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**CONSTRUCTING A DEFENCE OF INSANITY: THE ROLE OF
FORENSIC PSYCHIATRISTS**

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**A thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Philosophy in Health Science
The University of Auckland**

2010

ABSTRACT

This thesis explores the role of forensic psychiatrists as expert witnesses in criminal trials using the insanity defence in New Zealand. It relies on data generated through qualitative research methods and provides ‘thick descriptions’ of how the role works in practice as forensic psychiatrists, together with the instructing lawyers, construct the defence. Multiple data sources were accessed, including thirty-one interviews with lawyers and forensic psychiatrists, observation of a high profile criminal case, and interpretation of clinical and legal texts. The research extends the existing medico-legal literature that has studied the relationship between psychiatry and law and provides analysis which contributes to current debates around the use of psychiatric expertise in cases of insanity.

Drawing on contemporary socio-legal studies, the research focuses on the hybrid nature of the insanity defence, the hybrid expertise forensic psychiatrists’ practise as expert witnesses, and the symbiotic relationship between lawyers and forensic psychiatrists that occurs in this context. This thesis argues that the insanity defence is a hybrid construct that brings lawyers and forensic psychiatrists together in such a way that the boundaries, which should ideally define their discrete functions, become blurred. The way the insanity defence shapes forensic psychiatrists’ practices, and the relationship between lawyers and forensic psychiatrists, is also explored. The forensic psychiatrists’ practices are shown to be inextricably linked to the legal requirements for an expert witness and the defence of insanity. From this perspective, the forensic psychiatrists are not “doing psychiatry” as they would in a therapeutic setting, but rather they practise a hybridised expertise that reflects the hybrid nature of the insanity defence. The symbiotic relationship that occurs in practice as lawyers and psychiatrists make a case for insanity is demonstrated. This implicates lawyers in the production of effective expert testimony and illustrates how the defence of insanity is co-produced by both professionals in the courtroom.

This thesis highlights how the boundaries that aim to separate the responsibilities of forensic psychiatrists, lawyers and fact-finders become blurred in practice. It contends that these findings have significant implications for not only the continued use of forensic psychiatrists in cases of insanity, but also public understandings of madness.

ACKNOWLEDGEMENTS

First and foremost I would like to thank the lawyers and forensic psychiatrists who participated in this study. I am grateful to the judges and court staff, particularly at the High Court in Auckland, for making the process of accessing information as painless as possible. I appreciate all the time and effort these people put into helping me study the insanity defence.

The generous advice I received from my supervisors and the wider academic community contributed substantially to this thesis. I am indebted to my primary supervisor, Mary Finlayson, who provided encouragement during difficult times and approached my work with such enthusiasm (and with such an ‘eye’ for detail). To my supervisor Brian McKenna, many thanks for sparking my initial interest in forensic mental health and for proving constructive criticism throughout my PhD journey. Your flexibility around my work/PhD balance was most appreciated. To Warren Brookbanks for helping me access important people from within the ‘field’ and keeping me ‘in check’ with my interpretations of legal issues.

Special thanks to the ‘mental health crew’ and other colleagues at the School of Nursing. Tony O’Brien, Helen Hamer, Kate Prebble and Deborah Widdowson in particular, for their ongoing support, laughter and friendship. Without our philosophical discussions over coffee and lunch (and in the office when we should probably have been working on other projects), many of the ideas put forth in this thesis would not have developed as they did. To Judy Kilpatrick, thank you for allowing me to spend far too much time on my PhD and for providing the support to allow me to be with my family in difficult times. Valerie Smith, many thanks for proofreading the entire thesis in a very short time-frame.

Gary Edmond of the University of New South Wales was generous with his expertise and provided various opportunities for me to develop and present ideas to the wider academic community. Ivan Crozier supported me to travel to the University of Edinburgh and spend time in the Science Studies Unit. This was a fantastic opportunity that allowed me to mix with like-minded colleagues and forge long-term friendships.

The financial assistance of the University of Auckland Doctoral Scholarship and School of Nursing Postgraduate Scholarship was greatly appreciated. The Universitas 21 Doctoral

Mobility Scholarship provided me with the amazing opportunity to spend time at the University of Edinburgh. Every PhD student should try and get this scholarship!

Finally, I would like to thank my friends and family for their enduring support. Ryan for his encouragement throughout my academic endeavours and for putting up with the continual state of stress that goes with doing a PhD. Without your amazing ability to ease my anxieties and build my confidence who knows how I could have completed this thesis! My parents, Allison and Leon, for their limitless support, Dad your strength and courage over this past year has been an inspiration to me.

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CHAPTER ONE: INTRODUCTION

Forensic psychiatry is not just a way of getting paid for trying to answer unanswerable legal questions, although it does have a germ of that danger within it (Gunn & Taylor, 1993, p. 1).

In criminal trials using the defence of insanity, the court requires forensic psychiatrists to give expert witness testimony which is founded on a mixture of psychiatric and legal knowledge. This reflects the fact that the insanity defence itself is a hybrid construct (Edmond & Mercer, 1998; R. Smith, 1981), comprised of legal concepts that are founded on, and validated by, medical knowledge. When forensic psychiatrists perform their role in court, the hybrid features of this defence can lead to the blurring of the boundaries that ideally separate the responsibilities of the fact-finders and the expert witness. At its extreme, this situation can force forensic psychiatrists into positions in which they are attempting to “answer unanswerable legal questions” (Gunn & Taylor, 1993, p. 1). Drawing on multiple data sources this thesis investigates the blurring of such boundaries, focusing on the role that forensic psychiatrists play in the construction of the insanity defence and how their contribution in the courtroom translates in practice.

Forensic psychiatrists can be instructed by the court, the defence or the prosecution to complete a report and/or give verbal testimony to assist the judge or jury (hereinafter ‘fact-finders’)¹ in their determination of whether a defendant should be found ‘not guilty by reason of insanity’ (NGRI). Under section 23 of New Zealand’s Crimes Act 1961 a person who has committed a serious offence may be found NGRI if, when committing the act, they were labouring under natural imbecility or a disease of the mind. In such cases, the defence has to illustrate that the defendant was affected to such an extent as to render them incapable of understanding the nature and quality of the act or omission, or knowing that the act or omission was morally wrong in regard to commonly accepted standards of right or wrong

¹ ‘Fact-finders’ (or finders of fact) are the people who decide if the facts of the case have been proven in criminal trials. In cases of insanity, this could be a jury or a judge depending on what procedure is used to hear the case (see p. 7 of this introduction). Throughout this thesis, ‘fact-finder’ will be used to describe the collective of judge and jury.

(Brookbanks, 1998, 2007).² As part of this process, the defence and prosecution will employ an expert witness to give opinion on whether the defendant meets the above criteria. The purpose of the forensic psychiatrist's testimony in such cases is to reconstruct the mental state of the defendant at the time the offence(s) allegedly took place. On the basis of this reconstruction, they must then make inferences as to whether the defendant meets the criteria that underpins the defence of insanity. As such, this reconstruction involves a combination of psychiatric and legal knowledge.

This thesis broadly examines the role forensic psychiatrists undertake as expert witnesses in cases involving the defence of insanity. It closely focuses on the forensic psychiatrists' management of the problems they commonly face when undertaking this role and their interactions with lawyers as they assist in the construction of a defence of insanity. The analysis that comprises the following chapters is founded on data generated through qualitative research methods. In particular, the analysis draws on the material generated from interviews with forensic psychiatrists and lawyers, observation of a high profile murder trial using the defence of insanity, and readings of legal documentation (court transcripts, case law, and unreported case reports). Influenced by contemporary socio-legal studies of forensic expert witnesses, the overall aim is to attend to how the role translates in practice. This has led to an exploration of the murky, blurry and hybridised nature of the insanity defence itself and the role forensic psychiatrists undertake as expert witnesses. This focus departs from the current literature on this topic, which is not empirically based and largely written by professionals for professionals within the 'field'.³

² There are other criteria that the defendant could meet to be successful in receiving a verdict of NGRI, see p. 7 of this introduction for details. The legal constructs that comprise the defence of insanity will also be explored in greater detail using the data generated through this research in chapter five (p. 87).

³ This is not to say that there is no research conducted on this topic, rather there is limited social science research that has focused on how the role plays out in practice and from the viewpoint of forensic psychiatrists and lawyers. The research that does exist is mostly quantitative and focused on the forensic assessment process rather than the courtroom processes. Chapter two (p. 20) explores the existing professional literature in further detail.

This introductory chapter will provide the necessary background for the subsequent chapters. It will briefly contextualise the role of expert witnesses as it pertains to forensic psychiatrists and describe the defence of insanity as it stands in New Zealand legislation.⁴ The research focus, methods for data collection and analysis will then be introduced, followed by a structural overview for the chapters to follow.

CONTEXTUALISING THE STUDY

Forensic psychiatry in New Zealand

The role forensic psychiatrists perform as expert witnesses in cases of insanity, and as forensic psychiatrists more broadly, is very different from the tasks clinicians undertake in a therapeutic setting. This makes sense when considering definitions of the term ‘forensic’ in relation to psychiatry. The word ‘forensic’ is derived from the Latin notion *forensis*. This notion, itself a derivative of the word *forum*, described an ‘open court’ or public place where judicial matters were considered in Ancient Rome (Soanes & Hawker, 2005). Contemporary definitions use ‘forensic’ to describe the context in which scientific practices are applied to legal issues and criminal investigations and also to refer to the courts of law (Stewart, 2006). It is a term that describes the site where science, medicine and the law meet (Browne & Harrison-Spoerl, 2007). Forensic psychiatry, therefore, has been defined as a sub-specialty of psychiatry that is involved in the application of clinical expertise to legal issues in legal settings (American Academy of Psychiatry & the Law, 1995). When acting as an expert witness in cases of insanity, forensic psychiatrists are required to assist the court in legal determinations by drawing on their psychiatric expertise. This reinforces the idea put forth at the beginning of this chapter, that when these professionals undertake the role of expert witness their testimony is founded on a mixture of legal and psychiatric knowledge.

Specialising in forensic psychiatry involves many years of training. To become accredited as a doctor, an individual must firstly undertake six years of study that includes both teaching and clinical experience at a university in order to gain their basic medical qualification (New Zealand Medical Association, 2010). They must then gain their registration as a medical practitioner, which involves working as an intern in a general hospital for a year, followed by

⁴ Chapters five (p. 87) and seven (p. 140) explore current interpretations of ‘insanity’ and the role of forensic psychiatrists as expert witnesses in further detail.

another year as a resident medical officer. The Royal Australian and New Zealand College of Psychiatry (RANZP), the organisation which oversees the medical speciality of psychiatry in New Zealand, is responsible, amongst other things, for providing training, examination and awarding of the qualification of consultant psychiatrist.⁵ Specialising in psychiatry comprises a minimum of five years whereby doctors work across several areas of mental health service provision. The RANZP explains that a psychiatrist is a qualified medical doctor who has received further qualifications in order to specialise in the diagnosis, treatment and prevention of mental illness (Royal Australian and New Zealand College of Psychiatrists, 2008).

Training for psychiatrists wanting to specialise in forensic psychiatry is not a mandatory requirement of the RANZCP. After the first three years of ‘basic’ training in psychiatry, however, registrars must sub-specialise and forensic psychiatry is one approved option amongst other sub-specialities (including: old age, addiction, child and adolescent, adult, consultant-liaison, and psychotherapies). This ‘advanced training’ takes place over two years. On successful completion of training and examination requirements at both basic and advanced level, registrars then become a ‘Fellow of The Royal Australian and New Zealand College of Psychiatrists’ (Royal Australian and New Zealand College of Psychiatrists, 2008).⁶

Training in forensic psychiatry aims to prepare clinicians in the aspects of their role that extend beyond the traditional skills of psychiatry. As Chiswick and Cope (1995) explain, the sub-speciality of forensic psychiatry draws on a number of disciplines. Although its foundations are rooted in the medical science of psychiatry, they argue it is also a *requirement* that a psychiatrist practising in the forensic field have knowledge of the law and the criminal justice system (Chiswick & Cope, 1995). According to the Royal College of

⁵ The RANZP also administers continuing professional development programmes for practising psychiatrists and accredits the ‘Fellowship of the College’ to medical practitioners. Joyce (2002) has explained that prior to the establishment of the RANZP and local training posts in the 1970s, doctors who were interested in psychiatry would seek training in Australia, North America or the UK, often never returning to New Zealand, leading to significant workforce issues in New Zealand. Currently the College comprises of 2,900 fellows which account for approximately 85% of all practising psychiatrists in Australia and 50% of psychiatrists in New Zealand (Royal Australian and New Zealand College of Psychiatrists, 2008).

⁶ In the United Kingdom a similar ‘apprenticeship model’ is employed where over six years a registrar works across many clinical settings, under supervision for the first three years, followed by higher professional training where the psychiatrist does three years minimum to become a consultant forensic psychiatrist (Chiswick, 1995).

