware of the potential legal consequences of medicating somebody who may not have a relevant underlying medical condition.

There is a wider question, mostly unanswered here, about the *expectation* placed on clinicians to 'investigate', or follow up their doubts, following questions about the validity of a patient's self-reported statements. Likely, this requirement will differ significantly with context and with the potential risks of the treatment being considered. Clinicians seeing psychotic clients in forensic settings, therefore, may be expected to take much more active attempts to understand this than, for example, a General Practitioner dealing with a presentation of low mood.

B. Legal Issue 2: Informed Consent in Assessment of Malingering.

The question here is specifically whether a clinician should or must seek informed consent to conduct a clinical assessment, if the process of doing so risks potentially defeating the purpose of that assessment or test.

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[168] United Nations, 'Convention on the Rights of Persons with Disabilities (CRPD)' (2007).
[169] General Medical Council, 'Good Medical Practice (GMC, 2013) [57].

Professional guidance has tried to solve this problem by two broad approaches. Firstly, by presenting tests of 'effort' as a routine part of testing more generally, it may be argued that a clinician is not doing anything 'different' when they assess a patient they suspect of deliberately distorting their performance on a test. Secondly, by advising clinicians to warn patients that their effort may be tested, for instance by 'a general statement along the lines that the tester will assess how hard the testee is trying on the tests'.[170] However, there are problems with both of these approaches. In terms of the first, there is plenty of evidence that clinicians, in practice, do not use effort tests routinely.[171] Thus, most clinicians cannot truthfully rely on this explanation. In terms of the second, a 'general statement' that effort testing may be carried out does not specifically inform a patient that such testing would be carried out in their case, nor allow them any choice as to whether to take part in that part of the assessment. This hardly feels like informed consent in the contemporary use of the term.

The most straightforward situation for the clinician would be for a patient detained under the MHA falling under the scope of s.63. The broad definition of treatment used by the MHA[172] would clearly include any such assessment by a clinician. This would suggest that consent would not be required for such an assessment. Though the MHA Code of Practice at 24.37 indicates that consent should still be sought if practicable, the language here allows some scope for limitation. Similarly, professional practice guidelines (including recently updated guidelines for psychologists[173]) would seem to allow scope for delivery of psychological interventions, in some circumstances, if it was not possible to obtain informed consent. Further, the provisions of s.139[174] would seem to protect clinicians from any civil or criminal claim made on the basis of having conducted such an assessment to a patient detained under the Act (unless it was conducted 'in bad faith or without reasonable care'; and there is perhaps some uncertainty as to whether the decision *not* to gain consent would be considered an 'act purporting to be done' (as opposed to an omission)). However, overall, it would seem reasonable to advise the clinicians working with Mr Jones that they could proceed with the assessment without gaining informed

[170] British Psychological Society, *Assessment Of Effort in Clinical Testing of Cognitive Functioning for adults* (BPS, 2009) 12; Grant Iverson, 'Ethical Issues Associated with the Assessment of Exaggeration, Poor Effort and Malingering' (2006) 13 Applied Neuropsychology 77 similarly recommends that 'Neuropsychologists should emphasize the importance of honesty and best effort. Patients should be informed that there are methods to detect invalidity within the evaluation'.

[171] Renee McCarter, 'Effort Testing in Contemporary UK Neuropsychological Practice' (2009) 23 The Clinical Neuropsychologist 1050, states that whilst 59% of a large sample of neuropsychologists reported commonly using effort tests in legal cases, only 15% routinely used them in clinical assessments. Similar results were obtained in a New Zealand study (Suzanne Barker-Collo & Kris Fernando, 'A survey of New Zealand psychologists' practices with respect to the assessment of performance validity' (2015) 44 New Zealand Journal of Psychology 35).

[172] Mental Health Act 1983, s.145.

[173] British Psychological Society, *Practice Guidelines* (3rd Edition, BPS, August 2017).

