Self-Made Madness

RETHINKING ILLNESS AND CRIMINAL RESPONSIBILITY

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Preface

> *Dear Sir, I was very interested to read about your report today in The Times. I myself am on anti-psychotic medication (Stelazine and others) and can readily sympathise with those people who don't take them...in fact I often do not take the medication. My main point is, I often feel that I might be violent and seriously harm or kill someone. My problem (as with many in your study) is that I sometimes drink a great deal, and then I have the greatest tendency to be aggressive...I have given up on [psychiatrists] entirely. With one very notable exception they have only been interested in manifest symptoms and medication (the so called 'medical model')...I have told various psychiatrists (including a forensic one) about my murderous thoughts, but as I say I don't think they think I will ever do it. I just hope they are right...In the meantime, I hope I can find some psychotherapy. Any advice you can give on this, I would be most grateful for.*
>
> Letter received by The Zito Trust,
> published in ZTMonitor, Issue 4, July 1998

This book describes and examines the notion that mentally disordered offenders may, to varying degrees, be responsible for the causation or exacerbation of their[1] own mental disorder and thus their concomitant criminal responsibility. Such a concept is denoted by the neologism 'meta-responsibility' ('responsibility for one's criminal responsibility'). Societal reactions to such blameworthiness for mental disorder are examined, through the lens of the insanity defence in particular.

This book does not pretend to be a definitive statement on the nature of mental disorder; it does not espouse a voluntaristic model to the exclusion of other models such as the medical model. As Slovenko (1995) points out, it is neither necessary nor advisable to adopt a single model for every possible situation. The proposition 'mentally disordered offenders cause their own mental disorder and therefore should be held accountable for their criminal responsibility' is not made during the course of this book, and no subscription on the part of the reader to such a proposition is required. Instead, we examine a question: 'What if we were to contrast accepted doctrine on the nature of mental disorder with a voluntaristic model? What effect would that have on criminal responsibility?' Even if the reader does not subscribe to such a voluntaristic model of mental disorder, it is hoped that he or she will find the manner in which the question is treated

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[1] Where convenient, the pronouns *he, him,* and *his* are used generically (i.e. gender-neutrally) in contexts in which the grammatical form of the antecedent requires a singular pronoun.

satisfying, and the conclusions drawn appropriate ones given the research question in hand.

The meta-responsibility theory is a commonsensical one. The intuitiveness of the idea makes it a worthwhile object of study. That the mentally disordered can be easily conceived of as causing their own disorder (Chapter 1 shows that this has indeed been a major theme in the history of psychiatry) is precisely why, it is contended here, the idea of meta-responsibility impacts upon the processing of the mentally disordered in the criminal justice system[2] (and upon societal reactions towards the mentally disordered more generally). If such an idea was inconceivable – if the idea of meta-responsibility was so inherently complex and unobvious – then autonomy in illness (mental or otherwise) would remain largely theoretical, and the law could quite happily remain blind to the concept of meta-responsibility. There would be no mismatch between legal machinery and popular intuition.

However, it is contended that this mismatch in overt and covert acknowledgement is involved in many of the societal and legal difficulties that face the mentally disordered. If people (including the lay public, psychiatrists, lawyers, jurors and judges) intuitively take into account meta-responsibility, the law and societal zeigeist give them little or no chance to do so. This is perhaps the root cause of what Perlin (1994) refers to as pretextual decision-making and sanism: the processing and disposal of the mentally disordered (and particularly the mentally disordered offender) in a covert and discriminatory manner. Sanism (a process akin to racism or sexism) engenders such phenomena as incarceration for periods far longer than therapeutic concerns can justify as a 'punishment' for a successful insanity plea. Such disposals seem expressive of a 'barely concealed desire for retribution' towards mentally disordered criminals (Verdun-Jones, 1989: 23). Retribution for what? The theory of meta-responsibility developed here hopefully points the way to an answer.

The neologism 'meta-responsibility' would not have been introduced if it were not deemed necessary to service the concepts discussed in this book. The notion of causing one's own mental disorder and its concomitant effect on criminal responsibility – whilst perhaps a construct often used by society in the processing of mentally disordered offenders – has been so neglected as a research topic so as to leave it without even basic terminology.

