RODERICK MULGAN

PSYCHIATRY, LAW, AND THE INSANITY DEFENCE

LLM RESEARCH PAPER

LAW AND MEDICINE (LAWS 537)

LAW FACULTY,
VICTORIA UNIVERSITY OF WELLINGTON

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Contents.

Abstract.

This paper examines the area of interaction between the psychiatric and legal professions, with particular reference to the insanity defence. After a general discussion of some of the issues concerned with psychiatry in the courtroom, it discusses in detail the history and modern application of the insanity defence, and the well known M'Naughten rules. These rules are in widespread use in the English speaking world, and the paper discusses them in general terms, with limited reference to particular jurisdictions. The central importance of the concept of disease of the mind is examined, with emphasis on the definitional problems associated with it. A number of attempts made by the courts to define disease of the mind are examined, and the inadequacy of these attempts are detailed. The 'cognitive' and the less commonly applied 'volitional' arms of the M'Naughten test are discussed, as well as the special case of personality disorder. The options for reforming the insanity defence are examined, and are followed by some concluding comments.

The text of this paper (excluding contents page, footnotes, and annexures) comprises approximately nine thousand words.

1. Psychiatry in the Courtroom.

1.1. Giving evidence.

Psychiatry probably has more to do with the law than any other single branch of medicine. Forensic psychiatrists are employed extensively in civil as well as criminal proceedings, testifying not just on insanity defences but a wide range of other issues, such as emotional harms and fitness to plead. Their role is not just to advise the Court of the bare bones of a person's mental state, but to help the Court grasp a deeper understanding of their motivations and understanding of reality.

There are two particular ethical principles a forensic psychiatrist must observe when making an assessment that will be given in evidence. These are 'dual agency' and 'uniform skepticism'.

When a psychiatrist gives testimony, it is vital that he or she is not involved in the management and treatment of the accused, as an unacceptable conflict of interest will arise. Supporting the case for one side or the other is inconsistent with making judgments in a different context motivated only by the desire to treat. Furthermore, the accused is entitled to know that his or her confidences will be used only for treatment purposes. This is the problem of 'dual agency'. Breaches of the dual agency principle may well destroy the therapeutic relationship the accused and the doctor originally had, and make it difficult for the accused to trust a doctor again. It can also unfairly influence the jury if a person's doctor gives evidence against him, or is forced to admit damaging facts under cross examination. The attitude of the jury may well be that if the accused's own doctor will not stand by him, his guilt is obvious.

It may well be tempting to ask the treating psychiatrist to give evidence on the grounds that he or she already knows the case, and time and money can therefore be saved. But the attitude one brings to a therapeutic relationship is entirely different from the impartial one required by the Court, and appropriate testimony can only be given by a doctor who is not involved.

Uniform skepticism refers to the attitude of the assessing psychiatrist. The doctor must approach the case in a skeptical frame of mind, weighing the evidence carefully, and being aware of the interest the accused has in skewing his findings. No finding can be assumed until it is proven.

The late Bernard Diamond, a distinguished forensic psychiatrist, suggested the following principles should be observed by psychiatrists in the court room:[1]

- The testifying psychiatrist must clearly distinguish between his own idiosyncratic views and those of his colleagues.

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[1] Diamond B. The forensic psychiatrist:Consultant versus activist in legal doctrine. Bull Am Acad Psychiatry Law 20: 119-132, 1992. 124.

- He or she must not claim results that have not been replicated by others or accepted by the profession, or at least by a substantial part of it.

- Content and length of the examination must conform to the profession's standards; often it is necessary to go beyond the patient interview and consult significant others, like parents and spouses. This is particularly pertinent where hard pressed state agencies will not pay for an extensive evaluation. In such circumstances, Diamond recommends the psychiatrist must withdraw.

- The confidence level of the psychiatrist's opinion must always be stated.

1.2 Public attitudes

The insanity defence rarely succeeds in contested cases, and various reasons relating to psychiatric practice can be advanced as to why this might be so. The stereotype persists of psychiatry as unscientific, overly reliant on subjective observations and even more subjective interpretations of their meaning. Juries whose attitude has been formed by controversial high profile cases may well warm to legal argument suggesting that psychiatric testimony is imprecise and unreliable.

The general public's perception of forensic psychiatry's role is usually taken from a few sensational cases, such as that of John Hinkley, who caused a public outcry when he was found not guilty by reason of insanity for shooting President Reagan. It is often the case that specialised testimony is treated skeptically by the general public, when they perceive that it has led to a serious criminal being 'let off'.

Juries can also be influenced by the fear, usually groundless, that a finding of insanity will result in a dangerous person being put back on the street. There can also be the problem in some jurisdictions that a lack of funds may prevent defence experts conducting the expensive business of a thorough evaluation (including discussions with relatives and other doctors) to rebut the prosecution.

Concerns about the influence of psychiatric testimony in the post Hinkley early 1980s led the United States Congress to enact several provisions to limit the scope of psychiatric evidence and its potential to confuse the jury. Rule 704 of the Federal Rules of Evidence was modified to prevent an expert witness stating a conclusory opinion on whether the accused was insane. This reflects the position in most other jurisdictions, where expert testimony is limited to descriptions of the accused's mental state, and the Court reserves for itself the final decision on insanity. Congress also codified Federal insanity law with a version of the M'Naughten rules.

1.3 Scientific standards

Historically, psychiatry has often had a strained relationship with other branches of medicine, particularly prior to the treatment revolutions of the 1950s, as its guiding principles were seen by outsiders as unscientific. This has also affected its

relationship with the law, which sought objective and verifiable opinions that psychiatrists often could not provide.

