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'The Witness Who Saw, /He Left Little Doubt'¹: A Comparative Consideration of Expert Testimony in Mental Disability Law Cases in Common and Civil Law Systems

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Abstract

The question of how courts assess expert evidence—especially when mental disability is an issue—raises the corollary question of whether courts adequately evaluate the content of the expert testimony or whether judicial decision making may be influenced by teleology ('cherry picking' evidence), pretextuality (accepting experts who distort evidence to achieve socially desirable aims), and/or sanism (allowing prejudicial and stereotyped evidence). Such threats occur despite professional standards in forensic psychology and other mental health disciplines that require ethical expert testimony. The result is expert testimony that, in many instances, is at best incompetent and at worst biased. The paper details threats to competent expert testimony in a comparative law context—in both the common law (involuntary civil commitment laws and risk assessment criminal laws) and, more briefly, civil law. We conclude that teleology, pretextuality, and sanism have an impact upon judicial decision making in both the common law and civil law. Finally, we speculate as to whether the new United Nations Convention on the Rights of Persons with Disabilities is likely to have any impact on practices in this area. Copyright © 2009 John Wiley & Sons, Ltd.

Key words: expert testimony; criminal law; civil law; psychologists; risk assessment; mental disability law

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¹The first portion of the title of this paper comes from Bob Dylan's *Percy's Song* (Heylin, 1995). The song is 'a moving tale of backcountry injustice' (Trager, 2004, p. 488) sung from the point of view of a man who visits a judge in a futile, last-ditch attempt to save his friend from a severe prison sentence. Nearly 30 years ago, Poague (1979) characterised *Percy's Song* as reflected a world in which 'injustice is seen as a universal circumstance' (p. 96). All of us who work in mental disability law must be ever vigilant to identify and uproot such 'injustice'. We hope that, by calling attention to the factors that affect judicial decision makers in cases involving the cohort of persons with mental disabilities, we modestly can aid in this endeavour.

INTRODUCTION

The issues before a court may turn on questions that are beyond the common knowledge of judges or juries. In such a case, evidence from expert witnesses may be admitted into the court process. The question of how courts assess expert evidence—especially where mental disability is an issue—inevitably raises the corollary question of whether courts actually evaluate its content or whether, teleologically, they consider only the conclusion and/or recommendations. If so, do courts privilege certain testimony (because the conclusion serves what are perceived as socially desirable aims) and subordinate other testimony (because the conclusion serves what are perceived as socially undesirable aims)? If this privilege/subordinate pattern is found, is this a result of what [Perlin \(1991, 1992\)](#) refers to as ‘pretextuality’ or ‘sanism’, or is it something else?

This paper will consider these questions in a comparative disability law context in both common and civil law systems. First, we will describe teleology, pretextuality, and sanism (as factors that must be understood if the analysis in this paper is to make authentic sense). Second, we will consider the professional standards that govern the behaviour of forensic psychologists and discuss the relevant ethical issues. Third, we will consider these questions—and the implications of our conclusions—in the contexts of expert testimony in some common law jurisdictions and civil law jurisdictions. Finally, we will speculate as to whether the new United Nations Convention on the Rights of Persons with Disabilities is likely to have any impact on practices in this area and offer some modest conclusions.

Teleology, pretextuality, and sanism

The links between teleology, pretextuality, and sanism are relevant to expert testimony in the courts. Specifically, [Perlin \(1993–1994a\)](#) has argued that pretextual decisions about mental disability and sexuality are teleological, that the teleological application of social science data in disability discrimination cases is the vehicle through which pretextual decisions serve to reify sanist attitudes ([Perlin, 2000a](#)), and that sanist attitudes are shared by judges who decide cases pretextually and justify those decisions teleologically ([Perlin, 1994b](#)). We will now explain the concepts of teleology, pretextuality, and sanism.

Teleology

[Perlin \(1999\)](#) has argued that, in considering expert evidence, the courts teleologically ‘cherry pick’ social science evidence to justify judicial decisions. By *teleological*, we refer to outcome-determinative reasoning; social science that enables judges to satisfy predetermined positions are privileged, whilst data that would require judges to question such ends are rejected or subordinated (see [Perlin, 1993, 1993–1994a; Perlin & Dorfman, 1993](#)). In other words, ‘social science data is used and misused for teleological ends... in accordance with and in adherence to previously determined ultimate conclusions’ ([Perlin, 1993–1994a, p. 22](#)). Just as individuals ‘tend to ignore, subordinate or trivialise behavioural research in this area, especially when acknowledging that such research would be cognitively dissonant with our intuitive-albeit empirically flawed views’ ([Perlin, 2000a, p. 42](#)), fact finders in mental disability law cases give such evidence too *much* weight when it reinforces their previously internalised positions.

Writing about this phenomenon, La Fond and Durham (1992) articulated the contradiction in this manner:

Neoconservative insanity defence and civil commitment reforms value psychiatric expertise when it contributes to the social control functions of law and disparage it when it does not. In the criminal justice system, psychiatrists are now viewed sceptically as accomplices of defence lawyers who get criminals 'off the hook' of responsibility. In the commitment system, however, they are more confidently seen as therapeutic helpers who get patients 'on the hook' of treatment and control. The result will be increased institutionalisation of the mentally ill and greater use of psychiatrists and other mental health professionals as powerful agents of social control. (p. 156)

Obviously, teleological reasoning runs contrary to any notion of what a fair legal process should involve.

Pretextuality

Perlin (1991, 1993) first linked the role of expert testimony in the courts to the omnipresence of what he described as *pretextuality* in the US legal system. Pretextuality has two elements where (1) expert witnesses show a high propensity to purposely distort their testimony in order to achieve socially desirable aims; and (2) courts accept (either implicitly or explicitly) this testimonial dishonesty and, as a result, engage similarly in dishonest and frequently meretricious, decision making. This pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blase judging, and, at times, perjurious and/or corrupt witness testimony (Perlin, 2000b, 2003a).

In cases ranging from disability discrimination suits to sexual autonomy matters to death penalty trials, the linkage between pretextuality and teleological decision making is clear. Perlin has argued that pretextuality dominates all of the substantive and procedural mental disability law systems, no matter whether the topic under consideration is legislation, judicial decision-making, or lawyers' behaviour (see Perlin 1991, 1993, 1994a, 1998b, 2008b,c) as well as the intersection between international human rights law and mental disability law (see Perlin, 2007a,b, 2008b,d,e; Perlin & Szeli, in press).

With regard to the substantive question that is at the heart of this paper, Perlin's (1993) investigations have shown that 'the testimony of forensic experts and decisions of legislators and fact-finders reflect the pretexts of the forensic mental health system' (pp. 628–629) in that 'experts frequently testify according to their own self-referential concepts of 'morality', and openly subvert statutory and case law criteria that impose rigorous behavioural standards as predicates for commitment or that articulate functional standards as prerequisites for an incompetent to stand trial finding' (pp. 628–629). It is also pretextual to presume a 'level playing field'. On the contrary, the problems inherent in the frequent disparity in financial resources are significant both in criminal litigation (Gianelli, 2004) and civil litigation (Imwinkelried, 2007).

The question posed in this paper, however, takes these enquiries onto a slightly different path: Do these same factors dominate legal systems elsewhere in cases involving the admission and treatment of expert testimony, especially when that testimony deals with question of mental status? To the best of our knowledge, this is an issue that has never been addressed in the literature.

Sanism

In the US context, law, policy, and behaviour are also contaminated by sanism. *Sanism* is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry (Perlin, 2003b). Sanism infects both our jurisprudence and our lawyering practices, is largely invisible and socially acceptable, and is based predominantly upon stereotype, myth, superstition, and deindividuation (Perlin, 2000b, 2003b). Sanism is sustained and perpetuated by our use of alleged 'ordinary common sense' and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process (Perlin, 1993–1994b, 2003b, 2008a).

If mental health professionals are such agents of social control, as La Fond and Durham (1992) assert, what standards govern them in their actions, and how are these standards relevant to the questions presented in this paper?

PROFESSIONAL STANDARDS IN PSYCHOLOGY

Before considering the role of psychology in expert testimony, we will describe the current situation regarding codes of conduct for psychologists on an international basis. A Universal Declaration of Ethical Principles for Psychologists (Declaration) has been recently adopted (International Union of Psychological Science, 2008)². The Declaration provides a set of moral principles to guide psychological associations in codes of ethics and a universal standard against which to evaluate the ethical and moral development of psychological progress, reflecting the moral principles and values that are expected in both common law and civil law systems. The *Declaration* describes ethical principles based on shared human values '...to build a better world where peace, freedom, responsibility, justice, humanity, and morality prevail' (p. 1).

The *Declaration* is underpinned by four principles. *Respect for the Dignity of All Human Beings* (Principle I) recognises the inherent worth of all individuals. *Competent Caring for the Well-Being of Persons and People* (Principle II) maximises therapeutic effects and minimises antitherapeutic effects whilst being cognisant of psychologists' values, culture, and social context. *Integrity* (Principle III) includes open, honest, and accurate communication and recognises potential biases that could result in the harm and exploitation of others. *Professional and Scientific Responsibilities to Society* (Principle IV) recognises psychology as a science and a profession that increases knowledge of human behaviour, maintains the highest ethical standards, and contributes to social structures and policies that benefit all human beings. Adhering to Principle I ensures that individuals with disability are included, adhering to Principles II and III optimally avoids sanism, adhering to Principle III minimises the potential harm of teleological thinking, and adhering to Principles III and IV minimises the potential deleterious impact of pretextuality.