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[2] This study examines case and statutory Anglo-American criminal law. Where terms such as 'the criminal justice system' or 'the legal system' are used, this either refers to the general laws of the two jurisdictions (the United States and England and Wales), or it is made clear within the text (and/or index of cases in the bibliography) to which jurisdiction the case or reference is made (e.g. US State jurisdictions). Perhaps the most notable difference between the two major jurisdictions examined is the frequency of insanity defences; see *INFRA* note 1, Ch. 2. The meta-responsibility theory described in this study is perhaps most applicable to the US, where insanity defence usage is far higher and considerable public hostility exists towards the use of the defence (Appelbaum, 1994).

The ethical implications of introducing and researching the concept of meta-responsibility also need to be justified. The author has great interest in not seeing the mentally disordered face a further level of responsibility that might exacerbate their already problematic societal, clinical, and legal situation.

Instead, it is hoped that this research will challenge perceptions of the mentally disordered, particularly the low level of autonomy generally attributed to them that is responsible for much of their poor treatment in both criminal and civil law and in society more widely. The autonomy of mentally disordered persons promises to be a decisive factor in their fate with the proposal by the Richardson Committee[3] for a capacity test as the determinant of compulsion and coercion in treatment. The Committee reported that they believe capacity should have 'a central role within any future compulsory mental health structure'.

Furthermore, one of the central objects of enquiry of this book, medication non-compliance, has become a major concern to both the mental health field and society more generally over the last decade. Research shows not only that the non-medicated mentally disordered have a significantly elevated risk of violent offending (Mitchell, 1999a), but also that up to 70 per cent of psychiatric patients discharged from hospital become non-compliant within two years. Non-compliance has been shown to be a factor in the breakdown of care of over 50 per cent of mentally disordered persons who subsequently commit homicide (Howlett, 1998). The reaction of the press to such findings, and to policies such as Care in the Community, has thrown the situation of the mentally disordered into the centre of the political arena, with proposals for incarcerative/detentive approaches to care

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[3] Department of Health (1999) *Review of the Mental Health Act 1983: Report of the Expert Committee*. London. HMSO. The Richardson Committee was charged by the UK Government to provide detailed proposals for the overhaul of the Mental Health Act (1983). A capacity test was proposed as the central criterion for compulsory detention/treatment, using the Law Commission definition of capacity under which compulsion may be justified if 'he or she is unable to make a decision based on the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision' (p. 89). This study argues for a greater presumption of capacity, and that responsibility for decisions (or the failure to make them) rests, at least in part, upon the patient. It should be noted that the proposals for consultation presented by the Secretary of State for Health based on the Richardson Committee's report threw caution on the capacity model and proposed an alternative 'health and safety' model (Secretary of State for Health (1999) *Reform of the Mental Health Act 1983: Proposals for Consultation*, Cmnd. 4480. London: HMSO). Both models are compatible with a dominant theme in the call for change in UK mental health law: that of doing away with specific mental health legislation and introducing 'best interests' legislation (of the patient and community) common to both physical and mental disorder (e.g. Eastman and Peay, 1999). However, no author has yet proposed how such a theme of the integration of the physical and mental might be applied to the insanity defence (if indeed it *could be* applied to an exclusively mental defence).

being the predictable result.[4] Such a situation was paralleled in the United States with the outrage over the successful insanity defence of John Hinckley, President Reagan's would-be assassin (e.g. Appelbaum, 1994; Spring, 1998), with resultant restriction of the insanity defence and longer periods of detention for insanity acquittees. Through examining the autonomy of mentally disordered persons, apparently sanist societal reactions might become better informed.

There is one final aim to this book, and that is to contribute to the reconciliation of 'critical-psychiatric' approaches to mental disorder with the predominant medical or 'liberal-scientific' approach. Critical-psychiatric approaches, whilst seeming to have a great deal to offer the mental health field (particularly with regard to understanding the 'inner space' of patients; Ingleby, 1980: 10) were brushed aside by mainstream psychiatry after their brief rise to prominence in the 1960s and early 1970s. Attempting to impress the important elements of the former on the latter (and vice versa) does not, however, appear to be a futile aim, in spite of the widespread adoption of organic models in psychiatric research and therapy. Of the relation between medical and critical-psychiatric paradigms, Ingleby (1980: 26) states: 'Though the different paradigms are to a striking extent self-confirming and self-contained, they could logically be brought into some relation with each other…'. It is hoped that theses such as this help promote such relation, to the benefit of both paradigms and, perhaps more importantly, to the benefit of patients with which each is ultimately concerned.

