

PSYCHOSIS AND CRIMINAL RESPONSIBILITY: JUSTICE VIA PSYCHO-LEGAL MAPPING

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LAW AND PSYCHIATRY

Medicaland and Legaland

- Different terrains/languages/methods of inquiry

Within *Medicaland*:

- Various descriptions of mental states and diagnoses

Within *Legaland*: various 'domains':

- regions of 'criminal'; 'civil' (including 'family'; 'medical'; 'mental health')
- districts within regions: eg criminal: offences/defences; eg civil: tort/contract/tax
- parishes within districts ...

And legal constructs are 'district/parish specific' ...

Note crucial difference of 'purpose' between two 'lands' ...

- Medicine pursuing 'welfare' ['real']
- Law pursuing 'justice' [abstract]

Practical Relationships Between Psychiatry and Law

Bilateral relationship

- *Law using psychiatry (to address its questions) ...
- in pursuit of justice
- [Psychiatry using law (to pursue its purposes) ...
- within pursuit of welfare]

But with law always 'dominant', since ...

- It is inherently dominant in addressing 'its own questions'
[but also ...
- is dominant even 'within' psychiatry, since ...
- psychiatry is itself regulated by law]

Some Constructs to Consider

Consider the following words/terms in regard to the discourses in which they occur

- ‘schizophrenia’
- ‘bipolar disorder’
- ‘dementia’
- [diagnoses]
- ‘thought disorder’
- ‘depressed mood’/’incongruent affect’
- ‘persecutory delusion’/’primary perceptual delusion’
- [mental state abnormalities]

[all medical] [and ‘real’] [ie ‘real’ experiences in people;
**though see later]

- ‘mental illness’
- ‘mental disorder’
[medical and legal]
- ‘psychopathy’/‘psychopathic disorder’ (MHA 1983)
[medical / legal]
- ‘automatism’
[legal and medical]

[So: words with dual ‘ownership’]

- ‘intention’
- ‘capacity to form intent’
- ‘responsibility’
- ‘abnormality of mental functioning’
- ‘insanity’
- ‘disease of the mind’
- ‘mental capacity’ in re consent to medical treatment (MCA)
- ‘testamentary capacity’
- ‘nervous shock’

[legal] [artifices]

- ‘treatment’
- [*medical and legal (MHA)]
[medicine with the stronger claim?]
- ‘treatment for mental disorder’ (MHA)
[(?) *medical and legal]
[medicine has perhaps ‘adopted’ from law, without noticing]
- ‘preventive detention’
- ‘punishment’
[legal]

So, some constructs/words/terms occur ...

- solely within medicine
- solely within law
- both within law and medicine

Some are 'ambiguous'

- by 'nature'
- by 'claimed ownership': with varying degrees of 'natural ownership' by each, but ...
- 'diagnoses' and 'mental state signs' occur solely within medicine (unless they were to be 'adopted' by law)
- 'Moral' words occur explicitly within law

Words occurring 'across' discourses

So, clearly

- law defines its own 'mental words' [which are artifices] (eg 'intention', 'insanity', various 'capacities') for its own purposes but
- can also determine its own meaning to inherently 'medical' words (eg 'treatment') eg within mental health law

That is ...

Law, as the dominant discourse, ...

can 'take over' inherently medical words (rather than 'adopt' them as defined within medicine)

And, note

- In law *all* words convey legal constructs (eg *actus reus; mens rea; responsibility; capacity; even treatment*)
- albeit law then sometimes admits constructs from other discourses as evidence in order to *contribute* to ‘proof’ of a legal construct, though with many problems of communication] [real contributing to proof of artifice]

Now

In re criminal and civil legal constructs, psychiatry/psychology have no natural ‘interest’

Whilst

- In re mental health law they have much (and valid?) ‘interest’

So that

- application of words 'across' disciplines can lay the foundation for potential 'distortion' of their meaning and use within, eg, psychiatry, because ...
- Law may define 'things psychiatric' potentially very differently from psychiatry
- And law regulates psychiatry

Examples: 'psychopathic disorder' under the Mental Health Acts 1959 and 1983 for E&W; 'treatment for mental disorder' under 2007 amended MHA

Hence

Law re-defining 'things inherently medical' becomes a potential source of 'distortion' of the operation of clinical psychiatry if used in law concerned with the practice of psychiatry (most obviously mental health legislation)

And this can occur either through...

