Justifications for the Insanity Defence in Great Britain and the United States: The Conflicting Rationales of Morality and Compassion

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The law of excuses is a deeply entrenched concept in Anglo-American jurisprudence which has persisted since the Middle Ages.[1] The excusing conditions of necessity, mistake, duress and diminished mental capacity all embrace the unitary principle that a person is not culpable, and cannot be held criminally responsible, if he had no control over his behavior.[2] All the excusing conditions, then, involve a state of involuntariness. They are jurisprudential reflections of the intuitive moral statement, "I couldn't help myself." An excuse is based on the assumption that the actor's behavior is damaging and is to be deplored, but external or internal conditions which influence the act deprive the actor of choice; this negates or mitigates penal liability.[3]

Diminished mental capacity is the most personal of all excuses. It is difficult for us to accept because it says nothing about the performance of the act itself and its attendant circumstances. Rather, it is justified by the state of awareness and cognition of the actor. The determination is whether the actor had sufficient inner understanding of the act and its consequences to justify holding him responsible. The excuse is thus inherently more difficult to observe or to reliably identify.[4]

Diminished mental capacity may result from factors which originate outside of the body, such as with intoxication, or with automatism induced by a blow on the head, a bee sting or an emotional shock. This form of impaired cognitive volition is comparable to other excusing conditions; to the extent that the incapacity originates from outside the boundaries of the actor, it is subject to observation and, for limited purposes, can be measured. Other forms of diminished mental capacity are caused by physiological responses of the body which physically deprive the actor of choice. These physiological phenomena have an identifiable etiology and symptomatology — for example, automatism induced by an epileptic seizure, a sneezing fit or a hypoglycemic episode. Science can explain such autonomic reactions and can validly identify the physical cause of volitional impairment. An excuse based on insanity, however, has a unique combination of factors — none of which are subject to observation or validation: the justification for the excuse originates and remains wholly within the charac-

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ter or psyche of the actor, there is no cognizable etiology or measurable physiological process and clinical assessment in respect of nosology and classification, and the degree of separation of consciousness and action (particularly where judgments are made retrospectively), lack scientific reliability and validity.[5] It is for these reasons that we have had the greatest difficulty in defining the boundaries of this excuse or in even justifying it. The excuse of insanity has thus historically been a principal point of friction at the intersection of law, psychiatry and morals.

This article presents a conflict model of the insanity defence. Its thesis is that the defence and its antecedents were designed as an integral component of a criminal law system based on morals, common sense, fear and punishment. The system's concern was principally with the determination of blame—"Who is at fault?"—and that determination was the **sine quo non** for punishment, the ultimate sanction of the criminal law. Punishment was thus administered according to a framework of theology and moral disapproval of specified human activity.[6] It is within this context that the insanity defence must be understood. Any system designed to ask the question, "Who is to blame?" must devise rules for determining the corollary question, "Who will be exempt?" If the law punishes only those who have real choice, and not those who lack capacity to control their behavior, it squarely places the responsibility for acting in accordance with the law on those who are able. For a system which makes liability to the law's sanctions dependent on voluntary action maximizes the power of the normal individual to determine by his choice his future fate.[7] Thus, the insanity defence was devised as a necessary corollary to the General Justifying Aim of the criminal law—retribution and punishment.[8] It did not arise out of human compassion to care for the mentally ill or mentally retarded, and indeed should be regarded as the antithesis of humanitarianism. The defence began its development in the retributive moralism of Biblical times and was consolidated and found definitive judicial expression in the social ostracism of the Victorian era; it was from our earliest experiences essentially a guide to the determination of the moral, rather than the medical, fibre of the individual.

The conflict, then, is between retribution and compassion, between culpability and humanitarianism. The persistent error of commentators, practitioners and policymakers has been to attempt reconciliation of these distinct values within the restrictive confines of a single legal instrument. The defence was never a device for rational differentiation among offenders according to their psychiatric disabilities and susceptibility to treatment; it has nonetheless been stretched and distorted to attempt to achieve this purpose and subjected to criticism for its failure to do more than it inherently could.

A second conflicting value within the insanity defence concerns our affect and response toward an insane offender. Our jurisprudential and

moral view is that he is not culpable and, in keeping with the law of excuses, he should not be exposed to criminal sanctions. Our emotional and utilitarian feeling, however, is apprehension concerning his future behavior and a desire to prevent it. Our fear is that the same mental process which deprived the actor of choice, and triggered the charged offence, will repeat itself. The acquitted defendant has demonstrated his inability to conform; the mental incapacity which has in the recent past been legally related to criminality is said to justify the prediction that the disease may render the offender unable to conform in the future.[9] The insanity defence thus established marks the insane offender as someone who must be confined.

In Anglo-American jurisprudence, the excuse of insanity is one in name alone because the acquitted defendant is invariably the subject of mandatory or discretionary commitment to hospital. Whether the confinement is characterized as penal, therapeutic or preventive is a conceptualization; extended involuntary confinement by order of a court exercising criminal jurisdiction is inherently incompatible with the decision to exonerate from criminal responsibility.

This article will propose a rational framework for a jurisprudential system which does not limit its justifying base solely to principles of retribution and justice or prevention and compassion, but recognizes the essential utility of both these values. The components of such a system already lie awkwardly and inconsistently within Anglo-American law, but the United States has persistently rejected judicial policies based on the former, while the United Kingdom has rejected the latter.