[174] Mental Health Act 1983, s.139.

consent.

For patients who are not subject to the relevant provisions of the MHA, however, the issue becomes trickier. Broadly, the issue of informed consent for clinical practice generally is now informed by the seminal ruling of *Montgomery*[175] in the UK Supreme Court, which rejected the previous doctrines of *Bolam*[176] and *Sidaway*[177] as applying to the need to obtain consent. The ruling of *Montgomery* seems to leave the starting point that clinicians should seek informed consent for all their acts.

However, *Montgomery's* focus was primarily around the obligation to disclose *risks* of treatment to patients, and so allow the patient to make an informed decision between one treatment or another, or indeed between one treatment and no treatment. The context of the case in regard to warning of the risk of shoulder dystocia during labour is quite different to the present issue. What 'risks' apply in the current example? If the assessment goes ahead, the primary risk from the patient's perspective are the potential implications of being 'found out'.[178] However, if the assessment does not proceed, there may be other risks such as those associated with the prescription of unnecessary psychoactive medication with significant potential side effects;[179] however, of course, the clinician cannot warn of these risks without revealing to the client their concerns about the veracity of their presentation. The apparent patient, for their part, may well be unaware of the risks also.

In conclusion, the position from *Montgomery*, as well as that taken by professional practice guidelines (General Medical Council (GMC)[180] and Health and Care Professions Council[181] (HCPC)), of informed consent being a positive obligation on the practitioner may require clinicians to develop a standard form of wording which at least explains the possibility that effort, response styles and validity may be tested, and that the clinician will not be able to reveal their full clinical opinion until after completion of the assessment.

C. Legal Issue 3: At what point should the RC transfer Mr Jones back to prison?

Section 50 of the MHA deals with the remission of detained prisoners to prison. This provides for remittal if the Responsible Clinician, 'any other Approved

[175] Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11.
[176] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[177] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871.
[178] Presumably, the 'reasonable patient' in Montgomery would not be a 'reasonable patient who was malingering', however.
[179] (n 164).
[180] General Medical Council, 'Consent: Patients and doctors making decisions together: Good Medical Practice' (General Medical Council, 2008).
[181] Health and Care Professions Council, 'Standards of Conduct, Performance and Ethics' (HCPC, 2018).

Clinician',[182] or an 'appropriate tribunal' notify the secretary of state that the 'person no longer requires treatment in hospital for mental disorder or that no effective treatment for his disorder can be given in the hospital to which he has been removed'.[183] This would certainly seem to allow the RC to make an application to the secretary of state in the case of Mr Jones. However, would the RC be obliged to do so?

The only guidance in case law in regard to the operation of s.50 confirms that the Secretary of State is able to direct remission to prison even if mental health symptoms *are* present (the key issues being 'in hospital', 'requires' and 'effective treatment') (*R v RW,*[184] *R v Larkin*[185]).

Further guidance is available through the Department of Health's 'Good Practice Procedure Guide'[186] in relation to remission of patients under s.47 and 48. This states that:

> Once the clinical team providing treatment agrees that the criteria for detention under the Mental Health Act is no longer met or that no more treatment can be given and, where allowed under the legislative framework, remission to prison should be achieved with the minimum of delay.

Again, however, this is a guideline and does not specifically address the obligation on the practitioner. Regardless, even if no obligation exists, a failure to do so may cause wider consequences if detention continues past the point of a conclusion that the person is malingering. Specifically, a violation of Article 5 of ECHR,[187] or of Article 14 of CRPD,[188] seems a possible concern. The ECHR Article 5 Right to Liberty and Security is a qualified right allowing for the lawful detention of 'persons of unsound mind', so provided this is conducted 'in accordance with a procedure prescribed by law'. Of course, once a person is found to not be 'of unsound mind' this qualification would seemingly no longer apply. This may be less of a concern for a prisoner such as Mr Jones (another qualification allows detention of offenders) but may be a significant risk in the case of somebody detained under one of the civil sections of the MHA.

