

# Does the Insanity Defence lead to an Abuse of Human Rights?

**S Kaliski**

Forensic Mental Health Services, Western Cape & Department of Psychiatry, University of Cape Town, Cape Town, South Africa

Every day convicted murderers, rapists, and other violent offenders are released by the prisons into the community. Most have not even completed their sentences, as they earned remittances for good behaviour. No one seems to worry that statistically many of these former prisoners remain dangerous, and will probably harm others sometime in the future.<sup>1</sup> In fact, there are criminologists who argue persuasively that fewer offenders should be imprisoned, for the good of their families and communities. This may reflect the confusion about what the actual purpose of imprisonment is, ranging from urges for retribution to achieving rehabilitation. Nevertheless, we are satisfied that when an offender 'has repaid his debt to society' he is free to re-enter ordinary life, albeit for a while under the sometimes wavering, watchful supervision of a parole officer.

In contrast, as directed by sections 77 and 78 of the Criminal Procedure Act, if an accused by reason of 'mental illness or mental defect' (which is not defined) is unable to understand court proceedings, or to have committed (or omitted) an act during which he/she was incapable of appreciating the wrongfulness of the act, or of acting in accordance with such an appreciation the court will generally certify the accused as a 'state patient'<sup>a1</sup>, who will then be admitted to a designated psychiatric hospital for an indefinite period. Discharge can only be granted by a judge in chambers, who usually endorses the conditions recommended by the treating clinicians, for a designated period.

Unlike in usual court proceedings, where an accused can only be found guilty if his guilt is proven 'beyond reasonable doubt', the mentally ill offender will be certified if 'it can be proved on a balance of probabilities that, on the limited evidence available the accused committed the act in question' (section 77(6)). This has been a recent addition to the process, as previously such an accused would be found

not guilty by reason of insanity but committed to a psychiatric hospital. It is not clear whether nowadays this rudimentary determination of guilt still results in a 'not guilty' finding, or if it is a weaker version of a 'guilty but insane' verdict. But the use of a balance of probabilities using limited evidence does not *prima facie* seem like a fair carriage of justice.

Nevertheless, the mentally ill offender, whose guilt has been determined by a less stringent test, finds themselves committed almost forever, while their 'normal' counterpart, may serve only half their sentence. This is particularly galling when the state patient has to deal with the early release of their co-accused while they look forward to a seemingly endless detention. Commonly state patients are also aggrieved that they are detained despite not being found guilty. This has the effect that it usually is not possible to confront them with their offences as they point out, correctly, that they were not really found guilty.

The most surprising aspect of this practice is the lack of outrage at what seems, on the face of it, to be an abuse of human rights.

## The Problem of Definitions

Many surveys of legal systems in European, Australasian and North American countries have confirmed that there is a confusing profusion of legal terms that loosely correspond to the colloquially named concept of 'insanity'. These differences are found even between regions within these countries.<sup>2,3</sup> Worse still, no legislation actually defines 'mental illness', or gives any indication which psychiatric disorders would qualify for the legal definition. For example, Austria allows for a 'profound impairment of consciousness', Denmark a 'state equal to mental illness', Finland a 'state of lunacy' and so on.<sup>3</sup> Every country would allow psychosis, especially if due to schizophrenia, to be used as a valid insanity defence. But some allow addiction, neuroses, and personality disorders too.

Our law suffers the same impediments, and to compound the problem adds 'mental defect' as an additional criterion. The courts have accepted that the definitions of 'mental illness' and 'mental defect' can be entrusted to the experts, who must assess and provide an opinion on the accused, which is a quaint notion to use in an adversarial system. In our law the insanity defence is encapsulated within the legal construct of 'pathological incapacity', which implies that such an accused suffers from a discernable brain disorder that can be directly determined, and which is amenable to some

<sup>a1</sup> An interesting aside: in the Mental Health Care Act those suffering from psychiatric disorders are called 'mental health care users', but those certified for committing an offence are called 'state patients'. Somehow insanity miraculously allows us to medicalise mental disorders.