Psychiatrists in the United Kingdom (2010), the basic knowledge and skills a senior registrar (at advanced training level described above) should possess can be divided into three main areas: assessment, knowledge and therapeutic skills. Assessment includes learning how to write reports for the court and mental health tribunals. Knowledge focuses on mental health legislation, criminal and civil law and the ability to give expert evidence in court. Therapeutic skills relates to understanding the role of security as a method of control and treatment as well as learning specific treatment regimes for chronic illnesses and behavioural disorders (Chiswick, 1995). This gives some indication of how this role extends beyond diagnosis and treatment within the clinical setting to embracing different types of assessment within the constraints set by the legal context: providing treatment within the constraints of highly secure environments; and working with people suffering from serious ongoing mental illness and behavioural disorders (Reid, 2010). These aspects involve a very different set of skills and knowledge in addition to those learnt while practising in general psychiatry.⁷

Forensic psychiatry is a relatively recent development in New Zealand (Brinded, 2000). Up until 1988, specialised forensic mental health services and the subspecialty of forensic psychiatry practice did not exist. Rather, the ‘National Security Unit’ located at Lake Alice Hospital in the North Island housed the “54 most violent psychiatric patients nationally...and was therefore the main focus of forensic psychiatric practice in New Zealand” (Brinded, 2000, p. 454). A Commission of Inquiry in 1988 into the care of forensic patients detailed several recommendations that needed to be implemented to improve New Zealand forensic mental health services. In particular, the report recommended that regional forensic services be developed in Auckland, Hamilton, Wanganui, Wellington, Christchurch and Dunedin. Consequently, the government funded the building of medium-secure psychiatric units in these main centres (Mason, Ryan, & Bennett, 1988). Each of the regional forensic services comprise a medium and minimum security unit, a liaison service, a court liaison service, a community forensic service, and a consultation liaison service to general psychiatric services. It is only quite recently that the University of Auckland and University of Otago

⁷ Although a subspecialty, Golding (1990) reminds us that it is a mistake not to recognise the diversity of particular roles within the field of forensic mental health services. Forensic psychiatrists may be involved in several areas of the criminal justice system, civil justice system and as a consultant psychiatrist across both these domains. They may work within a variety of clinical settings (in inpatient, outpatient, or prisons for example) working independently or within multi-disciplinary teams (Chiswick, 1995).

(Christchurch campus) have implemented forensic psychiatry academic units (Brinded, 2000).

Correspondingly there is only a small pool of psychiatrists in the country who identify themselves as forensically trained. Between the years of 1998-2008 there were on average 29 forensically trained psychiatrists. More recently, the 2008 medical annual workforce survey identified 37 psychiatrists practising in the sub-specialty of forensic psychiatry, with this small group of forensic psychiatrists comprising only 5.5% of the total psychiatric workforce ($n = 674$) (Ministry of Health, 2009).

Forensic psychiatrists as ‘experts’ in the courtroom

As part of their many roles in forensic mental health services, psychiatrists may be requested by the court or lawyers to give evidence via writing reports or verbal testimony in court trials as expert witnesses (Chaplow & Peters, 1996). Although not mandatory, as part of the RANZCP sub-specialisation, advanced training in forensic psychiatry covers aspects relating to the role of expert witness (Royal Australian and New Zealand College of Psychiatrists, 2008). This is where registrars training in psychiatry learn and extend their skills beyond diagnosis, assessment and treatment to applying their practices within the context of the legal system.

There are also many legal rules that guide the admissibility and practices of expert witnesses.⁸ In particular, New Zealand’s Evidence Act 2006 comprises a series of rules that govern the admissibility of evidential material and the weight that should be assigned to it (France & Pike, 2007). This Act encompasses several exclusionary rules that govern what may or may not be accepted as evidence of fact by the courts.⁹ This Act stipulates that a statement of opinion is not usually admissible in court. Expert witnesses, however, are the exception to this rule and are given permission to give opinion on matters they have expertise

⁸ Chapter five (p. 101) of this thesis will consider these legal rules in further detail.

⁹ The exclusionary nature of the law of evidence has been attributed to the “deep-seated fear that evidence would be manufactured by or on behalf of parties” (Cross et al., 2005, para. EVA.2). These issues are considered in the review of professional literature related to psychiatric expert evidence in chapter two (p. 20) of this thesis.

in but which are unfamiliar to ordinary people (Cross et al., 2005). As the legal commentary of *Adams on Criminal Law* explains,

The Courts have acted on the opinion of experts from early times...Expert evidence is an exception to the rule that, in general, witnesses must speak only to observed facts and are not permitted to express their opinions or beliefs (Adams, Robertson, Brookbanks, & Finn, 2008, para. 2.14.01).

Subsection 25(1) of this Act stipulates that the opinion of an expert in a proceeding is admissible if the jury or judge is likely to acquire “substantial help” from the opinion in “understanding other evidence in the proceeding or in ascertaining any fact that is of consequence to the determination of the proceeding”. The aim of the expert’s testimony is to ‘assist’ the fact-finders in their decision-making rather than deciding the appropriate verdict of the case for them.

Under section 4(1) of the Evidence Act 2006 an expert means a person who has “specialised knowledge or skill based on training, study, or experience” and expert evidence “is the evidence of an expert based on the specialised knowledge or skill of that expert and includes evidence given in the form of an opinion”. This definition suggests that expert evidence may not be limited to one type of evidence and may include non-expert evidence as well as expert evidence which may also be in the form of an opinion (Mahoney, McDonald, Optican, & Tinsley, 2007). An expert’s competence, however, is a matter for the judge to decide. Although, once admitted by the judge the weight of the expert’s evidence is a matter for the jury to decide and they are entitled to reject it wholly or in part if they wish (France & Pike, 2007).

One of the areas of law in which forensic psychiatrists are required to give expert evidence is in relation to legal insanity. In these cases, the defence and Crown will each call psychiatric expert witnesses, usually but not limited to forensic psychiatrists, to give evidence as to whether the defendant meets the specific criteria that comprise the test for insanity (Brookbanks & Simpson, 2007). I will now provide a brief overview of the insanity defence as it stands in New Zealand law.

The insanity defence in New Zealand

Within the legal context, 'insanity' is concerned with assessing whether individuals should be held criminally responsible based on their state of mind at the time of an alleged offence (Brookbanks, 1998, p. 147, 2007; Tolmie & Brookbanks, 2007).¹⁰ The insanity defence is included in a class of defences termed 'excuse defences' which are 'complete defences' in that they must result in a 'not guilty' finding if accepted by the fact-finder (Rolf, 2006). This can be compared to diminished responsibility and infanticide which are partial defences that result in a guilty verdict, but with a lesser sentence of manslaughter.

Writing around 230AD one of the earliest examples of the reasoning behind the use of 'insanity' as a defence for murder was described,

...if a madman commit homicide he is not covered by the Cornelian Law [which laid down the legal consequences in roman time] because he is excused by the misfortune of his fate...he is punished enough by his madness (From Digest in Walker, 1985, p. 26).

At the start of the 11th Century it was noted that the Archbishop of York argued for special provisions for killings which were committed by a man who had fallen "out of his senses or wits" (Buchanan, 2000, p. 84). In 1724, Lord Tracy declared a man insane only if he is "totally deprived of his understanding and memory, and doth know what he is doing, no more than an infant, brute or a wild beast" (Cited in Buchanan, 2000, pp. 85-86). The 'wild beast' test, as it became known, was criticised in the Hadfield Trial of 1800, where Lord Erskine held that suffering from delusions alone was sufficient to render the accused insane. Considered a 'loosening up' of the wild beast test, the requirement for total deprivation was effectively debunked by the Hadfield decision and the defendant was acquitted. The acquittal of Hadfield raised questions as to the proper disposition of those found to be insane. Correspondingly, the Act of 1800, 'For the Safe Custody of Insane Persons Charged with

¹⁰ As Brookbanks (1998) has argued, insanity should not be confused with the doctrine of fitness to plead or fitness to be tried which is concerned with procedural fairness and ensures a person has the necessary functional ability to participate in a criminal trial. This procedural issue is not concerned with guilt or innocence, rather it is focused on whether the accused can understand the nature of the proceedings and is able to assist in their defence.

Offences' was implemented and introduced a 'special verdict' allowing for a person found not guilty to be detained 'until his majesty's pleasure be known' (Buchanan, 2000, p. 86).¹¹

By the beginning of the 19th Century, English courts were regularly acquitting individuals who were incapable of determining between 'good and evil' or 'right and wrong'. This occurred despite work being produced by those outside the legal arena focused on developing scientific understandings of the relationship between mental afflictions and criminal behaviour (Brookbanks, 1998). This began a theme that continues today—that the court, rather than the medical fraternity, was to have the final say in determining the sanity or not of an individual who commits criminal offences.

In 1843 Daniel M'Naghten¹² was acquitted for murdering the Prime Minister's secretary (in an attempt to assassinate the then Prime Minister Robert Peel). M'Naghten received a special verdict and was removed to Benthlem Hospital where he was detained indefinitely. The case caused ensuing controversy that resulted in a debate within the House of Lords where the Law Lords were asked to clarify procedure relating to the use of insanity in criminal trials wording (Buchanan, 2000; Memon, 2006, p. 230). Known subsequently as the M'Naghten rules,¹³ Tindal LCJ delivered the ruling of the judges in the House of Lords:

...jurors ought to be told that in all cases every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and if to establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under 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 (Cited in Matthews, 2004, p417).

¹¹ This is a very truncated history of the insanity defence. For further explorations of the development of the insanity defence see: Eigen (1995, 2003); Jones (1994); Robinson (1996); Smith (1981); and Walker (1985).

¹² The use of 'M'Naghten' in this thesis relies on legal spelling of this surname. There are many variations in spelling, with the most likely being McNaughtan. See Moran (1981) for further discussion of this.

¹³ Ironically, M'Naghten would not have been acquitted if he had been subject to these strict rules as he would have fallen short of meeting the cognitive-based test for insanity.

Described as a ‘knowledge-based cognitive standard’, in that the focus is on what the accused did *know* at the time of committing the crime (Rolf, 2006), this reasoning formed the basis of the insanity defence as used throughout Western countries today.¹⁴

The M’Naghten rules were incorporated into New Zealand’s criminal law under the Criminal Code Act 1893 (Robertson, 1967). Section 23 of the Crimes Act 1961 sets out an amended version of the M’Naghten rules that are currently applied in New Zealand courtrooms. It states:

- [1] Everyone shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved

- [2] No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable—
 - a) Of understanding the nature and quality of the act or omission;
 - or
 - b) Of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

- [3] Insanity before or after the time when he did or omitted the act, and insane delusions, though only partial, may be evidence that the offender was, at the time when he did or omitted the act, in such a condition of mind as to render him irresponsible for the act or omission.

As stated above, it is common practice in jury trials using the defence of insanity to involve the expert testimony of at least two forensic psychiatrists called by each party. Alternatively,

¹⁴ Throughout the United States there have been variations of the M’Naghten Rules in operation. The Durham Rule 1954 stipulated that no individual should be held criminally responsible if their actions were a consequence of mental disease. This test was disestablished in 1972 (S. R. Smith & Meyer, 1987). The Model Penal Code combined a cognitive and volition test so that a person could be found insane if their thinking was disordered or if they could not control their behaviour. Other States combined the M’Naghten Rules with a volition test called the ‘irresistible impulse’ test. An “irresistible impulse” has been defined as a behavioural response that is so strong that the person could not resist it by will or reason. The tests for insanity were restricted in 1984 when Congress passed the Federal Insanity Defense Reform Act. This Act adapted the Model Penal Code to a stricter M’Naghten based cognitive test, eliminating the irresistible impulse or volitional prong. Approximately 17 States use the M’Naghten based rules (Rolf, 2006). Some States have abolished the insanity defence altogether (Bonnie, 1983) while others have adopted the verdict of ‘guilty but mentally ill or insane’.

a person can be found NGRI by a judge alone under section 20 of the Criminal Procedures (Mentally Impaired Persons) Act 2003.¹⁵ Sub-section 20(2) allows for a procedure for dealing with a plea of NGRI in cases where both the prosecution and the defence agree on the basis of expert evidence that the only possible verdict available is not guilty by way of insanity. It states that a judge may find the accused not guilty for reason of insanity if:

- a) The defendant indicates that he or she intends to raise the defence of insanity; and
- b) The prosecution agrees that the only reasonable verdict is not guilty on account of insanity; and
- c) The judge is satisfied, on the basis of expert evidence, that the defendant was insane within the meaning of section 23 of the Crimes Act 1961 at the time of the commission of the offence.

Under both procedures, proving part two of the test for insanity set out under section 23 of the Crimes Act is most important. Natural imbecility is commonly understood to denote ‘congenital incapacity’ ‘subnormality’ or ‘mental retardation’.¹⁶ The major mental illnesses accepted by the court as amounting to diseases of the mind are those defined by the medical profession as “psychoses” which are characterised by loss of appreciation of reality, delusions and hallucinations (Adams et al., 2008, para. CA23.04; Garrow, Turkington, & Coghill, 2007, para. CR123.3). Chapter five will explore the legal constructs that comprise the legal test for insanity in detail. It will illustrate that what comprises these terms is always open to negotiation in the courtroom and what becomes important in individual cases is whether the mental illness affected the defendant’s ability to know the moral wrongfulness of their acts.¹⁷

The defence of insanity is used sparingly in New Zealand courtrooms. Figure 1 shows that in recent years (from 2004 onwards) the numbers of people acquitted by reason of insanity have

¹⁵ This legislation is concerned with various procedural aspects related to mentally impaired persons who come before the criminal courts. See Bell and Brookbanks (2005), Brookbanks (2005) and Brookbanks and Simpson (2007) for further interpretations of this Act.

¹⁶ This term is not used in the courtroom. See chapter five (p. 88) for a further discussion of this.

¹⁷ Rarely used, ‘nature’ and ‘quality’ relate to the physical character of the act or omission rather than separate terms denoting the ‘physical’ and ‘moral’ aspects of the case (Garrow et al., 2007, para 123.3). This legal construct will be referred to in chapter five, see p. 88).

increased. In 2007 there were 17 people identified by the Ministry of Justice (2009) as receiving the verdict NGRI.¹⁸ This could be a direct reflection of the new legal procedures implemented through the Criminal Procedure (Mentally Impaired Persons) Act 2003, although it is difficult to know what percentage of cases took place under the procedures implemented by this Act. Over the last ten years there were on average six people found NGRI per year (Ministry of Justice, 2009). To put this in a broader context, New Zealand statistics from 1970-2000 have indicated that homicides committed by persons with serious mental illness comprise 8.7% of all homicides.

Figure 1. Number of people found NGRI in New Zealand (1997-2007)

Year	Number of people found NGRI
1997	4
1998	3
1999	7
2000	4
2001	7
2002	10
2003	7
2004	15
2005	20
2006	13
2007	17

Source: Ministry of Justice, 2009

¹⁸ As with any administrative database it is important to note there may be some instances of data inconsistencies, arising from some miscoding. Thus all figures included in the above table are assumed to have an error band. Additionally, due to changes in coding systems early statistics may include a small number of people found ‘unfit to plead’ rather than NGRI.

