
Not Guilty by Reason of Insanity and the Recovery Paradigm: Are They Compatible?

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KEYWORDS

Recovery, Medical Model, Insanity Defence

Some individuals will be placed within forensic hospitals after being found not guilty of having committed a criminal offence by reason of insanity (NGRI). This defence removes responsibility for a criminal act and assigns it to the mental illness. This negation of responsibility is at odds with the key tenets of the recovery approach, which prioritizes the empowerment of individuals to self-determine their actions. An over-application of empowerment and self-determination for persons with severe mental illness can unfairly attribute guilt in such cases.

A medical model (MM) understanding of mental illness instead treats mental illness as a discrete entity subjectable to diagnosis and treatment. Emerging neuroscientific evidence supports this and is being adopted in criminal cases—including NGRI defences. Through an MM approach, the criminal justice system can focus on preventing future harms by providing care and forgo attributing blame unfairly.

However, fully embracing the MM in NGRI cases is problematic. A designation of NGRI is highly stigmatizing and counterproductive when considered within the recovery approach. This paper argues that a subjective mental state test that permits non-culpability for severely mentally unwell individuals and makes distinct the criminal act from the mental illness is needed.

Introduction

Forensic psychiatry offers treatment to mentally disordered offenders. Some individuals within forensic settings will be placed there after being found not guilty of having committed a criminal offence by reason of insanity (NGRI).¹ In these cases, the criminal justice system separates and makes distinct the mental illness experienced by the individual from the individual's self. This precludes individual liability for criminal

wrongdoing and assigns it to the mental illness. Doing this justifies from a legal and paternalistic perspective the imposition of an order for treatment in the place of a prison sentence or other punitive measure.² In short, NGRI is society excusing the person and attributing cause to the mental illness.

This assumes a side in a contentious philosophical debate in the field of mental health care—whether a mental illness, so called, is an intrinsic part of the individual living with it or a discrete and separate entity that can be diagnosed and treated.³ These contradictory positions as to the ontological nature of mental illness can best be illustrated through an exploration of two approaches to the provision of forensic mental health care and how they consider individuals' responsibility and self-determination.

The first of these, the recovery paradigm, assumes that mental illness is part of the individual, something that can be lived with when not exceedingly overbearing or inhibitive.⁴ It proposes that individuals with mental illness can take responsibility for, and, through empowerment, self-determine their actions.⁵ The second is the medical model. This treats mental health concerns as if they are biological maladies and foreign entities. It aims to identify symptoms and diagnose and prescribe suitable medication to subsequently treat a mental illness that is separate from the self and distinct from the self-determination of the individual.⁶

Aims of the Paper

This paper seeks to discuss the compatibility of the recovery approach and medical model in forensic psychiatric care with regard to individuals considered NGRI. The fundamental elements of the recovery paradigm and the medical model are described. This is followed by an assessment of criminal responsibility and mental illness in criminal law courts. It will be argued that the medical model and the recovery paradigm are incompatible when attributing levels of responsibility and self-determination to individuals found NGRI, as a full application of the recovery paradigm's principles would over-prescribe these concepts.

This contention is furthered by neuroscientific evidence and courts' contemplation of the NGRI defence in individuals with mental illness who arrive on criminal charges. In light of this, an alternative approach to the legal formulation of the NGRI defence as proposed by Slobogin,² in line with the UN Convention on the Rights of Persons with Disabilities (CRPD), is provided. It is proposed that this formulation is more convincingly compatible with both the recovery paradigm and the medical model. This approach would make distinct mental illness and crime whilst reducing stigma and not holding people responsible in circumstances in which it is not fair to do so.

This paper therefore hopes to further discussions concerning the attribution of responsibility to individuals' excused culpability following the commission of a criminal act in light of absent responsibility. This debate is salient given contemporary efforts to implement the CRPD internationally and furthers discussion of the recovery model's applicability to forensic settings.⁷

Recovery Approach

The recovery movement has its roots in various social, political, and economic reforms of the 1950s and 60s.⁸ During this period, mental health care in the West underwent a paradigm shift. No longer was it considered that the treatment of individuals with serious mental illnesses was best provided in large psychiatric asylums cut off from society.⁹ Instead, there were movements to promote patient autonomy and provide care as close to the individual's home setting as possible, and in the least restrictive manner.