## Correspondence:

Prof. S Kaliski  
email: Sean.Kaliski@uct.ac.za

treatment.<sup>4</sup> Is there a difference between 'illness' and 'defect'? Psychiatrists seem informally to have agreed that the former refers to psychotic or severe mood disorders, whereas the latter includes any disorder characterised by cognitive impairment. Clinically 'defect' and 'illness' are generally considered to be synonymous. But it is worrying that the law insists on the distinction, as cognitive impairment has a complicated and often reciprocal association with many serious psychiatric disorders.

This would all be well if psychiatric diagnoses were reliable and valid. But they are not. Each edition of DSM changes criteria, adds new disorders, or discards well used ones.<sup>5</sup> Some of these changes have profound implications, for example there is now a proposal that early dementia-like symptoms be encapsulated into a new category called 'minor cognitive impairment'. This means that this diagnosis, which previously was not available to commit an accused, may potentially be used to create another group of state patients. Worse still, it is well known that even using the universally well tried DSM diagnoses psychiatrists will only achieve consensus on a diagnosis in about 75-80% of the time, and then simultaneously will produce lists of other co-morbid and differential diagnoses.<sup>6,7</sup> Sometimes, this does result in the unedifying spectacle of experts offering diametrically opposing assessments in court (using the same clinical information), much to the confusion and bemusement of our learned law colleagues. So, fairness in the use of the insanity defence already stumbles at another hurdle.

### **Can psychiatrists really assist in determining criminal responsibility?**

Are people with severe mental illness really not able to appreciate wrongfulness, or control themselves? From the legal perspective the more serious the offence the more important it becomes that the court consider the offender's ability to form intent (*mens rea*). The Law assumes that every accused has the capacity to form intent (criminal responsibility), but will allow a defence of mental illness to negate this.<sup>4</sup> Actually in a local study we found that so-called normal defendants seem to be as ignorant about the meaning of wrongfulness, were as likely to report that they could not control themselves (usually as they were angry), and were as clueless about court procedures as their mentally ill counterparts.<sup>8</sup> Despite some tantalising findings that seem to show that psychopathy and damage to some regions of the brain are associated with problems in moral reasoning neuroscientists are still not able to demonstrate that mentally ill individuals are less responsible for their actions than unaffected people.<sup>9</sup>

Yet most psychiatrists would insist that the presence of psychotic symptoms (or cognitive deficits) during an offence is enough to qualify for a successful insanity defence. Unfortunately the courts generally accept the expert's opinion, where instead they ought to be deciding on this ultimate issue. My anecdotal experience is that almost all psychotic defendants can appreciate wrongfulness, and are able to control themselves. It's just that their motivations are crazy, and therefore deemed excusable.

### **Is indefinite hospitalization a just disposal?**

The rationale for certifying state patients seems to be based on two concerns. Firstly, it is not possible to predict how long it will take to stabilise any psychiatric disorder, or whether there will be a response at all. Therefore it seems reasonable not to specify the period a mentally ill person ought to receive treatment. Secondly there is always anxiety that people with mental illness are dangerous, and should be discharged back into the community with extreme caution. Not surprisingly, when someone with a serious mental illness commits an offence both of the above issues seem to coalesce to support the belief that a state patient should remain certified until he or she is 'cured' and no longer dangerous. Superficially it would seem that evidence from research justifies this, as it is now generally accepted that psychosis is associated with a slighter greater risk for violent behaviour, and of course it is a truism that many people with psychotic disorders do not respond completely to treatment. But these are particularly specious arguments.

As a starter the United Nations new Convention on the Rights of Persons with Disabilities specifies that 'the existence of a disability shall in no case justify a deprivation of liberty', and continues to assert that unlawful detention would include those cases where the assessment of mental or intellectual disability are combined with 'other elements such as dangerousness, or care and treatment'.<sup>1</sup> The UN High Commissioner for Human Rights has therefore urged that the insanity defence be abolished as practiced generally. This may just be a political victory for the anti-psychiatry lobby, but it should give us pause to consider whether there is justification for certifying state patients for indefinite periods.