Psychiatry and law as unhappy bedfellows

Despite the rareness of the use of the insanity defence, the intermingling of psychiatry and the law within this context has been controversial and much has been written by professionals within the area.¹⁹ The overriding duty of the expert witness is to assist the court on relevant issues impartially and within the expert's area of expertise (Adams et al., 2008). Psychiatric expert evidence, however, has been severely criticised as not being objective in nature (R. Rogers & Shuman, 2000), with popular notions that favourable testimony can be bought for a certain price tag (Champagne, Easterling, Shuman, Tomkins, & Whitaker, 2001; Gutheil, 1999; Hagan, 1997; Otto, 1989). The ways in which these highly contested cases involve conflicting psychiatric evidence has often been used in the literature to illustrate the lack of scientific basis of psychiatry (Coles & Veiel, 2001; Gutheil, 1999; Kenny, 1984; McSherry, 2001). While other commentators have argued that most disagreements between psychiatric experts revolve not around their opinions as to the mental illness of the defendants but whether the illness meets the narrow legal criteria for insanity – the 'ultimate issue' of the case (Gutheil, 1999). In this way, it is the debates over legal and moral questions that are argued to cause psychiatric experts to disagree.

Controversy around the use of psychiatric expertise in the courtroom reached its pinnacle with the acquittal of John Hinckley Jr in the United States. Hinckley was found NGRI in 1982 for attempting to assassinate President Regan and his press secretary. The jury believed that Hinckley, who suffered from paranoid schizophrenia, lacked the ability to know his actions were wrong because of the delusions he experienced (Rolf, 2006). The public reacted strongly to the verdict. They argued that the conflicting psychiatric evidence was caused by biased experts and that Hinckley's use of the defence was an abuse of the legal system to avoid punishment. Several legal reforms took place throughout the United States in response (Steadman, 1993).

These issues have often led to further discussion in the medico-legal literature around the incompatibility of medical knowledge with the legal context (Chaplow & Peters, 1996; Golding, 1990; Perlin, 1990b; T. Rogers, 2004). In particular, some of this literature has focused on how psychiatry's expertise of clinical diagnosis struggles to meet the legal

¹⁹ Chapter two (p. 20) will explore in detail the professional literature pertaining to the insanity defence.

system's definition of 'science' (Chaplow & Peters, 1996; Coles & Veiel, 2001; T. Rogers, 2004). Additionally, the ways in which the expert witness role creates ethical dilemmas for forensic psychiatrists in terms of the potential for the role to conflict with a doctor's therapeutic goals have also received significant attention (Appelbaum, 1990; Perlin, 1991; Sarkara & Adshead, 2002; Stone, 1984, 1994; Strasburger, Gutheil, & Brodsky, 1997). Overall, there is a general suggestion in this professional literature that psychiatry and law are essentially two very different knowledge systems that clash when insanity is being considered in the courtroom (Parker, 1996; Zemishlany & Melamed, 2006).

RESEARCH FOCUS

With the professional literature in mind, I became interested in exploring how the role forensic psychiatrists perform as expert witnesses works in practice. This research focuses on investigating how legal professionals and forensic psychiatrists work together in cases involving the insanity defence if the relationship between the two professions is as problematic as suggested in the literature. This led to an analytical focus on the role of the expert witness itself, as experienced by forensic psychiatrists, as well as the interaction between the two professionals, as a defence of insanity is being constructed.

There are three foci that provide the parameters of this research. Firstly, the study explores the practices that comprise the role of expert witness with specific reference to the processes forensic psychiatrists are involved in when assisting in the construction of a defence of insanity. Secondly, an additional focus is the difficulties associated with this role that the forensic psychiatrists face. Thirdly the study pays close attention to the interactions between the forensic psychiatrists and lawyers within the courtroom context.

Research questions and aims

These three foci led to the development of three research questions:

1. What practices are involved in the expert witness role that forensic psychiatrists take on?
2. What are the difficulties associated with the role for forensic psychiatrists?
3. How do the lawyers and forensic psychiatrists interact to contribute to the construction of the insanity defence?

The overall aim is to consider the implications of this research for existing social science research devoted to studying legal processes involving expert witnesses and the insanity defence.

Positioning and rationale

The three foci for this research were shaped by several assumptions that I had about the role of the expert witness in cases involving the insanity defence. Prior to working up the proposal for this research, I had assisted in the completion of a research project that involved a certain amount of interaction with the field of forensic mental health and mental health law. In particular, on working on a project that aimed to investigate the media reporting of homicides committed by people defined by the court as ‘mentally disordered offenders’, I soon began to notice the complexities involved with forensic psychiatrists taking on the expert witness role. Much of the reporting by the media on such homicides covered court trials and, in particular, illustrated the important role of the expert witnesses as the insanity defence was played out in the courtroom (McKenna, Thom, & Simpson, 2007). A large percentage of these articles, therefore, were focussed on the expert evidence given by psychiatrists. I became aware that this was an inherently complex role that psychiatric expert witnesses play in court that must not only have serious ethical ramifications for them within their medical profession, which largely embraces therapeutic goals, but also in terms of moulding their expertise to fit the legal rules within the context of the courtroom environment. On working with a forensic psychiatrist on this project, I started to inquire as to some of the complexity surrounding these issues. I soon became aware that there was a lot more going on than I had originally thought, and that there was no research in New Zealand that actually asked people involved in these

trials what common problems they faced and how they managed these difficulties in order to assist in the legal decision-making required in such trials.

These early experiences within the area directly shaped the first two foci of this research. I wanted to talk to forensic psychiatrists and legal professionals who had experienced these kinds of trials to see how they viewed the role of the psychiatric expert witness and the common problems that occurred. My first impressions led me to think of the relationship between psychiatry and law as problematic. I envisaged that within the context of the adversarial system the complex and often competing relationship between these two disciplines would be highlighted to the extreme, offering an opportunity to investigate the dynamics that occur when medicine meets law.

As suggested above, these initial assumptions were also based on my early readings of existing literature that largely problematises the relationship between psychiatry and law. Not only did this literature form the basis for my enthusiasm to explore these issues further, it also formed the rationale to use a socio-legal lens to analyse the role that forensic psychiatrists play in the construction of the insanity defence and how their contribution in the courtroom translates in practice. In this way, the research questions were the result of critical reflection on the existing professional literature.

In particular, it was through this critical reflection that I recognised gaps in knowledge around the role forensic psychiatrists undertake when performing as expert witnesses in cases involving the insanity defence. Much of the professional literature is conceptually based and there is a real lack of empirical research that has paid attention to the apparent problematic relationship between psychiatry and law in this context. However, there remains no in-depth qualitative research focused on how the role works in practice based on the experiences of forensic psychiatrists and lawyers who participate in trials using the insanity defence. Forensic psychiatrists are rarely asked about the difficulties they face when performing the role of expert witness. Instead, the limited quantitative research that does exist usually revolves around legal professionals' views of psychiatrists who give expert testimony. In this way, the voices of forensic psychiatrists are often excluded from empirical research endeavours. In sum, most of what has been written about the role of forensic psychiatrists in the courtroom has been written by practitioners for professionals consumption (R. Smith &

Wynne, 1989). There is little written by outsiders looking in on the role of forensic psychiatrists in the legal system.

Additionally, the ways in which some of the professional literature conceptualise the place of psychiatric expert witnesses in the courtroom, the relationship between psychiatry and law, and ‘science’ in general, is problematic. Specifically, the current thinking around the topic can tend to be analytically dualistic and grounded in idealised understanding of science. The end result of most conceptual papers on this topic, therefore, is to appropriate blame to either ‘side’ – psychiatry or law – for the problems that occur with the use of psychiatric expert witnesses in cases using the insanity defence. This thesis argues that this simplifies the complex interactions between legal professionals and forensic psychiatrists that occur within this context, and ignores the ways in which the insanity defence creates a situation in which psychiatric and legal knowledge cannot be easily separated. This murkiness that occurs in practice when psychiatry meets law in this context has received little empirical focus.

Analytical framework

The unease I experienced when reviewing the professional literature led me to search for a different approach to collecting data and conceptually understanding how the role worked in practice. In this way, the limitations found with the professional literature provided the rationale for using a socio-legal approach to investigating and analysing the role forensic psychiatrists inhabit as expert witnesses in insanity trials. Recent socio-legal focused research, particularly within the interdisciplinary field of science and technology studies (STS),²⁰ has explored the role of forensic science in contemporary criminal trials, focusing closely on the content of expert witnesses’ testimony and report writing, the interactions between experts and their instructing lawyers and the ways in which their expert knowledge becomes shaped for legal purposes (Bal, 2005; Edmond, 1998a, 1998b, 2001; Jasanoff, 1995; Lynch, 1998; Lynch & Jasanoff, 1998; Mercer, 2002b; R. Smith, 1988, 1989; R. Smith &

²⁰ STS is a label broadly used to describe an interdisciplinary field of academics, practitioners, researchers and professionals devoted to studying how various factors (for example social, political, and cultural values) affect scientific and technological endeavours. How these endeavours affect society, politics and culture are also a focus. STS specific undergraduate, doctoral and masters programmes are offered internationally, although no such programmes exist in New Zealand. Study topics vary tremendously and transcend specific academic disciplines and this thesis only uses a small group of researchers’ work that could be defined as falling under STS that studies forensic expert testimony. Chapter three (p. 43) will explore this work in detail.

Wynne, 1989; Solomon & Hackett, 1996; Wynne, 1989). This kind of research became increasingly important to my research endeavours because of its focus on how expert witness roles are played out as a defence is constructed in the courtroom.

The analytical framework developed to make sense of the data collected draws on this work produced by STS researchers. In particular, it influenced my analytical focus on the blurring of boundaries and the symbiotic relationship between lawyers and their instructing expert witnesses that occurs in insanity trials and the hybridised practices of forensic psychiatrists when conducting the expert witness role.

Research methods

The focus of this research led to the selection of particular methodological strategies. I took a qualitative approach which included the use of interviews, collection of legal texts and observation of courtroom practices as data collection methods. The research involved semi-structured face-to-face interviews with 17 forensic psychiatrists and 16 lawyers (7 defence and 9 prosecution lawyers) who had experience in criminal cases specifically involving the defence of insanity. The legal texts collected comprised both the official case reports (reported and unreported cases) on specific cases ($n = 38$) and legal commentary on the insanity defence which have significant implications for legal practices. The court records of nine trials were also accessed. Finally, to obtain further insights into courtroom interaction between psychiatric expert witnesses and legal professionals, one criminal trial using the defence of insanity was observed over six weeks.

THESIS STRUCTURE

Following this introduction, chapter two explores the professional literature that has discussed the role of forensic psychiatry in legal decision-making around insanity. The chapter aims to review the current thinking around the topic and pave the way for building a rationale for a socio-legal analysis of the expert witness role and the interactions between forensic psychiatrists and their instructing lawyers.

Chapter three sets out to develop the conceptual devices that are used in the analysis of the research findings for this thesis by drawing on the work of a small group of STS researchers who have attended to the socio-legal aspects of forensic expertise. This includes the use of

the metaphor of ‘boundary-work’ and associated concepts of ‘deconstruction’ and ‘reconstruction’. Boundary-work is continually used throughout the findings chapters of the thesis to interpret the practices of expert witnesses and lawyers in the courtroom which aim to maintain boundaries between facts and values, psychiatry and law, madness and badness. The way these boundaries become blurred in practice is captured with the additional conceptual tropes of ‘hybrid’ and ‘symbiosis’. These metaphors are used in the analytical chapters to interpret the role of expert witness as performed by the forensic psychiatrists and the interactions between forensic psychiatrists and lawyers as they construct a defence of insanity.

Chapter four details the research strategies used to collect and analyse the data and outlines the methodological and ethical issues experienced while conducting this research.

Chapters five, six, seven and eight present the research findings for this study. Chapter four is focused on how the legal texts and participants in this study interpret the defence of insanity and the role psychiatric expert witnesses play in its construction. The overall aim of the chapter is to provide an ‘ideal’ account of the test for insanity and the role of the expert witnesses in order to set the scene for the analysis of the murkiness that can occur in practice when these cases become contested. The chapter uses boundary-work to explore how ideal interpretations of the test for insanity and the role of the expert witness attempt to build several boundaries in order to mark out the territory that is under the jurisdictional control of legal professionals. It illustrates how the formation of these boundaries shows up the law’s understandings of expert knowledge, which are based on idealised views of science.

Chapter six explores one area where the boundaries set out in chapter five become blurred by focusing on the murkiness that occurs in practice when attempts are made to delineate internal from external factors, an integral criterion of the insanity test when pure methamphetamine is in issue. The chapter will conclude by reinforcing a recurrent theme of this thesis – that the boundaries that separate the responsibilities of the expert witness and the legal system can become blurred in this context to the point where it is also difficult to clearly separate where lay knowledge ends and expert knowledge begins.

In chapter seven the theme of blurring boundaries is continued through a discussion of the ways in which the practices of the forensic psychiatrists, when undertaking the expert witness role, are inseparable from the legal requirements that shape them. This chapter will aim to continue the theoretical theme developed in the preceding chapters that conceptualised the expert witness role in cases involving the defence of insanity as one which requires accommodation to the legal requirements for the insanity defence and that of expert witnesses. The chapter concludes that it is productive to view it as practice based not solely on psychiatric knowledge but rather resembles a ‘psychiatry-law’ hybrid formation (Edmond, 2001; Mercer, 2002b).