The principles that underpin the *Declaration* are supported in common law countries by the Code of Ethics and Conduct of the British Psychological Society (BPS, 2006), the Code of Ethics for the American Psychological Association (APA, 2002), and the Code of Ethics of the Australian Psychological Society (APS, 2007). All three Codes address

²The Declaration was adopted unanimously by the General Assembly of the International Union of Psychological Science and the Board of Directors of the International Association of Applied Psychology in Berlin in July 2008.

potential issues regarding pretextuality by ensuring integrity (e.g. psychologists do not engage in intentional misrepresentation [APA, 2002]) and competence (e.g. psychologists remain abreast of scientific innovations and practice within the boundaries of their competence [BPS, 2006]). All three Codes warn against unfair discrimination or prejudice against people with disability (Standard 3.01: Unfair Discrimination in the APA, 2002; Ethical Principle 1.1: Standard of General Respect in the BPS, 2006; and Standard A.1: Justice in the APS, 2007). In addition, the Australian Code addresses the pitfalls of sanism in that Standard A.1 stipulates ‘psychologists demonstrate an understanding of the consequences for people of unfair discrimination and stereotyping related to their... disability’ (p. 11), and General Principle C: Integrity stipulates ‘psychologists are aware of their own biases, limits to their objectivity...’ (p. 26).

Expert testimony by psychologists

Compared with standards set by codes of conduct, expert testimony by psychologists can be, variously, ethical, incompetent, and/or biased.

Ethical expert testimony

Competent psychologists do not go beyond the limits of their competence. They provide expert opinion based on special knowledge and expertise, clearly describe generalisability and limitations of findings, consider the court or justice system to be the client, and communicate the limitation of their role to all participants (Haas, 1993). Principles of ethically sound psychological conduct have been listed by Dickey (2008) as beneficence (acceptance of responsibility to do good), non-maleficance (do no harm), autonomy (respect for freedom of thought and action), justice (basing actions on fairness between individuals), fidelity (trustworthiness to commitments), and, generally, respect for a person’s rights, dignity, competence, responsibility, and integrity. However, such principles are difficult to apply within the legal system as it currently operates (McGuire, 1997). Nevertheless, if the court admits evidence that does not support codes of conduct, ethical psychologists can decline to appear whilst knowing that ‘...the judge would instead send the case to Jones, who, unlike you, is of doubtful character and capability’ (Faust, 1993, p. 362).

Incompetent expert testimony

There are times when expert testimony can be incompetent—the seductive power of the courtroom and the subtle gratification of being on stage as the expert can sometimes blind the psychologist to the need for particular skills and particular frames of mind necessary to both serve the court system and do justice to the complexity and integrity of the psychological profession’ (Haas, 1993, p. 259). Haas indicated that incompetent practice can be demonstrated in various ways. First, failing to understand the justice system includes testifying about the facts or providing a legal opinion, and relying on persuasion rather than content (i.e. style over substance). Second, exhibiting professional arrogance includes overconfidence, inadequate assessment, inappropriate use of third-party reports, and so on. Third, advocating rather than testifying includes psychologists believing they understand the legal outcomes required. Fourth, failing to keep abreast of a rapidly changing field results in out-of-date empirical knowledge. Fifth, psychopathology and abusing substances result in psychologists burning out and/or becoming impaired. Last, overservicing clients

for financial gain leads to exaggerating credentials and findings. These obstacles to competency can be overcome through adequate forensic supervision and less professional hubris.

Biased expert testimony

There are times when expert testimony can be biased (or even dishonest, as previously described in the context of pretextuality). Most recently, Dvoskin and Guy (2008) have maintained that

...the most egregious errors by expert witnesses are almost always attributable to narcissistic needs, including the need to be praised, to make money, to be right, and to win...it feels good to have so many people care what one thinks and says about the case. But yielding to those needs is a dangerous and slippery slope...attempted to embellish the evidence...enhance their credentials...tempted to tell prospective clients what they want to hear, thus landing in positions that do not fit the evidence. (p. 203)

If the court rejects evidence that supports professional standards (i.e. scientific evidence is excluded because it is new and relatively unknown), the psychologist is then placed in direct opposition to the legal system and so experiences an ethical dilemma (Faust, 1993). The unethical psychologist (as described above) may try to circumvent the legal system through deception—exaggerating the quality or certainty of particular evidence—because other options are limited, and the lawyer’s desire to ‘put the best case forward’ is compelling (Faust, 1993). Faust argued that ‘inadvertent misrepresentation’ is more common than ‘intentional distortion’; ‘...sometimes those who will enter the courtroom to opine about a particular issue are there mainly because they hold erroneous beliefs or possess a greater faith in some method than warranted’ (p. 363). Haas (1993) provided an example where a forensic psychologist offered opinions without adequate data and used strong language to cover up the lack of scientific evidence, and ‘there was no indication that the psychologist was alert to pressure that could have led to the misuse of his influence’ (p. 258). Perlin (2008c) provides starker examples of experts who may be described pejoratively as defendant or prosecutor ‘whores’ and who may profess neutrality but are, in fact, biased.

In summary, expert testimony ought to be ethical but, at times, can be incompetent or biased (or even dishonest). In addition, Haas (1993) noted that competence is a necessary but not a sufficient condition for expert testimony. Expert witnesses also require professional virtues such as fidelity, prudence, discretion, integrity, public-mindedness, benevolence, and hope. That is, high-quality and competent forensic practice draws on scientific underpinnings *and* promotes human welfare. Competent forensic practice is therefore influenced by the values of the profession, which are then played out through expert testimony in legal jurisdictions.

EXPERT TESTIMONY IN LEGAL JURISDICTIONS

The question must be addressed: How is expert evidence—especially in cases involving mental status issues—dealt with in different jurisdictions? Research suggests a significant split between common law jurisdictions (those whose legal systems have been influenced primarily by British law) and civil law jurisdictions (those whose systems were similarly influenced by continental law).

The following section will consider the differences in the treatment of expert testimony, broadly, as between civil and common law jurisdictions and, within these two overarching categories, how such testimony is considered in specific civil and common law nations. For a helpful comparison of the common law and civil law systems, see Barnes (2005).

Common law

The fundamental aspect to the common law tradition is the adversarial system, in which opposing lawyers control the testimony through the questions they pose, and, thereby, only aspects of the evidence that support their respective arguments are presented (Haas, 1993). Therefore, the central feature of this system places almost total responsibility on the parties for bringing suit, developing legal theories, producing evidence, and deciding which witnesses to call; no investigation or witness selection is actioned by the judge (Cound, Friedenthal, Miller, & Sexton, 2007)³. As the common law depends upon the parties rather than upon a 'neutral' observer to gather and present evidence, it 'relies at least as much on the power of persuasion and rhetoric than on a formal, scientific-like investigation' (Slobogin, 2003, p. 285). Deferring to professional standards can result in expert testimony being admitted if it meets the court's standards, whilst, simultaneously, the court relies upon expert testimony to convince it that the evidence meets the court's standards (a pragmatic approach, Slobogin, 2003). Faust (1993) argued that the role of psychologists in the courtroom requires interaction between legal standards (whether the court accepts or rejects the evidence) and professional standards (according to codes of conduct as discussed above).

There are rules about the circumstances in which a court may allow expert evidence to be admitted and what is to be considered to be expert evidence. These questions may overlap. By using the example of the New Jersey Evidence Code (see *N. J. Evid. R. 104*), expert testimony is admissible if: (1) the intended testimony concerns a subject matter that is beyond the ken of the average juror; (2) the field testified is based on state-of-the-art evidence such that an expert's testimony could be sufficiently reliable; and (3) the witness has sufficient expertise to offer the intended testimony. For another example using a slightly different definition, see the Evidence Act 2006 (New Zealand), which defines expert evidence as evidence 'based on the specialised knowledge or skill of that expert', and an expert is defined as 'a person who has specialised knowledge or skill based on training, study or experience' (section 4). Although this suggests that the evidence is

³There are some significant differences *within* common law systems between the US model and the model in other common law nations. The US model is unique in its (1) reliance on jury trials; (2) use of discovery rules giving wide latitude for exploration of all issues (including oral depositions); (3) far greater latitude in case presentation; and (4) in most cases, an each-party-pays-its-own-costs rule (Rowe, Sherry, & Tidmarsh, 2008). In England, for example, jury trials in civil matters are limited to matters involving fraud, defamation, or 'pre-scribed matters', which have been limited to false imprisonment and malicious prosecution actions (see *Supreme Court Act 1981* [UK], s69, and *County Courts Act 1984* [UK], s66); disclosure of documents is usually limited to documents on which reliance is placed or which undermine the party's case, and there is only a limited duty to search for documents, which is what is reasonable in circumstances, including the complexity of the proceedings, the significance of the document, and the ease and expense of any retrieval of documents (Civil Procedure Rules Part 31.6 and Part 31.7); trials—and all other aspects of civil proceedings—are subject to the 'overriding objective' as set out in the Civil Procedure Rules, namely, of dealing with cases 'justly', an aspect of which is the saving of expense and another aspect of which is the proportionality of steps in light of matters such as the importance and complexity of the case and the financial position of the parties (Civil Procedure Rules, Part 1). The Court has to bear this in mind whenever making decisions and the parties are under a duty to assist the court. The English approach to costs is also different: generally, the losing party pays the reasonable costs incurred by the winning party (see Civil Procedure Rules Part 44.3(2)).

limited to specialised situations, (i.e. those beyond the ken of most people) section 25 of the Act conditions admissibility on the ability of the evidence to provide ‘substantial assistance’ to the fact-finder in either understanding other evidence or making a finding of fact, and it is expressly provided that it is not inadmissible because it is a matter of common knowledge.