Psychiatry in the modern world is considerably more scientific than it used to be, particularly since internationally standardised definitions of psychiatric illnesses became widely adopted. These definitions are provided by DSM IV (DSM stands for Diagnostic and Statistical Manual), which has become the working 'bible' of psychiatric practice. Since DSM IV was developed there has been more consistency between different psychiatrists, with less room for disagreement for the lawyers to make hay with. It is now more likely that defence and prosecution experts will find themselves in agreement, so the case can end in a stipulated 'not guilty by reason of insanity', and a courtroom battle can be avoided.

Psychiatry has also made considerable progress in the last thirty years with understanding some of the biological disturbances that underlie psychiatric illness, and with developing drugs to treat them. There is now far less reliance on complex psychoanalytical explanations of mental disturbance, and more on biological ones.

It is ironic that while psychiatry has moved in recent times to become more objective and consistent, more like other sciences, the other sciences have been moving in the opposite direction. There is now a widespread acceptance in the 'hard' sciences like physics that the Newtonian concept of fixed relationships and predictable outcomes has considerable limitations, and that better results are obtained from models based on uncertainty and probability. Such models are concerned with multiple causes, uncertain outcomes, and the value of subjective perceptions. In other words, they have many of the features of the hard sciences' poor cousins, psychology and psychiatry.

At the same time the criminal law has also moved away from rigid definitions, and has progressively allowed some of psychiatry's less precise concepts to be introduced into evidence. Battered woman syndrome, for instance, is a relatively modern concept, and has at various times supported defences of duress and self defence, as well as insanity. Similar developments have occurred with post traumatic stress disorder, and repressed memories. The relatively modern explosion of cases dealing with sexual assault on children has raised complex issues about memory, affect and credibility, all areas where psychiatric and psychological testimony is indispensable. These are also areas where the medical profession is feeling its way just as much as the courts, and strong disagreements exist within its ranks about the nature of these phenomena.

As science in general becomes more concerned with complex systems where causality is unable to be pinned down exactly, the law has become less willing to insist on reductionist standards of explanation. From the States comes the case of *Daubert and Daubert v. Merrell Dow Pharmaceuticals*,[2] where the U.S. Supreme Court ruled that scientific testimony can be admitted irrespective of the consensus of accepted principles in the field. The case concerned the drug Bendectin, and whether it had caused birth defects. The defendants produced numerous published

[2] U.S. Sup. Court No. 92-102 (1992)

studies showing that it had not. The plaintiffs sought to admit evidence from well qualified experts who claimed otherwise, but represented a minority opinion in their field. In their ruling, the Justices overturned a seventy year old standard that expert testimony must have gained general acceptance in the particular field to which it belongs. The ruling recognises the changing nature of science. Where the courts could once refer to the accepted consensus in a field, they now have to acknowledge multiple points of view.

There remains, however, a significant part of psychiatry that relies on the subjective impressions of the examiner to form conclusions, in a way that would not be accepted by 'bench science'. This fact of life for psychiatrists can be a means of undermining a psychiatric testimony when attacked in Court. It is necessary for courts and the public to accept that this is a legitimate part of psychiatric testimony.

2. The modern insanity test and its history.

Since at least the thirteenth century the law has recognised in some form or another that allowances must be made for people who are not fully responsible for their actions because of mental illness.

Some authorities[3] claim that when the aspects of insanity emphasised by the law are dissected, the common impulse usually relates to the danger the accused poses to society if he or she is released. This common denominator reflects the whole raison d'être of the insanity defence, which is to provide for people who are not criminally or morally responsible for their actions, but who still require restraint for society's sake.

The modern insanity defence based on the M'Naughten rules has antecedents reaching back to the thirteenth century. There was no insanity defence per se prior to Norman English Law. An insane offender would not be tried, but his family would be required to pay compensation to the family of the victim. Early formulations, such as that provided by Bracton[4], were narrow in their focus and equated mental illness sufficient to defend a criminal act as rendering the accused on the same level as children or animals. Bracton considered an insane person to be:

> 'one who does not know what he is doing, who is lacking in mind and reason, and who is not far removed from the brutes'.

In 1723, in *R v Arnold*, the judge directed the jury that in order to be found insane:

> 'a man must be *totally deprived* of his understanding and memory and does not know what he is doing, no more than an infant, a brute, or a wild beast'[5].

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[3] McSherry, B. *Defining what is a 'Disease of the Mind': The Untenability of Current Legal Interpretations.* Journal of Law and Medicine October 1993.

[4] Henri de Bracton, On Laws and Customs of England.

[5] (1724) 16 St. Tr 695 at 765 (emphasis added)

The courts in the eighteenth and nineteenth centuries continued much the same line, and generally permitted only the most obviously deranged individuals to be excused from serious crimes[6]. However, at the same time a development of the rule can be traced, whereby it was recognised that incarcerating deranged people did not solve any deterrent function, which was considered the primary purpose of punishment. Accordingly, when James Hadfield was tried in 1800[7] for attempting to assassinate the King, he was acquitted on the basis that a delusion had directed his actions, though no florid and intractable derangement was present.

This case created something of a stir, when it was recognised that there was no place for offenders like Hadfield to go, when they were acquitted of any criminal responsibility, but continued to present a threat to society.

Almost all the common law tests in use around the world today are some variation on the M'Naughten principles, which were formulated by the House of Lords in 1843. The infamous Mr.M'Naughten suffered from a paranoid delusion that Tory politicians were plotting to harm him, and he shot the British Prime Minister's secretary as a result. When the case reached the House of Lords, Tindal LCJ gave what is now regarded as the classic definition of the legal view of insanity:[8]

> '...to establish a defence on the grounds of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, he did not know that what he was doing was wrong'.

This statement represented the culmination of a century of development of the law relating to insanity. Previous definitions had dwelt on a deprivation of reason, a want of understanding, and inability to distinguish good and evil. It has become widely adopted around the world, and there are now only a very few jurisdictions[9] that treat all perpetrators of crimes equally, without provision for any sort of insanity plea.