The Conflicting Rationales of Retribution and Compassion

The law relating to criminal responsibility in England and Wales rests upon the unadorned M'Naghten Rules which were formulated by the judges in 1843 in answer to questions submitted by the House of Lords following the acquittal of murder of Daniel M'Naghten on the grounds of insanity. For the defence to be established, it must be shown that "The party accused was laboring 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, that he did not know it was wrong."[10]

The first limb of the M'Naghten Rules—"nature and quality of his act"—is a particular statement of the doctrine of **mens rea.** An offence is committed only where the defendant has proceeded with intention or recklessness in respect of all the circumstances of the act which constitutes the **actus reus** of the crime; however, this statement of the requirement of a guilty mind is coextensive with the provision in M'Naghten that the defendant did not know the nature and quality of the act; a person who is unable to comprehend the physical quality of his act could not have formed an intent in respect of that act. Critical impairment in comprehension of the physical act, therefore, excuses the actor from criminal responsibility irrespective of his underlying psychiatric condition.

The application of the doctrine of **mens rea** to sane and insane actors results in two apparent anomalies. First, where it is established that a sane actor was conclusively deficient in his appreciation of the behavior which constitutes the offence for which he is charged, he will receive an ordinary acquittal. Where one of the elements of an offence is not proved, there is no authority for conviction and subsequent confinement or control. Where the same impairment of cognition is established in respect of an insane actor, this results in a special verdict which requires the court to impose an indefinite period of psychiatric confinement. Accordingly, absence of the mental element necessary for a particular offence will result in freedom for the sane actor, but indefinite confinement for the insane actor; the special verdict of insanity is special only to the extent that it will result in mandatory confinement in cases where, under ordinary legal principles, the accused would simply be acquitted. This is one factor which suggests that the insanity defence is not uniquely constructed to absolve the mentally ill offender from blame and punishment; there is no special doctrine which need be constructed to achieve this purpose. Rather, the construction of a special defence for the insane indicates a contrary purpose: to impose control, and perhaps punishment, where the law would not ordinarily tolerate this. Further, if the latter is accepted as at least a partial rationale for the insanity defence, it follows that any proposal to widen the special defence (insofar as this wider construction more closely approximates the defence of **mens rea**) would be to further limit the circumstances under which a mentally ill offender could be entirely exempted from judicially ordered confinement. Plenary exemption from criminal liability, however, would not prevent the use in any appropriate case of civil procedures under a police power or **parens patriae** rationale.

A second anomaly associated with the insanity defence concerns the burden of proof. The prosecution is charged with proving beyond a reasonable doubt all of the requisite elements of an offence. The mental element is one of the particulars within the prosecution's case. Consequently, a heavy burden rests with the prosecution to establish **mens rea**. The M'Naghten Rules shift this burden to the accused who must prove to a balance of probabilities the absence of **mens rea.** The Rules, therefore, have the effect of making exculpation more difficult for the insane than the sane defendant. It is now accepted in other jurisdictions[11] and in relevant committee reports[12] that the burden should logically rest with the prosecution to negative a defence based upon the first limb of M'Naghten.

The M'Naghten Rules provide that a person who knows the physical quality of his act will, nevertheless, be excluded from punishment if (under the second limb of the Rules) he did not know it was wrong. Insanity established under this criterion provides the only pragmatic rationale for the special verdict. It is on this limb alone that an insane defendant may be excused from responsibility in circumstances that would otherwise render him criminally liable. Knowledge by a sane actor of the wrongfulness of his

act is not within the prosecution's case; accordingly, a deficiency in such knowledge would not be a ground for acquittal. To the contrary, a sane actor cannot succeed in a defence which pleads ignorance of the law or good motive.

Criticism of the M'Naghten Rules

The M'Naghten Rules are preeminently concerned with the ability to reason. A disease of the mind must affect the comprehension of the accused, not his emotion, will or volition. The Rules therefore separate cognition from other components of a man's personality. This simple statement of the M'Naghten Rules forms the basis upon which it has been criticized almost since its inception.[13] Modern science regards the personality as an integrated whole; in determining the psychological antecedents to behavior, one cannot divide the mind into different functional categories. Psychiatry is unable to explain behavior except by examining variations in mood, thinking and volition. By requiring the physician to explain behavior solely by what a man knows produces an inaccurate jurisprudential understanding of medical insanity and places an impediment to full and expert testimony.

If the Rules were strictly construed, they would provide a very limited defence. Insanity seldom wholly deprives the actor of reason. A psychotic actor generally will comprehend the nature and quality of his act (e.g., he will know he is killing or setting fire to a building) and that it is wrong (e.g., he will know that murder and arson are imprisonable offences). Yet, alterations in mood and thought may rob the actor of choice. A person may kill another because of a persecution complex or a psychotic jealousy; volition may be sufficiently impaired so that he could not reasonably be regarded as a free agent. Nevertheless, the actor will know that his own feelings of persecution or jealousy do not provide an excuse in respect of murder. Under the M'Naghten Rules, the person would be criminally responsible.

The foregoing criticisms of the M'Naghten Rules are based upon an inaccurate view of the rationale for an insanity defence. The underlying assumption of the critics is that legal insanity should, as closely as possible, comply with modern psychiatric concepts of unsoundness of mind. This reflects the intuitive position that, for reasons of compassion, the severely mentally disordered person should not be dealt with as criminally responsible; however, diagnosis and assessment of need for care are medical issues which are not incorporated within the Rules. Legal insanity is determined by moral jurisprudential judgments; criminal responsibility and unsoundness of mind are not coextensive. Seen in the context of the pure legal moralism of the defence, the Rules appear more rational. The judges in M'Naghten were not professing to define mental disorder or to make sensible differentiations in respect of the need for treatment; rather they sought to define the degree of disorder that would negative **mens rea.** The legal test is thus logically directed to the intellectual or cognitive faculties, and yet that it is so directed is the main ground of attack on the Rules. The responsi-

bility that has to be destroyed under M'Naghten is responsibility in respect of a particular act and its lawfulness. Knowledge of that act and of the proscription set by law is thus the relevant standard. Those who would support the legal moralism of M'Naghten observe that if an accused man knew he was doing an act which he knew to be contrary to law, he must be held accountable under the law.[14]