The final findings chapter brings together the theoretical themes developed over the preceding three chapters. It uses a specific court trial – the case of ‘X’ – to explore the interactions between forensic psychiatrists and lawyers as they build a persuasive narrative ‘for’ or ‘against’ a verdict of insanity. Again using the trope of boundary-work, a close examination of the strategic techniques employed by these professionals to show up the alignment or misalignment of a forensic psychiatrist’s testimony with ‘ideal’ understandings, described in chapter five of an expert witness, will be undertaken. In doing so, chapter eight will show that part of being an ‘ideal’ expert witness in this context is the effect of the forensic psychiatrist’s relationship with the legal party instructing them, which resembles Edmond’s (2008) illustrations of the symbiotic relationship that occurs within the courtroom between forensic experts and lawyers. It is argued that this implicates the legal professionals, as well as the forensic psychiatrists, as enablers (or hinderers) of effective expert testimony.

Chapters nine and ten concludes the thesis. Chapter nine draws the findings of the study together and highlights the contribution of this study to existing research in this area. It also considers the theoretical and practical significance of the research. It then considers the implications of this research for the continued use of forensic psychiatrists as expert witnesses in cases of insanity and for public understandings of ‘madness’. Chapter ten considers future research that could be conducted to further enhance understandings of the use of psychiatric expertise in legal settings.

CHAPTER TWO: THE MEDICO-LEGAL LITERATURE

This chapter reviews the existing literature on the role of forensic psychiatrists as expert witnesses in insanity trials. This literature is strongly focused on the controversy surrounding the role and the problematic relationship between law and psychiatry.²¹ The chapter reviews the literature under five thematic categories, relating to:

1. The lack of objectivity associated with psychiatric expert evidence
2. The problems of conflicting psychiatric expert evidence
3. The lack of a scientific basis for psychiatry
4. The legal constraints of the adversarial system on psychiatric knowledge, and
5. The idea that psychiatry and law are two separate knowledge systems that are always going to clash.

This chapter aims to explore these five areas, providing the background for chapter three's critical analysis of conceptual underpinnings of this work.

Most of the work reviewed in this chapter can be characterised by its intention to be used for professional consumption. In other words the articles are often *by* professionals *for* professionals. They usually include authors from within the fields of psychiatry, psychology, and/or the law, although it must be noted that scholars from philosophy have also contributed

²¹ The insanity defence is one of the most contested areas of criminal law and has generated significant debate among supporters and opponents alike (for example: Arenella, 1982; Arrigo, 2002; Bonnie, 1983; Brookbanks, 2002; Moore, 1985; Perlin, 1990b, 1997, 2000; Wales, 1976). Correspondingly, there is a large body of literature focused on the legal issues that have emerged from these debates. Although this is important work, this thesis is focused on the relationship between psychiatry and law with specific reference to the legal context of insanity jurisprudence. It does not attempt to engage in debates about the effectiveness of legal insanity as a defence. Rather, the ways in which the psychiatrists and legal professionals' interactions contribute to the construction of the insanity defence and the problems associated with the role of psychiatric expert witness is the topic of this thesis.

to the debate (cf. Kenny 1983, 1984).²² The review of the literature, therefore, also provides an overview of the practitioners within the field perceptions of the problematic aspects of the relationship between psychiatry and law in the context of insanity trials.

THE OBJECTIVITY OF PSYCHIATRIC EXPERT EVIDENCE

The overriding duty of the expert witness is to assist the court on relevant issues impartially and within that expert's area of expertise. Readings of New Zealand case law suggest expert evidence is embraced sceptically by the courts due to the fact that juries often give more weight to the testimony of 'experts' than other witnesses (Adams et al., 2008, para. 2.14.01). There is also a general sense in the literature that the legal profession mistrusts mental health experts (R. Rogers & Shuman, 2000). For instance, if experts concur on evidence in an insanity case they are seen as usurping the role of the jury, however, when they disagree it is often described as a 'battle of the experts'. Post Hinckley,²³ these concerns of legal professionals were exacerbated due to the American public's strong reaction to the conflicting evidence that occurred in this trial which they surmised was caused by biased experts (Hans, 1986; Hans & Slater, 1983; Low, Jeffries, & Bonnie, 1986; Slater & Hans, 1984). Federal jurisdictions responded to this case by implementing several legal reforms that tightened or abolished the test for insanity (Perlin, 2000).

²² It is important to note that the way in which some of this literature conceptualises: (1) the role of forensic experts in the courtroom, (2) the relationship between forensic experts and lawyers, and (3) 'science' in general has been subjected to critique (Caudill, 2001, 2002; Edmond, 1998a, 1998b, 2001, 2003, 2004, 2005, 2008; Gieryn, 1983, 1995, 1999; Good, 2007; Jasanoff, 1995, 2008a, 2008b; Jones, 1994; Lynch & Jasanoff, 1998; Mercer, 2002a, 2002b; R. Smith, 1981, 1985). The STS focused research on forensic expert evidence offers an alternative way to understand what occurs when psychiatry meets law. This alternative way of viewing expert evidence may not mesh with the existing medico-legal literature. This will be elaborated on later in chapter three.

²³ As chapter one (p. 13) explained, Hinckley attempted to assassinate President Ronald Reagan and successfully pleaded NGRI. This verdict caused public outrage not only in relation to the use of psychiatric experts, but Hickley's use of the defence was considered to be an abuse of the legal system to avoid punishment (see Steadman (1993) for a comprehensive review of these reforms in light of empirical studies on the use of the insanity defence in North America).

Sceptical accounts by New Zealand legal practitioners have often emphasised the biased nature of experts. In *R v Griffin* (2001) Justice Thomas argued that although the evidence given by expert witnesses is probably the best means within an adversarial system of providing fact-finders with information on matters calling for expertise:

[m]any barristers have been heard to observe, without any suggestion that they are being unduly cynical, that you can find an expert to support any proposition...Experience suggests that the Courts should be prepared where appropriate to approach the evidence of experts with a healthy scepticism (Thomas J cited in Adams et al., 2008, para. 2.14.01).

Justice Mahon (1979), in his address to the *Congress of the Australian and New Zealand Association for the Advancement of Science*, described occasions where advisers for a plaintiff would consult many experts in the search of an opinion that ‘fits’ with their argument:

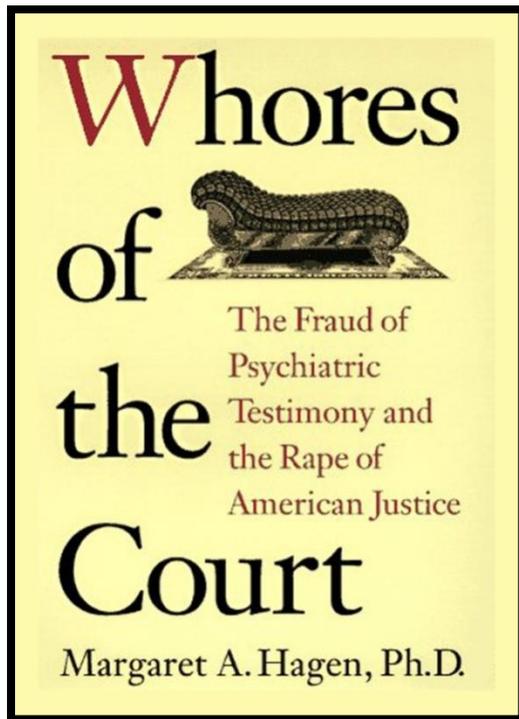
It used to be quite common when I was at the Bar for the advisers for the plaintiff in a personal injury case to go to one doctor after another in search of an opinion which would relate the present condition of the plaintiff to his accident...the case went to trial upon the opinion of perhaps the fifth or sixth doctor consulted and, not unnaturally, the jury would remain unaware that the preponderance of opinion among the doctors consulted by the plaintiff was totally against the proposition now advanced with some confidence before them (Mahon, 1979, p. 123).²⁴

Beyond the New Zealand context there is a common public perception that court trials are an arena for “battles of the experts” and that mental health professionals are often “hired guns” (Champagne et al., 2001; Gutheil, 1999; Mossman, 1999; Otto, 1989). This claim has even been extended to suggest psychiatrists are ‘whores for hire’ as illustrated in Hagan’s (1997) book (see Figure 1. below). Following this logic, economic incentives and the adversarial system are seen to produce evidence to fit a particular argument demanded by either the defence or prosecution, even if it does not reflect the consensus view of the scientific community in which it is embedded (Champagne et al., 2001; Golding, 1990). Gutheil et al.,

²⁴ Mahon’s address goes on to review several attempts by jurisdictions overseas to appease the apparent impartiality of expert witnesses, these include the introduction of assessors and court appointed experts. Assessors are court appointed scientific experts or a panel of experts that are charged with the duty of evaluating scientific testimony and advising the Court thereon. Court-appointed expert witnesses perform the duty of other expert witnesses utilised by the Crown and defence, but are instructed by the Court rather than counsel. Judge Mahon argues against both these procedures, arguing that judges are quite capable of assessing scientific evidence put before the Court. This idea will be considered in the chapter three (p. 49).

(2006) discussed instances where the notion of experts as ‘hired guns’ is exploited by lawyers in court to discredit testimony: “cross-examining attorneys commonly ask what the expert’s fee is, how much the expert has earned on the case so far, and what percentage of an expert’s income or time comes from forensic work” (Gutheil, Simon, & Simpson, 2006, p. 518).²⁵

Figure 2. Cover of Hagan’s Book (1997)



International research has indicated that legal professionals have similar views. An Australian study (2001), for instance, surveyed judges’ ($n = 244$) perceptions of the presentation of expert evidence in the courts. Their summary of the findings indicated that judges were concerned about experts’ lack of objectivity in the form of bias, partisanship and lack of neutrality. Within the criminal justice arena, psychiatric evidence was cited as the most common concern for judges, followed by science and psychology (Freckelton et al., 2001).

Apart from this study, there is a dearth of research devoted to examining these notions empirically. Dattalio et al., (2006) examined attorneys’ perceptions of the biases of their

²⁵ The legal practice Gutheil et al (2006) describe can be understood as a strategic technique of ‘deconstruction’ – a term used by socio-legal researchers exploring law-science interactions. The idea of popular notions of bias in experts being used as a deconstructive device by lawyers is described in chapter three (p. 57).

retained mental health expert. The study sought to explore whether attorneys considered experts who only worked for one ‘side’ (defence or prosecution) more likely to be biased, or alternatively, whether they viewed those who did work for both sides as: “prostitute[ing] themselves by working for whoever pays them without allegiance to one side or the other” (Dattilio et al., 2006, p. 489). The results suggested that attorneys viewed mental health experts who worked for both sides as less biased and more balanced in their testimony—they were considered more trustworthy and loyal. Experts who only gave evidence for one side were less desirable.²⁶

Other research has considered what has been labelled the ‘pull to affiliate’ whereby the expert witness becomes emotionally committed to aligning their opinion of a legal outcome with the side that retained their services (Murrie & Warren, 2005). Otto’s pilot study (1989) examined the degree to which the testimony of mental health professionals in criminal trials differ according to which party retains the expert. Participants, who were doctoral psychology students ($n = 32$), were split into two groups of 16. The first group was retained by the prosecution and the second by the defence. They were then presented with two fictitious cases (1 = civil, 2 = criminal) and asked to provide their verdict for the case. The results indicated that respondents recruited by the prosecution were more likely to find the defendant guilty, while those recruited by the defence were more likely to conclude the defendant was insane. There was no significant difference in the two groups’ perceptions of the degree of mental illness suffered by the defendant, rather the two groups differed in their views on whether the defendant’s actions were a product of their mental state. The group retained by the defence was more likely to link mental illness with the crime than the group retained by the prosecution (Otto, 1989).

Rogers (1987, p. 151) has theorised this occurrence as ‘forensic identification’ whereby clinicians unintentionally take on the “fact pattern” or “theory” of the attorney who recruited their services. Otto argues that this seriously implicates the objectivity and impartiality that is required of expert witnesses (Otto, 1989). Additionally, various cases of intentionally

²⁶ The authors also talked about court appointed experts being more objective and neutral. This idea will be discussed later in chapter three (p. 49).

biased testimony have been identified in literature, including: financial incentives, promotion of a particular social issue, and a need to meet employers' expectations.²⁷

As a result of intense criticism of psychiatric expert witnesses, labelling them as biased, partial and not objective (Champagne et al., 2001; Homant & Kennedy, 1987b; Otto, 1989; Redding & Reppucci, 1999), some researchers have explored the 'extra-clinical' factors that can influence clinical opinions in the legal context (Murrie & Warren, 2005). Homant and Kennedy (1987b) surveyed 262 American psychiatrists and psychologists (27% response rate) to elicit their opinions on criminal responsibility in three hypothetical insanity defence cases. They also measured respondents' political ideology and their attitude generally to the insanity defence. The psychiatrists in their study appeared to be slightly more supportive of the insanity defence in the hypothetical cases, although this finding was not statistically significant. Measurements of respondents' ideology indicated that 'liberals' were more likely to be supportive of the insanity defence (Homant & Kennedy, 1987b).

CONFLICTING PSYCHIATRIC EXPERT EVIDENCE

The above suggested that in court proceedings of an adversarial nature, where evidence is disputed or in conflict, the less objective side of psychiatric expert evidence can be revealed. This may have grave implications for jury decision making. As Justice Mahon discussed, in most cases where the juror considers the facts in light of evidence which she or he hears from expert witnesses, the average juror performs conscientiously and faithfully. However, in cases where there is disputed scientific evidence that is lengthy and conflicting, the juror determines the outcome of the case with only a vague impression of the scientific or technical evidence or, in some cases, may largely ignore or put expert testimony to one side (Mahon, 1979, p. 126).²⁸ It has also been noted in the international literature that the juror's ability to understand subtle differences amongst the opinion of psychiatrists, especially in cases that involve complex and conflicting testimony, may be limited (Freckelton, 2007).

²⁷ One attempt to curb this bias was seen in the reinstatement of the 'ultimate issue' rule in American courts around this time (R Rogers & Ewing, 1989; Slovenko, 2006). This rule excluded expert opinion on issues which are to be considered by the fact-finder, for instance whether or not the defendant was insane at the time the offence was committed. This is discussed further below on page 26.