With such aims in mind, the meta-responsibility theory is cast as a project in psychiatric and legal ethics, and to help understand why society and its criminal justice system treats the mentally disordered in the manner that they do. Furthermore, the experimental component of the study detailed in Part II demonstrates that considering meta-responsibility may actually improve the legal standing of the mentally disordered offender by reducing sanist decision-making with regard to recommended length of hospital detention. Whilst it has been previously proposed that there may be an autonomous component to mental disorder, this is the first piece of research to thoroughly examine such a component and apply a multi-disciplinary approach, particularly in the socio-legal implications of the notion of voluntaristic conceptions of mental disorder.

The structure of this book has been based largely on the need to examine fundamental background issues to the meta-responsibility theory. Part I of the book therefore details historical, legal, philosophical and clinical issues. Part II details the methodology of a large mock juror study designed to examine the meta-responsibility theory, with analyses of quantitative and qualitative data obtained from the study. This study examined the effect of manipulating information concerning a defendant's meta-responsibility on insanity defence verdicts in mock

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[4] See, e.g. Home Office/Department of Health (1999) *Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development*. London: Home Office, recommending a detentive approach even in the absence of any index offence by the individual.

jurors (n=334). In addition, the study examined the effect of a meta-responsibility insanity test (MRIT: a test making provision for the mock jurors' evaluation of the defendant's meta-responsibility) in comparison to the McNaughton Rules (the traditional test for insanity in Anglo-American criminal law).

Chapter 1 introduces the meta-responsibility theory, and examines its relation to contemporary and historical conceptions of mental illness and notions of freewill and autonomy. The terms used in the book, most notably 'mental disorder' and 'mental illness', are also defined.

Chapter 2 introduces the insanity defence and examines the mismatch in the ability of the legal system to consider voluntarism in the incapacitating conditions of intoxication and automatism (in which the presence or absence of voluntarism in the incapacitating condition is central to the legal outcome) and insanity (in which the presence or absence of voluntarism is not considered). This chapter further examines how such a paradoxical mismatch has arisen: either a) through an autopoietic model of the relationship between law and psychiatry (an inability for the self-referential law to consider principles from psychiatry); or b) through the deliberate refusal of the law to consider meta-responsibility in insanity but not in other incapacitating conditions.

Chapter 3 builds on the introduction to the meta-responsibility theory in Chapter 1 by examining how mental disorder could be self-caused or exacerbated (i.e. voluntaristic, autogenous, or autonomous), with recourse to clinical models of medication non-compliance and the two 'critical-' or 'anti-' psychiatric models of mental disorder highlighting voluntarism: the existential phenomenological and social constructivist models. This chapter also examines the controversial notion of benefits of the mentally disordered state, a central tenet of the two voluntaristic models. Two types of meta-responsibility are delineated: consensual meta-responsibility (in which the individual consents to the generation or exacerbation of mental disorder through, for example, medication non-compliance due to medication side effects); and purposive meta-responsibility (in which the individual's actions are primarily directed toward the purposive goal of generating or exacerbating mental disorder).

Chapter 4 examines the notion that the ostensibly therapeutic/sympathetic insanity disposal is in fact punitive and retributive, and examines the constructs of sanism and pretextual decision-making in light of the meta-responsibility theory. This chapter posits that the treacherous passage that the mentally disordered offender faces through the criminal justice system is due, at least in part, to covert feelings amongst society and the criminal justice system that individuals may be culpable for mental disorder (and hence meta-responsible). Harsh insanity disposals punish meta-responsibility in the absence of any other societal or legally acceptable means of reflecting culpability for disorder.

Chapter 5 examines psychological and legal research that has a bearing on the meta-responsibility theory, particularly that derived from social psychological and socio-legal frameworks, and from the mock juror research genre that is used as the methodology in the experimental work detailed in Part II of the book.

Chapter 6 details the methodology of such a mock juror study, conducted to examine the effect of meta-responsibility information on mock juror decision-

making. Previous mock juror research with a methodological bearing on the present study is examined. The research design used factorial manipulations of meta-responsibility information within insanity defence case vignettes (a between-subjects design), with subjects being asked to reach a verdict (guilty/NGRI – Not Guilty by Reason of Insanity), make disposal recommendations, etc. The vignette was embedded within a survey instrument eliciting attitudinal responses to issues concerning the vignette and other areas of interest with regard to the insanity defence.