Although this statement still forms the basis of most contemporary legal tests, it has been expanded in some jurisdictions to cover contingencies not captured by simple lack of understanding. The M'Naughten rule survives in the 'cognitive' arm of modern tests, while the 'volitional' arm is a more recent development.

The insanity defences in use around the world tend to follow similar formulas, and for the purposes of this paper the generic principles will be discussed without detailed reference to particular jurisdictions.

Practically without exception, the legal tests of insanity have followed the McNaughten rules' requirement that some disease of the mind must be present,

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[6] *R v Ferrers* (1760) 19St Tr 885; *R v Hadfield* (1800) 27 St Tr 1281; *R v Bellingham* Coll Lun 636;

[7] Fingarette, The Meaning of Criminal Insanity, University of California Press, 1972. 138.

[8] (1843) 10 Cl & Finn 200, 8 ER 718, [1843-60] All ER Rep 229 (HL).

[9] The States of Montana and Idaho in the USA.

and that this disease is pivotal to, and not incidental to, the commission of the offence. This is to ensure that:

> '...mere excitability of a normal man, passion, even stupidity, obtuseness, lack of self control and impulsiveness do not give rise to the insanity defence.'[10]

One of the major problems for insanity defences is the inability of either the courts or the medical profession to define what a disease of the mind actually is, and this point is discussed in detail below.

Secondly, tests require either a cognitive arm, or a volitional arm, to be satisfied in addition to the presence of disease of the mind. The cognitive arm has two alternative parts: either the defendant did not understand the nature and quality of his actions, or that knowing this, he did not know that they were wrong (*M'Naughten*). The volitional arm, which may be satisfied in addition to, or separate from the cognitive arm, requires that the defendant lacked the ability to control his actions, or in other words, was acting under some irrepressible impulse.

3. Use of the insanity defence

There are several reasons why an accused will raise a defence of insanity:

- To avoid the stigma of conviction (which would have to be balanced against the stigma of mental illness);

- To avoid a lengthy prison sentence. This differs between jurisdictions, depending on the available penalties for the crime. Where, for instance, there is a mandatory sentence of life imprisonment, an accused is more likely to raise the insanity defence than where there is sentencing discretion. For instance, when England introduced the defence of diminished responsibility, there was a marked reduction in the number of insanity verdicts.[11] Freiberg found, as one might expect, that there was a dramatic decline in the number of insanity verdicts after the abolition of capital punishment in Australia.[12]

- Where it would be beneficial for the accused to receive psychiatric care in a mental institution rather than a prison;

- Where the offender's mental illness is temporary and unlikely to recur; in this case, the offender may not be detained very long if the insanity plea is accepted.[13]

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[10] Quoted in McSherry, *Defining what is a "Disease of the Mind": The Untenability of Current Legal Interpretations*. Journal of Law and Medicine, Vol 1. October 1993.

[11] N. Walker, *Crime and Insanity in England*, vol. 1, University Press, Edinburgh 1968.

[12] A Freiberg, *Out of Mind, Out of Sight: The Disposition of Mentally Disordered Persons involved in Criminal Proceedings* [1976] 3 Mon. Law Rev. 134, 159.

[13] But see discussion in this paper that where the condition is unlikely to recurr, it is less likely to be accepted as a case of insanity.

Insanity pleas are by no means commonly invoked. The tests in common use around the world invariably set high standards and it is often only in cases of obvious insanity that they are used. There is no truth in the popular perception that the insanity plea is a soft option for serious criminals. For instance, one study of eight States in the US found the plea used in less than one percent of a representative sample of cases[14]. Furthermore, only 26% of these pleas were successful. According to *Myths and Realities: A Report of the National Commission on the Insanity Defence (USA)*, less than 0.2% (52 out of 32,000) defendants in New Jersey entered the insanity plea, and less than a third were successful. In New York City, only one in six or seven hundred criminal cases invoke the insanity plea.[15]

4. Disease of the mind.

Insanity is a legal concept, not a medical one, and although psychiatrists are usually employed to describe a defendant's state of mind, it is the court that must decide whether the accused was insane. Mental illness by no means automatically meets the insanity test when it present, nor does it even meet it in a majority of cases. The great majority of people with mental illness are not insane in legal terms.

Unfortunately, both the law and psychiatry lack an adequate definition of what a disease of the mind actually is, despite having spilled a lot of ink in the search for it over the last few hundred years, and despite the relevance such a definition would have to both fields of enquiry.

A workable definition is important for not just for the application of legal tests, but for fairness at other stages of the judicial process, like sentencing and parole. Beyond the criminal law, the label can have far reaching implications. One can be deprived of liberty and other civil rights, like the right to refuse treatment, if the 'mental illness' cap fits. It is obviously important that medicine and the law understand what is meant by the term. Yet where mental disease is referred to in a legal context, as with legislation, judgments, or instructions to a jury, the term is rarely given explicit definition.

In the era of *M'Naughten,* questions of science were seen in physical terms, and it was assumed that psychiatric phenomena were due to disturbances of brain function. It was expected that it was only a matter of time before medical science would elucidate the precise nature of these physical disturbances, and would give the law a solid hook to hang its legal tests on. With precise descriptions of brain disorder, the law would be able to determine with a high degree of accuracy when mental disease was present or absent, and the legacy this model has bequeathed to subsequent generations is a lasting emphasis on mental disease.

Unfortunately, precise descriptions of brain disorder have not evolved with the march of science, and even with the most sophisticated modern technology, there

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[14] *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 19, No 4, 1991.
[15] Www.psych.org/public info/INSANI-1.HTM.

is no prospect of this changing in the foreseeable future. It is still the case, as it was a hundred years ago, that a definition of mental disease can only rest on the symptoms and signs observed in the patient. It is now appreciated that most mental disorder concerns the unnatural *working* of the mind, and not organic or structural deformity. (Some fine points can be argued here: must unnatural working of the mind not relate at *some* level to organic function? It depends on whether the mind is simply the sum of the parts of the brain (cells and chemicals) or something else. This question is not yet resolved, but most psychiatrists regard the mind as something apart from the brain).