²⁸ Justice Mahon further argued that there should be procedural reform in New Zealand to allow for the presiding judges in such a case to prepare a typescript memo for the jury stating the "salient facts relied upon by each of the experts, and the conclusions and reasons for those conclusions which the expert witness has advanced" (Mahon, 1979, p. 126).

There is limited research focused on the possible implications of conflicting and complex expert evidence on jury or judicial decision-making (Devine, Clayton, Dunford, Seying, & Pryce, 2001). Freckelton, Reddy and Selby's (1999; Freckelton et al., 2001) survey of the Australian judiciary found that a large proportion ($n = 178$, 76.72%) reported they 'occasionally' did not understand the expert evidence in the case put before them and 21.96% ($n = 51$) reported finding it difficult to evaluate opinions expressed by one expert against those expressed by another. There is scarce research that has questioned the psychiatrists who regularly give expert evidence in criminal trials on these issues.

Some of the literature has pointed to the idea that conflicting psychiatric expert testimony illustrates the lack of true science in their evidence. Gutheil (1999, p. 768) explained that the public have the naïve view that: "If psychiatrists cannot agree on who is insane, then psychiatry itself must be bogus". Most of the disagreements between psychiatric experts, he argued, revolve not around their opinions as to the mental illness of the defendant but whether the illness meets the narrow legal criteria for insanity, the 'ultimate issue' of the case (Gutheil, 1999). In this way, it is the debates over legal questions that cause psychiatric experts to disagree. This is discussed further in the next section (p. 37).

THE SCIENTIFIC BASIS OF PSYCHIATRY

One of the main criticisms directed at psychiatric expert evidence has surmised that psychiatry lacks a scientific basis (Faust & Ziskin, 1988; Kenny, 1983, 1984). This literature has noted that the issues discussed above relating to impartiality and conflicting evidence all relate back to the uneasy fit of psychiatry with science and therefore with the 'expert' status it is granted in court. This has been most profoundly displayed in discussions over the admissibility rules which govern the 'inclusion' or 'exclusion' of scientific evidence in court and the evidence regarding the 'ultimate issue'.

There are many rules of evidence that govern the admissibility and use of expert evidence in criminal trials. Generally, these rules dictate that to be accepted in court the evidence of psychiatrists must speak to an issue that is beyond the experience of members of the jury (Law Commission, 1991). Psychiatric expert evidence is admissible, therefore, when focused on the issue of whether the accused was suffering a "recognised form of mental impairment at the time of committing an offence because the determination of mental impairment

requires a level of specialist knowledge that goes beyond the realm of experience of members of the jury” (McSherry, 2001, p. 14). Some commentators have suggested that one of the ‘problems’ associated with psychiatric expert witnesses is the profession’s inability to *meet* and *maintain* these admissibility criteria of ‘expert’ status throughout court proceedings (Chaplow & Peters, 1996; Shuman, 2002). The following section discusses the literature focused firstly on psychiatry meeting the criteria of ‘expert’ and secondly the ability of the discipline to maintain this status in the courtroom.

Meeting the ‘expert’ criteria

There are several American Court decisions²⁹ that have showcased two different approaches to the inclusion and exclusion of expert evidence. Before 1975, the testimony of an expert was admissible only if it provided specialised information outside of the jury’s knowledge base and did not rely on hearsay nor address the ultimate issue of the court case (Showalter, 1994-1995). Judicial scrutiny largely focused on the qualifications of the experts (Shuman, 2002).

In *Frye v. United States* (1923) the admissibility of evidence moved beyond the qualifications of experts being the sole criteria of inclusion of expert opinion (Shuman, 2002). In *Frye* the United States Court of Appeal held that the results of a polygraph test were not admissible because the fundamental elements of the test were not ‘generally accepted’ in the field to which it belonged. The *Frye* test, which emerged from this case, held that to be admissible the testimony of scientific experts must be based on a discovery or principle that have gained general acceptance in the particular field they originate from (Gatowski et al., 2001). Following this ‘general acceptance’ from scientists became the sole criterion by which a particular domain of knowledge was determined as admissible in court.

Then in *Daubert v. Merrell Dow Pharmaceuticals* (1993) the Supreme Court held that for testimony to be admissible, the judge must have determined the evidence as scientifically ‘valid’ and ‘reliable’. Consequently, judges were given the explicit role of ‘gatekeepers’ in the evidentiary process by determining the relevance of scientific knowledge for the trial on

²⁹ It is important to note that common law relating to the admissibility of expert evidence in New Zealand has not accepted the *Frye* or *Daubert* tests. The current test used in New Zealand is discussed in further detail in chapter five.

which they presided (Showalter, 1994-1995). Validity and reliability had to be determined by the judge in various ways including the consideration as to: (1) the testability of the theory and method; (2) the rate of error associated with the theory and method; (3) the extent to which the theory or method had been subject to peer review and publication; and (4) the general acceptance of the theory or method by the scientific community (Gatowski et al., 2001; Slobogin, 1998).

Both these court decisions suggested that in order to be admissible as expert evidence, expert testimony has to be based on 'scientific' knowledge. How the legal system defines science, therefore becomes important. The above suggested that to be considered scientific knowledge, the theory and methods on which the evidence is based should be testable and have been subject to testing having also been accepted by the scientific community.

Philosophers have attempted to erect criteria for assigning the label of scientific to particular bodies of knowledge. Kenny (1983) developed four criteria that determine a discipline's body of knowledge to be 'scientific'. His work is singled out here because of the focus on how psychiatry finds it difficult to meet his criteria and therefore the criteria of 'expert' in the courtroom. Kenny argued that a discipline to be considered scientific must: (1) be a part of a body of knowledge that is reliable and agreed upon. In this way, science is a body of knowledge comprised of *consistent, reliable* data that is generally agreed upon by members of the discipline to which it belongs. In the legal setting different experts must, therefore, not give conflicting answers to questions central to their discipline. The discipline must also have (2) appropriate *methods* that can *replicate* results. There must be agreed upon and accepted methods to gather data so that if these procedures are carried out by different members of the discipline they should result in the same findings. The body of knowledge must also be (3) *cumulative* in the sense that any additional knowledge must expand and build upon the foundations of existing knowledge not merely add to it: "Research once done, does not need doing again; if you have to repeat someone else's experiments...that shows you think there is something wrong with this experiment" (Kenny, 1983, p. 206). Lastly, (4) results must be predictive and thereby *falsifiable*.

Kenny's article coincided with a capital sentencing trial in America that illustrated how psychiatry may not meet the criteria for 'science' nor be admissible as 'expert knowledge' for

the Court. The case of *Barefoot v Estelle* (1983) involved a psychiatrist who gave evidence on behalf of the prosecution in which he predicted the future risk of dangerousness. He argued that “based on his experience” if *Barefoot* “was not executed there was a “one hundred percent and absolute chance” that he would commit further acts of criminal violence” (*Barefoot v Estelle* cited in Shuman, 2002, p. 221). Despite the American Psychiatric Association filing an amicus brief stipulating the predictions of ‘dangerous’ were largely considered unreliable in the current psychiatric research, the Supreme Court upheld the admissibility of the evidence. The fact-finders would have the benefit, the court argued, of cross-examination of the expert and contrary evidence by the opposing side before they weighed up all the evidence (Appelbaum, 1987-1988). It appears, therefore, that in this case, the underlying theory and methods of the clinically-based opinion were not considered by the court. Rather, the potential unreliability of the evidence could be revealed through rigorous cross-examination.

Shuman (2002) has argued that the *Barefoot* case highlighted the difference in treatment by the court of expert testimony that is clinically-based as opposed to that derived from scientific-research endeavours and that this practice is not restricted to this one case. In other words, he has suggested that expert evidence derived from clinical practice receives less scrutiny than testimony reliant on scientific research. Shuman has been critical of the lack of any explanations by the court as to why they make such distinctions and why there are no explicit rules as to how they apply such distinctions between these two sorts of expertise (Shuman, 2002, p. 223). So although courts routinely scrutinize the scientific basis of other expertise, clinical opinion testimony appears to sidetrack admissibility processes. Similarly, Slobogin (1998) stated that most forensic mental health professionals have never had their testimony challenged through the above methods.

Regardless of the lack of scrutiny, the issue remains that there are several problems related to psychiatric expertise of clinical diagnosis meeting the legal system’s definitions of science (Chaplow & Peters, 1996; Coles & Veiel, 2001; T. Rogers, 2004). Referring back to Kenny (1983), within the context of the courtroom, he argued, psychiatrists do not display the criteria of science that he devised. Firstly, they often contradict each other’s diagnoses, not just in borderline cases where it may be difficult, but in typical cases. Second, within the discipline, practitioners doubt their own concepts, for instance the debate over the inclusion

of homosexuality within the *Diagnostic and Statistical Manual of Mental Disorders*. Chaplow and Peters (1998) expanded Kenny's argument and illustrated the ways in which the reliability of diagnoses depend on methodological usage of classification systems, of which there are two versions (DSM-IV-TR and ICD-10),³⁰ and the ways in which clinical diagnoses can be presented differently depending on which fundamental conceptualisations the psychiatrists embrace (psychodynamic or psychosocial for instance).

Bernstein (1995) has argued that psychiatry and psychology are underpinned by both scientific and non-scientific elements and that this creates difficulties for how legal systems currently approach the admissibility of psychiatric opinion evidence. In his view, a psychologist giving testimony as to the existence of a condition known as rape trauma syndrome can be considered to be giving 'scientific' evidence. If that same psychologist gave evidence, however, on whether a defendant suffered from rape trauma syndrome then they would be providing 'unscientific evidence'. This is because the former is based on tested theories or research and the latter involves professional judgements based on clinical education, training and experience. Applied to the context of expert testimony regarding legal insanity, Bernstein explained that psychiatric evidence may be unscientific when giving opinion as to whether a defendant suffers from a 'disease of the mind', but this opinion may also be simultaneously underpinned by a scientific "proposition that it is possible to distinguish between "normal" and "abnormal" minds (Bernstein, 1995, p. 76).³¹ Bernstein concluded by stating that the *Fyre* and *Daubert* tests were developed in relation to scientific testimony only and are not relevant to non-scientific evidence and that there needs to be different approaches by courts in considering scientific and non-scientific aspects of psychiatric testimony.

³⁰ The DSM-IV (published in 1994 by the American Psychiatric Association) is the current classification system used widely by the psychiatric community. The next version of this manual is due to be released in 2010. The International Classification of Diseases (ICD-10 current version) is produced by the World Health Organisation and is also used widely by psychiatrists worldwide. The DSM-IV is designed so that the classification system corresponds to the ICD-10, although there are some differences between the coding systems of both. Chapter five (p. 105) further describes the classification system contained within the DSM-IV.

³¹ Bernstein's acknowledgement of the scientific and non-scientific components of psychiatric expertise resembles the work of philosophers of psychiatry who have argued that psychiatric diagnostic procedures involve a judgment based on values and facts (Cf Fulford, Broome, Stanghellini, & Thornton, 2005). The difficulty in demarcating facts from values and science from non-science is a topic central to the work of Science and Technology Studies scholars discussed in chapter three.

Maintaining ‘expert criteria’

In his landmark paper, Kenny (1983) concluded that the major problem with psychiatric evidence is its consistent usurpation of the role of others in the courtroom which is beyond their role as experts and “men of science” (sic). Thus apart from the admissibility rules related to what exactly meets the criteria of expertise, expert witnesses are also subject to admissibility rules that stipulate they must stick to their area of expertise and not give expert opinion as to the ultimate issue which is to be decided by the judge or jury.

For psychiatrists in insanity defence cases this becomes particularly complex. There is much debate in the literature over whether they effectively achieve this and whether the courts effectively govern psychiatrists’ ability to stick to their area of expertise. Kenny (1983) argued that psychiatrists do not acknowledge where their expertise begins and ends. In other words, problems arise between law and psychiatry when experts do not maintain their academic factual base (Kenny, 1983, p. 208). He maintained that in psychiatry it becomes difficult to divide ‘fact’ from ‘value’, with fact being matters that should be given in evidence and values which are not in the province of experts to make. This, Kenny argued, becomes abundantly apparent when psychiatrists usurp the role of jury, the judge, and parliament by giving opinion on those who should and should not be sent to prison: “The question whether an individual accused should be convicted should be a question, not for the psychiatrists, but for the jury; the question whether persons of a certain kind should be punished is a question not for the psychiatrists, but the legislature” (Kenny, 1983, p. 209). Kenny was somewhat sympathetic towards psychiatrists, concluding that the adversarial system does not fit well with “the use of experts to assist the court” and is perhaps not the best environment in which to contest the foundations of scientific knowledge (Kenny, 1983, p. 214). (This is discussed further in the next section).

Coles and Veiel (2001) have not been so lenient and have taken Kenny’s proposition further arguing that the attitudes and practices of mental health professionals corrupt science and pervert the original purpose of the expert. Not only have psychiatrists and psychologists embraced methods and conceptualisations that do not meet the criteria of ‘scientific’, they have also applied these to legal situations in an inappropriate manner which is outside of their brief as experts for the Court. Coles and Veiel noted there are several ways in which psychiatric experts have done this, one of which is the utilisation of ‘inappropriate

conceptualisation'. This refers to the practices whereby psychiatrists attempt to conceptualise legal issues in psychiatric terms of which they are more familiar:

When psychologists become expert witnesses, they similarly recast legal concepts in the mould of their conceptual framework. The conceptual framework of both psychiatry and psychology is prone to describe individuals in terms of fundamental, unitary characteristics, whereas many of the legal concepts in which mental health experts deal tend to be situation dependents, synthetic, and heterogeneous (Coles & Veiel, 2001, p. 610).

This is particularly prevalent, they surmised, with knowledge embedded in the medical model of disease. The authors contended that this model is too individualistic for the legal context with its focus on mental disorders as a dysfunction inherent within the individual regardless of the situation in which they are immersed (Coles & Veiel, 2001, p. 611). Human behaviour, they explained, is not dependent solely on characteristics of the individual; an individual's behaviour is the result of their interaction with his/her environment.