Chapter 7 details the quantitative analysis of results of the experiment, which suggest that meta-responsibility is an important construct in decision-making with regard to insanity defence cases, and that a meta-responsibility insanity test allowing mock jurors to consider meta-responsibility has, under certain conditions, a significant effect on verdict and disposal outcomes (particularly the ability to reduce the length of hospital disposals).

Chapter 8 discusses the quantitative experimental results, with reference to the qualitative data derived from subjects' reasons for their verdicts.

Chapter 9 concludes the overall study and enquires whether the meta-responsibility theory is a viable birth; it examines methodological limitations of the mock juror study, and suggests possibilities and directions for future related research within the area of psychiatry and law.

The appendices contain each factorial version of the case-vignette and the measuring instrument used in the experimental research, as well as selected journal papers published during the course of this doctoral research.

Whilst this book espouses and examines voluntaristic models of mental disorder, it does not hold that mental disorder is simply 'self-caused'. Instead, it suggests that there is a continuum of autonomy to be found in all mental disorder, with some patients having a greater capacity for self-regulation than others. While advocating a change in legal, clinical and societal provision for considering meta-responsibility, it does not espouse punishment of those found to be meta-responsible as a respectable goal (indeed, it is contended that this is the current position taken by society and the criminal justice system and that it is an inherently *sanist* solution to dealing with mentally disordered offenders). In short, considerable effort has been made to deal with the issues surrounding culpability for mental disorder in as sympathetic a manner as possible.

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List of Abbreviations

-2LL	-2 Log Likelihood
ALI	American Law Institute
APD	Antisocial Personality Disorder
CAR	Capacity Activation Responsibility
CDR	Capacity Development Responsibility
CMR	Consensual Meta-responsibility
DOM	Disability of Mind
DSM (IV)	Diagnostic and Statistical Manual of Mental Disorders *(with edition number)*
EP	Existential Phenomenological (model of mental disorder)
GBMI	Guilty But Mentally Ill
ICD (10)	International Classification of Diseases *(with edition number)*
IDRA	Insanity Defence Reform Act
KMO	Kaiser-Meyer-Olkin (test of sampling adequacy)
LS	Liberal-scientific (model of mental disorder)
MDO	Mentally Disordered Offender
MHA	Mental Health Act
MHRT	Mental Health Review Tribunal
MR	Meta-responsibility
MRIT	Meta-responsibility Insanity Test
NGRI	Not Guilty by Reason of Insanity
NGRIs	Persons found Not Guilty by Reason of Insanity
NMR	No Meta-responsibility
OCS	Ordinary Common Sense
PCA	Principal Component Analysis
PMR	Purposive Meta-responsibility
PPD	Psychopathic Personality Disorder
PSRB	Psychiatric Security Review Board
PTSD	Post-traumatic Stress Disorder
QSJ	Quasisubjective Insanity Test
RSU	Regional Secure Unit
SC	Social Constructivist (model of mental disorder)
SES	Socio-economic status
WHO	World Health Organization

Notation of factors within case vignettes and tables:

Diagnosis:

D	Depression
P	Personality disorder
S	Schizophrenia

Type of Meta-responsibility:

CMR	Consensual meta-responsibility
NMR	No meta-responsibility
PMR	Purposive meta-responsibility

Type of Insanity Test:

MN	McNaughton insanity test
MR	Meta-responsibility insanity test (MRIT)

The case vignette denoted by S>PMR>MR therefore described the defendant as schizophrenic, having purposive meta-responsibility, and required subjects to render a verdict using the meta-responsibility insanity test.

Notation denoting questions and attitudinal measures in the measuring instrument:

ABOLISH	The insanity defence should be abolished
AFFECTED	Tom's illness affected his ability to look after himself (e.g. take medication) and resist getting more ill
CAREFUL	Tom should have been more careful in taking his medication
CAUSED	Tom caused his own illness
CENSOR	Censorship of films and magazines is necessary to uphold moral standards
COGEAT	Mental illness is caused by learning from others with similarly strange and bizarre behaviour
COGTREAT	Mental illness should be treated by showing patients the proper way to act and think
CRIMRATE	The insanity defence doesn't affect the crime rate
DANGER	The insanity defence allows dangerous people out on the streets
DEATHPEN	For some crimes, the death penalty is the most appropriate sentence
DUTY	Tom has a duty to take responsibility for his own illness
ENTTREAT	Insane defendants are entitled to treatment
FAIRSHAR	Ordinary people do not get their fair share of the nation's wealth
FAULT	Tom made his illness worse through his own fault
FREE#	Out of every 100 defendants found Not Guilty by Reason of Insanity, how many go free immediately?