- tight substantive legal definitions which fail to reflect psychiatric reality (eg some definition of *treatment* which is *incongruous* with medicine)

or

- loose legal definitions which allow either ...
‘valid’ or ‘contaminated’ operation of them ...
through exercise of medical and/or legal discretion

Key Slide ...

Hence:

Law operates definitions in more than one 'mode'

- 'Tight' [broad] or 'loose' [wide] definition
- being 'congruous' or 'incongruous' with medicine

Note: significance for required 'mapping' of psychiatric onto legal constructs [see later], which can be:

- 'focused' (ie mapping onto a tight definition)
- 'blurred' (ie mapping onto a loose definition)
- With definition which is 'congruous' or 'incongruous'

[And, a given mental state configuration will 'map onto' different legal definitions with more/less room for 'discretion']

Now, of course, within criminal (and civil or mental health) law, eg, law *could potentially* ...

- 'adopt' medical terms into 'into substantive law' (eg 'not guilty by reason of schizophrenia'; ('incapacity to consent to treatment by reason of hypomania'; 'detainable by reason of psychotic depression') ...
- With no paradigmatic distinction, and ...
- with no evidence used in proof other than psychiatric expert evidence
- So there would be 'identical' construct mapping
[although ?unlikely... because law 'guards its own discourse']

Mapping of Psychiatric onto Legal Constructs ***[a way of viewing the relationship of psychiatric and legal constructs]***

So, there are ...

- Legal constructs, legally defined
- Mental state abnormalities within a diagnosis relevant to a particular legal construct
- Crucial is not the diagnosis, but the mental state 'disabilities'

And there are ...

- Myriad legal constructs to which multiple individual and combined mental state abnormalities/disabilities are evidentially relevant

Psycho-legal Case Types

- Notion of the ‘psycho-legal case type’
- Mapping of a *particular* (set of) mental state abnormalities onto a *particular* legal definition or test

Where

- Mapping may be ‘*focused*’ or ‘*blurred*’, onto construct of given ‘*congruence*’ [could be ‘*identical*’!]
- [Eg. Retarded cognition onto *capacity to make a will/capacity to make a contract* within contract law/*capacity to consent to medical treatment* under MCA/*appropriateness of detention/necessity of detention* under the MHA/*abnormality of mental functioning* under Coroners and Justice Act etc ...]

Crucial is:

- 'detail of the abnormalities of mental state', not diagnosis, and the detail of the legal definition

Plus note:

Impact of difference of process between law and medicine [ie the way in which the law allows a medical construct 'in' as evidence] can affect its influence [distinct from difference of construct formation per se]

IE

- What medical constructs are in allowed evidentially
- The way in which a medical construct is interrogated
- [Adversarial v. investigative]

Legal Relevance of Psychiatric Disorder to Criminal Verdict

- Historical recognition of relevance, in *natural justice*
- Information from a discipline, medicine, with different purposes and constructs from law
- Legal purposes and constructs, towards *justice*
- Medical purposes and constructs, towards *welfare*
- Legal ‘artifices’ versus mental health ‘reality’

- Can be addressed via ‘mapping’, or ‘construct/semantic mapping’, as an exercise in ‘construct relations’

- Within legal v. medical method; adversarial v. investigative

Some Examples of Legal Constructs

- Capacity to form intent
- *Insanity
- Automatism
- *Diminished responsibility
- Provocation
- Self defence (?)
- Reasonable fortitude (within duress)
- Infanticide (alternative charge)

Also

- Fitness to plead
- Reliability of police interviews
- etc

That is, within two legal situations where:

- ‘Law uses psychiatry’

Criminal law as 'paradigm': *legal definition* and *psychiatric evidence* in relation to trial

ie mental state abnormalities (defined psychiatrically) may properly be seen (sometimes) to be relevant to 'proof' of particular criminal constructs (legally defined)

Legal Constructs Considered

So, in regard to a variety of 'meetings' between psychiatry and law ...