The definition of ‘expert testimony’ in the US was clarified in *Daubert v Merrell Dow Pharmaceuticals (Daubert)* (1993) and *Kumho Tire Co. v Carmichael (Kumho)* (1999) (see Slobogin, 2003). *Daubert* established that expert evidence must comprise information that is based on scientifically valid reasoning, is reliable, and was obtained through sound scientific methods; in effect, the court is asking two questions: (1) ‘Why should we believe the expert?’ (i.e. the credibility, reliability, and validity of the expert opinion in terms of fact and logic); and (2) ‘Why should we care?’ (i.e. the relevance of the opinion to the specific issue) (Dvoskin & Guy, 2008). Six years later, *Kumho* established that expert testimony captures scientific, technical, and other specialised knowledge and should be considered on a case-by-case basis (Dvoskin & Guy, 2008). In other words, expert evidence is contextualised rather than being based on hard and fast rules (as previously discussed regarding teleology, pretextuality, and sanism). Concern for credibility and relevance means that ‘this reification of the trial judge as gatekeeper is of paramount importance to expert witnesses’ (p. 204). Under this general framework, psychologists’ evidence is used in the courts on the basis of claims to use scientific and professional knowledge and skills to ‘...make better-than-chance assessments of an individual’s fitness to stand trial, possession of mental competence, degree of psychopathology, fitness to care for a child, likelihood of acting in a violent manner, and so forth... accomplished by reviewing existing scientific literature, performing scientific research, and conducting sound psychological assessments’ (Haas, 1993, p. 257).

Scientific method requires valid information that has incremental validity (or predictable validity) and surpasses base rates (Faust, 1993). However, the scientific criteria of reproducibility and ecological validity in the behavioural sciences are difficult to achieve in applying laboratory data to the ‘real world’ (Orme, 2002). Surpassing base rates in, for example risk assessments, is difficult to attain, as base rates for reoffending of 30–60% are required for predictive accuracy (Andrews, Bonta, & Hoge, 1990). Meanwhile, sexual and violent offenders have low reoffending rates. In sex offenders, the reoffending rate is typically around 13% and rarely exceeds 40% at 15–20 years follow-up (Hanson, 1998). Slobogin (2003) warned that psychological testimony based on the behavioural sciences may ultimately be unacceptable to the courts (although this does not appear to have been the case to date). An empirical analysis of how judges carried out *Daubert*’s ‘gatekeeping’ function in cases involving different sorts of expert testimony has been conducted (see Merlino, Murray, & Richardson, 2008). Here, it is obligatory to note the *disparity* in decision making in *Daubert* cases; the prosecutor’s position is sustained (either in support of or in opposition to questioned expertise) vastly more often than the defence counsel’s position (Risinger, 2000).

Writing about the role of experts in common law cases involving testamentary capacity, Champine (2006) concluded that ‘concerns about the (mis)use of mental health experts are widespread’ (p. 83 n. 273). Champine surveyed the leading authorities, noting that they extensively discussed inaccuracies in decision making by mental health professionals in forensic contexts (see Bersoff, 1992), explained the difficulties that clinicians had in applying legal standards (see Lambie, 2001), considered the assumptions about expert knowledge that were implicit in the standards governing admissibility of expert testimony

(see [Sanders, Diamond, & Vidmar, 2002](#)), and compared the limitations of clinical decision making with statistical decision making (see [Mossman & Kapp, 1998](#); [Redding, Floyd, & Hawk, 2001](#); [Shuman & Sales, 1998](#)).

Beyond this, we have known for years of the meretricious power of *heuristics*—intuitive decision making influencing judgement that, although reducing the complexity of the task at hand, may also lead to severe and systematic errors (see [Kruglanski & Ajzen, 1983](#); [Tversky & Kahneman, 1993](#)). The use of heuristics leads to distorted and systematically erroneous decisions and causes decision makers to ‘ignore or misuse items of rationally useful information’ (Perlin, 1990, p. 966 n. 46), leading to the problem that

one single vivid, memorable case overwhelms mountains of abstract, colourless data upon which rational choices should be made. Through the availability heuristic, individuals judge the probability or frequency of an event based upon the ease with which they recall it, leading generally to demands for harsher punishment in all cases. Through the typification heuristic, people characterize a current experience via reference to past stereotypic behaviour. Through the attribution heuristic, they interpret a wide variety of additional information to reinforce pre-existing stereotypes. (Perlin, 1997, p. 1417)

Scholars have considered the pernicious impact of these devices on the admissibility of expert testimony and other related issues such as psychotherapy and medical practice. Several studies have concluded that clinical assessments of the likelihood of dangerousness are clouded by bias (Bersoff, 1992), that expert testimony by physicians and psychologists will be affected by hindsight bias ([Anderson, Lowe, & Reckers, 1993](#); [Arkes, Faust, Guilmette, & Hart, 1988](#); [Arkes, Wortmann, Saville, & Harkness, 1981](#); [Jolls, Sunstein, & Thaler, 1998](#); [McNeil, Pauker, Sox, & Tversky, 1982](#)), and that expert testimony is often the product of cognitive errors and erroneous beliefs ([Chapman & Chapman, 1969](#); [Meadow & Sunstein, 2001](#); [Rachlinski, 2003](#)). [Plous \(1993\)](#) concluded that ‘several studies have found that experts display either roughly the same biases as college students or the same biases at somewhat reduced levels’ (p. 146).

Expert witnesses are not the only individuals vulnerable to heuristics. Judges can be susceptible to the overuse of the availability heuristic ([Schauer, 2006](#)), may idealise science ([Hans, 2007](#); [Mnookin, 2007](#)), and ‘like other people, judges rely on simple decision rules, or heuristics, to make decisions’ ([Rachlinski, Guthrie, & Wistrich, 2006](#), p. 1229). A recent study of magistrates that tested for several common heuristics (or ‘cognitive illusions’) in different litigation settings showed ‘statistically significant biasing effects, with the strongest for anchoring, hindsight, and egocentric [overconfidence] biases’ ([Bone, 2007](#), p. 1987, quoting [Guthrie, Rachlinski & Wistrich, 2007](#), pp. 787–816). As [Perlin \(2000a\)](#) wrote nearly a decade ago, ‘Judges’ predispositions to employ the same sorts of heuristic bias as exhibited by expert witnesses further contaminate the process’ (p. 33).

In a consideration of the potential biases of expert testimony, which may result in dishonesty, how do these biases ‘play out’ in the context of experts’ purported neutrality—to what extent are experts neutral, and to what extent do we expect that they will be neutral? ([Deason, 1998](#); [Mnookin, 2008](#); [Perlin, 2008c](#)). Some expert bias is intentional, and some expert bias is unintentional ([Beckham, Annis, & Gustafson, 1997](#)), but it is still a ‘real risk’ even if unintended ([Haroun & Morris, 1999](#)). [Dvoskin and Guy \(2008\)](#) warned that, in considering whether to accept a case, potential experts must evaluate their limitations and biases and ‘...realise that not all referrals will be a good fit with their expertise’ (p. 205). [Appelbaum \(1987\)](#) noted the ‘frequency with which highly respected [psychiatric]

experts arrive at conclusions favourable to the side for which they are working or to which they have been assigned' (p. 21), and this bias is inevitable (Marcus, 1985 cited by Prentice, 2000). Morse (1982) said flatly, 'Mental health professionals, like all other citizens, have social and political biases that extend to their views of criminal justice' (p. 1057). Otto (1989) identified examples of both sorts of bias: intentional (financial incentives, desire to promote a particular viewpoint on a social issue, and desire to please one's employer) and unintentional (empathy or identification with a litigant or a side; 'unwitting involvement in the adversarial process...the need to defend one's position in the face of a hostile opposing attorney', p. 268). Bernstein (2008) identified that, because of conscious, unconscious, and selection biases, expert testimony is 'uniquely vulnerable to "adversarial bias"' (p. 453).

An awareness of bias in expert testimony has been present for some time. In 1959, Bernard Diamond, reporting on results from an empirical study on criminal cases, argued (persuasively, to our mind) that bias may be inevitable. Perlin first discussed this issue in 1993:

I begin with the proposition that the phrase 'neutral expert' is an oxymoron. Bernard Diamond, for one, believed that a witness' unconscious identification with a 'side' of a legal battle or his more conscious identification with a value system or ideological leanings may lead to 'innumerable subtle distortions and biases in his testimony that spring from this wish to triumph'. (p. 641)

The above analysis reflects the common law approach as developed in the US; the following section deals with two other common law jurisdictions. First, the English Mental Health Review Tribunal is provided as an example of legal decision making. Second, Australian law, English and Welsh law, and New Zealand law are contrasted regarding forensic risk assessments.