For the past two decades long stay beds in psychiatric hospitals have been reduced drastically to deinstitutionalize chronic psychiatric patients. The underlying assumption is that people with serious mental illness are better served by living and being treated in the community. In contrast forensic mental health units have been expanding steadily over the corresponding period. Currently in the Western Cape, South Africa, the forensic mental health service occupies at least 8 wards in two hospitals, and will probably continue to expand. The curious irony is that the acute system is now overwhelmed by admissions of severely psychotic people, most of whom are admitted because of disruptive and aggressive behaviour, who are not supposed to remain in hospital for longer than 2 months (and often have to be discharged prematurely to create space for more admissions), whereas the forensic system contains state patients who are generally clinically stable (and thoroughly institutionalized) but deemed too risky to be discharged easily. Add to this the ever increasing influence of the Recovery Model that rightly emphasises that, given our inability to achieve idealised treatment endpoints in mental health, we should strive to optimise our patients' lives within the confines of their disabilities. So, already we have both ideological and practical reasons to limit the periods that patients spend in hospital and accept the limits of their capacities.

The second concern that indefinite certification at least addresses the risk of future violence strikes at the heart of the largely failed enterprise of risk assessment. Since the

early 1990's there has been a profusion of research into producing actuarial tools that could assign measures of risk that patients will engage in aggressive or violent behaviour. Despite the injection of bucket loads of research funding into this enterprise two major deficiencies persist; regardless of the tool or scale used the highest accuracy that any can possibly provide is actually about 75% , and all predictions are only valid in the short to medium term.<sup>10,11</sup> Therefore there is no objective method that can ascertain whether it will ever be safe to discharge a state patient into the community, with the assurance that he will not act aggressively for years or decades henceforth. Again, the state patient can now shift his gaze from his 'normal' co-accused who wins an early release from prison to the severely mentally ill patients (many of whom are more violent than he) who enjoy relatively brief sojourns in acute psychiatric facilities.

### Why is discharge so difficult to achieve?

A judge-in-chambers will generally grant a discharge if the state patient's mental state is stable (if not 'normal'), and if there are assurances that he will not abuse substances, will attend a clinic, be compliant with treatment, and will be supervised by an identified family member for a designated period. Most state patients derive from deprived circumstances, live in areas that have poor resources, and often can only be placed with the very people against whom their index offence was committed. Many community facilities are reluctant to provide accommodation and supervision for people who have been doubly stigmatised by mental illness and criminality. In the Western Cape only a handful of state patients really fulfil the requirements for discharge.

The process for discharge is unwieldy. Applications (supported by clinical reports) have to be lodged with the Registrar of the High Court, who then forwards this to the Director of Public Prosecutions (DPP) for a report and recommendation. The DPP then requests reports from the treating clinicians (that can include all members of the multidisciplinary team). These are then forwarded to a judge in chambers. The system is inefficient, and to date we still await decisions from applications submitted eons ago.

### Proposals

It is unrealistic to expect our legal system to overhaul the insanity defence completely. But several modifications could be debated and implemented:

1. The finding under section 78 of the Criminal Procedure Act should be changed to a 'guilty but insane' verdict. This will enable the court to issue an order that could initially limit the period that a state patient would remain certified. The court could either impose mandatory periods, which could compare to those that may have been imposed for a comparable conviction, or every state patient could be certified for an initial period, for example, 2 years.
2. At the end of the court ordered period of certification the state patient would automatically be discharged (as a prisoner would be released at the end of a sentence), unless the treating clinicians motivate for a further designated period of certification.
3. If an accused is only certified, under section 77 of the Criminal Procedure Act, in other words is unfit to stand

trial, then the court should set a date when the accused will be returned to court for continuation of the trial, unless the treating clinicians provide a report that the state patient remains unfit to stand trial.

4. The discharge of forensic patients ought to be simplified. It may be more appropriate that discharge applications be submitted to the Mental Health Review Boards that perhaps, anyway, should have more responsibilities in the care and administration of forensic patients.

### Conclusion

The application of the insanity defence has resulted in a burgeoning population of institutionalised patients, whose care and rehabilitation increasingly is at odds with the prevailing philosophies of mental health care. I am not proposing wholesale changes to the Law, but have suggested that important modifications be considered. The advantages of these changes would include being able to deal therapeutically with state patients, in that they would probably be more willing to deal with the implications of their offences, psychiatric impairments, and be able to foresee their own reintegration into the community. But most important of all, we would be able to offer them a very precious therapeutic commodity called hope.

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