Address mental state abnormalities occurring specifically in psychosis in relation to mainly two E & W, plus one Norwegian, legal definitions/tests within ... criminal legal domain ...

- E&W Diminished responsibility ['old' and 'reformed/new']
- E&W Insanity ['existing' and 'proposed reform']
- Norwegian Criminal Code S. 44 [reformed 1989]

Categories of Symptoms/Signs of Psychosis

Distinguish into ...

- Cognitive
 - Process
 - Content
- Perception
- Mood
- Biological
- Behavioural
- etc

DSM Schizophrenia Symptoms

- A. Two or more (one must be 1,2,3) of ...
 1. Delusions
 2. Hallucinations
 3. Disorganised speech
 4. Grossly disorganised or catatonic behaviour
 5. Negative symptoms (ie diminished emotional expression or avolition)
- B. Level of functioning is markedly below the level achieved prior to onset
- C. Continuous signs ... persist for at least 6 months

Note:

?

- a 'disaggregated' approach on functioning?
- an *'aggregated' (overall effect) approach on functioning?

Therefore:

‘map’ an individual’s detailed mental state (in terms of each abnormality, and in terms of the inter-relation of abnormalities) onto any given legal definition/test

Here

- Diminished responsibility [‘old’ and ‘new’]
- Insanity
- S. 44 Norwegian Criminal Code

And compare ‘natures’ of mapping [exercise in comparative law]

‘Old Diminished Responsibility’ (ODR): S 2 Homicide Act 1957

- The defendant “shall not be convicted of murder if he was suffering from such *abnormality of mind* (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as *substantially impaired his mental responsibility* for his acts and omissions in doing or being a party to the killing”
- Significance of ‘two limbs’
- One is ‘almost medical’
- The other is not

Abnormality of mind is

“A state of mind so different from that of ordinary human beings that *the reasonable man would term it abnormal*”.

It appears to be wide enough to cover the mind's activities in all its aspects, not only the *perception* of physical acts and matters and the ability to form a *rational judgement* whether an act is right or wrong, but also the ability to *exercise will-power* to control physical acts in accordance with that rational judgement”.

(Byrne [1960])

Includes medically therefore...

- Disorders of *cognition, perception, affect, volition* and *consciousness*.

Within

- Diagnostic categories of *psychosis, neurosis, personality disorder, learning disability*, plus *brain disorder*.

Legally accepted clinical diagnostic examples under 'old' DR

- Psychosis (most obviously)
- 'Reactive depression' (Seers [1984]; Reynolds [1988])
- 'Pre-menstrual syndrome' (Craddock [1981])
- Elements of 'battered woman syndrome'
- 'Chronic post traumatic stress disorder', severe anxiety symptoms
- Learning disability
- Personality disorder (Byrne [1960])
- 'Substance dependence syndrome', but must have been 'brain damage' or 'irresistible craving' if intoxicated (Tandy, Stewart, Wood)

Advantages and Critique of ODR

Advantages:

- ? Allowed for 'natural justice'
 - Because 'loosely' defined

Disadvantages:

- Too 'loosely' defined
 - No standardised and defined medical diagnosis required
 - [Although had to be some psychiatric evidence to suggest presence of abnormality of mind (Dix [1981])]
- Uncertain law/results?
- Inter-case inconsistency?
- [******Not reflective of medical 'disabilities'!]

How Played Out...

- Diagnosis and mental state usually *not* the issue (often agreement on 'first limb') (the 'almost medical' limb)
- Moral/legal inference usually *was* the issue (within 'second limb') (the 'non-medical' limb) *even if the D was psychotic*

So that ODR is:

A 'moral' defence which *refers* to psychiatric constructs

Summary of legal determining of ‘substantial impairment of mental responsibility’

- Moral/legal, clearly not medical
- ‘Balancing’ abnormality of mind against other causal factors
- Room ++ for jury variation (in search for ‘natural justice’?)