Involuntary civil commitment laws

One of the areas of law where the problems noted above have been outlined in the largely US-based research and writing is that of mental health law, particularly as it relates to the involuntary civil commitment process. The UK consists of three legal jurisdictions, England and Wales, Northern Ireland, and Scotland; statutes passed by the UK Parliament might be valid for the entire UK—the Human Rights Act 1998 is an example of that; or they might be limited to one jurisdiction—the Mental Health Acts 1959, 1983, and 2007 discussed here are or were valid for England and Wales only. Since the promulgation of the Mental Health Act 1959 (UK), this process in England and Wales has involved a process of administrative detention with a right of review by a specialist Mental Health Review Tribunal, comprising a lawyer, psychiatrist, and a lay member (often involved in social work). This body was continued by the Mental Health Act 1983 (UK). Naturally, the Tribunal involves an assessment of the evidence of the professionals involved in the process of placing the patient in detention, although it is not entirely an adversarial testing of the evidence since, as is discussed in more detail below, the body makes use of something of an inquisitorial role: in particular, it considers the views of the tribunal psychiatrist, who not only helps assess the medical evidence given but obtains evidence from an interview of the patient and a review of the relevant hospital records.

It is worth noting that, in relation to civil commitment, the use of administrative detention followed by a right to a review by the Tribunal is likely to be a central feature in

England and Wales for many years. The government proposal was made in the first half of this decade that the role of the Tribunal become one of making decisions on detention: this was a feature of the Draft Mental Health Bills of 2002 and 2004. However, they were never formally introduced into Parliament, and the eventual reform, in the form of the Mental Health Act 2007 (UK), which contained several changes to the 1983 Act, left in place the regime whereby civil patients are administratively detained and may then apply to the Tribunal. The Tribunal model which is used in Northern Ireland under the Mental Health (Northern Ireland) Order 1986 has also been adopted by Scotland, which has a separate legal system and its own legislation relating to mental health, the Mental Health (Care and Treatment) (Scotland) Act 2003 and by Ireland, which has introduced Tribunals in the Mental Health Act 2001. The Irish Tribunal has to review all decisions made to place a patient under an admission order or to renew such an order (see sections 15 and following of the 2001 Act). One significant difference is that the Tribunals in Scotland make decisions as to whether to detain for anything beyond an initial short-term period of detention (under sections 44 and following of the 2003 Act), albeit on the basis of an application made by mental health social workers and psychiatrists who set out the basis for concluding that the criteria for detention are made out (see sections 57 and following of the 2003 Act).

It is perhaps worth commenting that the European Convention on Human Rights (ECHR) has not been interpreted in a manner that makes administrative detention impermissible, provided that there is an adequate and speedy court process available to review the continuation of detention. The ECHR has had a role in the Tribunal's jurisdiction, however. Patients in England and Wales can also be sent into hospital by the criminal courts, and their release is also a matter for the Tribunal because the effect of the 'hospital order' (made under section 37 of the 1983 Act) is that the patient is treated for most purposes as if civilly detained. However, there used to be a different release regime for those forensic patients designated as dangerous by the criminal courts. The Tribunal had previously only made recommendations to the Executive (in the form of the Home Secretary, who had the final decision on the question of release). This changed under the Mental Health (Amendment) Act 1982 (UK) and then the 1983 Act because the European Court of Human Rights found that Article 5 of the ECHR was breached by the existing regime because there was no court making the final decision on the lawfulness of detention (see *X v UK*, 1981).

Having set that background to the process of detention, the task of the English Tribunal, as set in sections 72 and 73 of the 1983 Act, is to determine whether the criteria for detention are made out: these are, in essence, that the patient suffers from a mental disorder of a nature or degree such that treatment in hospital is appropriate, and that such treatment is necessary for the health or safety of the patient or for the protection of others. So the statutory scheme allows detention not just as part of the police power of the state to secure the protection of others but also in order to safeguard the patient. There is no requirement that the patient have any impairment of capacity. Indeed, once the patient is detained, it is a matter for the treating psychiatrist as to what treatment should be given, although a second opinion must be obtained for medication beyond 3 months (see Part IV of the 1983 Act, although note that there are separate provisions for invasive brain surgery and the use of hormonal implants to reduce the male sex drive, which do require consent, and ECT requires consent or a second opinion from the outset). Whilst it is possible for a patient to take court action to try to injunct medication, it does not appear that this outcome has ever been achieved. There have been several instances of the courts—not the Tribunal, which has no jurisdiction over this question—requiring doctors to justify the giving of

medication, invariably when the patient has been able to obtain a further opinion to question the propriety of the medication, but those cases have ended with the court upholding the decision.⁴ For the somewhat different experiences in the US, see Perlin (2005).

The Mental Health Review Tribunal sits in private in the hospital that detains the patient; that is a matter of practicality, although it does mean that there is the absence of the check of public scrutiny. Even if that is not a particular concern, the very name of the judicial body, the Mental Health *Review* Tribunal, creates an impression that it does not start with the *tabula rasa* presumption that should be the hallmark of a fair hearing, namely, the concept that those that make allegations—particularly allegations that infringe a fundamental right such as liberty—must prove them. Rather, as a body that is reviewing the propriety of the decision to detain, its function is to ascertain whether it should be overturned. This coincides more naturally with a presumption as to the regularity of the decision to detain. Indeed, this was formally the structure of the Mental Health Act 1983 (UK) until recently: section 72 of the Act as originally drafted provided that those applying to the Tribunal had the burden of proving that they did *not* meet the criteria for detention. Any failure by the patient to demonstrate that he or she did not meet the criteria for detention—that is, if the evidence was equivocal—meant that the status quo would remain, that is, detention. It was only after the Human Rights Act 1998 (UK) incorporated the ECHR and its presumption of liberty (Article 5(1)) into domestic law that the courts were able to declare that placing the burden of proof on the detained patient to justify their release was a breach of their fundamental rights. Note that *R(H) v London North and East Region Mental Health Review Tribunal* [2002] resulted in a finding that the burden of proof on the patient breached Article 5 ECHR; the reaction to this case was the Mental Health Act (Remedial) Order 2001, SI 2001/3712, whereby the burden of proof in section 72 of the Mental Health Act 1983 was placed on the detaining hospital.

However, it is worth noting that the concerns raised of the nature of pretextuality and sanism mean that legal tools such as the placement of the burden of proof are not a major safeguard because they merely condition the language of the conclusion that the judicial body has to reach (i.e. making it necessary to conclude that the hospital authorities have made out the case for detention rather than that the patient has not made out the case for release). So, is there evidence that the concerns of teleology, sanism, and pretextuality are present?

As noted above, the Tribunal is not a purely adversarial judicial body. In particular, Rule 34 of the relevant procedural rules—the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI 2008 no 2699)⁵—requires the medical

⁴See *R (Wilkinson) v Broadmoor Hospital* (2002) and others 1 Weekly Law Reports (WLR) 419, which established the jurisdiction of the courts; the general approach of the English courts was endorsed by the ECHR in *Wilkinson v UK* (2006) Mental Health Law Reports 142. In *R (N) v M* (2003) and others 1 WLR 562, the Court of Appeal gave further guidance in upholding a High Court decision to grant doctors the right to impose medication (reported at [2003] Mental Health Law Reports 138) after a trial of the issue. See also *R (PS) v (1) Dr G (RMO) (2) Dr W (SOAD)* (2004) Mental Health Law Reports 1; *R (B) v (1) Dr Haddock (2) Dr Rigby (3) Dr Wood* (2005) Mental Health Law Reports 317 (High Court) and (2006) Mental Health Law Reports 306 (CA); *R (B) v (1) Dr SS (2) Dr AC (3) Secretary of State for the Health Department* (2005) Mental Health Law Reports 96; *R (B) v (1) Dr SS (2) Dr G (3) Secretary of State for the Health Department* (2005) Mental Health Law Reports 347 (High Court), (2006) 1 WLR 810 (CA); *R (Taylor) v (1) Dr Haydn-Smith (2) Dr Gallimore* (2005) Mental Health Law Reports 327. For a Scottish example, see *Petition of WM* (2002) Mental Health Law Reports 367.

⁵The Tribunal in Wales is separate and has its own rules, the Mental Health Review Tribunal for Wales Rules 2008 (SI 2008 No 2705), which provides for the medical examination in r20. These came into effect on November 3, 2008: the previous regime for both England and Wales was found in r11 of the Mental Health Tribunal Rules 1983, SI 1983/942.

member of the Tribunal to examine the patient and the patient's notes and form an opinion as to the condition of the patient. The medical member then sits as a judge in assessing whether the criteria for detention are made out, when the evidence will include the views of the medical member. At first sight, this might be thought problematic from the perspective of concerns as to bias, which both the patient and the detaining hospital could be concerned about, given that the Tribunal is considering expert evidence from one of its own members. However, the English courts have found that there are no problems as to bias, provided that the medical member does not form a concluded opinion in advance of the end of the hearing. For example, see *R (S) v Mental Health Review Tribunal* [2003]; in a more recent decision, *R (RD) v Mental Health Review Tribunal* [2007], the English High Court found that it was acceptable that a medical member expressed an opinion before the hearing began not just about whether the patient suffered from a mental disorder but whether the criteria for detention were made out, provided that the opinion was expressed to be provisional and subject to change at the end of the hearing.