Thus, appropriate guidance to Mr Jones' RC would be that Mr Jones should be referred back to the Secretary of State for remittal to prison at the point of making a determination of malingering. In practice, if a court date was

[182] As a somewhat divergent point, this presumably leaves the position that if an Approved Clinician working alongside another patient's Responsible Clinician has cause to assess the patient and believes they are malingering, they could in theory notify the Home Office and request remittal. How a disagreement here would be dealt with is unknown.
[183] Mental Health Act 1983, s.50.
[184] *R v RW* [2012] EWHC 2082 (Admin), [2012] MHLR 288.
[185] *R v Larkin* [2012] EWHC 556 (Admin), [2012] MHLR 161.
[186] Department of Health, 'Good Practice Procedure Guide: The Transfer and Remission of Adult Prisoners under s.47 and s.48 of the Mental Health Act' (Secure Services Policy Team, DH, 2011).
[187] (n 166).
[188] (n 168).

imminent, the team may well wait until legal proceedings had concluded.

D. Legal Issue 4: How to assess capacity?

The question here fundamentally concerns the clinician's application of the diagnostic test contained within the Mental Capacity Act. If the RC believes the client's presentation is accounted for by malingering they would not meet the test for '*impairment of or disturbance in functioning of the mind or brain'.*[189]

Fortunately, this seems one of the more straightforward situations on which to give guidance. Whilst the Mental Capacity Act places obligations on the practitioner, these are generally imperatives couched in language that allows wide limitation ('duty to consider'; 'take into account'; 'so far as reasonably practical'). The test for capacity is made on the balance of probabilities.[190] Thus, whilst the clinician cannot avoid consideration of capacity, they do not have to have reached clinical certainty to draw conclusions about capacity.

This is the one question on which opinion appears more established, with the process of assessment of capacity in a case of malingering being detailed within an article by Nick Airey.[191] This paper outlines how an assessment of a bizarre clinical presentation initially concluded that the apparent patient lacked capacity, but as more evidence came to light demonstrating a fabricated presentation of symptoms, the assessment was changed. Such a process would likely occur in the case of Mr Jones.

E. Legal Issue 5: What considerations should the clinicians have when disclosing their reports to the court?

The primary issue here is whether or not the clinicians are obliged, or even permitted, to pass on their report to the courts if Mr Jones objects to disclosure. In the present case, the issue is more fundamentally about the circumstances under which a clinician can disclose any unfavourable report. Case law provides some guidance here.

R v Crozier[192] involved a case of attempted murder. The defendant had been seen by two psychiatrists prior to sentencing, both of whom had prepared reports. The psychiatrists had been instructed by the defence. The first psychiatrist indicated he did not believe the defendant to fall within the scope of the MHA. The second psychiatrist concluded that the defendant did fall within the scope of the MHA (under the previous category of Psychopathic disorder). However, the second psychiatrist arrived late at court, shortly after the judge had passed a custodial sentence. The counsel for the prosecution was made

[189] Mental Capacity Act 2005, s.2(1); presuming of course there was no other disorder or the clinician was not reasoning that the malingering was in some way caused by a disorder.
[190] Mental Capacity Act 2005, s.2(4).
[191] Nick Airey, 'Physically ill, mentally ill, or malingering? A case of impaired capacity (or probably not!)' [2017] Family Law Journal 435.
[192] *R v Crozier* [1988] 8 BMLR 128.

aware of the contents of his report. After the first doctor confirmed he now agreed with the second, the crown invited the court to vary the sentence to a s.37/41 Hospital Order with Restrictions.