This aimed to help individuals reintegrate or stay integrated within their social and economic circles and reduce the stigmatizing 'otherness' of those living with mental illness. These reforms built on research that found large asylums were at times harmful and advances in psychopharmacological medication that made psychotic symptoms more self-manageable.¹⁰ This occurred at the same time that broader human rights movements aimed to curtail stigma and exclusion associated with an individual's sexual orientation and civil status.¹¹ The recovery approach's main proponents come from the psychosocial rehabilitation and consumer movements who wanted an approach to the treatment of mental health issues that explored a patient's entire life circumstances and not simply their medical diagnosis.⁸

Advocates of the recovery approach dedicate much time trying to conceptualize and operationalize the concept. This is in large part due to the increased importance given to recovery approach in countries' national mental health policies.¹² Myriad definitions exist, but recovery is typically defined as an inherently subjective experience.⁵ It may be considered a journey or an end-point. Anthony defines recovery as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles... and a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness."¹³

Several reviews have attempted to describe and operationalize recovery. Leamy et al. conducted a systematic review and narrative synthesis.⁵ The authors found that recovery comprised five key aspects: Connectedness, Hope and optimism for the future, Identity, Meaning in life, and Empowerment (CHIME). Jacobson & Greenley proposed that there are internal and external facilitators in the process of recovery.¹⁴ Internal factors mirror the CHIME acronym including: hope, optimism about the future, and control over one's life. External factors include the human rights conditions facilitating treatment, a positive culture of healing, empathy, trust, compassion, and respect from healthcare providers. Ultimately, recovery approaches aim toward achieving a sense of purpose and mastery over one's life, rather than the elimination of psychiatric diagnoses.¹⁵

Fundamental to the recovery process are notions of responsibility and self-determination. Conceptualizations and experiences of recovery emphasize that individuals should play a role in planning their care and daily life, and take responsibility for their actions.¹⁶ This helps to reduce the stigma of those with mental illness as being incapable and lacking control. This sentiment is reflected in the UN CRPD. Article 12 of the document stipulates that "states shall [recognize] that persons with disabilities enjoy

legal capacity on an equal basis with others in all aspects of life.” The document precludes deprivation of liberty on the sole grounds of mental illness.¹⁷

Accompanying documentation to the Convention asserts that “recognition of the legal capacity of persons with disabilities requires abolishing defences based on the negation of criminal responsibility because of the existence of a mental or intellectual disability.”¹⁸ This embodies the sentiment explicit in the consumer rights movement, and is concomitant to the recovery approach’s contestation that individuals with mental illnesses are self-determining, autonomous actors capable of making life decisions and assuming responsibility for these.

Medical Model

Conversely, the medical model aims to understand the causes, symptoms, and progressions of illnesses in the body through the application of the scientific method.¹⁹ The scientific method adopts the methodical and transparent collection and collation of observations and data about the world.²⁰ The medical model can thus be described as the “[s]cientific process of observation, description and differentiation, which moves from [recognizing] and treating symptoms to identifying disease aetiologies and developing specific treatments.”²¹ It is the accumulation of such knowledge that informs the day-to-day practices of medical professionals, particularly doctors and psychiatrists.

The medical model is at times criticized for being paternalistic, inhumane, and reductionist.²² This is in part because of the historical importance the medical profession has given to understanding the biological aetiologies of illness. Practitioners or researchers embracing the medical model may appear to look through the individual, choosing to concern themselves with the endophenotypic over the phenomenal or emotional.⁶ The medical model has since turned towards a biopsychosocial approach in order to better understand the causes and prognoses of illnesses.²³ However, the epistemology of the medical model remains the same, and the scientific method is the most prominent method used to study and treat ill-health.

In mental health care, the influence of the medical model can be seen in the paradigmatic Kraepelinian classification systems of the DSM²⁴ and ICD²⁵ manuals. Mental illnesses are categorized into discrete, diagnosable entities. Each diagnosis has a set of symptoms and expected developmental stages. The utility of this system allows research to be conducted on mental illnesses across multiple settings, aiding in the development of effective medications. Patients with similar diagnoses can be placed together to encourage peer support and shared experience. Greater transparency as to how diagnoses were arrived at can be demonstrated. Proponents also assert that the medical model is evidenced-based and therefore value-free.¹⁹

However, detractors argue that these classifications are operationalized in a way that have little empirical weight; disparate reliability; cannot suitably capture comorbidities; and further that many diagnoses do not traverse cultural boundaries.²² Patients also report the negative effects of stigmatizing or pathologizing diagnostic labels.²⁶

Mental illnesses understood through the lens of the medical model are entities that can be studied and designated. They can be 'treated' with medication, which implies that on an endophenotypic level, mental illnesses are to a certain extent predictable or determinable, operating outside the determination of the individual with the mental illness.