Another way in which psychiatrists or psychologists have made inappropriate conceptualisations in court is with their persistent use of theorising that embraces ideas of human behaviour as homogenous and one-dimensional and able to be observed (Coles & Veiel, 2001). Clinical diagnosis, they noted, "presumes a unitary character for most disorders, evidenced by the inter-changeability of pathological symptoms by which they are expressed" (Coles & Veiel, 2001, p. 612). Schizophrenia, for example, is diagnosed by two of five listed symptoms being exhibited by an individual. In contrast, Coles and Veiel contended that legal concepts are synthetic and heterogeneous. For instance, to be found insane or criminally responsible, two concepts – appreciating the nature and quality of the act and the ability to know that the act committed was wrong – can both be considered to meet legal insanity criteria. In the end legal decisions are based on dichotomies (insane or not insane) and Coles and Veiel argued it is wrong to apply psychiatric conceptions to such binaries: "...mental health experts...have tended to overlook the fact that legal concepts are not meant to represent reality, but normative, abstract constructs; and that the lack of a middle ground is not due to lack of precision, but is intrinsic to the subject matter" (p. 614).

Allnutt and Chaplow (2000) have also discussed the importance of forensic psychiatrists sticking to their expertise, that of medicine, not law:

Medico-legal questions are legal questions informed by medical opinion. Terms such as...‘insanity’...are legal concepts. They are not medical concepts. The justice system invites experts to provide psychiatric information which it can utilise to apply to the legal concept in order to determine the presence or absence of the issue in legal terms. Although experienced experts can intimate understanding of the medico-legal concept, sometimes better than that of a relatively inexperienced lawyers, it is in our view better to be cautious when crossing such professional boundaries (Allnutt & Chaplow, 2000, p. 985).

New Zealand common law has made it clear that the decision as to whether the accused is insane when committing an offence is always one for the jury. This view is expounded in *R v Clark*:

There can be no doubt that the decision in such a case as this must always be for the jury and not for the medical experts who have been called to give evidence. A plea of insanity does not open the way for trial by psychiatrists. So that the fact by itself that a verdict is inconsistent with medical evidence given at the trial will not necessarily provide grounds for holding the verdict to be unreasonable (*R v Clark*, 1983, p. 133).

This has meant that the expert was excluded from expressing an opinion about the “ultimate issue”. In other words, the expert’s opinion must not unjustifiably influence the fact-finder on a matter which it is their task to decide. This requirement, however, has been continually debated in the courtroom, particularly in a criminal case where the defence is that of insanity. *Adams on Criminal Law* has suggested that in the past it has been common for psychiatric expert witnesses to provide their opinion as to whether or not the accused was insane when he or she committed the offence (Adams et al., 2008, para 2.17.05). With the recent passing of the Evidence Act (2006) expert evidence is not necessarily excluded simply because it expresses an opinion on an ultimate issue (Cross et al., 2005). Prior to the passing of this Act, expert evidence was subject to three rules: the common knowledge rule, the factual basis rule and the ultimate issues rule. The new Act abolishes the common knowledge and ultimate issue rules and replaces it with the “substantial help test” meaning that to be admissible, expert opinion must substantially assist the fact-finders in determining material facts (Law Commission, 1991, 1999a, 1999b). This has suggested the ultimate issue rule is still a hotly debated topic and it will be discussed in further detail in chapter seven (p. 171).

Internationally, the ultimate issue rule³² in cases involving the insanity defence has been applied inconsistently by the courts. It has either been bypassed, modified in use, or abandoned in some jurisdictions over recent years (McSherry, 2001). McSherry (2001) argued that this exemplifies a wide gap between what admissibility rules mean in theory and how these rules are practically applied. In many cases, she suggested, psychiatrists have been able to give evidence as to the *effect* of the accused's "disease of the mind". This has meant they are giving expert opinion on whether the disease of the mind affected the accused to such an extent as to render them incapable of understanding the nature and quality of the act, or from knowing the act they committed was morally wrong. These legal constructs will be discussed further in chapter five (p. 94) when interpreting the data generated through this study.

Following the high profile case of John Hinckley in America and the public criticism that followed, Congress reinstated the ultimate issue rule for mental health experts. This excluded expert witnesses from giving opinion as to whether the defendant did or did not meet the threshold of insanity (McSherry, 2001; R Rogers & Ewing, 1989).

Rogers and Ewing (1989) have argued that the reinstatement of the ultimate issue rule in America was a 'cosmetic fix' to remedy several misconceived assumptions about the problems associated with psychiatric expert witnesses. Firstly it is assumed that the rule will remedy the "appalling circus atmosphere" illustrated in a few highly publicised cases thereby assisting in further instances of public and collegial outcry over conflicting opinions regarding the ultimate issue (Buchanan, 2006; R Rogers & Ewing, 1989, p. 361). Secondly, it is assumed that the rule will lead to the elimination of expert opinions based on insufficient clinical data which speak to the ultimate issue. Thirdly, it is assumed that the ultimate issue rule will curb undue influence of expert opinion on the judge or jury (R Rogers & Ewing, 1989).

³² The medico-legal literature points to three different ways in which the term 'ultimate issue' can be interpreted, including: (1) decision making regarding the *effect* of the disease of the mind on a defendant's knowledge of right or wrong (McSherry, 2001), (2) decision making regarding whether a defendant meets the criteria for legal insanity, and (3) whether the defendant should be found NGRI. The term 'ultimate issue' was used in this research to refer to the decision as to whether a defendant meets the legal criteria for 'insanity'. This final decision is considered in many jurisdictions to be the job of the fact-finders, rather than forensic psychiatrists.

Buchanan argued that this third assumption reflects the longstanding and widespread concern that “psychiatric evidence is more likely than other evidence to intrude into the jury’s realm” (Buchanan, 2006, p. 19). Some commentators have noted that this third assumption underestimates the jurors’ ability to evaluate expert testimony and exaggerates the ability of experts to “sway” jurors inappropriately influencing the legal system (Golding, 1990; R Rogers & Ewing, 1989). Mock jury studies have indicated that jurors are not uncritical consumers of expert testimony by mental health professionals and are “unmoved by ultimate opinion” (R. Rogers & Shuman, 2000). Adding to this, Freckelton has explained that the assumption that juries give more weight to expert evidence than is deserved is based upon anecdotal rather than empirical evidence (Freckelton & Selby, 1994).

Ultimately, by excluding experts’ ability to talk to the ultimate issue, Rogers and Ewing (1989) surmised that this strategy aims to emphasise that ‘insanity’ is not a mental health issue. Insanity, following this logic, is a moral and legal question and not one for the psychiatric experts to answer. These authors, however, argued that the line between when a question encroaches on the domain of ‘morality’ is not set in stone,

But what determines whether opinions are, in fact, moral judgements?...If an opinion purports to distinguish “right” from “wrong” or “good” from “bad,” that opinion is clearly moral or religious in nature. However, if it is assumed that criminal behavior is, by definition “wrong” and implicitly “bad,” then the purpose of the insanity evaluation is primarily etiological: The clinicians simply attempt to determine why and under what psychological circumstances the criminal conduct occurred (R Rogers & Ewing, 1989, p. 363).

In arguing this, the authors suggested there is a fine line between moral, legal and psychiatric questions. Allnutt and Chaplow (2000, p. 986) similarly suggested that giving opinion on the ultimate issue “potentially blurs the lines of responsibility and boundaries between the forensic psychiatrist and the legal system”. This murkiness between issues assigned as legal and moral and those that remain in the domain of psychiatry is interesting and worthy of further exploration. This murkiness is returned to in the next chapter to show how a STS lens helps analyse these issues.

In contrast, other commentators remain firm about the idea that psychiatrists should not give evidence to the ultimate issue as these are moral, not medical questions (Stone, 1984). As

McSherry (2001, p. 18) explained “it remains true that the jury’s role in criminal trials in which mental impairment is raised is to decide the question as to the accused’s criminal responsibility. This is...essentially a moral question”. Literature in this vein has argued that psychiatrists should refrain from giving an opinion on the ultimate issue even if they are being pressured to do so by legal professionals (Chaplow & Peters, 1996).

THE LEGAL CONSTRAINTS OF THE ADVERSARIAL SYSTEM

Literature discussing similar issues to the above has also pointed to the ways in which the adversarial system may constrain psychiatric knowledge. Golding (1990) argued that the fundamental structure of evidence production in the adversarial system is incompatible with the basic tenets of expert knowledge systems grounded in scientific methods. Chaplow and Peters (1998) discussed how the legal system’s understandings of ‘science’ limit the inclusion of temporality or the idea that mental disorders may change over time. In this way, the legal system’s definition of science seems to conflict with psychiatric understandings. The law prefers categorical concepts rather than concepts which are dynamic, multi-dimensional or based on linear notions that allow for change over time (Chaplow & Peters, 1996). Even if the complexities of psychiatric explanations are considered in the courtroom, the law will force black and white decision making. In the case of insanity, therefore, Allnutt and Chaplow (2000) argued that it is best to be a ‘phenomenologist first’ and a ‘diagnostician second’. They contended that it is wise to approach medico-legal issues in terms of phenomena and relative symptoms rather than by diagnosis: “An explanation of the nature of the individual’s delusions at the time of the offence and their impact on the offending behaviour has more relevance than saying ‘this person has schizophrenia and is therefore insane’” (Allnutt & Chaplow, 2000, p. 985).

Rogers (2004) also discussed the difficulty with psychiatry meeting the ideals of science required in the courtroom. He argued that psychiatry cannot meet the legal expectation that diagnoses be ‘valid’ and ‘reliable’ because this is not possible given the current state of psychiatric knowledge: “Most psychiatrists might very well agree with one another that a particular patient has a particular disorder, but we are no closer to knowing whether such a disorder really exists or whether it is merely a taxonomic fiction” (p. 286). Manuals such as the DSM-IV-TR have been used to focus on ensuring reliability of diagnoses rather than the validity of diagnoses or the “underlying reality” of a particular diagnosis (T. Rogers, 2004, p.

286). Indeed the DSM-IV-TR is marketed as an ‘a-theoretical’ manual, in that it is not focused on the aetiology of mental disorders (American Psychiatric Association, 2000). The manual has aimed to practically assist clinicians in the diagnosis of mental disorders and to foster effective communication between mental health professionals (American Psychiatric Association, 1994).

Of particular importance is that which Rogers explained as ‘construct validity’ which refers to external tests that can establish the validity of a diagnosis. For instance, he described how “syndrome A will have a high construct validity if it is always associated with a particular result on Test X, when no other diagnosis is associated with that result on Test X (and Test X is known by independent means to be a reliable and valid test in its own right)” (T. Rogers, 2004, p. 286).³³ Rogers argued that psychiatry has low construct validity. This becomes important when considering the admissibility of psychiatric evidence as scientific because of the direct link between construct validity and the notion of ‘falsifiability’ held as important in *Daubert* (1993). Psychiatric diagnoses, however, are not testable or falsifiable and can only be projected as opinion. Psychiatric experts, Rogers asserted, should acknowledge this limitation in their testimony:

The low construct validity of many psychiatric diagnoses is hardly a criticism of psychiatry itself. Psychiatrists have to work with the world they find. The slippery concepts and blurred boundaries are intrinsic to the subject matter itself, but psychiatrists would do well to acknowledge this in their expert testimony (T. Rogers, 2004, p. 288).

The limitations with using the manual in the forensic setting has been recognised in the DSM-IV-TR (American Psychiatric Association, 2000).

Rogers and Shuman (2000) suggested this reflects a deep-seated mistrust and derogation between legal and psychiatric professionals. Psychiatrists, on the one hand, feel they are abused and tricked in the courtroom in the way they are prohibited from answering questions

³³ Rogers discusses three other types of validity: (1) face validity: where a diagnosis fits well with clinical experience (2) descriptive validity: existence of agreed criteria by a variety of experts that distinguishes one diagnosis from another, and (3) predictive validity: the ability of a diagnosis to predict future outcomes (for example that symptom A will respond to treatment B). Construct validity, is argued to be the strongest marker of validity as it affirms the “diagnosis as a real concept by independent and external means” (T. Rogers, 2004, p. 286). Chapter nine (p. 195) will revisit this material when discussing the implications of the findings of this study for the role of expert witnesses in constructions of insanity.

fully and telling the court what they consider really important or by being forced to answer unintelligible questions. On the other hand, lawyers complain that psychiatrists use incomprehensible “psychobabble” and do not understand the court or the adversary system (R. Rogers & Shuman, 2000). In sum, psychiatrists can feel manipulated in court and lawyers are sceptical of the psychiatric professionals’ lack of criteria to which their knowledge can be verified objectively. As Freckelton (1993) has stated:

...the relationship between law and psychiatry is one of host and unwelcome but obligatory guest. No expert witnesses are more mistrusted than those said to be unable to provide hard data, and yet lawyers have done little to educate themselves as to what forensic psychiatry can and cannot offer them” (Freckelton, 1993, p. 1).

Freckelton has noted that this has a lot to do with the lack of knowledge that legal professionals may have of forensic psychiatry. He has given the example of lawyers’ inadequacies when it comes to understanding psychiatric diagnosis and terminology. Few Australian lawyers, he explained, own a DSM manual or landmark textbooks specifically designed to assist legal professionals in dealing with psychiatric testimony. Although the Australian and New Zealand Association of Psychiatry, Psychology and the Law have provided interdisciplinary educative sessions, training programmes and forums, few legal professionals attend. This limitation in knowledge of forensic psychiatry and all “its warts, limitations and potentials”, Freckelton argued, has grave implications for lawyers’ abilities to effectively cross-examine expert witnesses. In contrast to their North American counterparts, he implied that Australasian lawyers do not collate relevant psychiatric information in order to gain ‘the winning edge’ in cross-examination (Freckelton, 1993, p. 189).