The appeal was based on an argument that the second psychiatrist breached confidentiality by sharing the report with counsel for the prosecution. The judgment drew on an earlier appeal case, *W v Edgell*[193] in which a doctor had been instructed to assess a client detained at Broadmoor, with the prospect of the client being transferred to a Regional Secure Unit. Here, the report had been highly unfavourable to the client. Consequently, the solicitors chose not to use the report as evidence in a forthcoming Mental Health Review Tribunal. The client's solicitors informed the psychiatrist that they opposed him releasing the report to the Tribunal. The psychiatrist did so anyway, concerned that the report might not be put before the tribunal. The patient made a claim for damages against the psychiatrist.

This case was resolved very clearly in favour of the doctor with Bingham J writing that:

> Where a prison doctor examines a remand prisoner to determine his fitness to plead … the professional man's duty of confidence towards the subject of his examination plainly does not bar disclosure of his findings to the party at whose instance he was appointed to make his examination.

The judgment notes that in the case at hand, and indeed in the case of *Crozier*, the psychiatrist was instructed by a party other than the court. Nonetheless, in both cases it was agreed that the public interest in disclosure outweighed the patient's duty to confidentiality; in both cases the severity of the offending and associated risk was highlighted as a justification for taking this stance.

In the case of Mr Jones, therefore, both clinicians could arguably rely on this case-law to disclose the report to the court, regardless of Mr Jones' views. However, a medical doctor, under direct instruction from the court – for example in the context of the Criminal Justice Act s.157(1), may be in a slightly stronger position than a clinician who has not received such direct instructions but has completed an assessment on the patient for other purposes. A medical doctor, in the context of Mr Jones, would also often have access to a range of other multidisciplinary opinions which could also contribute towards developing their views, although a doctor in such cases may be best advised to include any reports verbatim, to avoid any potential risk of providing hearsay evidence.[194] However, s.157(3) is noteworthy here, since this does provide recognition that courts may have before them other information which relates to the defendant's mental health, which they are also obliged to consider.

[193] *W v Edgell* [1990] 1 All ER 835 (Ch).

[194] Lionel Haward, 'Hearsay and Psychological Reports' [1965] Bulletin of the British Psychological Society, 18, 21-26.

IV. SUMMARY AND CONCLUSIONS

Undoubtedly, the present review has highlighted that malingering is a thorny issue for clinicians and lawyers alike. There appears much scope for improvement in the many ways in which clinicians' skillsets are best harnessed for the courtroom environment. However, to achieve this requires change. Firstly, it requires there to be a much wider acceptance of the problem of malingering in courts and in the clinic room. Clinicians need to avoid the delusion that they will always and obviously 'catch' a malinger; courts need to avoid fuelling this belief through misplaced expectations and expect to see clinicians considering the validity of symptom presentations more routinely within clinical assessment. Courts should question clinicians generally who present clinical opinions that do not have 'sound workings' beneath them. Secondly, it requires a development of processes, and a much better reciprocal understanding between lawyers and clinicians as to what the other profession does. In particular, clinical psychologists, who arguably have in many cases the most obvious skill-set to conduct formal assessments of malingering, need to work harder to understand how they can contribute to the problems faced in the court-room; lawyers and judges might benefit from understanding how such assessments take place and for what sorts of questions they can be useful. These better working relationships need to lead to development of agreed models by which psychological assessments would be conducted and commissioned, and look at the most efficient and effective ways to make use of the clinical resource.

In terms of the law, too, there are opportunities for change. Whatever other merits it may or may not have, the Irish approach to false reporting in the civil court setting, if accepted in England and Wales, would lead to radically different outcomes to any cases where evidence of malingering had been clearly established, but some partial valid element to the claim was also made out. Arguably, claimants would be much less likely to risk malingering in a civil claim if they believed it may prejudice a valid claim; currently, there seem to be very few risks to a claimant malingering mental health difficulties.

In criminal law, whilst it is likely that there are issues with malingering particularly during the sentencing stage, these are hard to capture and measure; as noted, it is impossible to know how many 'successful' malingerers there are. As things stand, there is little evidence of malingering in regard to the defences of insanity and diminished responsibility, but this is largely because of the general inaccessibility of these defences, and this may change if access to these defences is widened. Many opportunities for clinical-legal research present themselves.