It is not suggested that a proper explanation of the causes of mental illness is necessary for the functioning of the law *per se*; if the concept can be adequately defined in other ways, the law can apply its tests and definitions, and safely leave the nuts and bolts to the medical profession. But where an alternative basis for the concept is lacking, the lack of abnormal physical phenomena in insane people becomes a stumbling block.

Definitions in both medicine and law have tended more recently to use 'dysfunction' in place of 'illness' or 'disease' to emphasise that the concepts are not analogous to purely physical disorders.

It might be assumed that the question is essentially medical, and that psychiatrists could guide the courts, and advise, as the guardians of mental health sciences, when mental disease is present. However, psychiatric science is no more equipped than the law to rule on when a disease of the mind is present, particularly at the fringes of normal behaviour, which is where any dividing line must be drawn.

It is exactly the same problem that bedevils any definition of health and disease. What is normal health? Is it something positive, or merely the absence of illness? If it is something positive, what is that? Does it concern, for instance, the ability to reach one's potential? In that case, laziness would constitute illness, and those born congenitally deformed would be considered normal.

The question is comparable to defining 'normal' eyesight. An ophthalmologist can measure a person's visual acuity, but is no better equipped than anyone else to say what is 'normal'. What is adequate to drive a car may not be adequate for some occupations, what is inadequate to read small type may be adequate for walking down the street. What is acceptable in old age is a disorder for a youth. The definition of 'normal' vision is a legal one: what level is needed to drive safely or undertake any other task for which licensing is required. The point is that what is normal is not decided by the relevant medical specialists, but by experts in law and public policy, and is not made with reference to some fundamental property of the test, but to an arbitrarily defined standard.

The same principles apply to defining mental disease, and experts in the field have long wrestled with their responsibilities on this question. One authority[16] describes some of the solutions that have been proffered:

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[16] Fingarette, The Meaning of Criminal Insanity, University of California Press, 1972.

- There is no such thing as mental disease;
- Mental disease is psychosis but not neurosis;
- Mental disease is any substantial mental disturbance dealt with by psychiatrists;
- Mental disease is substantial social maladaption or incompetence;
- Mental disease is the failure to realise one's nature, capacities or true self.

Neither the medical or the legal professions possesses fundamental criteria for accepting one state as mental illness and not another, and all criteria proffered can be seen to be inadequate. For instance, if prevailing social norms were the key, changing norms would leave the definition high and dry (homosexuality is a good example). If treatability were the key, (a stance the medical profession tends towards), none of the major psychoses would have constituted an illness prior to the 1950s.

Furthermore, some authorities claim a workable definition simply isn't available as the concept means different things for different purposes. A doctor's definition emphasises treatability, a sociologist's emphasises social functioning, and a lawyer's emphasises awareness and responsibility. Each must seek definitions for their own purposes, which can and indeed must differ from one another, and these individual and diverging paths preclude a single universal solution.

Could be accepted that a precise definition is not essential, given that commonsense ones can easily be invoked that are adequate for the purpose? Concepts like time and space lack easy definition, but that doesn't stop the terms being used in everyday parlance, as well as the upper reaches of theoretical physics. Courts are often expected to draw conclusions from imprecise and incomplete evidence, and seen in this light, maybe mental disease is not exceptional.

5. Aspects of legal tests of 'disease of the mind'.

McSherry[17] describes three principles that have been developed by the courts to assist in determining the legal view of disease of the mind. These tests are of particular importance in distinguishing sane from insane automatism.

- The recurrence test: a mental state which is likely to recur is a disease of the mind;
- The internal/external test: A mental state arising *within* the accused's mind is a disease of the mind, whereas a state arising from an external cause is not;

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[17] McSherry, B. *Defining what is a 'Disease of the Mind': The Untenability of Current Legal Interpretations.* Journal of Law and Medicine October 1993. [17]

- The sound/unsound mind test: similar to the external/internal distinction, this has been used deal with dissociative states. A disease of the mind exists where the mind was disturbed before being exposed to external stimuli, and does not react the same way a sound mind would.

5.1 Recurrence test.

The recurrence test has only been referred to in a small number of judgements, and was summed up by Lord Denning in *Bratty v Attorney General for Northern Ireland*[18] :

' any mental disorder which has manifested itself in violence *and is prone to recur* (emphasis added) is a disease of the mind. At any rate it is the sort of disease for which a person should be detained in hospital rather than be given an unqualified acquittal'.

Sholl J in *R v Carter*[19] agreed, and said in his judgement:

' potentiality of repetition...might be regarded as a discrimination between cases of irrational behaviour due to some transient cause...other than disease of the mind, and cases of irrational behaviour due to defective reason from disease of the mind'.

Despite this, there are problems with the concept. It is entirely conceivable that a serious mental disorder may not recur, particularly with the modern treatments that are available for serious disturbances, as indeed is true by definition of the phenomena of temporary insanity.

Also, conditions like epilepsy and hypoglycemia will be considered diseases of the mind on this test, although they are generally regarded to be outside its ambit, and they are eminently treatable.

If recurrence matters, it can be argued that its importance lies with the sentencing stage of proceedings, and not the question of guilt. The recurrence test confuses the question of what should be done with an insane defendant with the entirely separate question of whether the accused's state of mind excuses his conduct.

One authority[20] has pointed out that if the recurrence test was overly relied on, then it would be more appropriate to direct the jury to determine whether they find the accused guilty of being dangerous in the future.