[And with some doctors

- commenting upon not the nature/extent of mental state abnormalities but also the ultimate (moral) question

Yet

- may be contested data (including non-medical)
- may be contested narrative
- need to ‘balance’ factors
- with ‘translation’ from medical to moral/legal

So becoming ‘the thirteenth jury person’]

[IE Being ‘contaminated’ medically by law]

Mapping of Old DR

Hence:

- *Blurred* mapping onto an *incongruous* legal definition
ie
- Mapping onto an only quasi medical construct plus onto a loose legal/moral construct (within two limbs)
- Open to wide legal and medical discretion
- With uncertainty of outcome

REFORM INTENTION

Reasons for reform included...

Law Commission

- Intention to 'modernise' and bring DR more in line with current psychiatric and psychological knowledge [make more *congruous*]
- More to 'objectify', or at least 'clarify' the defence [make more *focused*]

- That is, to allow for more *congruous* and more *focused* 'mapping' of medical constructs onto legal.

Via

- Tighter definition
- Reflection in law of medical constructs

So

- *More justice [see later re need to reflect psychiatric reality in order to enhance justice]
- Less room for discretion
- Less room for inter-case variability

'NEW DIMISHED RESPONSIBILITY'

Coroners and Justice Act 2009

- (1) A person (“D”) who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from
- an abnormality of mental functioning which:
- (a) arose from a recognised medical condition,
and
- (b) substantially impaired D’s ability to do one or more of the things mentioned in subsection (1A),

and (the abnormality)
- (c) provides an explanation for D’s acts and omissions in doing or being a party to the killing.

- (1A) Those things (re ‘substantial impairment of mental ability’) are:
- (a) to understand the nature of D’s conduct;
- (b) to form a rational judgment;
- (c) to exercise self-control.

- (1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct.

- NDR reflects greater specificity of *qualifying medical conditions*, defined medically
 - With effectively tying evidence into *accepted international classifications* of mental conditions
 - Plus narrowing of the ambit of the defence, from a medical perspective
 - Arguably there is also a greater role for medical evidence, versus the role of the jury [via ‘medicalisation’]
- So [in terms of mapping]
- Psychiatric evidence *more focused* onto a *much less incongruous* definition

How May/Is Expert Medical Evidence Play/ing Out Under New Diminished Responsibility?

Distinguish

- Legal interpretation of the Statute (CA)
- Jury behaviour

[Distinguish two issues

- Medical translation into legal: ‘the nature of the defence’
- Relative roles of doctors and jury: ‘who decides?’]

- On one interpretation of the Act, if there is unanimous medical opinion on all elements it can be argued that there would seem to be limited/no room for a jury to reject the partial defence of NDR.

- However, if it could be shown that the unanimous medical evidence about ‘disability(s)’ was flawed [because there was ordinary, non-medical evidence that the defendant did express the relevant ability(s)],

or

- as regards the ‘recognised medical condition’, diagnosis was based upon flawed data
- then clearly the jury could reasonably go against such unanimous medical evidence.

But note

- There is *apparently* no room for ‘translation’ from medical description into moral implication ...
- in that diminution of responsibility is inferred by the defendant having suffered from one of more of the specified disabilities.

- So the intention was mapping that is '*more focused*' and '*more congruous*'

BUT

- The Court of Appeal will decide/is deciding ...
- (?) going against Law Commission's intention for 'modernisation' (more focused and more congruent mapping)

- By virtue of 'primacy of the jury'

- Back to old DR?

- So courts can thwart Parliament

Insanity

- Defect of reason such that ...
- did not know nature and quality of act, or
- did not know it was (legally) wrong

le

- Restricted in regard to psychological domains 'allowed'
- Very high threshold

[compare with 'diminished responsibility']

- Mapping that is *focused* (tight) and *incongruous* [because ignores major aspects of mental state abnormality and corresponding disabilities]
- And, excludes many medical states/conditions that many would consider highly relevant to absent culpability.

Reform of Insanity

Law Commission for E and W

‘not guilty by reason of a recognised medical condition’

- Appears to ‘give over’ to experts

Appears similar to **Butler Report (1975)**:

Butler Report (1975):

- ‘not guilty on evidence of mental disorder’
- [“ theoretically possible” for there to be no element of causation, but “very difficult to imagine a case in which one could be sure of the absence of such a connection”]

So mapping is *‘focused’* onto virtually *‘identical’* construct

But ?