HARDTIME	Judges and juries have a hard time telling whether defendants are really sane or insane
HARSH	In general, the courts deal too harshly with criminals
HOSP#	How many are sent to mental hospital?
HOSPSTAY	If defendants are sent to a mental hospital, how long do they stay there on average?
ILLEVID	Illegally obtained evidence should not be admissible in court even if that evidence is the only way of obtaining a conviction
INSAPUN	Even if people are insane, we should punish them if they break the law
INSAPUN2	Insane people should be punished for their crimes just like everyone else
JUSTIFY	The insanity defence is sometimes justified
KILLED	Tom killed his wife because of his illness
LAWOBEY	The law should always be obeyed, even if a particular law is wrong
LAWRICH	There is one law for the rich and one for the poor
LEGTECH	Too many guilty persons escape punishment because of legal technicalities
LIKED	Tom liked being ill
LOOPHOLE	The insanity plea is a loophole that allows too many guilty people to go free
MANEMPL	Management will always try to get the better of employees if it gets the chance
MDEXP	Please rate the amount of experience you think you have of mental disorder (e.g. personally suffered from it, friends/family suffered from it, etc.)
MDINFORM	Do you think you are well informed about mental disorder and mental disorder issues?
MDTESTIF	Psychiatrists should testify about a defendant's medical condition in insanity trials
MEDAET	Mental illness is caused by medical problems such as chemical imbalance in the brain
MEDTREAT	Mental illness should be treated through the use of medical drugs
MESSAGE	The insanity defence sends a message to criminals that they can get away with crime
NECESSAR	The insanity defence is a necessary part of our legal system
NGRI#	Out of every 100 defendants who plead insanity, how many are actually found Not Guilty by Reason of Insanity?
OBEYAUTH	Schools should teach children to obey authority
PLEAD#	Out of every 100 defendants who are charged with a crime, how many do you think plead Not Guilty by Reason of Insanity?
PSYAET	Mental illness is caused by a number of social stresses such as money worries
PSYCH$$$	If psychiatrists are paid enough, they will say anything about a defendant's sanity

PSYTREAT	Mental illness should be treated by producing a more comfortable and less stressful society
PUNWORK	Punishment doesn't work on the insane
REALYMAD	Most people found Not Guilty by Reason of Insanity are really insane
REDIST	The Government should redistribute income from the better-off to those who are less well off
REFORM	The insanity defence needs a lot of reform
RELSAFE	I'm confident that people found Not Guilty by Reason of Insanity are only released when it's safe to do so
RESISTED	Tom should have resisted his illness more
RESPBRIT	Young people today don't have enough respect for traditional British values
RICHDEF	The insanity defence is mainly a rich person's defence
STIFFER	People who break the law should be given stiffer sentences
TREATPUN	The insane should be treated rather than punished if they commit crime
UNDSTOOD	Tom understood that he was ill
WRONGPUN	It is wrong to punish insane people who break the law

Notation denoting factor score variables emerging from principal component analysis or other data analysis:

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CCHANGE	Measure of Tom's degree of character change pre- to post-illness
FBEATRAP	Measure of support for notion of insanity defendants 'beating the rap'
FCOG	Measure of ascription to the cognitive-behavioural model
FLEFRIGH	Measure of left-wing atttidues
FLEGCONC	Measure of concern about legal aspects of the insanity defence
FLIBAUTH	Measure of authoritarian attitudes
FMDKNOW	Measure of subject's self-reported knowledge and experience concerning mental disorder
FMED	Measure of ascription to the medical model of mental disorder
FMEDCONC	Measure of support for medical involvement in the insanity defence and associated disposal
FMR	Measure of appraisal of Tom as meta-responsible
FNGRISUP	Measure of support for the insanity defence
FPROD	Measure of Tom's behaviour appraised as product of his illness
FPSY	Measure of ascription to the psychosocial model of mental disorder
FPUNISH	Measure of support for punishing the insane

Contents

PART I
AN INTRODUCTION TO THE THEORY OF META-RESPONSIBILITY