The British Approach: The Effectuation of the Principles of Compassion and Utilitarianism

Most of the criticism of M'Naghten reflects the intuitive assumption that (1) the Rules are too narrow and do not include all of those who are ill and should be treated, and (2) the Rules should be expanded to provide a mechanism to divert mentally ill and retarded people from punishment which the law might otherwise require. This line of argument, although propounded in influential quarters in the UK,[15] has not been accepted by Parliament. This is largely because the insanity defence is no longer considered principally to be a method of diverting mentally disordered people from the prisons; other legislation has been enacted to achieve that objective; however, jurisdictions in the US have made arduous attempts to expand the scope of the insanity defence to achieve a compassionate objective. The clearest example is the American Law Institute (ALI) provision to include a "control" or "irresistible impulse" component within the framework of the M'Naghten Rules. Variations of this formula have been adopted widely in the US.[16] The ALI considered that the insanity defence is solely a means of distinguishing those cases "Where a punitive-correctional disposition is appropriate and those in which a medical-custodial disposition is the only kind that the law should allow".[17] The Durham Rule,[18] which effectively made legal insanity coextensive with mental disease, is a further illustration of the attempts in the US to alter the insanity defence for reasons of compassion. Indeed, discussions of various methods of reforming the insanity defence to more closely coincide with medical concepts and to allow for more humane disposals, have literally pervaded American jurisprudence.[19]

A finding of legal insanity requires a retrospective assessment as to whether a particular mental disease causally affected specific past behavior. There are no observable or objective criteria to aid in this determination; the justification for the excuse lies wholly within the covert mental processes of the actor. Further, there is no evidence that clinical judgments of present mental disease and behavior associated with it are sufficiently reliable to justify a particular legal outcome; professional opinion concerning a person's state of mind and behavior in respect of a past event is still more problematic. Even if critically defective cognition could be reliably assessed, it would still be difficult to determine the degree of non-responsibility or causality that would be needed to establish the insanity defence. Plainly, a person's behavior is, to some extent, determined by diverse psychological and social antecedents. Poverty, environment and

situational variables are some of the more "normal" influences upon behavior. To identify any one of these factors as a legally relevant cause of offending behavior (to the exclusion of most other causes) and then to make an all or nothing judgment either that the defendant was or was not responsible for that behavior has no convincing scientific, empirical or clinical rationale.

There are also pragmatic and utilitarian objections to the insanity defence. Here, the arguments are based upon outcome or disposal. The most important aspect of the insanity defence in individual and societal terms is not the jurisprudential nicety of whether the accused should be blamed for his behavior and thus nominally—although not pragmatically—exempt from punishment. Rather, the primary consideration is the form and duration of the court's order.

Sensible policy requires an outcome which flows from a rational assessment of the offender's current state of mind, need for care and treatment and propensity toward future violence. The insanity defence is concerned with the moral blame to be attributed to the accused; the investigation of state of mind is backward-looking to the time when the behavior occurred. The defence, therefore, is inherently unable to provide an assessment of current psychological and behavioral characteristics necessary for logical sentencing. Indeed, determinations concerning present mental condition and dangerous propensity are not elements for establishing the defence. Analysis of the insanity defence suggests that it will result in effective disposals only idiosyncratically—i.e., where past mental disease currently exists, is susceptible to medical intervention and, save for that intervention, would probably result in future violence. The insanity defence, as a method for producing reasonable outcomes, is both under- and over-inclusive. The defence requires a causal relationship between a mental state of mind and particular offending behavior; where this relationship cannot be demonstrated the verdict is inapposite and principles of ordinary punitive sentencing will apply. Accordingly, a mentally ill offender who needs treatment in a hospital context will not be eligible for entry by virtue of the special verdict if the illness has not caused the offence. Clinical and empirical evidence[20] suggest that this will be the case in respect of the majority of mentally ill offenders. The crimes of mentally abnormal offenders are usually attributable to specific rational motives such as hunger, greed or jealousy. In these circumstances, it could not be established that the offender would not have committed the offence had he not been mentally disordered, for the motives and offences themselves are indistinguishable from those of a large number of "normal" people. The special verdict will not provide a hospital place for these mentally disordered offenders and thus substantially underestimates the number of therapeutic outcomes appropriate within the criminal process.

The special verdict is also over-inclusive because it would include within its remit certain offenders who do not require therapeutic outcomes. An

offender may qualify for the special verdict as a result of a mental illness which, although present at the time of the offence, is in remission at the time of sentencing. Moreover, a mental disease such as diabetes or arteriosclerosis which may qualify for the special verdict[21] may not be one which is susceptible to psychiatric treatment, and thus does not require a therapeutic outcome.

The insanity defence, then, is far too occasional a device for reliably assessing the need for hospital care. It is inherently an instrument to determine issues relating to culpability, morality and responsibility. These are backward-looking issues which are antithetical to a rational policy in respect of therapeutic assessment; yet, that such a policy is needed has seldom been disputed. It is repugnant to traditional values to place a seriously mentally infirm or retarded person in a punitive setting or to impose other forms of punishment.[22] The concept of being "fit to be punished" is a persistent ethical and humanitarian feature of the common law.[23] There are also policy objections to the imprisonment of mentally disordered people:[24] a prisoner requires competence to understand and obey prison rules; he needs cognitive awareness and the ability to cope in order to safely exist within a punitive environment and to avoid exploitation and abuse. Confinement of a seriously mentally ill or retarded person in prison, therefore, may constitute greater punishment than the equivalent confinement of a mentally healthy person.