Perlin (1990b, 1992-1993, 2000) has also been critical of the legal system’s treatment of psychiatric expert evidence. He has argued that the legal system’s “persistent ambivalence” about mental health systems and mental health practitioners has created most of the tensions between psychiatry and the law (Perlin, 1990b, p. 602). The insanity defence, for Perlin, is a symbol of the gap between the two polemic worlds of psychiatry and law. Simply put, on the one hand, the legal system is founded on notions of free will, self-control, rationalism and objectivism, while on the other hand, psychiatry embraces conceptualisations of human behaviour as subjective and multi-dimensional.

Perlin (1990b) also put forth the notion that the conflicting relationship between psychiatry and law within the context of the insanity defence is the result of the legal system's maintenance of power over legal decision-making. The rejection and ambivalence towards psychiatry arise, he contended, as a "conflict between the aid that the legal system desires from psychiatrists and its fear that, as a result of the acceptance of that aid, an unacceptable amount of power over legal decision-making will accrue to psychiatrists" (Perlin, 1990b, p. 675). In order to maintain power over legal decision-making, psychiatry has often been portrayed by legal professionals as a soft science, "exculpatory, and confusing", an "invisible and imprecise science", and psychiatrists are "wizards or charlatans" (Perlin, 1990b, p. 675).

The legal system's maintenance of power has also been exemplified in the way that psychiatric evidence is seen to be crucial in determining whether at the time the accused committed the offence they were too mentally disordered to be held criminally responsible, yet it is the law that stipulates the appropriate test for determining this. In this way, medical experts are required to assist the court on whether the defendant is suffering from a mental disorder and how this disorder may impact on his/her criminal responsibility, while the judge or jury decides whether this evidence meets the criteria for legal insanity. Brookbanks (2007) has explained that this can create a "clash of values and expectations" in that the insanity defence is,

...required to reflect underlying principles of criminal responsibility; accommodate current scientific understanding of mental disease; and allow mental health experts the opportunity to present their insights to the Court and still defer to the Judge or jury the ultimate authority on the issue of criminal responsibility (Brookbanks, 2007, p. 124).

To conclude this section, Justice Goddard (2002) eloquently summarised that:

...it is not the divergence of expert psychiatric opinion of itself that is problematic; one does not expect a range of experts to always form unanimous opinions, anymore than one expects appeal Judges to always be unanimous in their decisions. The majority of problems arise because of the incompatibility of the legal test for insanity with contemporary psychiatric understanding (Goddard, 2002, p. 103).

PSYCHIATRY AND LAW AS TWO KNOWLEDGE SYSTEMS CLASHING

Some literature has attributed the overall problematic relationship between law and psychiatry to the conceptual differences between the two professions. As Parker has explained: “not only are there differences between the professions in the manner of reasoning, but also in epistemology, values, modes of argument and methods of practice” (Parker, 1996, p. 239). Shuman drew attention to the fact that values, methods and goals of the legal system are far removed and have little in common with the goals, values and methods of mental health professionals (Shuman, 2002).

Zemishlany and Melamed (2006) further illustrated that the problem with psychiatry and law is an effect of the ‘language gap’ between the two disciplines. They argued that on the one hand, the medical discipline describe the patient’s state on a continuum with one end of extreme illness and the other complete wellness; on the other hand, the language utilised within the legal context emphasises dichotomies. For example a mentally ill defendant is competent or not competent, dangerous or not dangerous, guilty or not guilty by reason of insanity. The language exemplified in the M’Naghten Rules is binary and absolute which is very different to the concepts used within psychiatry that are “more relative, multifactorial and often far from absolute” (Zemishlany & Melamed, 2006, p. 152). This seems in stark contrast to Coles and Veiel’s argument discussed earlier in this review which emphasised the homogenous nature of psychiatric expertise (Coles & Veiel, 2001).³⁴

In his address to the New Zealand Legal Research Foundation Conference, Justice Tompkins (2002) succinctly summarised that at the heart of this issue is the apparent disconnection between the ‘nature of science’ and the adversarial system. The factual information put before the court, he explained, is constrained by “what parties choose to, or are able to, bring before the court” (Tompkins, 2002, p. 3). Further, it is a coercive process in that once the dispute has been resolved, the parties and wider community must accept the result which is final (in the absence of legislative intervention), fixed in time, and backed by the coercive

³⁴ Zemishlany and Melamed also explained that issues related to co-existing disorders of schizophrenia and personality disorders and/or drug abuse can complicate the differentiation between full and non-responsibility in that the secondary or associated factors may be the primary cause of criminal acts during psychotic states. So although schizophrenia may be accepted under the insanity test, the secondary factors may not, clouding issues of responsibility. Chapter six (p. 118) explores the way the use of methamphetamine in combination with mental disorders creates problems for decision-making in cases of insanity.

power of the state. The overall effect of this, Tompkins argues, is that "...the legal consequences are determined on the basis of limited material, and are crystallised at the point of judgement...our legal system...an artificial construct fashioned and characterised by its underlying history and philosophy" (Tompkins, 2002, pp. 4-9). In contrast to this "fixed in time" approach, science, he argues, is never fixed in time. It is constantly being evaluated and adapted and progresses with time: "To freeze something in time runs counter to most of what a scientist does and how he or she does it" (Tompkins, 2002, p. 11).

CONCLUSION

This literature review has suggested there are many issues that give rise to the problematic relationship between psychiatry and law within the context of insanity jurisprudence. It has also illustrated the varied ways in which this problematic relationship has been conceptualised by medico-legal commentators.

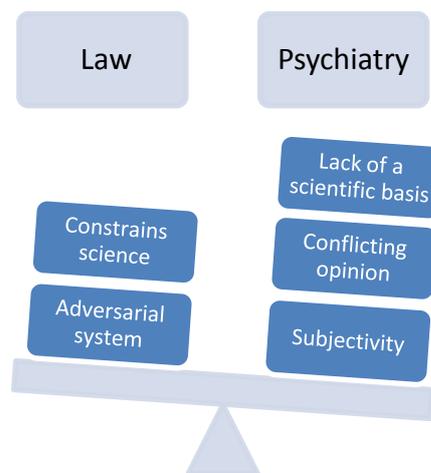
Much of the medico-legal literature is conceptually based in that there is limited empirical research that has paid close attention to these issues. There remains, however, no in-depth qualitative research focused on the experiences of those involved in trials using the insanity defence. This has meant that forensic psychiatrists have rarely been asked about the difficulties they face when performing the role of expert witness. As the above has suggested, what limited quantitative research that does exist usually revolves around legal professionals' views of psychiatrists who give expert testimony. Furthermore, as Smith and Wynne (1989) have argued most of what has been written about the role of scientific experts in the courtroom has been written by practitioners for professional consumption. There is little written by outsiders looking in on the role of forensic psychiatrists as expert witnesses.

The review of the medico-legal literature, however, is an important illustration of the many issues professionals from within the 'field' may potentially face and what could be done to improve the situation. To summarise, the medico-legal literature has suggested that psychiatric evidence is, in some instances, biased, impartial, not objective, too technical, and that conflicting evidence is not useful for jurors who, in the end, utilise common-sense understandings to make decisions regarding legal insanity. Lawyers and judges have also been subjected to criticism, with descriptions of them as biased, favouring expert opinion that aligns with their own ideological understandings of science. Other authors have argued that

the problems associated with psychiatric expert evidence relates to the incompatibility of science with the adversarial legal system. It is said that the epistemological assumptions of science and law are very different and opposing, with the law being interested in definitive answers that are fixed in time or frozen, while science is seen as something that progresses with time and its knowledge is not able to be fitted into the dichotomous ‘slots’ required by law. Overall the medico-legal literature contended that there are many ‘problems’ in the context where psychiatry meets law under insanity jurisprudence.

The professional literature around this topic, therefore, is largely focused on problematising the relationship between psychiatry and law in a dualistic manner. Accordingly, it is either psychiatry or law that is to ‘blame’ for the problems that occur in cases of legal insanity. The ‘blame’ dichotomy is illustrated in Figure 2.

Figure 3. Law psychiatry ‘blame’ dichotomy



On considering the focus for this research, the existing medico-legal literature reviewed formed a rationale for the utilisation of a different approach. I knew as I was reviewing this medico-legal literature that by researching the role of psychiatric expert witnesses and their interactions with legal professionals through a different lens I could contribute something new to the current debates related to psychiatric expertise in insanity cases. I contended that my unease with the way in which the medico-legal literature has resorted to blaming either law or psychiatry in a dichotomous manner, without any really close empirical investigation into the interactions within this specific context, can be alleviated by utilising a socio-legal

approach. The next chapter will consider the socio-legal work that allowed for a different method of addressing the role of the expert witness and the relationship between forensic psychiatrists and their instructing lawyers in the context of insanity trials.

CHAPTER THREE: STS OF LAW-SCIENCE INTERACTIONS

Moving away from the specialised medico-legal literature described in chapter two, this chapter reviews a set of empirical studies that have used a socio-legal framework to explore the role of forensic expertise³⁵ in the legal setting and the interactions between legal and scientific/medical professionals in the courtroom. These studies, which can be described as using a STS approach, formed the basis for my rationale to adopt a sociologically focused theoretical approach for this study.

The chapter begins by *briefly* introducing the broad aims of STS related research.³⁶ As stated in chapter one, the umbrella term of ‘STS’ is used in this thesis (and elsewhere) to describe the huge array of work devoted to studying the place of science and technology in society. The work described in this introductory passage is included here to set the necessary ontological background for the specific work researchers have completed in the field devoted to forensic expertise and courtroom interactions. The rationale for using an alternative sociological approach guided by STS approaches is extensively explored in the remaining sections of the chapter. These sections thematically review the work completed on forensic experts in the criminal trials by STS scholars and describes the theoretical contributions that have emerged from this body of work. The chapter concludes by summarising how this STS work on law-science interactions became important for this study and why a sociological focus that differs from the medico-legal literature reviewed in chapter two was adopted. How these tools were used in the analysis of the data for this study will be detailed in chapter four.

³⁵ I use the term ‘forensic expertise’ to describe research that has studied the role of various forensic experts, not just forensic psychiatrists, in courtroom proceedings. This chapter considers research that has focused largely on the role of forensic pathologist and DNA experts, while the focus of this study is solely on forensic psychiatry.

³⁶ It is beyond the scope of this thesis to consider the diverse and significantly large amount of STS work. This chapter is specifically focused on describing the research devoted to law-science interactions because of its relevance to developing an analytical framework for this study. The work I discuss originates from many different fields of academia and although the authors’ work is often described as within the field of STS, whether they prescribe to this field on an individual basis may be debated. My focus is on their similar treatment of expert evidence and legal professionals’ interactions with expert witnesses and STS provides a broad platform for describing this work.

SCIENCE AND TECHNOLOGY STUDIES

STS is a label that has been used to broadly describe the field of research in the social studies of science and technology and their interactions with society (Sismondo, 2008). Very simplistically, research within this field has been devoted to studying how various factors – social, political, and cultural values – affect scientific and technological endeavours and vice versa. The work that falls under the category of STS has been “characterized by its engagement with various publics and decision makers, its influence on intellectual directions in cognate fields, its ambivalence about conceptual categories and dichotomies, and its attention to places, practices, and things” (Hackett, Amsterdamska, Lynch, & Wajcman, 2008a, p. 1). STS work is varied and interdisciplinary in nature; academics, practitioners, researchers and other professionals have studied topics that transcend specific academic disciplines.

Despite this variance, across all the work that falls under STS there has been a commitment to studying how various science and technology knowledges are constructed. As the third edition of the *Handbook for Science and Technology Studies* (Hackett et al., 2008a) explained, such work has focused on the practices that produce knowledge, the fuzziness of categorical distinctions that occur in scientific practice, and the importance of context, history and place in the production of scientific knowledge. Such understandings of scientific knowledge have drawn attention to the social nature of science and technology and the ways in which science and technology are active or processural. By illustrating the work that goes into producing scientific knowledge, STS has dismantled epistemological claims of science as merely direct reflections of nature.

A thorough overview of all the work within this field is beyond the scope of this thesis; however, of specific importance to this study are the ways in which STS have drawn attention to the negotiable and fluid boundaries that people may take for granted as stable, such as facts, institutions, social roles, and objects. In the mid 1970s sociologists in Europe began to question the neutrality of ‘science’ by exploring the possibility that scientific outcomes (‘facts’) may not be direct reflections of nature but determined in part by interests, such as structural commitments, political positions, and other institutional commitments (Barnes, 1974; Bloor, 1976). This kind of work became the focus of the ‘Strong Programme’ at the University of Edinburgh, which embraced an anti-positivistic focus and argued for attention

to the socially constructed nature of science. In 1979 *Laboratory Life* was published by Latour and Woolgar. An ethnographic study, it examined the construction of biological facts in the context of laboratory work using the techniques of anthropology, semiotics and ethnomethodology (Latour & Woolgar, 1979). This study directed attention to the skills that scientists practise to construct facts, showing up the ways in which culture shapes what becomes known as facts (Sismondo, 2008, p. 15):

Laboratory phenomena, then, are not in themselves natural but are made to stand for nature; in their purity and artificiality they are typically seen as more fundamental and revealing of nature than the natural world itself can be.