5.2 Internal/external test.

This was developed by Martin JA in the Canadian case of *R v Rabey*[21] as follows:

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[18] [1963] AC 386
[19] [1959] VR 105
[20] Campbell, I. Mental Disorder and Criminal Law in Australia and New Zealand. Butterworths, Sydney, 1988. Pg 129.
[21] (1977) 37 CCC (2d) 461.

'In general, the distinction to be drawn is between a malfunctioning of the mind arising from some cause that is primarily integral to the accused, having its source in his psychological or emotional make up, or in some organic pathology, as opposed to a malfunctioning of the mind which is the transient effect produced by some specific external factor such as, for example, concussion'.

The practical effect of this is to place behaviour arising from blows to the head, drugs, or hypnotism within the ambit of sane automatism, and not insanity. However, this test can create arbitrary distinctions, such as for instance, between hyper and hypoglycemia.

Hyperglycemia occurs in diabetics when they fail to take their insulin treatment, and their blood levels of glucose rise. Hypoglycemia occurs when an excess of insulin, or fasting, or an excess of alcohol, cause levels to fall. Both states can give rise to confused behaviour.

In *R v Quick* [22] William Quick was charged with assaulting a patient at a mental hospital where he worked as a nurse. He was a diabetic, and on the day of the assault he had injected himself with insulin without having anything to eat afterwards, and had drunk alcohol. He claimed in court that he was suffering from hypoglycemia, and that this explained his uncharacteristic behaviour. The judge, Bridge J, ruled that this defence concerned factors internal to the accused (his diabetes) and therefore invoked the insanity defence. Mr. Quick then pled guilty.

On appeal, the Judge's ruling was overturned, as the court held that the hypoglycemia was caused by taking insulin and not by the diabetes (diabetes per se causes abnormally *high* glucose levels). The insulin was an external factor and could have given rise to the defence of sane automatism.

However, in *R v Hennessy* [23], Andrew Hennessy was charged with driving while disqualified. He raised a defence of automatism on the basis that he was a diabetic who had not taken insulin for several days and that his behaviour was due to the resulting hyperglycemia. The judge ruled that the diabetes was responsible for his state of mind, and Mr. Hennessy changed his plea to guilty.

The Court of Appeal upheld the judge's reasoning and the conviction based on it. Lord Lane CJ ruled that hyperglycemia is an 'inherent defect' which can be considered a disease of the mind. He stated that:

' if it (hyperglycemia) does cause a malfunction of the mind, then the case may fall within M'Naughten Rules'. [24]

The conclusion of these two cases is that hyperglycemia from untreated diabetes is an internal factor, and therefore invokes the insanity defence, and hypoglycemia arising from over treated diabetes, is not. Diabetics who commit crimes are therefore likely to receive an unqualified acquittal if they over treat themselves

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[22] [1983] 1 QB 910
[23] (1989) 1 WLR 287
[24] (1989) 1 WLR 287 at 293

with insulin, and to find themselves in a mental hospital if they fail to take their medication altogether.

The same sort of problems arise with the phenomenon of sleep walking. In the Canadian case of *R v Parks* [25], Kenneth Parks killed his mother-in-law and wounded his father-in-law, and claimed afterwards that he was sleepwalking at the time. He pleaded a defence of automatism, based on the claim that he was sleepwalking. Five medical witnesses gave evidence that the accused was indeed sleepwalking at the time he committed the acts. The jury acquitted him of murder, and the judge acquitted him of attempted murder.

The Crown appealed to the Court of Appeal and then to the Supreme Court of Canada, claiming that the Court had erred in finding that sleepwalking was not a disease of the mind. Both appeals failed, and Parks' acquittal stood.

In a similar case in England, *R v Burgess,* [26] Barry Burgess hit a friend on the head with a bottle and a video recorder, then attempted to strangle her. It was only when she cried out that he backed off and appeared to come to his senses.

At his trial, his lawyer argued that Mr. Burgess was sleepwalking when the acts were committed, which entitled him to entitled to the defence of automatism. Medical evidence was brought to support this. The trial judge ruled that sleepwalking came under an insanity defence, and the jury returned a verdict of not guilty by reason of insanity. The Appeal Court upheld this finding and Mr. Burgess was sent to a mental hospital.

So in the case of *Parks*, sleepwalking was not considered to be a disease of the mind, and in *Burgess* it was.

To cloud the waters even further, Lamer CJ and Cory J stated with respect to *Parks*, that while sleepwalking did not lead to a defence of insanity in that case,

'this in not to say that sleepwalking could never be a disease of the mind, in another case on different evidence'. [27]

This allows the possibility that some conditions will be accepted and rejected as diseases of the mind on a case by case basis.

5.3 Sound/unsound mind.

The sound/unsound mind test is a variation of the internal/external factor test, and it was first developed in the Australian High Court in the case of *R v Falconer.* [28]

Gordon Falconer had a long history of violence to his wife and their daughters. After 30 years of marriage Mrs. Falconer separated from her husband and obtained

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[25] *R v Parks* (1990) 56 CCC (3d)449 at 458.
[26] *R v Burgess*(1991) 2 WLR 1206 at 1209.
[27] (1992) 2 SCR 871 at 891.
[28] (1990) 171 CLR 30

a non molestation order to prevent him continuing to harass her. Despite the order, Mr. Falconer continued to see his wife and mentally and physically abuse her. On one of these occasions Mary Falconer shot and killed her husband with a shot gun kept in a wardrobe in the house. She had no recollection of what she had done, and only remembered 'coming to' holding the gun with her husband's body beside her.

At the trial, the defense called two psychiatrists to give evidence that the accused had experienced a dissociative state, consistent with sane automatism. Both experts considered that the circumstances preceding the shooting were severe enough to produce a dissociative state, where, according to one of them:

'part of [the accused's] personality would be sort of segmented and not functioning as a whole and she became disrupted in her behaviour, without awareness of what she was doing'.[29]

The Commissioner hearing the case ruled this evidence inadmissible and the accused was convicted.