But does it create a situation in which the problems of teleology, pretextuality, and sanism might thrive? The obvious concern must be that the views of the medical expert who sits as a judge are formed by information gleaned in private from reviewing notes and speaking to staff in circumstances where not only is there no room for challenge but also the patient does not even know what is heard or considered relevant unless the medical member of the Tribunal is able to recreate the entirety of his or her investigation during the Tribunal hearing, including any perceptions of the attitude of the patient during that interview. This in turn makes key the integrity of the medical member of the Tribunal as an evidence gatherer and his or her ability to avoid cherry-picking or misinterpreting evidence. This is best achieved by a Tribunal that is able to demonstrate its robust independence and commitment to fair processes.

The process of decision making in English Tribunals was studied by Peay (1989) at the request of the department of central government then responsible for their organisation. She concluded that 'rather than reaching decisions in the sense of exercising choice between real options, the tribunals invariably endorsed the recommendations made to them ... tribunals routinely acquiesced, almost irrespective of the content of the recommendation' (p. 209; see also Perlin, 1998b). This was not just an unreasoned or impressionistic conclusion. Part of the study had involved comparing outcomes for equivalent patients whose cases were considered by different tribunals. There were different results in equivalent Tribunal hearings, which seemed to reflect the different approaches of the psychiatrists at the different hospitals involved. In short, if the patient was at a hospital where the ethos was more in favour of treatment in the community such that release was more likely to be recommended, that was more likely to be the outcome at the Tribunal. But if the ethos at the hospital was more conservative such that release was not recommended, that was also the more likely outcome even if the patients were similar to those at the other hospital. Therefore, what Peay (1989) found to be consistent amongst the Tribunals was the tendency to follow the view of the treating psychiatrist. It happened in 86% of cases. Moreover, the key feature of those cases where the Tribunal did not follow the view of the treating psychiatrist was that the Tribunal was more cautious, with that being the outcome in 69% of these cases. By looking first at the level of consistency, this can be taken as an indication of pretextuality in operation. Might it rather reflect the fact that the treating psychiatrist performed his or her role in a fully conscientious manner and so only cases in which there was a significant prospect of the psychiatrist having got it right would go before a Tribunal? That view cannot stand with the findings of Peay that similar cases

were treated differently by different Tribunals. The purpose of having judicial decision makers is to bring objectivity to a decision and hence consistency, ensuring that like cases are treated alike. As she put it, 'given that the Tribunals agreed with the decisions of the [treating psychiatrists] and these were, in turn, quite flexible depending on, for example, the hospital at which the [treating psychiatrist] worked, it seems more credible that the Tribunals adopted a passive role' (p. 209, fn. 12).

Where the Tribunal did not follow the views of the treating psychiatrist, usually being more cautious, including cases in which an independent psychiatrist testified in support of discharge, problems of sanism also infected the decision-making process. In this regard, Peay's (1989) research raised these issues: (1) the deliberations of Tribunals were often perfunctory, (2) the statutory criteria were, on occasion, ignored, seemingly where compliance with them would have resulted in discharge; (3) there were occasions when Tribunals displayed a reluctance to seek further information and, as a result, did not address properly the need for detention; and (4) there were also occasions when the legal or medical member of the Tribunal made it clear at an early stage of the deliberations that there were limits to how far they would go, which limited the range of options about which the Tribunal could agree because of any reluctance by the others to take a stand. At the very least, these conclusions present a problem as to the perception of the Tribunal as it operated during the course of the study to provide a fair hearing (see [Lind & Tyler, 1988](#); [Ronner, 2007](#)).

A later study into the English Tribunal was commissioned by the relevant department of central government, carried out by Perkins (2003), who reviewed Tribunals in a 6-month period starting in December 1996. She also found several situations that give rise to concerns relevant for present purposes: (1) the decision had been made and written up in 15 minutes in two-thirds of Tribunals and in 10 minutes in more than a third; in some cases, there was no discussion before the legal president of the Tribunal began to write up the decision; (2) where there had been conflicts in evidence, a common method of establishing the truth involved reliance on finding a credible narrative or identifying credible witnesses, thereby allowing a speedy conclusion in complex or borderline cases; and she noted that the evidence of patients was invariably subjected to a greater level of scrutiny, often as a result of a framework of challenge to the credibility provided by the report of the medical member to the Tribunal before it commenced its hearing; (3) the thorough application of the legal criteria for detention was often sidestepped by 'hunch and common sense and ... a more intuitive approach' (pp. 101–102); as a result, for example, limited evidence of symptoms of mental disorder was felt to found a clear case for concluding that a patient was mentally disordered; and (4) the process of being a review tribunal means that the assessment made is based on a case for detention set out on the papers which is difficult to reinterpret when contrary evidence is adduced.

The picture presented by Peay (1989) and Perkins (2003), thus, is less than a happy one when it is assessed from the prospect of fairness. It should be noted that the period since the research by Perkins has been marked by a significant amount of litigation designed to improve standards of fairness and that the Mental Health Review Tribunal has instituted training processes for both new and existing members. Also, the Tribunal is administered now as part of the judiciary, through the Tribunals Service⁶, rather than being operated

⁶See www.tribunals.gov.uk; a new Tribunal structure is in place as from November 3, 2008, as a result of the Tribunals, Courts and Enforcement Act 2007 (UK).

by the Department of Health (i.e. the body that also has overall responsibility for the hospitals that detain, the majority of which are part of the National Health Service in the UK).

In addition to these studies of the process of Tribunals—in essence, first-instance trial courts—there have been statements from the higher courts that endorse situations in which pretextuality and sanism can flourish and that might indeed rely on such reasoning. One issue that has arisen is the standard of proof to be applied by a Mental Health Review Tribunal. The Mental Health Act 1983 (UK) is not express about the standard of proof, merely providing that a Tribunal must discharge if not satisfied that the patients meet the criteria for detention. The question was determined by the English Court of Appeal in *R (AN) v Mental Health Review Tribunal* (2006). This case was a judicial review application, which was, at the time, the method available to challenge decisions made by Tribunals. Counsel for AN had made an argument that the appropriate standard to apply was an intermediate standard between the criminal standard (proof beyond a reasonable doubt) and the civil standard (preponderance of evidence), namely, clear and convincing evidence. Reliance was placed on US case law, in particular *Addington v Texas* (1979), in which the Supreme Court indicated that the risk of error—leading as it did to loss of liberty—required such a standard as the appropriate balance for the risk. For a discussion of the rationale of the US Supreme Court in arriving at its decision in *Addington v. Texas* (1979), see Perlin (1998a) § 2C-5.1a. The English court first set out that the English system had only two standards of proof, namely, the criminal and civil standards, but it then explained that the civil standard was flexible and required stronger evidence if the allegation made was more serious or the consequence of the finding was more significant. That could, in practice, lead to a situation in which detention would require clear and convincing evidence in order to satisfy the civil standard because of the consequence for the liberty rights of the patient. But the final part of the Court of Appeal ruling was that the Tribunal should not apply a test beyond requiring cogent evidence. This was because person suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma, and so it cannot be said that it is much better for him or her to go free rather than lose his or her liberty; and an erroneous release may result in risks to the person and to others. The Court then emphasised that AN had been detained after a criminal offence of violence.

What of this reasoning? The first factor relied on by the Court of Appeal—that it is not better to be at liberty but ill—is no doubt cogent but only if it has been established that the person involved is mentally unwell. To determine how reliance on such facts being established is a ‘fact not in evidence,’ see Perlin (1993). So it is a circular argument and cannot justify a lower standard of proof. And the second factor—the risks of an erroneous decision to release—rests on assumptions as to risk that might well be in issue in front of the Tribunal. Does this reflect a sanist approach, or is this a situation where ordinary common sense supports a lower standard of proof? Well, aside from the questions that can be raised as to the reliability of the assessment of future risk, the applicability of the same argument to another situation demonstrates that it involves a differential approach to those detained on the basis of mental disorder. It could not properly be suggested, for example, that recidivist criminals—whose repeated offending showed that they posed a risk to others—should be subject to a lower standard of proof in a criminal trial because of the risk to the public of not being able to convict and detain them.

A second case to note went to the UK’s highest court, the House of Lords, *R (B) v Ashworth Hospital Authority* (2005). The basic question was whether a patient with a

diagnosis of more than one form of disorder could be treated against his or her consent for a mental disorder that would not justify detention; his contention was that he could only be subject to treatment for the disorder on the basis of which he was detained. The House rejected this contention, deciding that the statute properly construed authorised detention for any and every disorder, not just such disorder or disorders as were the basis for detention. The Court of Appeal had reached diametrically the opposite conclusion. For a full discussion of the decision of the House of Lords, setting out a preference for the contrary decision of the Court of Appeal, see [Gledhill \(2005\)](#). The interesting point of the Lords' reasoning for present purposes is that the aim of psychiatry is to treat the whole person, and indeed the loss of liberty places an obligation on the state to meet the patient's needs. Baroness Hale, speaking for the court, stated at paragraph 31 of the judgement: '... psychiatry is not an exact science. Diagnosis is not easy or clear cut. As this and many other cases show, a number of different diagnoses may be reached by the same or different clinicians over the years. As this case also shows, co-morbidity is very common...' The Baroness cited the Tenth Biennial Report of the Mental Health Act Commission, *Placed Amongst Strangers*, para 7.30, which in turn cited Blackburn, Logan, Donnelly, and [Renwick \(2003\)](#) for the proposition that co-morbidity is common.