The Mental Health Act 1959 made it possible for the first time in England and Wales for the courts to rationally assess the need for hospital care on the basis of current medical and social advice. The governing consideration under the 1959 Act is not whether mental disease negates culpability, but whether the individual could benefit from treatment in-hospital. In pursuance of section 60 of the Act, a court may authorize a person's admission to a hospital or place him under guardianship following conviction of an imprisonable offence. The court must be satisfied on the evidence of two medical practitioners that the offender is suffering from one or more forms of mental disorder (mental illness, subnormality, severe subnormality or psychopathic disorder) which is of a nature or degree which warrants detention in a hospital or guardianship.

The effect of a hospital order under section 60 is to place the person in the hospital on a virtually identical basis to a patient admitted for treatment under the civil provisions of section 26 of the 1959 Act. Patients so admitted may be detained for a period not exceeding one year; the authority for detention may be renewed by the responsible medical officer for a further year and, thereafter, for periods of two years at a time.

In making a hospital order, the court is relinquishing control of an offender and nominally forgoing the imposition of punishment. Therefore, (unless the order is coupled with restrictions on discharge under section 65 of the Act) the patient may be discharged at any time by the responsible

medical officer, by the hospital managers or by a Mental Health Review Tribunal.[25]

The utilitarian approach introduced by the 1959 Act represents a significant advance over traditional legal procedures for achieving the sensible policy objective of making rational differentiations among offenders in respect of the need for hospital care. Indeed, the utilitarian measures of the Act are so highly regarded that they have virtually supplanted the traditional procedures; offenders found not guilty by reason of insanity or unfit to plead constituted only 1.9% of the total number of mentally abnormal offenders admitted to hospitals in 1979.[26]

The US, which largely inherited its jurisprudence on the insanity defence from the English common law, continues to follow essentially a traditional approach. Alteration of the law to adopt more humanitarian and sensitive measures for diverting mentally disordered persons from the penal system should be focused at the point of disposition. Traditional concepts within the insanity defence, however expanded by the legislature or by judicial construction, cannot be a satisfactory method of achieving compassionate objectives. The approach of the 1959 Act represents one approach to assessing the need for care at the dispositional stage, without any formal consideration of blame. Adoption of similar measures in the US would not pose constitutional problems, as it still authorizes the defendant to place his mental state in issue at the trial stage.

There are, however, further provisions under the 1959 Act which are decidedly unsatisfactory from a constitutional or policy perspective. Here, jurisprudence from the US and Europe represents the preferred approach. There are several instances under the 1959 Act in which a restriction order can be imposed along with a hospital order. The terms of the restriction order and their effect are examined below, together with a brief examination of the constitutional limitations on the authority to detain "for therapy" in the US and under the European Convention of Human Rights.

The Inherent Conflict of Exculpation and Preventive Confinement

In Great Britain, the special verdict requires the mandatory confinement of those acquitted by reason of insanity.[27] The form of confinement is a hospital order under section 60 of the Mental Health Act together with restrictions upon discharge without limit of time under section 65 of the Act. A hospital order with restrictions is also mandatory following a successful plea of incompetency to stand trial. Further, a Crown Court has discretion to add a restriction order to a hospital order made following a finding of guilt. In 1978, there were 809 hospital orders made in England and Wales; 127 were with restrictions upon discharge.[28]

A person admitted to a hospital with restrictions on discharge under section 65 of the 1959 Act is not subject to the civil provisions (Part 4) of the Act relating to duration, renewal or expiration of the authority for the

compulsory detention of patients. Accordingly, the Responsible Medical Officer, the hospital managers or the Mental Health Review Tribunal have no authority to grant a discharge, transfer or leave of absence without the consent of the Secretary of State for the Home Department.[29]

A restricted patient has the right to have his case referred to a Mental Health Review Tribunal at specified periods; however, the tribunal has no authority in respect of a restricted patient. It may only advise the Home Secretary in the exercise of his powers. The decision on whether to accept the tribunal's advice remains exclusively with the Home Secretary, who does not have a statutory obligation to provide reasons for his decisions. In 1977, the Home Secretary rejected 45% of tribunal recommendations for discharge of restricted patients; all recommendations against discharge were accepted.[30]

The restriction order is considered a therapeutic, not a punitive, order. The therapeutic nature of the disposition ostensibly justifies its imposition following a verdict which purports to be an acquittal. It is also the therapeutic nature of the disposition which constitutes the rationale for the absence of judicial review of the nature and duration of confinement; ordinary principles of criminal sentencing, particularly relating to the tariff principle or porportionality of sentence, are considered inappropriate in a "best interests" context; however, the restriction order should not be regarded as wholly a therapeutic measure.[31] It is a hospital order without restrictions which authorizes detention for the purpose of therapy. The accompanying restriction order has the sole jurisprudential effect of taking the decision concerning discharge, transfer and leave of absence from medical and quasi-medical authorities (i.e., the Responsible Medical Officer, the hospital managers and the Mental Health Review Tribunal) and placing it with the Home Secretary. The Home Secretary retains unfettered discretion in the exercise of his powers; he has no statutory duty to discharge a restricted patient, although he may receive advice that the patient is not mentally disordered or in need of treatment.[32]