Mental Illness and Responsibility for Criminal Acts

Criminal responsibility traditionally requires actus reus and mens rea.¹ The former is the criminal 'act' itself and the latter the 'intention' to commit the crime. In common law jurisdictions such as England and Wales, the classic legal formulation to assess mens rea is the McNaghten construction. This asks whether

"at the time of committing the crime the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know what he was doing was wrong."²⁷

Where insufficient mens rea is established, an individual might be considered not guilty by reason of insanity.

Legal systems differ in their designation of individuals with mental illnesses following the commission of a criminal act. In England and Wales, NGRI defences are rare and typically used only in cases concerning murder. Most forensic patients are admitted following a prison transfer or conviction for a criminal act and being found to be suffering from a mental illness "of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment" at the time of sentencing (Section 37 Mental Health Act, 1983 (as amended)). Ultimately, individuals found NGRI are not convicted of an offence and thus are not punished, but rather given involuntary treatment in a secure setting.

The preclusion of explicit punishment in this instance falls within what Slobogin calls the preventive model of liberty deprivation.² This model presupposes that individuals may cause future harm to themselves or others, and the state is not concerned with ascribing blame for previous harms. In contrast to this, a retributive model of liberty deprivation holds to account and seeks to punish individuals considered responsible for committing harm to others. This approach assumes that individuals who commit criminal acts do so in a way that reflects principles of autonomy and self-determination—long-standing principles in the administration of criminal justice.²⁸ Thus, according to these models, individuals found NGRI are deprived of their liberty for future harm prevention and not punishment for autonomous behaviour.

This presents the recovery paradigm with a dilemma.^{8,29} One of the key tenets of recovery approach is the ability of individuals with a mental illness to self-determine and be responsible for their actions. This is to aid empowerment in recovery and reduce the stigma of incapacity and mental illness—sentiments reflected in the UN CRPD. However, some individuals experience debilitating mental illnesses against which it is hard and arguably unethical to hold them accountable for particular actions. This leaves

one asking whether a strict application of the recovery paradigm to these individuals would advocate removing the NGRI defence, thereby resorting to a retributive model of liberty deprivation or assigning responsibility in circumstance to which it may not be fair or accurate to do so.

Neuroscientific Evidence and Criminality

Given that the medical model proposes that mental illnesses are discrete entities distinct from the individual, it purportedly provides a reasonable empirical justification for the NGRI defence. Research conducted within the neurological sciences questions the extent to which human behaviour and emotion may be fully self-determined.^{30, 31}

Neuroscientific research using fMRI, MRI, and EMR techniques suggest that individuals scoring highly on measures of psychopathy demonstrate paralimbic system dysfunction in the brain.³² Research using fMRI techniques has also shown that individuals diagnosed with psychopathy that have committed a criminal offence exhibit abnormal functioning in specific areas of the brain when distinguishing abstract from concrete linguistic stimuli.³³

Anderson and colleagues found that individuals receiving injuries to the prefrontal cortex region of the brain at an early age were likely to later develop behavioural deficits; struggle to appreciate future consequences of decisions, including the prospect of punishment; and present defective moral and social reasoning.³⁴ These behavioural deficits are diagnostic criteria for psychopathy and reflect the content of the Psychopathy Checklist-Revised (PCL-R).³⁵ These deficits limit the extent to which psychopathic individuals can employ theory-of-mind techniques such as empathy and placing oneself in another's shoes. These traits play an important role in conforming to socially accepted and non-criminal behaviour.

The neurobiology of psychosis and violence has been explored with similar techniques. Studies are in their infancy and results are mixed; however, there are indications that differences exist for the functioning of certain areas of the brain between schizophrenic patients with and without a history of aggression.³⁶ Indeed, in a review of current neurobiological research on schizophrenia and aggression, Soyka notes:

“Several findings seem to indicate that in schizophrenia patients with aggression or persistent violence, certain brain functions or areas—in particular the prefrontal and frontal cortex—may be more severely impaired than in schizophrenia patients without aggression or violence.”³⁷

Dysfunction of the prefrontal cortex has been associated with violence and antisocial behaviour.

This brief summary suggests that there may be dysfunctions in the brain that increase the likelihood for some mentally ill persons to demonstrate behaviours deemed antisocial or criminal.

These examples highlight a medical model approach to the aetiology of psychopathy and psychosis. They suggest that certain criminogenic behaviours and emotional regulation may be associated with dysfunctions in the brain. Such studies are being used in criminal cases to mitigate individuals' liability for criminal behaviour.³⁸ It should be noted that evidence linking biological and neurological traits with criminality is mixed, its use in courts limited. More research is needed.^{38,39} However, research is slowly generating evidence to suggest that responsibility for one's actions can be diminished or negated by mental illness or defect—a position supporting the NGRI defence. This is not compatible with the emphasis the recovery paradigm places upon individual self-determination and empowerment.