But the difficulties faced by mental health professionals in being correct as to diagnosis surely should make it more difficult rather than less difficult to take away basic rights. Again, consider this chain of reasoning in a different situation such as proving that a cluster of leukaemia is linked to high-powered electricity lines or to mobile phone masts. At the present time, the science may mean that this is a difficult allegation to prove because the evidence is not yet clear-cut, perhaps in part because there are no conclusive studies (as used to be the case in relation to smoking and lung cancer). A plaintiff who sought a ruling from the courts that invited a lower standard of proof to take into account the evidential problems would not succeed. But a detained psychiatric patient loses the autonomy rights to chose or reject treatment when the psychiatrist wishes to treat for a disorder that he or she cannot testify to the balance of probabilities is such as to justify detention.

In summary, the picture presented here of the regime applicable to patients detained in England and Wales on account of mental disorder raises concerns of the same nature as those present in the extensive literature relating to the US, namely, that the court process provides the conditions in which the rhetoric of fair trial can be undermined because adjudicated outcomes are infected by reasoning that reflects pretextual and sanist processes. This in turn means that the ethical standards of expert witnesses become central to the achievement of just outcomes.

Risk assessment t criminal laws

The next area in relation to which we have examined whether the teleological, sanist, and pretextual arguments identified in the US literature have parallels in other jurisdictions is that of risk assessment linked to the criminal process, particularly in the context of orders made against sexual offenders designed to provide post-sentence monitoring or additional detention based on the ongoing risk the offender is said to pose.

Australia—Queensland Some common law countries other than the US have adopted laws designed to provide protective detention or supervision regimes, invariably involving sexual offenders. For example, Queensland, Australia, has the Dangerous Prisoners (Sexual

Offenders) Act 2003 (Qld). The legislation is designed to provide for ongoing detention or community supervision 'to ensure adequate protection of the community' and to provide continuing control 'to facilitate their rehabilitation' (see section 3). The Attorney-General must make an application for an order during the last six months of a sentence imposed for a sexual offence involving violence or children. The court assesses whether there are reasonable grounds to believe that the prisoner is a serious danger to the community. If so, it may order two psychiatrists to prepare risk assessment reports (section 8 of the statute). The reports must contain a reasoned conclusion as to 'the level of risk that the prisoner will commit another serious sexual offence (i) if released from custody; or (ii) if released from custody without a supervision order being made' (sections 11[2]). The final hearing can lead to what is termed a Division 3 order if the prisoner is a serious danger to the community without such an order (sections 13[1]). This can be an order for preventive detention of an indefinite duration. There is a definition of what amounts to such a serious danger: it is '(2)...an unacceptable risk that the prisoner will commit a serious sexual offence—(a) if the prisoner is released from custody; or (b) if the prisoner is released from custody without a supervision order being made.' The standard of proof is (sections 13[3]) '...acceptable, cogent evidence...to a high degree of probability...of sufficient weight to justify the decision'. The statute also sets out factors the court should take into account, including information as to propensity to commit further crimes and efforts at rehabilitation and whether he or she has succeeded.

The propriety of the Queensland statute has been considered by Australia's highest court, the High Court of Australia in *Fardon v Attorney-General* (2004). The majority found that the statute was valid. However, one of the seven justices, Kirby J dissented. He concluded that the statute was unconstitutional: 'It sets a very bad example, which, unless stopped in its tracks, will expand to endanger freedoms protected by the Constitution' (par. 126). Kirby J noted that the statute authorised detention on the basis of expert evidence as to a matter that was notoriously difficult to predict, namely, future criminality. 'Even with the procedures and criteria adopted, the Act ultimately deprives people such as the appellant of personal liberty, a most fundamental human right, on a prediction of dangerousness, based largely on the opinions of psychiatrists which can only be, at best, an educated or informed "guess"' (par. 125). The majority had no particular qualms. For example, Gleeson CJ noted that it was a problem as to how to deal with prisoners who present a serious danger to the community on release, before commenting 'No doubt, predictions of future danger may be unreliable, but...they may also be right' (par. 12). His Honour did not even pause to reflect that this sentence simply amounts to a statement that risk assessments may occasionally coincide with the future. That does not give them a predictive power or level of accuracy. After all, a broken clock is right twice a day; but it is no more than a matter of coincidence, not a reflection of accuracy. Moreover, the test of an 'unacceptable risk' of further offending was not too vague; it was a risk of a magnitude that justified an order, and, indeed, should not be given a greater degree of definition than it was capable of yielding (par. 22).

On this reasoning, from a teleological perspective, the court would not even have to engage in the cherry-picking of evidence to reach a conclusion in favour of detention. It could merely say that a risk not shown to be significant was nevertheless too high to be acceptable. This indeed is the message conveyed by the Chief Justice's reliance on a case, *Veen v R* (1979), where a life sentence—which had been imposed on the basis of a finding of dangerousness following a conviction for a serious offence, namely, manslaughter on the basis of diminished responsibility—was quashed on appeal by the High Court of

Australia and replaced by a determinate term. The prisoner was duly released from that determinate term and killed again. This led to a further conviction for manslaughter on the basis of diminished responsibility (*Veen v R* [No 2] (1988)). The implication is clearly that, as courts may get it wrong by not detaining people who turn out to be dangerous, they should err on the side of caution. On the use of the vividness heuristic in this context, see Perlin (2003a). The High Court's reasoning also touches upon detention on the grounds of mental illness (although the judicial comment was not necessarily essential to the decision). Gleeson CJ starts his judgement with a description of the issue in the case as the lawfulness of preventive detention of those 'who are shown to constitute a serious danger to the community' (a description that presupposes the possibility of reliably identifying such people) before adding 'No one would doubt the power of the Queensland Parliament to legislate for the detention of such persons if they were mentally ill' (par. 2).

Kirby J, whose dissent on the main question was based on the views that criminal dangerousness could not be predicted reliably, and that the supposedly protective detention of dangerous sex offenders must be viewed as an additional punishment, accepted that involuntary detention is generally viewed as penal or punitive (par. 150) and must be subject to intense scrutiny by the judiciary (par. 151). Indeed, he linked the two concepts (par. 152), noting the penal nature of detention 'precisely because only the judiciary is authorised to adjudge and punish criminal guilt.' But he noted (par. 154) that the exceptions to the general scheme of the constitution included 'detention of the mentally ill and the legally insane for the protection of the community', which, along with analogous situations such as quarantine detention, was protective and non-punitive.

This was not just an unthinking passing reference because, in a subsequent part of the judgement, Kirby J dealt at length with the reason why the preventive detention of sex offenders viewed to be dangerous cannot be analogous to detention for mental illness (par. 167–175). This survey is completed with the comment that 'the misuse of psychiatry and psychology in recent memory in other countries demands the imposition of rigorous standards before courts may be enlisted to deprive persons of liberty based on psychological evidence, *absent an established mental illness, abnormality or infirmity*' (par. 175; for which proposition his Honour cites Bloch & Reddaway, 1977; Masserman & Masserman, 1996). The added emphasis is of language that reflects an implicit assumption that there is a greater degree of reliability in the predictive power that applies when there is a mental disorder of such an extent that it justifies a different approach in law. That is not to say that there are not instances where a mental disorder can be seen to be linked with violent behaviour that justifies intervention, just as someone who is engaged in a criminal attack or has made it plain that what they are going to do can be prevented from acting. The point, rather, is that Kirby J recognised that there was a problem in predicting distant criminal behaviour, and so a statute requiring it to be carried out was unconstitutional; but he accepted that the nature of prediction in mental health situations was sufficiently different that it allowed a different approach from the judiciary. This is a sanist approach.

England and Wales The Criminal Justice Act 2003 (UK) introduced an extensive set of risk-based sentencing options. Previously, there had been the option of a life sentence if the offence was particularly serious and the offender was assessed as being dangerous for an unpredictable period of time; and the Crime (Sentences) Act 1997 (UK) had introduced a presumption that those convicted for the second time of one from a list of serious

offences carrying life imprisonment should receive a life sentence. The new provisions contain a list of over 100 sexual or violent offences. Those that carry a maximum sentence of 10 years or more are classified as 'serious offences'. Under section 225 of the 2003 Act, if a serious offence is committed by someone 18 years old or over and '(1)(b) the court is of the opinion that there is a significant risk to members of the public of serious harm occasioned by the commission by him of further specified offences', then the court must impose either life imprisonment if the criteria for a life sentence are met and that is the maximum sentence available or 'imprisonment for public protection', which is an indeterminate sentence the release from which is treated in the same way as a life sentence. The presumption arising from a second offence, as introduced in the 1997 statute, is retained and extended in the 2003 statute. The risk of further offending is presumed, by reason of section 229(3), if the offender has a previous conviction for one of the list of offences unless it would be unreasonable to make the assumption. In effect, committing one from the list of serious offences when combined with a finding of a risk of further offending (which need not be a serious offence) leads to a requirement to impose a life sentence or indeterminate detention even if the maximum sentence for the offence is not life imprisonment.