However, this was overturned on appeal, where the Western Australia Court of Criminal Appeal held that the evidence was admissible on the issue of voluntariness, and ordered a retrial. The Court agreed that the evidence did not come under the terms of insanity, but whether the firing of the gun was voluntary.

Concerning sane versus insane automatism, the Justices ruled that the internal/external test was inadequate in relation to dissociation, and attempted to define when a dissociative state would lead to sane automatism and when it would lead to the insane variety. To this end, they drew on a judgement in *R v Radford* [30] where King CJ addressed the issue of whether mental conditions stemming from 'psychological blows' should be considered sane or insane automatism:

'The significant distinction is between the reaction of an unsound mind…on the one hand and the reaction of a sound mind… on the other'.

Gaudron J with regard to *Falconer* expressed a similar view:

' The fundamental distinction is necessarily between those mental states which, although resulting in abnormal behaviour , may be experienced by normal persons as, for example…a blow to the head, and those which are never experienced by or encountered in normal persons'.[31]

Adding to this, Mason CJ, Brennan and McHugh JJ proposed an objective test to the sound/unsound mind distinction:

'The law must postulate a standard of mental strength which, in the face of a given level of psychological trauma, is capable of protecting the mind from malfunction to the extend prescribed in the respective definitions of insanity. That standard must be the standard of the ordinary person: if the mind's strength is below that standard, the mind is infirm; if it is of or

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[29] Ibid at 109

[30] 919850 42 SASR 266.

[31] *R v Falconer* (1990) 171 CLR 30 at 85.

above that standard, the mind is sound or sane. This is an objective standard which corresponds with the objective standard imported for the purpose of determining provocation'.[32]

6. Cognitive arm.

This test has two parts. The first part relates to the capacity of the defendant to know the 'nature and quality of his act or omission'. This is usually taken as more than the 'narrow physical action and its surrounding circumstances, and also encompasses the result, injury or damage that flows from the action'[33]. This test is usually satisfied only by gross delusional states, such as those that occur in schizophrenia. It has been phrased by different authorities as referring to 'an insane mistake of fact'[34] or '[the defendant] could not appreciate the physical thing he was doing or its consequences'[35].

An oft quoted example of such gross disorder is where a person cuts another's throat believing he is cutting a loaf of bread.

The second part of the test, which is an alternative to the 'nature and quality' grounds, is that the accused did not know his acts to be wrong. Wrong is understood in New Zealand and Australia to mean 'contrary to the ordinary principles of reasonable people'[36].

The tests described above are those found in English law. Courts in the United States usually omit the nature-and -quality test and depend on the knowledge of wrongness to establish a plea of insanity.

The majority of insane people retain an understanding of the nature and quality of their actions, and those that do not will usually lack the capacity for organised action they would require to commit an offense. In other words, they are so deranged that purposeful action is beyond them. It is the second part of the cognitive test that is most often invoked in court, the lack of knowledge of wrongness.

The majority of people found not guilty by reason of insanity are in a situation where they understand what they are doing but possess a delusional reason for doing it. McNaughten himself fully understood that he was committing a murder, but believed in a delusional fashion that it was necessary for his self preservation.

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[32] *R v Falconer* (1990) 171 CLR 30 at 85.
[33] Campbell, I. Mental Disorder and the Criminal Law in Australia and New Zealand. Butterworths, Wellington, 1988. 122.
[34] Campbell, I. Mental Disorder and the Criminal Law in Australia and New Zealand. Butterworths, Wellington, 1988. 122.
[35] Howard C, Criminal Law, 4th Ed, Law Book Co, Sydney 1982, 333.
[36] Campbell, I. Mental Disorder and the Criminal Law in Australia and New Zealand. Butterworths, Wellington, 1988. Pg. 123.

It is not uncommon in psychotic states for people to believe they are acting as agents of God, or of some extra terrestrial force, or that they have to defend themselves against bizarre plots being hatched by others.

In these situations the courts usually take the view that the accused must be judged on what the law would have been had the facts of the delusion been real. So a man who kills another person he wrongly believes to be having an adulterous affair with his wife may not be acquitted on grounds of insanity, as his action would not have been lawful if his beliefs had been grounded in reality. But a person who genuinely believes himself an agent of the almighty may claim that his delusion excuses him.

The heart of the cognitive arm of the insanity plea is the principle of mens rea, the guilty mind. There is a distinct difference between absence of mens rea by reason of insanity, and absence of mens rea on other grounds. In the latter case the accused is a responsible agent who acted without criminal intent. In the former case the accused lacks the status to be judged responsible for his actions; his state of mind renders questions of guilt or innocence superfluous. The absence of mens rea does not lead to a finding of innocence and a discharge, but to incarceration, albeit not for punitive reasons.

7. Volitional arm.

There are jurisdictions that recognise that the cognitive grounds alone do not cover all aspects of mental illness that might result in crime being committed. A person who understands the nature and quality of their acts may still lack the ability to control their actions. The cognitive criteria taken on their own exclude concepts such as emotions or mood, (e.g. depression), or what one Justice termed the 'moral perversion of feelings unaccompanied by delusion'[37]. As one contemporary text describes it, the McNaughten based tests are:

'...for the most part thoroughly cognitive in emphasis and, arguably, fail to give adequate consideration to disorders of the will or emotions'.[38]

Some jurisdictions therefore recognize that an alternative to the cognitive arm is a volitional one: insanity that resulted from 'irresistible impulse, incapacity to conform to the law, or impaired emotional processes'[39]. It is by no means universal that this arm is recognised. New Zealand law does not recognise it, nor do a number of American States, but most Australian States do. Its use is not endorsed by the American Psychiatric Association.