Jurisprudential Limitations Under the European Convention of Human Rights

Article 5(4) of the European Convention of Human Rights[33] provides that "Everyone who is deprived of liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court." Article 5(4) must be read in conjunction with article 5(1)(e), which specifies "unsoundness of mind" as a substantive condition which would justify lawful detention. The European Court in **Winterwerp v. The Netherlands**[34] relied upon article 5(4) to review the minimum procedural elements relating to confinement based upon the condition of unsoundness of mind. The condition, like others within article 5(1), is subject to change, amelioration or cure. Thus it must be shown that mental ill health continues throughout the period of confinement. The

European Commission had previously decided that article 5(4) required periodic review of the lawfulness of psychiatric detention. In **6859/74 v. Belgium,**[35] the Commission held that a domestic court had the responsibility to "Establish that the conditions prescribed by law . . . are still satisfied and justify the continuance of the detention." The Court in **Winterwerp** held that a conviction by a domestic court did not constitute sufficient authority for indefinite detention of a person of unsound mind; the requirements of article 5(4) were not fulfilled by a decision of a court at the close of judicial proceedings.

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The form of review specified by article 5(4) is a court. The term "court" was construed in the Austrian case, **Neumeister,**[36] as a body which is independent of the executive and the parties to the case. It must also exercise minimal standards of judicial procedure. The Home Secretary's review of the need for continued detention in the UK would not be regarded as sufficiently independent under the **Neumeister** test. The Home Secretary, as a member of Her Majesty's Cabinet, exercises executive functions. Further, as the detaining authority, he is an integral party to the case. The Court in **Winterwerp** observed that judicial proceedings conducted within the meaning of article 5(4) need not reach the same standard as those required elsewhere in the Convention for civil and criminal litigation. Nevertheless, the person concerned must have "the opportunity to be heard either in person or, where necessary, through some form of representation . . . mental illness may entail restricting or modifying the manner of exercise of such a right . . . but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves." It should be observed that the Home Secretary is not obliged to follow what the Court in **Winterwerp** called "The fundamental guarantees of procedure applied in matters of deprivation of liberty." The Home Secretary reaches decisions on the basis of confidential information and highly private deliberations, and he gives no reasons for his decisions. He is not, accordingly, acting in the capacity of a court exercising periodic review of the lawfulness of psychiatric confinement.

The ECHR has adopted a report (as yet unpublished) in respect of four cases of restricted patients from the UK.[37] The **Winterwerp** ruling, as far as it went, clearly undermined the validity of a restriction order under article 5(4) of the Convention; however, the fundamental issue which still awaits resolution by the Court is the scope of periodic review. The Commission, in its previous jurisprudence, expressly required a periodic review of both the formal lawfulness of detention—i.e., a judicial examination of the facial validity of an order—and its substantive justification. The European Court in **Winterwerp** held that the former was required, but expressly reserved the

question of the need for periodic review on the merits. Given the previous jurisprudence of the Commission and the important issue left unresolved by the Court, the Commission's decision in the UK cases predictably should go against the respondent government and the case should be referred to the Court for final resolution. There are indications, then, that the jurisprudence under the ECHR will require some limitation of psychiatric confinement arising from the insanity defence and in other contexts.

US Constitutional Limitations

Judicial pronouncements in the US also suggest certain constitutional limitations upon the nature and duration of psychiatric confinement under the criminal process. These derive from the equal protection and due process clauses of the Fifth and 14th Amendments to the US Constitution. Equal protection does not require that all persons be dealt with identically, but it does require that the purpose of a classification bear a reasonable relation to a valid government objective. Thus, any distinction between psychiatric commitments under a criminal process and commitments under a civil process must have a rational justification. US courts have held that there are constitutional boundaries in respect of the procedures and standards for hospital admission and the conditions and duration of confinement. Such holdings have been made in the context of indefinite therapeutic confinement during the pendency[38] or at the expiration of a prison sentence,[39] following a conviction,[40] a finding of unfitness to plead[41] or not guilty by reason of insanity.[42] The due process clause of the Fifth and 14th Amendments has been held to apply where the court finds an element of "criminal punishment," however labelled. The US Supreme Court has held that compulsory state action which deprives a person of liberty constitutes criminal punishment, even though designed not for retribution but for rehabilitation and prevention.[43] Accordingly, "Due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."[44]

Conclusion

The narrow remit of the insanity defence—relating to cognitive awareness of the act and its lawfulness—is consonant with the objective of the defence—**viz** to excuse an actor from responsibility and punishment where he is unable to comply with the law's dictates. The defence—which is reliant upon a retrospective assessment of covert mental processes—is difficult to establish or even to justify. Nonetheless, its continuance would not undermine any interest of the accused so long as there were alternative and more direct methods of achieving a therapeutic disposition. Maintaining the defence for rare occasions where the accused chooses to place his state of mind in issue provides a means for the insane defendant to ask to be excused from the formal statement of societal condemnation represented by a conviction; however, it is inconsistent to formally excuse a mentally ill defend-

ant from responsibility, but then to invoke coercive powers of detention. Accordingly, the insanity acquittee should have the same substantive and procedural protections in respect of therapeutic confinement as individuals so confined under civil processes. This is essentially the approach taken in the US and under the ECHR.

Much of the controversy surrounding the insanity defence has resulted from the persistent feeling that humanitarianism is its only valid justification. Proponents of this view have sought to stretch and distort the defence to achieve an objective for which it was never designed. The ethical and retributive concerns of the insanity defence suggest that, inherently, it could not provide a rational assessment of the need for care and treatment. Regardless of how it is altered, it would continue to remain both under and over inclusive in this regard. In order to achieve important compassionate objectives, the courts should be directly empowered to make a therapeutic order following conviction.