If the offence is not a serious offence, then the sentence to be imposed on the finding of risk is an extended sentence (s 227), which is a period of custody plus extended licence supervision in the community for up to 5 years for a violent offence or 8 years for a sexual offence (but not beyond the maximum sentence for the offence). The prisoners may be placed in custody if they are felt to pose too great a risk during their period on licence. Note that, for those under 18 years of age, there is a sentence of detention for public protection, but there is an additional requirement, namely, that an extended sentence for a serious offence will not be adequate.

The legislature has given guidance on the assessment of dangerousness in section 229. Under subsection (2), the court

- (a) must take into account all such information as is available to it about the nature and circumstances of the offence,
- (b) may take into account any information which is before it about any pattern of behaviour of which the offence forms part, and
- (c) may take into account any information about the offender which is before it.

Unlike the Queensland statute, there is no requirement for a medical report to be obtained, but, in giving guidance on the application of the statutory provisions, the Court of Appeal has indicated that, in the case of a prisoner suffering from a mental disorder, it might be necessary to obtain a medical report to allow a proper assessment of risk (see *R v Lang* (2005), although also note that in *R v S and Others* (2005), the Court suggested that this would be an infrequent requirement). The comments in the latter case were not made on the basis of any analysis of the lack of reliability of risk assessment. However, it reflected a more traditional view that sentencing is a judgement based on the offender's antecedents and circumstances rather than expert evidence. The Court also went on to indicate that a court would rarely find it necessary to allow cross-examination of the authors of the presentence report (typically a probation officer) about the assessment made of the seriousness of the risk posed, which is not consistent with most concepts of fairness when potentially lifelong detention is at stake. But the English courts do not seem to have made any assessments of the reliability of risk assessment evidence and indeed suggest

that it is best challenged by way of comment rather than cross-examination or challenge.

New Zealand New Zealand has also introduced a regime of preventive detention, currently set out in section 87 of the Sentencing Act 2002 (NZ). This is similar to the later English statute although involving fewer offences. However, like the Queensland statute, it requires the provision to the court of medical expert reports as to risk (section 88). New Zealand also has a regime for imposing supplemental orders on convicted sex offenders (limited largely to those whose victims were children) due to be released from prison. This was introduced by the Parole (Extended Supervision) Amendment Act 2004 (NZ), which added to the Parole Act 2002 (NZ) the Extended Supervision Order regime. This provides for ongoing supervision in the community, for up to 10 years, based on a finding of a real and ongoing risk of further such offences, specifically (section 107I[2] of the 2002 Act) that the offender is 'likely to commit any of the relevant offences' if not under supervision. Breach of the Order is punishable by up to 2 years' imprisonment. The making of the Order requires consideration of a medical report. In practice, these reports are prepared by the psychology department of the Department of Corrections, which runs the New Zealand prison system. It is important to note that section 107H(2) provides that the court 'may receive and take into account any evidence or information that *it thinks fit*... whether or not it would be admissible in a court of law.' (The emphasis is added, and the particular language is considered below.)

It was established in the case of *Belcher v Department of Corrections* (2007) that the Extended Supervision Order was to be considered as penal. This was key to an argument that it involved retrospective punishment. The Court of Appeal found that it was, and there was no suggestion from the Crown that it was a justified breach of the statutory prohibition on retrospective punishment (in the New Zealand Bill of Rights Act 1990). But the 1990 statute is merely a statute and not of a constitutional nature, and so another statute that breaches its provisions remains valid. The Court also recorded that counsel for Mr Belcher had relied on an argument that the Extended Supervision Order breached the prohibition on arbitrary detention (par. 27), but the Court described this as merely a subset of the argument as to the penal nature of the regime and did not address it in any detail (par. 60). Of course, an Extended Supervision Order could only lead to loss of liberty if it were breached and the sanction imposed was imprisonment.

The Court of Appeal then moved to the question of whether the Order was required on the facts and was able to conclude that actuarial assessments and the professional judgement of a psychiatrist (the one which the trial judge preferred) were such as to meet the statutory test of 'likely' to commit a further offence, which it interpreted as meaning a possibility that could not sensibly be ignored. The Court recorded that the Appellant mounted a 'sustained attack' on the admissibility or validity of the actuarial assessments used (par. 70) and summarised his case that the methodology was flawed and the prosecution response, including its evidence, that 'there is a wealth of material which validates' its use of the particular methods employed (par. 80). Unfortunately, from the point of view of seeking an understanding of its reasoning process, the Court does not explain its conclusion as to the rationale for admissibility despite the challenge made, although as it upheld the Extended Sentence Order on the basis of the evidence available, it clearly did find the material both admissible and reliable.

However, the New Zealand Court of Appeal had a further opportunity to confront the particular problems of risk assessment techniques in *R v Peta* (2007), in which many of

the things that can go wrong did. Actuarial tools had been poorly scored, misinterpreted, and then not explained properly to the court; and the trial judge had given inadequate reasons, and appeared to rely only on static factors referenced in the expert report rather than give allowance for any of the dynamic factors capable of change over time. The Court of Appeal then applied the statutory test to the revised evidence it had in front of it and felt that the risk posed did not meet the test and so it set aside the order made below. The revised evidence was such that the Crown accepted that, whilst it still sought an order, the risk was at the lower end of the scale, and so the Court was not faced with a strong case to reject.

In light of that, it is perhaps not surprising that there does not appear to have been any challenge to the admissibility of risk assessment evidence; indeed, at par. 16, the Court was able to record that the prosecution and defence experts, both of whom were psychologists (a coauthored paper from whom was quoted by the Court at par. 48 of its judgement), agreed that actuarial risk assessments were more accurate than non-structured clinical assessments 'despite the limitations of those instruments'. So the Court limited itself to a description of various materials that were put in front of it and concluded, 'as can be seen from the above review, there are well-validated actuarial measures that can help distinguish between higher and lower risk offenders', and the inability of those measures to detect changes in risks over time was not an issue because 'such measures are now augmented by standardised approaches to assessing dynamic risk factors' through another tool used in New Zealand (par. 50). As to the limitations in the risk instruments to which it had earlier made reference, the Court of Appeal noted that 'risk is contingent on a variety of factors that are difficult or impossible to predict with certainty' (at par. 51); but, rather than use this point to raise concerns about the propriety of using the risk assessment instruments because of concerns about their use, the Court stated that 'the utility of tools such as ASRS [Automated Sexual Recidivism Scale] and SONAR [Sex Offender Needs Assessment Rating] is only realised when they are properly administered, scored and integrated with other relevant information known to relate to the risk of reoffending', and so the other relevant information should be included, as well as any recognisable contingencies that influence the level of risk (par. 51).

Of course, it is possible to think that as the New Zealand Parliament has indicated in the statutory provisions that medical evidence has to be provided, that provides an answer to the admissibility point: in short, Parliament has directed that it be considered. The statute, however, as is noted above, provides that the court 'may receive and take into account any evidence or information that *it thinks fit*' (section 107H[2], quoted above). This makes it clear that the question is a matter for the court, and a conclusion that material is not adequately reliable would presumably lead to a court concluding that it is not fit to be admitted. But the courts in New Zealand have not—at least not so far—given any consideration to whether the risk assessment tools are suitable for use in court proceedings where individual decisions have to be made about particular individuals.

In summary, what is apparent from this review of the material is that several common law jurisdictions outside the US have developed penal measures designated as protective and based on the view that courts are in a position to predict future dangerousness. These are areas where there are obvious risks from the teleological, pretextual, and sanist reasoning we have described: so far, it does not seem that the Courts in these jurisdictions have developed rules to guard against these problems. The consequence of this, naturally, is that the professional integrity of witnesses giving evidence to the court is of central importance in ensuring the achievement of fairness in the legal process.

Civil law

The following discussion will consider the roles of expert testimony civil law jurisdictions.

In civil law jurisdictions, the 'inquisitorial system' model places far greater responsibility on the judge. In civil law nations, the court conducts an 'active and independent enquiry into the merits of each case,' (Cound *et al.*, 2007, p. 2), and this enquiry may include the judge calling and questioning witnesses and ordering specific fact finding.

Civil law considerations lead to the next enquiry: To what extent do judges in nations other than those in the common law tradition have expectations of neutrality in this subject matter? What follows is not meant to be an exhaustive study but a sampling of certain specific relevant jurisdictions. However, a closer examination reveals important differences even within these two gross categories (see Legrand & Machado, 1998, on the differences in legal cultures in common law and civil law nations).

First, it is important to note that many countries that currently have no regulation of the psychology profession. This should not be a surprise, as 25% of all nations in the world have no mental health law (Perlin, 2007b). Recently, the UK had transferred regulation of the profession from the British Psychological Society to legal regulation through health-care legislation, whilst Ireland, Portugal, Malta, and Switzerland were working towards lincencing legislation (Tikkanen, 2004).