- A 'cop out' position for law,
- Avoids (the need for) any definition of any construct of 'responsibility'
- Illness is presumed to infer reduced(?) or absent responsibility
- Is a legal defence essentially with an eye on disposal
- Assumption that mental disorder should infer treatment (and *therefore* reduced/absent culpability)
- [False assumption since 'legally', the criteria for reduced/absent responsibility must surely be different from those for non-consensual treatment and detention]

That is

- Mere diagnosis infers absence of culpability
- (almost?) ‘perfect/identical mapping’ of ...
- not *medical constructs onto legal ones*,
- but *legal onto medical!*

- [But: within ‘identical mapping’, how ‘loose’ the (legal) construct is deemed to be depends upon the view of ‘tightness’/’looseness’ of medical definition of ‘mental illness’, see later]

(Back to)

Reform of Insanity (Law Commission)

‘not guilty by reason of recognised medical condition’

- Appears as if to ‘give over’ to experts

Not so ...

“So that ...

- D wholly lacked the capacity to
 - rationally form a judgment
 - understand the wrongfulness of (his actions)
 - control his physical acts in relation to the relevant conduct of circumstances”

So

- Still very narrow domains and high threshold
- Law keeps to itself the relevant construct, and so is construct mapping of a medical evidence onto a (purely) legal test
- So mapping is still highly *focused* and [?] *non-congruent*

Norwegian Law: Equating Insanity with Psychosis

S.44 Penal Code:

“a person who was psychotic or unconscious at the time of committing the act shall not be liable to a penalty”

“decisive importance must be attached to the way in which psychiatry at any given time defines the concept of psychosis”
(Breivik)

[“principle characteristic (of psychosis) ... is that *the relationship to reality is lacking* ... the person loses control over his thoughts, emotions and actions ...” (Breivik)]

Plus: exculpation irrespective of ‘causation’

- Special Sanctions Committee, subcommittee of Penal Code Committee had recommended ...
- replacing ‘insanity’ with ...
- “ a person who was psychotic at the time of committing the act and hence unable to make a realistic assessment of his relationship to the surrounding world shall not be liable to a penalty” (Special Sanctions Committee, subcommittee of Penal Code Committee, 1989) (emphasis added)
- [ie recommending legal specification of meaning of ‘psychotic’]
- With emphasis of ability to operate ‘*realistic assessment*’

Ministry adopted ...

- Replacement of ‘insanity’ with simply ‘psychotic’
- “exemption should depend as little as possible upon on the judge’s own discretion ... conditions of criminal insanity must be described in the terminology that is recognised in psychiatric practice” (emphasis added) !!!
- [“Ministry does not support the proposal of the SSC to specify in the text of the law what the concept of psychosis entails”]

That is, there is '*identical* mapping'/mapping 'by identification'

Hence:

- law gives over definition of lack of criminal responsibility to medicine; and does so by adopting a psychiatric term into the criminal law, that is 'psychosis'

Without specification required of 'failed reality testing'

And

- court will adjudicate on disputes over psychosis only within a medical paradigm [that is, will address conflicting medical opinions within a medical paradigm]; albeit taking into account not only medical data but also legal data (evidence)].
With reference to ICD10, or DSMV

Made evident in cases:

- “the question in our case is ... whether the defendant was psychotic in a diagnostic - and consequently also in a legal - sense psychotic when he committed the acts” (*Breivik*) (emphasis added)

[Dispute within *Breivik* resolved therefore solely into a difference of clinical opinion on diagnosis, with the court adjudicating within solely a medical paradigm; and with detailed analysis of all data relevant to the diagnosis and detailed consideration of whether ICD 10 or DSMIV diagnostic criteria were met.

Including concerning whether the D was ‘psychotic’ or reflected ‘an extremist subculture’]

How different from

- Insanity (E & W)
- Reform of insanity (E &W)
- Old diminished responsibility (E & W)

Even

- New, reformed diminished responsibility (E & W)

But: are there a ‘flies in this mapping ointment’

First:

- Is there a valid distinction between ‘*focus*’ and ‘*congruence*’?
- How can psychiatry ‘focus’ (at all) onto a legal construct with which it is ‘incongruent’?
- Ie, can psychiatry *focus* only on legal constructs which are *congruent* with psychiatry?
- **Do we not merely assume that there is ‘some sort of basis’ for utilising evidence from one paradigm (psychiatry) in addressing a construct from another paradigm (law)?
- **And is there only the appearance of validly using psychiatric evidence in relation to ‘proof’ of a legal construct?