References

1. Ancient English law adopted a system of absolute liability for the effects of acts. Men were made to answer for "All the ills of an obvious kind that their deeds bring upon their fellows." Moreover, the concept of causation was not, as at present, foreseeable harm engendered by an unlawful act; rather, the ancient law held men responsible for harms brought about by extended causal chains — "You take me to see a wild beast show or that interesting spectacle, a madman; beast or madman kills me; you must pay." In the 12th Century, the resuscitated Roman law introduced culpa or the psychial element of crime, but even here, misadventure was recognized as an excuse if, but only if, the act was itself unlawful and was also done with all due care. Infancy was only beginning to establish itself as a lawful excuse. 2 F. Pollock and F. Maitland, The History of English Law 470, 471, 474-84 (2d ed. 1898). The principle of intent and capability to form intent did not find clear expression in the English criminal law until approximately the 14th Century. The English law adopted the "right-wrong" test of moral culpability, which itself had Biblical origins. Platt and Diamond, The Origins of the 'Right and Wrong' Test of Criminal Responsibility and its Subsequent Development in the US: An Historical Survey, 54 CA L. Rev. 1227 (1966). For contemporary historical references on the excuse of insanity, see generally, S. Glueck, Mental Disorder and the Criminal Law chp. 5 (1925); A. Deutsch, The Mentally Ill in America, chps. 1-5 (1949); K. Jones, A History of the Mental Health Services, chp. 1 (1972); 1 N. Walker, Crime and Insanity in England, chps. 1-6 (1968); Dershowitz, The Origins of Preventive Confinement in Anglo-American Law, 43 U.Cinn.L.Rev. 1, 28-52 (1974).
2. Aristotle, Blackstone, Bentham and Hart each examined the excusing conditions of their day. In Aristotle's, The Nichomachean Ethics, trans. J.A.K. Thompson 77-93 (1953), it never occurred to him to doubt man's freedom of will. His sole understanding of involuntariness was where the cause of action was found in things external to the agent. Blackstone, 4 Commentaries 20-32, reduced all the excusing conditions to the single consideration of "Want or defect of will." Bentham, The Principles of Morals and Legislation (1948), regarded Blackstone's discussion of "vicious will" as "Nothing to the purpose, except as the deficiency of will reduced the efficacy of punishment." Bentham's utilitarianism would thus excuse an actor where the will could not be deterred. Hart, A Punishment and Responsibility 18-19 (1968), in turn, regarded Bentham's utilitarian justification for excuses as irrational. Bentham sets out to prove that to punish those who had no control over their behavior must be inefficacious, but he proves only that the threat of punishment is ineffective in respect of this class. This may be described as individual deterrence; however, to punish this class might well serve the ends of general deterrence. Although the actor may be incapable of responding to the law's sanctions, he might be used as an example to others of the effect of the law's directives.

   For an examination of the excusing conditions in contemporary jurisprudence see, generally, Gross, Mental Abnormality as a Criminal Excuse in Philosophy of Law 466 (J. Feinberg and H. Cross, eds. 1975); Fletcher, the Individualization of Excusing Conditions, 47 S.CAL.Rev. 1269 (1974).
3. An excuse must be distinguished from a justification, such as self-defence, where the actor proceeds with intent, and the act is something which the law does not condemn and may even welcome. See generally, H.L.A. Hart, supra note 2 at 13-14; Austin, A Plea for Excuses, Proc. Artistotelian Soc'y 1 (1956-57).