The concepts can overlap. Inability to act calmly and reasonably might satisfy a jury that the accused lacked the ability to know what he was doing, as well as lacking ability to control his actions. In other words, where a person is deprived of control over volition, it is likely he will be deprived of one of the cognitive

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[37] *Frere v Peacock* (1846) 1 Rob Eccl 442; 163 ER 1095.
[38] Simester and Brookbanks, 1998, Principles of Criminal Law, Brooker's Ltd, Wellington, New Zealand, pg. 268.
[39] Campbell, I. Mental Disorder and the Criminal Law in Australia and New Zealand. Butterworths, Wellington, 1988. Pg. 145.

capacities as well. The law in these instances parallels the thinking in psychiatry, that aspects of one's mental makeup like cognition and volition are interwoven with each other, and do not exist in separate boxes.

Where criticism of the volitional test has arisen, it has centered on the jury's inability to distinguish between an impulse that could not be resisted and one that was not resisted. Yet a jury has to make this distinction whenever an issue of involuntarism is raised, and the task is not impossible.

8. Local and global insanity.

A relatively recent development in the insanity defence, and in the wider question of diminished capacity, is the principle of distinct competencies, in other words the ability to be incompetent or insane with respect to some abilities but not others. Traditionally competence was all or nothing, but developments in both psychiatry and the law have rendered this model obsolete.

On the psychiatric level, this concept can be traced back to Freud's theories of conflict and dissociation, in combination with more modern principles such as the multiple personality disorder paradigm. The mind is best understood as differentiated phenomenon, not a unitary whole. Although the numerous different facets of the mind interact with each other, they can be disentangled in a psychiatric evaluation, so that the patient can be pronounced incompetent for some functions but not others.

A man might kill his children because of the delusional belief they would be better off in heaven. He may well be able to distinguish right and wrong, and have a normal perception of reality, in all other respects except the respect in which he acted.

Another example is white collar crime. Traditionally, the skill needed to embezzle money ruled out any consideration of the accused suffering any sort of impairment. However, it is increasingly recognised that congitive ability may persist when the mind is affected by depression or psychosis.

9. The special case of personality disorder.

One particular problem with the definition of insanity is the case of personality disorder. A personality disorder is defined by a contemporary authority[40] as:

> 'Disordered patterns of behaviour characterised by relatively fixed, inflexible and stylised reactions to stress...other people and external events regardless of external realities'.

Personality disorder is a unique form of illness, if an illness it is, and represents the pinnacle of the mad versus bad dilemma. Other types of mental disease strike 'normal' people, and cause them to pass from a state of sanity into insanity. A personality disorder, by contrast, is a fixed and unchanging pattern of behaviour,

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[40] Merck Manual of Diagnosis and Therapy, Sixteenth Edition, Merck Research Laboratories.

that exists from birth, and by definition is intimately bound up with who a person is. Personality disorders are for life, and do not respond to any form of treatment. A psychopath is a working example.

Many jurisdictions, particularly in the United States, specifically exclude personality disorder from their definitions of mental illness. Other areas have case law rulings that personality disorder does not meet the definition of mental dysfunction. The question is whether this is fair and appropriate.

Personality disorders are recognised by DSM IV and comprehensive descriptions of the different types are available. They seriously impair normal personal functioning. People suffer from them through no fault of their own. Where a person with a personality disorder commits a crime, could they not claim they have less intrinsic inhibition to commit crimes, through a grossly twisted and abnormal personality?

The problem is whether people can claim diminished responsibility because of the way the are. There are many people who come before the courts, who do not meet the full criteria for personality disorder, who could nevertheless claim that their personal make up makes them less respectful of the law than the average person. The problems of allowing such a claim to equate to diminished responsibility are obvious. But is it not possible to draw a line between people who simply choose to commit crimes, and people who meet the criteria for a recognised disorder?

It could be argued that recognising diminished responsibility in personality disorder comes dangerously close to the concept of a 'criminal mind'; the idea that some people, by dint of their basic make up, are more likely to commit crimes. The only means of determining whether such a tendency was present would be the actual commission of crimes, so a circular logic pervades the whole definition. Should people who commit crimes be leniently treated, as they obviously had a personal tendency, through no fault of their own, to engage in such behaviour? The impossibility of such logic is an insight into why the test for insanity is so strict and exclusive.

Further considerations in this dilemma are, firstly, that the criteria for personality disorder are looser than for other conditions, and it is often not difficult to find a user friendly psychiatrist who will make the diagnosis on request. Secondly, if a plea of mental illness succeeds, the accused usually spends longer locked up than if they had been found guilty. Society might paradoxically be safer if a liberal policy on reduced responsibility was adopted.

10. The future of the insanity defence.

It is notable that the insanity defense in most jurisdictions remains faithful to the original principles of the M'Naughten rules, formulated over a hundred and fifty years ago. That M'Naughten has stood the test of time is indisputable, and this strongly suggests that radical departures from it are unlikely in the future. However, where the subject of reform crops up, there are two recurring themes:

that the defence should be abolished, or alternatively, that the defence should be reserved to the judge at time of sentencing, and not be placed before the jury.

The rationale for abolishing the defense arises in part from the acknowledged problems with terminology and meaning; where the law can not be clear about its terms, and straightforward definitions for concepts like disease of the mind can not be formulated, a case can be made for avoiding the whole quagmire entirely by abolishing the defence. In further support for this course of action, several other points can be made. The insane offender is really no more dangerous to society than many entirely sane people who come before the courts every day. In the case of sane offenders there is no provision for open ended detainment for society's protection, except in the most extreme cases; should the treatment of insane offenders be any different?

It is often assumed that the insanity defence permits deranged offenders to be placed in mental institutions instead of prison, where their daily life will be more comfortable, and they can receive treatment. In practice, however, this is often not the case. Potas [41] presents evidence that around half of people found not guilty by reason of insanity serve their detention in ordinary prisons, which, if this continues to be true (the figures are around twenty years old) undercuts a large part of the rationale for having an insanity defence available.