Second:

- Does the whole notion of ‘mapping’ of the one discipline’s constructs onto the other’s operate on the false assumption that ...
- Law adopts ‘artifices’
- Medicine describes ‘real things in being’
- And is psychiatry (almost?) as value laden as law

That is:

- Are (most) psychiatric constructs 'real'
- Or are they also 'artifices'

Being

- Attempts to 'reduce' and 'operate', impossibly 'high order' constructs (eg 'mental illness' itself; and 'mental state descriptions/components')
- [Note: Fulford, conditions with (varying) 'fact to value' ratios (with differing 'room' for values dispute)]
- With DSM and ICD as attempts to reduce inter-rater unreliability in doing so
- ***So ... are not both law and psychiatry therefore 'value laden'/moral?

And:

Does not the lawyers' 'love' of DSM demonstrate

- Law attempting to 'de-clinicalise', and therefore 'legalise', mental disorder (because it cannot cope with the 'vagaries' of the clinical paradigm, or individual psychiatrists!)

With

- Psychiatry succumbing to a similar 'artificial construct field' as that openly acknowledged by law

So

- ***Are law and psychiatry actually less distinct inherently than at first seems the case, in both being *abstract*?

And

- *** Does mapping of psychiatric constructs onto legal ones amount to one value laden construct being mapped onto another value laden construct?
- [mapping of 'artifice onto artifice', rather than 'science onto law']

So that ...

- ***[for two reasons] psychiatry and law 'pass in the night', but 'assume/pretend they can see one another'

And

- Does not only the Norwegian Criminal Code, S 44, at least remove one aspect of the problem of the relationship between psychiatry and law ...
- by 'adopting directly' a psychiatric construct into law; thereby avoiding/abolishing at least incongruence per se

And

- Isn't all we can say about each 'mental disorder' and 'responsibility' (and also their relationship) like an elephant, "I can't define it, but I know one when I see one" ...

IE

- "I know mental illness when I see it"
- "I know reduced/absent responsibility when I see it"

CONCLUSIONS ON PSYCHOLEGAL MAPPING FOR CRIMINAL PROCEEDINGS

- Legal constructs are determined by 'justice', medical by 'welfare'
- Medical constructs can be evidentially relevant to legal determination
- Each 'meeting' of law and psychiatry infers a 'psycho-legal case type' ? within 'mapping'
- Tightness or looseness of legal definition infers 'focused' or 'blurred' mapping; within lesser or greater construct congruence
- With more or less room for discretion/variation of interpretation of the map
- ***But ? mapping per se is only 'valid' if law adopts medical constructs

Recent examples of attempts of law directly to 'reflect' advancing medical knowledge

(1) Reform of 'diminished responsibility' (enacted post Law Commission reports) in E & W

(2) Reform of insanity proposed in E & W

Fail to overcome the core problem of the relationship between law and psychiatry of core construct incongruence

Only

(3) S 44 Norwegian Criminal Code largely abolishes the construct problem

But this 'gives over' justice to psychiatry

Law's Problem

So

- Law's problem is to determine *whether* or to *what extent*, and *in what manner* to reflect 'psychological reality' in its own 'mental and responsibility constructs'
- **If it directly adopts medical definitions then it abdicates its responsibility for justice to medicine (? as in S.44 Norwegian Criminal Code)
- **If it fails to reflect any aspect of medical reality then it runs the risk of being 'unjust'
- A 'psycholegal catch 22'!

But

- Whatever your view of the notion of ‘mapping’ as a way of ‘exploring’ and ‘explaining’ the relationship between psychiatry and law ...
- (?) it is relevant to all lawyers and clinicians struggling with the relationship ...
- In order better to understand the nature of ‘two ships passing in the night’ ...

... And perhaps to avoid at least *some* 'collisions'!