An examination of the law of expert testimony in civil law nations reveals some important commonalities, and many individual variations (note that Taylor, 1996, provides a helpful and comprehensive history of the origins of expert testimony in France). First, in a significant number of these jurisdictions, there is only one expert involved in cases, and that expert is appointed by the court. For example, China (Schmidt, 2003), France (Pradel, 1993; Taylor, 1996), Korea (Browne, Williamson, & Barkacs, 2002; Lee, 1997), and Germany, although parties can also hire their own experts (Timmerbeil, 2003). Second, experts are not paid by the parties. For example, in France 'the expert may not accept any remuneration... from the parties' (Taylor, 1996, p. 206) and in Germany the losing party must pay the reasonable expenses of the winning party's expert (Timmerbeil, 2003). Third, most expert reports are submitted to the court in writing and there is often no oral testimony (see Greve, 1993), although courts often have the option of requiring the expert to make an oral presentation to the *parties* (Taylor, 1996). Fourth, at least in cases involving evaluation of mental state in criminal cases, experts have a long period of time in which to examine the defendant in Germany (Kühne, 1993) and Greece (Mylonopoulos, 1993).

There is a plethora of other individual variations. In at least one nation (Israel), the forensic witness has an expanded role; in insanity defence cases, by way of example, he or she can furnish the court with information about diagnosis, prognosis, and treatment possibilities as well (Simon & Ahn-Redding, 2006). In Nigeria, Bienen (1976) noted that a judge is free to deny the defendant's use of expert testimony (Simon & Ahn-Redding, 2006). In China, Munro (2000) described psychiatric appraisals conducted by committees 'at different echelons of the government' consisting of 'responsible officials and experts' from 'courts, procuracy, and public security, judicial administration, and health departments' (cited in Simon & Ahn-Redding, 2006, p. 170). In Italy, an expert *must* accept a court appointment and neither psychological nor behavioural tests are allowed as parts of psychiatric examinations (Corso, 1993). In Japan, Satsumi and Oda (1995) found that experts can be retained by the prosecution, the defence, or by the court (Simon & Ahn-Redding, 2006). In Germany, although court-chosen witnesses may be called to testify,

party-selected witnesses cannot testify at all (Timmerbeil, 2003). In South Africa, the use of experts is mandatory in potential death-penalty cases if the issue of mental illness is raised (Simon & Ahn-Redding, 2006).

Perhaps most interestingly, in Korea, the expert takes a different oath than does the lay witness (Lee, 1997). Expert witnesses take the following oath: 'I swear that I will give my opinion faithfully in accordance with my conscience and will be subject to the penalty of false expert testimony in case of any falsehood in my opinion'.⁷ This oath differs from the oath for all other witnesses, which reads: 'I swear that I will conscientiously speak the truth without concealing or adding anything and will be subject to the penalty of perjury in case of false statement'.⁸ In that nation, the court decides whether the witness may attend court proceedings or review the evidence presented (Lee, 1997).

In summary, there is no 'one size fits all' answer to the question of how courts assess expert evidence in cases involving questions of mental disability. What is clear, though, is that, putting aside the extensive range of variations—both as between civil and common law systems and within *different* civil and common law systems—the same attitudinal barriers of sanism and pretextuality, reflected in false 'ordinary common sense' and teleological reasoning, have a significant impact on the ways that such testimony is constructed.

INTERNATIONAL HUMAN RIGHTS LAW AND DISABILITY

In addition to enquiring into the comparative law of evidence and substantive mental disability law, we must now turn our attention to questions of *international law*. This has been a neglected area for decades (Perlin, Kanter, Treuthart, Szeli, & Gledhill, 2006) but it is being significantly rejuvenated by the adoption of a new United Nations Convention. The Convention on the Rights of Persons with Disabilities (United Nations, 2006a) was adopted in December 2006 and opened for signature in March 2007 (United Nations, 2006b). The Convention entered into force—thus becoming legally binding on States parties—on May 3, 2008, 30 days after the 20th ratification (see Melish, 2007; Stein & Stein, 2007).⁹

The Convention on the Rights of Persons with Disabilities (2006) calls for 'respect for inherent dignity' (Article 3(a)) and 'non-discrimination' (Article 3(b)). Subsequent articles declare 'freedom from torture or cruel, inhuman or degrading treatment or punishment' (Article 15), 'freedom from exploitation, violence and abuse' (Article 16), a right to protection of the 'integrity of the person' (Article 17), 'equal recognition before the law' (Article 12), and finally equal 'access to justice' (Article 13). This treaty furthers the human rights approach to disability and recognises the right of people with disabilities to equality in most every aspect of life (see Dhir, 2005).

Commentators have concluded that the Convention 'is regarded as having finally empowered the 'world's largest minority' to claim their rights, and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection' (Kayess & French, 2008, p. 4, n. 17). See, for example,

⁷Korea Code of Civil Procedure, art. 311, translated in 2 CURRENT LAWS OF THE REPUBLIC OF KOREA 753, 753–43 (Korea Legislation Research Inst. ed., 1992).

⁸Korea Code of Civil Procedure, art. 292(2) translated in 2 CURRENT LAWS OF THE REPUBLIC OF KOREA 753, 753–41 (Korea Legislation Research Inst. ed., 1992).

⁹On the 20th ratification, see <http://www.un.org/News/Press/docs/2008/hr4941.doc.htm>.

statements made by the High Commissioner for Human Rights, Louise Arbour, and the Permanent Representative of New Zealand and Chair of the Ad-Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Ambassador Don Mackay, at a Special Event on the Convention on Rights of Persons with Disabilities, convened by the UN Human Rights Council, 26 March 2007.¹⁰ In 2007, Kayess and French noted, 'Proponents emphasised that a convention on the human rights of persons with disability would give shape to the nature of, and add specific content to, human rights as they apply to persons with disability, and in turn, provide a substantive framework for the application of rights within domestic law and policy' (p. 17). Prof. Arlene Kanter in 2007 had noted, 'The extent to which the Convention can realise its goals will depend in large part on the extent to which the Convention is ratified, and whether the world's nations will comply with and further the goals of the Convention through enactment of or changes to their domestic laws' (p. 309). Prior to ratification, Perlin (2007b) noted:

The new United Nations Convention on the Rights of Persons with Disabilities obligates all state parties '[t]o adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present Convention'. The extent to which this obligation is honoured will reveal much about the Convention's ultimate 'real world' impact. (p. 339)

The Convention leaves open many important questions in many areas of law and policy. Its focus—and the focus of the scholarly debate now taking place—has certainly been more on questions of empowerment than on questions of trial procedure and includes the relationship between the Convention and the International Classification of Functioning, Disability and Health (Kayess & French, 2008). Yet, it is clear that it opens up for reconsideration the full panoply of issues discussed in this paper as they relate to persons with mental disabilities. If, by way of example, rules of evidence and procedure create an environment that perpetuates the sort of sanism and pretextuality that has had such a negative impact on the lives of persons with mental disabilities and that condones teleological judicial behaviour through overreliance on cognitive-simplifying heuristics, then a strong argument could be made that these rules must be re-crafted in the context of the Convention. Certainly, this question *must* be 'on the table' for lawyers and for advocates in the coming years.

CONCLUSION

This paper has considered expert testimony in mental disability law cases in common and civil law systems, discussing, in the context of expert testimony, the concepts of teleology, pretextuality, and sanism. Professional standards in psychology require a code of ethics based on a set of moral principles. As discussed, the Universal Declaration of Ethical Principles for Psychologists provides international guidelines for the practice of psychology. In practice, expert testimony can variously be ethical, incompetent, or biased and underpinned by teleology, pretextuality, and sanism. Court testimony in common law and civil law were explored in this context.

¹⁰Available at: [http://www.unog.ch/80256EDD006B9C2E/\(httpNewsByYear_en\)/7444B2E219117CE8C12572AA004C5701?OpenDocument](http://www.unog.ch/80256EDD006B9C2E/(httpNewsByYear_en)/7444B2E219117CE8C12572AA004C5701?OpenDocument) [last accessed 13 November 2007].

There is little question that, internationally, courts interpret expert evidence in cases in which mental disability is an issue in ways that track preexisting pretextual attitudes towards mental disability and persons with mental disabilities. Much of the judicial decision making in this area is pretextual, and those pretexts flow from sanist roots. Although there are significant differences within legal systems and on jurisdiction-by-jurisdiction bases, the underlying attitudinal factors continue to infect and affect jurisprudence throughout the world. The United Nations Convention on the Rights of Persons with Disabilities— and its potential impact on this jurisprudence— remains a ‘wild card’ with regard to future developments, but it is still far too early to speculate as to its ultimate impact.

The central character in Bob Dylan’s *Percy’s Song* (from which the lyric that begins the title of this paper comes) had ‘little doubt’ about the testimony the witness offered (ultimately leading to an unjust prison sentence). Many judges in mental disability law cases similarly have ‘little doubt’ about the testimony they hear from experts, even though their assuredness is often based on pre-existing prejudice and premised on false ordinary common sense. This paper seeks to expose that behaviour and, we hope, inspire new and creative thinking on this topic, particularly amongst expert witnesses.

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