For the practitioner carrying out an assessment of a client who is potentially malingering, this remains a delicate task. The guidance previously noted addresses some of the major questions, but many of these issues have not been tested in law. Professionals working with clients who may be malingering where they are not being seen in the context of a court-ordered assessment, or

detained under the provisions of the MHA, may need to take particular care. Professional guidance in these issues needs to be developed with close advice from professionals with significant legal, as well as clinical, experience.

The article, of course, says little about those who have real mental health problems. Jill Peay[195] has rightly emphasised that one should not let a fear of malingering come before the need to help people with genuine problems, and this, indeed, is a very real concern. Certainly, the authors would not wish to advocate for a focus on malingering that neglected the much greater need for statutory services to attend to people who present to services with mental distress. On the other hand, the scarcity and cost of mental health treatment for offenders (a single secure hospital bed may be in the order of £200,000 per year[196]) serves as a very real limitation to those who do have genuine mental health problems, and the extent of resource that could be better used because of the problem of malingering is unknown, though unlikely to be negligible.

To conclude? We need to do better. Clinicians who are concerned about an over-stretched health service cannot ignore the impact of potential malingering on the provision of care. Society cannot ignore the cost of potential unwarranted welfare payments or financial settlements from insurance companies. And in the legal system, justice is not done when a person malingering mental health difficulties gets a disposal meant for somebody with a genuine mental health need. Malingerers, particularly convincing ones, will happily ignore both clinicians and lawyers, and we ignore the problem at our peril. Yet, the legal landscape in assessing a potentially malingering client risks creating a context that leads clinicians to shy away from this important task, perhaps risking the production of conclusions that are more tentative than their actual view. Whilst this may be understandable, even desirable, in situations where there is significant doubt, it certainly becomes problematic for a clinician that has developed serious and well-founded concerns about the veracity of a client's presentation.

Yet, fundamentally, we would caution against knee-jerk reactions exclusively focused on getting better at 'catching' malingering. The issues here may be symptoms of a bigger problem that deserves wider attention: the process of clinical governance and quality assurance of expert evidence in the court room, and the reciprocal understanding of clinicians and lawyers of each other's skillsets. As currently configured, there is significant latitude afforded to clinicians to offer and structure expert opinion, so long as they address the primary issues of instruction. But there are many variables that differentiate clinicians in their approach to assessment and that may be determinants of the quality of outcome; for instance, the length of time spent with a client (and period over which assessment is completed); the nature and focus of the

[195] (n 22).

[196] Centre for Mental Health, 'Briefing Note – Secure Care Services' (2013) <https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/securecare.pdf> accessed 11th March 2021.

questions asked of the client; the type of measures of clinical symptomatology adopted, and even the skillset of the clinician in non-verbal communication in enabling engagement with a client. Clinicians, too, have quite different areas of expertise, the breadth of which might well be under-appreciated by the courts, with even job titles potentially becoming a source of confusion (psychiatrists, psychologists and psychotherapists each have highly different training routes and different skillsets, but may be readily confused). Further confusion can occur since clinicians *within* a profession might align themselves to particular 'schools of thought' or theoretical orientations that influence both approach and opinion, but of which legal practitioners may well be unaware. In the courtroom, the confusing picture is mirrored by a 'black and white' approach of legal philosophy, and taken together with the basic complexities of mental health problems, may lead to a 'pull' towards clinical evidence that reflects a more reductionistic view of classification and causation than is warranted. This much wider issue might well account for some of the issues for courts in grappling with malingering.

A wider solution, thus, is to consider the broader question of how clinical evidence and expertise is best used to help the courts make decisions about people presenting with mental health problems. This may be informed by research enterprises to support joined-up discussions between both clinicians and lawyers. As well as stimulating thought about the challenge of malingering, the authors hope the present paper provides impetus to these objectives more broadly.