Reconciling NGRI and the Recovery Paradigm: A New Approach

It would seem that to apply all the principles of the recovery model to all individuals all the time would be unfair and unhelpful. The recovery paradigm's key tenets of self-determination, responsibility, and empowerment are difficult to reconcile with the above studies and the NGRI defence.⁸

The medical model addresses self-determination and responsibility differently. This approach can better facilitate care for mentally disordered offenders. By mitigating or removing responsibility for one's action based on the presence of a mental illness, the criminal justice system can forgo a retributive model or avoid attributing blame unfairly. Instead, it can focus on preventing future harms by providing care.

Any finding of NGRI and subsequent treatment order is provided in the place of a punitive measure or unfair attribution of blame. This coincidentally serves several of the aims of the recovery approach. Individuals found NGRI can be placed within secure settings. These are ostensibly non-punitive environments that can provide a culture of care not possible in prison settings; permit periods of leave intended to maintain ties to the community; administer suitable medications; and will not condemn the individual as a fully accountable criminal wrongdoer. This all seems positive.

However, the NGRI defence still carries significant stigma. This is a flaw of the medical model approach. Slobogin has proposed a formulation of the NGRI defence in line with the UN CRPD stipulation that "...persons with disabilities shall enjoy legal capacity on an equal basis with others in all aspects of life."¹⁷ His approach removes mention of mental illness from the defence and replaces it with a subjective mens rea criteria that can be applied to both individuals with or without mental illness.

In this construction, an individual would be excused responsibility from an offence if they

“(a) lacked the subjective mental state for the conduct, circumstance, or result element of the crime; (b) believed circumstances existed that, if true, would have justified the offense; or (c) believed circumstances existed that, if true, would have amounted to duress; provided that he or she did not cause any of these mental states.”²

This reformulation would still permit a mitigation of responsibility for criminal acts in line with the prevailing medical model approach. Where an individual lacked the subjective mental state, they would not be held culpable. However, the assessment of culpability is not contingent on the presence of a mental illness per se. It would accommodate the recovery paradigm's emphasis on reducing stigma by making distinct the nexus between a mental illness—which is evolving, fluctuating, and not inherently criminogenic—and the criminal act.

Such a test would be applicable for individuals living with a mental illness and those not. It assumes that individuals with mental illness are capable of self-determination 'generally,' but in this particular instance lacked the subjective mental state. Individuals that present at court with a mental illness at the time of sentencing could still receive a treatment order, but the crucial nexus between mental illness and crime is lost; instead, the nexus between subjective mental state and crime is adjudicated. Individuals excused of culpability in this way can then engage in any needed treatment framed within the recovery paradigm.^{4,16}

The principles of autonomy, empowerment, and self-determination can consistently be embraced by these individuals in their recovery. This is because these concepts are ascribed to individuals living with a mental illness that has not been denied when found NGRI due to that mental illness. Instead, responsibility and autonomy are negated only for the purpose of assessing culpability at a single moment.

Conclusion

This paper has argued that the forensic psychiatric care system highlights an incompatibility between the medical model and the recovery paradigm. This incompatibility considers the extent agency is attributed to individuals with mental illness and the degree to which they ought to be held responsible for their actions.

The criminal justice system, tasked with establishing culpability for wrongdoing, does mitigate or preclude responsibility for certain individuals' actions, sometimes through the NGRI defence. This draws on principles taken from the medical model's approach to understanding the aetiology, symptoms, and prognosis of discrete, classifiable mental illnesses. This approach separates to a degree the mental illness from the individual and in doing so ascribes blameworthiness to it.

This runs counter to the recovery paradigm, which proposes that individuals can live alongside their mental illness, take responsibility for their actions, and, through empowerment, are capable of self-determination. In cases of criminal conduct connected to severe mental illness, these concepts are stretched. The medical model's removal of the mental illness from the self arguably better facilitates treatment for these individuals and precludes assigning guilt where it does not morally belong.

It is important to reconcile current NGRI defences with the recovery paradigm. Thinking critically about how to ascribe empowerment and self-determination to individuals found not responsible for their actions is a necessary step toward this. Slobogin's contribution removes mental illness from assessments of responsibility and provides for a subjective

mental state test.² Such an approach reduces the stigma of mental illness by making distinct culpability for criminal acts and mental illness. It avoids situations wherein individuals that ought not to be held culpable for their actions are held fully responsible—a possible proposition if all tenets of the recovery paradigm are strictly implemented.

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