4. See Gross, supra note 2.
5. For a consideration of the difficulty in reliably diagnosing psychiatric illnesses, see e.g., 1 L. Gostin, A Human Condition 37-43 (1975); Ennis and Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 CAL.Rev. 693 (1974). Morse, Crazy Behavior, Morals and Science: An Analysis of Mental Health Law, 51 S.CAL.Rev. 527, 542-43, 592-600 (1978). On the difficulty of validly predicting future dangerousness, see generally, National Institute of Mental Health, Dangerous Behavior: A Problem in Law and Mental Health (C. Frederick, ed. 1978); Levinson and Ramsay, Dangerousness, Stress and Mental Health Evaluations, 20 J. Health and Social Behavior 178 (1979); Cocozza and Steadman, The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence, 29 Rutgers L. Rev. 1084 (1976); Cocozza and Steadman, Prediction in Psychiatry: An Example of Misplaced Confidence in Experts, 25 Social Problems 265 (1978); H. Steadman, Beating A Rap? (1979); Megargee, The Prediction of Dangerous Behavior, 3 Crim. Just. 3 (1976); Shah, Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology, 33 Am. Psychologist 224 (1978).
6. See generally, Platt and Diamond, supra note 1; Livermore and Meehle, The Virtues of M'Naghten, 51 Minn.L.Rev. 789 (1967).
7. Hart, supra note 2 at 46-49, 181-182; H. Fingarette, The Meaning of Criminal Insanity, 58 (1972).
8. Hart, supra note 2 at 1-29. See also A. Goldstein, The Insanity Defense, 11-18 (1967).
9. See, Goldstein and Katz, Abolish the Insanity Defense—Why Not? 72 Yale L.J. 853 (1963).
10. Daniel M'Naghten was under an insane delusion about the Conservative Party which focused upon the Prime Minister, Sir Robert Peel. On Jan. 20, 1843, he shot Sir Robert's Private Secretary, Drummond, by mistake. M'Naghten successfully pleaded insanity (1843) 10 Cl. and F. 200, 8E.R.718. He was admitted to Bethlem Hospital and later became one of the first male patients admitted to Broadmoor Hospital, where he died of tuberculosis. The House of Lords subsequently decided to require the judges to answer a number of hypothetical questions. This is their traditional right, but one which they seldom exercise. The answers to these questions constitute the M'Naghten Rules. Such answers do not have the force of law in England, but have been followed so consistently by the courts that they now are established principles of law.
11. E.g., Pantelic (1973) 1 ACT R. 1, 5.
12. Criminal Law Revision Committee, 14th Report, Cmnd. 7991 (1972), para. 140; Report of the Committee on Mentally Abnormal Offenders, Cmnd. 6244 (1975), para. 18-25.
13. For English criticism of the M'Naghten Rules, see e.g. Report of the Royal Commission on Capital Punishment (the Gowers Commission), Cmnd. 8932 (1953); The Report of the Committee on Mentally Abnormal Offenders, paras. 18.5-18.14 (the Butler Committee), Cmnd. 6244 (1975). English commentators who have supported the position taken by the judges in M'Naghten include Devlin, Criminal Responsibility and Punishment: Functions of Judge and Jury, (1954) Crim.L.Rev., 661, 677-86. Devlin, Mental Abnormality and the Criminal Law in Changing Objectives, 71, 85 (R. St. J. MacDonald, ed. 1963); Report of the Committee as to the Existing Law, Practice and Procedure Relating to Criminal Trials in which the Plea of Insanity as a Defence is Raised (the Atkin Committee), Cmnd. 2005 (1923). In the American context, Livermore and Meehl, The Virtues of M'Naghten, 51 MN.L. Rev. 789 (1967) have offered the most comprehensive defence of M'Naghten. The debate on the M'Naghten Rules has recently widened to include whether the insanity defence itself should be abolished. Those in favor of this position include H.L.A. Hart, Punishment and Responsibility 205-210 (1968); B. Wootton, Crime and the Criminal Law (1963); Goldstein and Katz, Abolish the Insanity Defence—Why Not? 72 Yale L.J. 853 (1963); Morris, Psychiatry and the Dangerous Criminal, 41 S.CAL.Rev. 514 (1968). Those opposed to the abolition of the insanity defence include: H. Fingarette, The Meaning of Criminal Insanity (1972); Fingarette, Disabilities of Mind and Criminal Responsibility—A Unitary Doctrine, 76 Colum.L.Rev. 236 (1976); Fingarette, Diminished Mental Capacity as a Criminal Law Defense, 37 Mod.L.Rev. 264 (1974); Kadish, The Decline of Innocence, 26 Camb.L.J. 273 (1968); J. Goldstein, The Insanity Defense 222-26 (1967); Monahan, Abolish the Insanity Defense?—Not Yet, 26 Rutgers L.J. 719 (1973); Brady, Abolish the Insanity Defense—No! 8 Houston L. Rev. 629 (1971).
14. The Atkin Committee, supra note 13; Devlin, Criminal Responsibility and Punishment: Functions of Judge and Jury, (1954) Crim.L.Rev. 661, 681-82.
15. The Royal Commission on Capital Punishment, supra note 13 at para. 278; Report of the Committee on Mentally Abnormal Offenders, supra note 12 at para. 18.35.
16. American Law Institute, Model Penal Code, para. 4.01 (Proposed Official Draft 1962). For a general development of the irresistible impulse model in the US, see, generally, A. Goldstein, The Insanity Defence, 67-142 (1967); G. Morris, The Insanity Defence: A Blueprint for Legislative Reform, 13-14, 16-25 (1979). English courts, however, do not recognize this defence on the pragmatic ground that it would be impossible to distinguish between an impulse which could not be resisted and one that simply was not resisted. R v. Kopsch (1925) 19 Cr.App.R. 50.

17. American Law Institute, Model Penal Code, para. 4.01, Comments, 156 (Tent. Draft No. 4, 1955).
18. Durham v. US, 214 F. 2d 862 (D.C. Cir. 1954). The Durham Rule was abandoned in the District of Columbia in 1972. US v. Brawner, 471 F.2d 969 (D.C. Cir. 1972).
19. For a brief survey of relevant literature pertaining to the insanity defence, see supra note 13. Earlier examinations of the defence in America are contained in I. Ray, Medical Jurisprudence of Insanity 32 (1st ed. 1838); S. Glueck, Mental Disorder and the Criminal Law (1936); P. Roche, The Criminal Mind 84 (1958).
20. See 2 N. Walker and S. McCabe, Crime and Insanity in England 129 (1973). Morse, Crazy Behavior, Morals and Science: An Analysis of Mental Health Law, 51 S.CAL.Rev. 527, 560-90 (1978); McGrath, The Mentally Abnormal Offender, 41 Medicolegal Journal 4, 7 (1973); McGrath, The Treatment of the Psychotic Offender, 10 Howard Journal 38 (1958).
21. Devlin, J. (now Lord Devlin) established the standard under the M'Naghten Rules for "disease of the mind" in R v Kemp (1957) 1 Q.B. 399, 406-07 "A malfunction of mind, however caused." Accordingly, physical malfunction of the brain—for example, associated with epilepsy or arteriosclerosis, cerebral tumor or diabetes—may amount to a disease of the mind if it produces the required defect of reason. Devlin's expansive view of "disease of the mind" was supported by the House of Lords (per Lord Denning) in Bratty v. Attorney General for Northern Ireland (1963) A.C. 386, 412. In R v. Quick (1973) 1 Q.B. 910, 922, Bridge, J. limited the Kemp/Bratty definition of "disease" by excluding "malfunctioning of the mind of a transitory effect caused by the application to the body of some external factor." Accord, R v. Rabey (1977) 17 O.R. (2d) (A. Ontario). Dicta in earlier judgments supports the position taken in Quick. Kay v. Butterworth (1945) 61 T.L.R. 452, 458 (involuntary act as a consequence of a blow from a stone, sudden illness or an attack by a swarm of bees would be non-insane automatism); Hill v. Baxter (1958) 1 Q.B. 277, 282-83 (cites Kay v. Butterworth with approval and adds the examples of a stroke and an epileptic fit). See also, Mackay, Non-Organic Automatism—Some Recent Development, (1980) Crim.L.Rev. 350.