The other suggestion regularly mooted is to reserve considerations of mens rea and sanity for the sentencing judge, and to use the jury merely to decide whether the accused carried out the criminal act or not. The law would provide for a crime of unlawful killing, with discretion at sentencing for the presiding judge. The jury would hear evidence relating to whether an unlawful killing occurred, and by whose hand; only after that decision had been made, would the judge hear arguments about the appropriate disposition of the offender.

The advantage of this course would be to streamline the trial, by not requiring the jury to struggle with difficult evidence of sanity and responsibility. The problem is that sanity and responsibility are exactly what the jury is there to decide; the judgement of one's peers is not a technical exercise to decide who wielded a murder weapon, but is intended to encompass the whole wider issue of blame and moral culpability.

11. Conclusion.

The interface between psychiatry and the law contains some difficult issues, probably the most prominent of which are the definitional problems surrounding the legal concept of insanity, and its central principle, the problematic disease of the mind.

The imprecision and difficulty of diagnosis in the psychiatric area is a cause of tension between the perspectives of the two professions, as one seeks to embrace the complexity of the human mind, and the other seeks transparency and

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[41] Potas, I. Just Desserts for the Mad. Australian Institute of Criminology, Australia, 1982.

straightforward answers. In some respects psychiatry has evolved towards the legal fraternity's position in the last two decades, by relying more on organic causation (particularly that which is amenable to drug treatment) than complex psychoanalysis, and by adopting internationally standardised definitions. At the same time, other areas of the scientific community have been moving in the opposite direction, rejecting strict precision and embracing uncertainty. This is a boost for psychiatry, which has long operated on such principles, and gives more force to the profession's struggle to interest the law in this perspective.

The complexity of psychiatric testimony has also created problems for the profession's public image, and the consequent attitudes adopted by jurors. There is a widespread perception that psychiatric testimony leads to criminals being able to avoid responsibility and punishment for their crimes, and that the theories of erudite boffins lack the common sense of ordinary people. Probably for this reason, the insanity defence is rarely invoked, and even more rarely succeeds.

Almost all English speaking jurisdictions work with the landmark legal test for insanity that was first promulgated one hundred and fifty years ago in the House of Lords judgement in *M'Naughten*.

The central concept of the M'Naughten rules, as they have been termed, is that a 'disease of the mind' must be present. It is on this point that the rules face their most severe criticism, for no workable definition of what a disease of the mind is has been forthcoming from either the medical or the legal professions for the last one hundred and fifty years, despite numerous attempts to address the problem.

It is likely that when the test was first framed, the legal profession was expecting that doctors would be able to provide the courts with precise opinions as to when mental disease was present, particularly as their knowledge and confidence grew with time. This hope has not been fulfilled. No litmus test for disease of the mind has been developed, and the understanding of mental illness now available suggests that such a narrow approach will be a dead end for the forseeable future. Mental disease does not lie in demonstrable abnormalities of the brain or the genes or metabolism, but in the behaviour, thoughts, beliefs and experiences of the affected person. Such phenomena are highly complex and varied in health, let alone illness, and fitting them into a box labeled mental illness for the guidance of the legal profession is an unrealistic expectation.

At various times, the courts have developed several criteria to try and elucidate the nature of disease of the mind. All are inadequate, and lead to demonstrably perverse conclusions. One is the 'recurrence' test, where a mental condition that is likely to recur is more likely to be a disease of the mind, and one that occurs only once is not. In fact, serious mental disorders may present only once, and mind altering states, like hyperglycemia, that occur in mentally normal people, are prone to recur. The second is the 'internal/external' distinction, where conditions arising within a person constitute a disease of the mind, while those arising from external forces do not. This has lead to some contradictory and hair splitting decisions in cases of sleepwalking and diabetes. The sound/unsound mind test is a variation of this, and considers how an external force, such as a psychological blow, would

affect the mind of an ordinary person. If behaviour in relation to the external force is consistent with the reaction of a normal person, a disease of the mind is not present.

What these attempts at definition most forcefully demonstrate is how nebulous the concept of disease of the mind actually is, and how neither profession can define the concept adequately. There is little prospect of this situation improving, and most suggestions for reform concern limiting or abolishing the insanity defence entirely. These ideas have never found widespread favour, and it appears inevitable the law will have to continue as best it can with the insanity defence as it stands.

Appendix.

The number and range of mental illnesses is considerable, but a thumbnail sketch of the ones that most commonly come before the courts is provided below.

The Psychoses.

A range of disorders in which the key component is impairment in the perception of reality. Schizophrenia is a well known example[42]. Schizophrenia affects around one percent of the population, and is characterised by bizarre behaviour, delusional beliefs, and hallucinations, usually auditory. It is a gross derangement of normal mental function. Some of the most deranged and infamous criminals, like the Yorkshire ripper, and the Raurimu gunman, Stephen Anderson, suffered from this disorder.

Depression also fits this category, as severe forms may involve delusional beliefs. Mild and moderate depression is a common disorder, and affects around ten percent of the population at some stage of life.

A delusion is a common feature of psychotic illness, particularly that which comes before the courts. It is generally held that a delusion is a belief fulfilling four conditions:

- It is fantastic in content, or at least very unlikely;
- It is not shared by other people of similar background;
- It is not amenable to reason or experience;
- It has great personal significance.

Common delusions are believing oneself to be a famous person, thinking the media are broadcasting personal messages, and ascribing fantastic motives to the behaviour of other people.

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[42] Please note schizophrenia is NOT 'split personality'.

The Neuroses.

A range of disorders such as anxieties, phobias and obsessions, in which perception of reality is not impaired, but there are compulsions to bizarre behaviour, Such disorders do not usually meet the test for insanity, though some of the more extreme ones might do under the volitional criteria.

Personality disorders.

Defined in the text of this paper, they represent a considerable definitional problem for the law.