    A principle difficulty with the Kemp/Bratty position is that it belies the ostensible compassionate concern of the special verdict. Confinement in a mental hospital of a person suffering from diabetes, tumor, transient concussion or arteriosclerosis would be custodial or preventive and not therapeutic. Such involuntary confinement of persons not medically insane and not susceptible to psychiatric treatment is incompatible with the supposed rationale of compassion and exculpation from criminal punishment.
22. The Atkin Committee, supra note 13 at 17, stated that "After conviction, insanity may develop in its most extreme form; we cannot imagine a civilized community in which it would be considered necessary or desirable to keep such a person confined among ordinary prisoners of sound mind, and deprived of any treatment for the alleviation of his mental disorder."
23. The Atkin Committee, supra note 13 at 16-17, 19, noted that there is "Authority of some weight from the time of Lord Coke for considering that . . .it was contrary to common law to execute an insane criminal," irrespective of criminal responsiblity. Unsoundness of mind, even if it occurred after sentence, would mean respite from punishment by death. The Committee stated its policy on these matters as follows: If a person who is convicted of murder is shown to be insane, we must always remit the prisoner to an asylum. "We should not be less humane than our forefathers . . . .[The] reasons given for the merciful view of the common law continue to have force even under modern conditions. Everyone would revolt from dragging a gibbering maniac to the gallows." See also. Platt and Diamond, supra note at 1233-34; Dershowitz, The Origins of Preventive Confinement in Anglo-American Law, 43 U.Cinn.L.Rev. 1, 47-48 (1974); 4 Blackstone, Commentaries 20-32.
24. See generally, Orr, the Imprisonment of Mentally Disordered Offenders, 133 Brit. J. Psychiat, 194 (1978); The Butler Report, supra note 13 at para. 3.22; 2 L. Gostin. A Human Condition, 37-59 (1977); Parliamentary All Party Penal Affairs Group, Too Many Prisoners, 3-6 (1980).
25. Mental Health Act 1959, Section 63.
26. Criminal Statistics England and Wales 1979, Cmnd. 8098, 472 (1980).
27. Section 1 of the Criminal Procedure (Insanity) Act 1964 provides for acquittal on the grounds of insanity. Sections 2 and 3 of the Act make provision for an appeal against the special verdict. Section 5(1)(a) and Schedule 1 require the court, following an insanity acquittal, to make an order that the accused be admitted to such a hospital as specified by the Home Secretary. The patient must be detained under a hospital order with restrictions on discharge without limit of time in pursuance of sections 60 and 65 of the MHA 1959.
28. Criminal Statistics England and Wales 1978, Cmnd. 7670 (1979).
29. MHA 1959, Section 66.
30. Figures provided directly by the Department of Health and Social Security, UK.
31. See generally, 2 L. Gostin, A Human Condition: The Law Relating to Mentally Abnormal Offenders, 79-93 (1977).

32. In R v. Secretary of State for the Home Department, ex parte Powell, Queen's Bench Divisional Court, Dec. 22, 1978, the Home Secretary's refusal to comply with a recommendation for discharge made by the responsible medical officer was upheld. Unpublished transcript of decision reproduced in L. Gostin and E. Rassaby, Representing the Mentally Ill and Handicapped: A Guide to Mental Health Review Tribunals, 170-74 (1980). In R v. Secretary of State for the Home Department, ex parte Kynaston, unpublished, now subject to appeal, the Court upheld the decision of the Home Secretary not to discharge a patient who was not regarded as mentally ill by the hospital and who was not receiving psychiatric treatment.
33. The Council of Europe promulgated the Convention for the Protection of Human Rights and Fundamental Freedoms on Nov. 4, 1950. The Convention created two organs "To ensure the observation of the engagements undertaken by the High Contracting Parties:" the European Commission of Human Rights, which determines applications initially, and the European Court of Human Rights, which takes the final decision on whether there has been a breach of the Convention. See generally, F. Jacobs, The European Convention of Human Rights (1975).
34. Winterwerp v. The Netherlands, Application No. 6301/73. Report of the Commission adopted on Dec. 15, 1977. Judgment of the Court given on Oct. 24, 1979.
35. 6854/79 v. Belgium, 3 Decisions and Reports of the European Commission of Human Rights 139.
36. The Neumeister case, reported in F. Jacobs, supra note 33 at 73.
37. Application numbers 6840/74, 6998/75, 6870/75 and 7099/75 v The UK. Argued and held admissible Spring Session, 1977.
38. Vitek v. Jones, 63 L.Ed. 2d. 552 (1980).
39. Baxstrom v. Herald, 383 US 107 (1966).
40. Specht v. Patterson, 386 US 605 (1967).
41. Jackson v. Indiana, 406 US 715 (1972).
42. Bolton v. Harris, 130 US App. D.C.1, 395 F 2d 642 (1968); Cameron v. Mullen, 128 US App. D.C. 235, 397 F 2d 193 (1967); People v. Lally, 19 NY 2d 27, NE 2d 87 (1966); Wilson v. State, 287 NE 2d 875 (Ind., 1972). See generally, Developments, Insanity Acquitees: Problems at Trial and Disposition, 4 Mental Disability Law Reporter 8 (1980).
43. Specht v. Patterson, 386 US 605 (1967).
44. Jackson v. Indiana, 406 US 715 (1972). □