Following varying works on the laboratory practices of scientists in Europe (Collins, 1985; Knorr Cetina, 1981; Lynch, 1985), symbolic interactionists³⁷ in the United States embraced the anti-positivism of STS and ethnographic fieldwork was begun by these scholars. Research within this field focused on scientific practices while highlighting the importance of the symbolic nature of objects and their role in allowing such work to be completed (Fujimara, 1992; Star, 1998; Star & Griesemer, 1989). Actor Network Theory, developed by Latour, Law and Callon (Callon, 1991; Callon & Law, 1997; Latour, 1999b; Law, 1992; Law & Mol, 2002), extended this role of objects as a focus. These authors argued that what constitutes society, people and objects are all effects, facilitated by patterned networks of many different materials (human and non-human) (Law, 1992). Further, these networks gain more power as interests are meshed and agreement between actors is found (Sismondo, 2008). Jasanoff (2008a) has also considered the co-production of scientific knowledge and artefacts focusing on the ways in which they are simultaneously shaped, adjusted and moulded to fit particular requirements or contexts in order to be accepted. Bowker and Star (1999) consider the relevance of this concept in terms of classification of diseases; for a disease to be classified requires diagnosis while at the same time a diagnosis reinforces that classification. Finally, Edmond (2008) has shown how this type of symbiotic relationship can be useful in understanding the interactions between science and law within particular legal settings. This is discussed further below.

³⁷ Again it is beyond the scope of this chapter to consider the symbolic interactionist perspective. Symbolic interactionism can be described as micro-level sociological investigations into how people create meaning during social interactions, how they present and construct the self (or their "identity"), and how they define situations of co-presence with others. One of the perspective's central ideas is that people act as they do because of how they define situations, this has been called labelling theory (Scott & Marshall, 2009).

This short review of the STS field has illustrated how studies have emphasised that the boundaries between the ‘social’ and the ‘natural’ and ‘facts’ and ‘values’ are fluid and negotiated anew as scientists go about *doing* their work. By focusing on the practices of scientists, STS have shown how what counts as ‘science’ is produced and solidified by “socially accredited systems of rhetoric and practice” (Jasanoff, 1995, p. xv). This thesis embraces the STS focus on the constructedness of scientific knowledge in its development of an interpretive framework because of the nature of the research questions. The research questions direct attention to the *practices* of forensic psychiatrists and their instructing lawyers, the murkiness of legal *categories* and *requirements* that occurs in action within the courtroom setting, and the role of broader contexts (i.e. institutional, social and historical) in the shaping of psychiatric expertise in the legal setting and in the construction of a insanity defence.

STS OF FORENSIC EXPERTISE

Apart from the STS research focused on the production of scientific knowledge in the laboratory reviewed above, the rationale for using a constructivist approach was strengthened by the work of scholars who have paid close attention to many areas where science interacts with the legal system. This has included topics such as: the legal rules governing the admissibility of evidence (Jasanoff, 1995; Solomon & Hackett, 1996) and, of most importance to this thesis, forensic science and expert evidence (Edmond, 1998a, 1998b, 2001; Lynch & Cole, 2005; Lynch & Jasanoff, 1998; R. Smith, 1989; R. Smith & Wynne, 1989). Regardless of the differences in topics of investigation there are overlapping themes that these varying studies addressed. In particular, STS informed research on science-law interactions has attended to the fact/value categorical distinction upheld in court; the ‘boundary-work’ of lawyers and scientists; the legal shaping of scientific knowledge; the legal ‘deconstruction’ and ‘(re)construction’ of scientific knowledge that takes place in the courtroom; and the hybridised scientists and institutions that have come about as a result of legal constraints (Mercer, 2002b).

This section reviews this work aiming to develop a rationale for drawing on it in the interpretation of the research data presented in this thesis. This will include a discussion of relevant works under four interrelated themes:

1. The fact-value distinction within the legal setting
2. The boundary-work practices of judges, lawyers and forensic experts
3. The legal shaping of scientific knowledge
4. Hybridised expertise and institutions

Following this review, a summary of how and why the analytical approach employed in this thesis differs from that of the medico-legal literature is outlined. How particular analytical tools that emerge from this work were used in the interpretation of the research findings for this thesis is discussed in chapter four (p. 88).

THE FACT-VALUE DISTINCTION WITHIN THE LEGAL SETTING

As described in the introductory passage for this chapter, some of the STS work has drawn attention to the fluidity of boundaries that occur in the courtroom and how these are commonly taken for granted as stable. One important boundary in relation to the nature of science relates to the common understandings that this type of knowledge is factual and divorced from the social environment and interests embedded in it (Solomon & Hackett, 1996; Wynne, 1989). STS have shown that this distinction becomes difficult to uphold when examining scientific knowledge production. A smaller group of researchers have extended this work, drawing attention to the ways in which the legal system idealises scientific knowledge using these common understandings. In particular, Solomon and Hackett (1996) have contended that the legal system relies on the ideal that legally sanctioned decisions should be founded on impartial and objective information and divorced from any political, social or economic interests. Using scientific expertise to assist the court in its decision-making can be seen as a method of maintaining this separation (Solomon & Hackett, 1996). What we can conclude from this is that the legal procedures presume that ‘facts’ can be distinguished from ‘values’ and that ideally expert witnesses’ testimony is comprised of scientific knowledge which is autonomous from the social processes that may ‘taint’ its

objective basis (Jasanoff, 1995; R. Smith, 1989; S. R. Smith & Meyer, 1987; Solomon & Hackett, 1996). STS of expert witness testimony have illustrated how the distinction between facts and values becomes blurred in practice. Further, what counts as facts (knowledge for the expert witnesses to provide) and values (which are judgements for the fact-finders to decide) are fluid in structure and negotiated anew in each case as different experts are employed (Jasanoff, 1995). Setting and maintaining boundaries between law and science, therefore, has been considered by STS scholars to be an outcome of practices that occur as law and science interact (Mercer, 2002a).

Regardless of this murkiness that STS researchers have illustrated occurs in practice, many idealised accounts of the use of scientific knowledge in the courtroom uphold the fact/value distinction. This was particularly evident, for example, in the professional medico-legal literature reviewed in chapter two when discussing the various reasons for the problems that occur when psychiatric expertise is used in the courtroom. Such discussions polarise the problematic nature of scientific interactions with the law. In this way, it is either the experts themselves or the adversarial system that create the ‘problems’. STS have illustrated that similar criticisms around the use of other forensic expert witnesses occur and have argued that such criticisms operate within the fact/value distinction (Jasanoff, 1995; Wynne, 1989). The following section develops these types of arguments further within the broad context of forensic expertise, while returning to some of the medico-legal literature to show the relevance for this study of forensic psychiatry.

Scientific experts as the ‘problem’

In chapter two it was shown that some of the medico-legal literature pointed to the fact that psychiatrists do not ‘meet’ and ‘maintain’ the legal requirements for an expert witness in cases involving the insanity defence. The expert evidence they give has often been conceptualised in this literature as lacking objectivity and neutrality and this has been said to be particularly highlighted in contested cases where psychiatric expert witnesses conflict. This type of criticism puts the ‘problems’ squarely with the experts and often leads to the conclusion that psychiatric knowledge lacks a scientific basis.

It is important to note that these kinds of criticisms are not limited to psychiatric expertise in cases considering legal insanity (Edmond, 2000). In his research on controversy surrounding

the use of forensic pathologists as expert witnesses, Smith (1988) found that they too are not always seen to be objective. He explained they are often perceived to be socially linked to the prosecution to the point where their knowledge is shaped to fit that party's story (R. Smith, 1988). This mimics many of the criticisms surrounding the use of forensic psychiatrists as expert witnesses outlined in chapter two (p. 22).

Wynne (1989) has also argued that within the courtroom, there is an expectation that if forensic experts speak to the bare facts of the case, this ideally would mean they would not disagree. As well as presuming that disagreements will not occur if the expert witnesses only present the facts in their evidence, it also relies on the idea that disagreement between expert witnesses is an indication that values have come into play. Like the medico-legal literature, this places the problems with the use of forensic experts firmly with the expert witnesses and not the adversarial system; it is because the forensic experts are biased that problems occur.

To control such bias, Wynne has further argued that 'defenders' of the adversarial system suggest that a distinction between what is factual and value based in an expert's evidence can be made through legal rules and procedures (Wynne, 1989). Following this logic, when there is conflicting opinion between expert witnesses, he contended that there is an expectation that facts can be separated from values through the use of rigorous cross-examination. In this way, legal methods such as cross-examination can reveal the 'truth'.

In chapter two, it was shown how the medico-legal literature also suggested that legal procedures can illustrate the value-laden aspects of expert evidence. For example, despite the unreliability of psychiatric predictions of future dangerousness in the case of *Barefoot v Estelle* (1983), the court decided to proceed with such evidence because cross-examination would show up any potentially unreliable evidence (Appelbaum, 1987-1988). The medico-legal literature also paid attention to other legal procedures, such as admissibility rules. It was suggested that better enforcement of rules that clearly define legitimate science for legal purposes would ensure that only evidence based on facts is put forth as evidence in the courtroom. Correspondingly, such criteria would prevent psychiatrists usurping the role of fact-finders by effectively giving opinion on those who should and should not be sent to prison (Kenny, 1983).

The adversarial system as the ‘problem’

STS of forensic expert evidence have also illustrated the contrasting position held by some commentators to the above which understands the adversarial system as problematic in the way it introduces artificial polarisations that simplify and demean science in the public eye (Wynne, 1989). Cross-examination techniques, for example, have been argued to have created problems in the context of the courtroom. Those critical of the adversarial system argue that conflicting opinions, rather than being created by unseen bias, are the direct result of science being placed within an antagonistic environment that does not foster consensus (R. Smith, 1989).

The consequence of these sorts of criticism has called into question the very nature of the adversarial system. Jasanoff (1995) has explained how many commentators on forensic expertise in the courtroom see the mismatch between law and science as a result of the procedural rules that aim to control experts. Simply put, these legal rules put legal actors, who have inadequate knowledge of science, in positions where they have to judge what knowledge is scientific and reliable. This then leads to the inadequate application of legal rules by judges, who have a lack of understanding of science. This allows for ‘junk science’ to enter the courtroom (Edmond & Mercer, 1998). From this perspective, science can be seen as a truth seeking enterprise, while the courtroom is understood as involving ‘games’ that need to be won. Jasanoff (1995) argued that these framings conceptualise science as autonomous from social processes and experts as rational decision-makers.

Similarly, the review in chapter two suggested that some medico-legal commentators argue that legal rules are inconsistently applied by the courts in cases involving the defence of insanity to the extent that psychiatrists have been able to give expert opinion as to the ultimate issue. McSherry (2001) argued that this exemplifies a gap between what admissibility rules mean in theory and how these rules are practically applied. To alleviate some of the problems created by the legal system, some commentators have called for inquisitorial rather than adversarial approaches, new methods for instructing experts, and procedures allowing for better interaction between experts outside of the court. The medico-legal literature argued that employment of court appointed experts or assessors is the key to eliminating the problems associated with expert evidence (Mahon, 1979). Court appointed experts and assessors are those that would be instructed by the court, rather than the

prosecution or defence, to provide evidence or advise the court on the issue at hand. In other words, court appointed experts or assessors perform the same function of those expert witnesses used by the Crown or the defence but are instructed by the court not counsel. It is thought that experts of this kind would be less likely to fall into the trap of aligning their opinion to the side that retained their services (Dattilio et al., 2006). This suggests that it may be the legal processes that create bias in the expert's testimony.

These suggestions rely on the idea that consensus and neutrality amongst experts can be found outside legal cross-examination. The wider research conducted by STS scholars has shown how conflict occurs within science continually (Mulkay, 1979). These studies have illustrated how scientific knowledge construction is fluid, continually being modified as agreements over what is "truth" are negotiated anew over time (Gieryn, 1995; Gilbert & Mulkay, 1984). What happens in the courtroom, Smith has noted, is that the normal negotiation processes which take place within science break down as expert knowledge is subjected to adversarial tactics that highlight differences between scientists, simplifies the content of evidence, and results in a weakening of the equation of 'science' with 'truth' (R. Smith, 1988).

Shifting focus: fact/value murkiness

As Mercer summarised, the type of commentary illustrated in the medico-legal literature is often focused on describing the similarities and differences between law and science/medicine as if their epistemic features neatly define and separate each domain. STS have avoided using categorical distinctions, arguing that such domains cannot be defined "on a priori epistemic grounds by the analyst" (Mercer, 2002a, p. 138).

At a broader level, the work of STS scholars has drawn attention to the ideal views of science that are embedded in both sides of the medico-legal debate described in chapter two in the way some of the literature subscribes to the fact/value distinction. Jasanoff (1995) argued that such commentators, with their focus on the difficulties faced by fact-finders in recognizing 'good' from 'bad' science, 'legitimate' from 'illegitimate' expertise, assume that good or legitimate knowledge "exist[s] unproblematically in a world that is independent of the day-to-day workings of the law" (p. xiii). External factors, including the legal procedures that settle

disputes over what can be considered legitimate or illegitimate expert knowledge, are not seen to be influential over the experts.

Smith (1988) has suggested that forensic scientists can never provide a “neutral” social service for the court. He noted that they cannot “produc[e] answers to questions quite independently of the clients who ask the questions and the audiences who hear the answers – or of the medium that links the question and answer” (R. Smith, 1988, p. 93).³⁸ Regardless of this, the legal system has continued to view legitimate expert knowledge as that which is autonomous from outside sources; knowledge which has the appearance of objectivity and neutrality is easily incorporated into legal decisions.

STS have allowed for a way to navigate the murkiness that occurs with the fact/value distinction in the courtroom. Although the end result of court cases may instil clear distinctions between values and facts, a focus on the processes that occur in the courtroom can illustrate the values and interests that have become naturalised in legal closures (Wynne, 1989, p. 46). Viewed through this lens, the appearance of objectivity and neutrality is a consequence of “cultural and discursive practices” used by these actors rather than an intrinsic feature of evidence (Edmond, 1998a, p. 401). This has led the development of a focus in the analysis presented in this study towards the practices of experts and legal professionals in the courtroom, as will be discussed in chapter four.

THE BOUNDARY-WORK OF LEGAL PROFESSIONALS & FORENSIC EXPERTS

The concept of ‘boundary-work’ is often drawn upon by STS that have focused on the practices between legal professionals and forensic experts. The conceptual approach of ‘boundary-work’ as it has been applied to the legal setting relies largely on the work of Gieryn (1983, 1995, 1999). Before reviewing the use of boundary-work in the context of law-science relations, the following section provides an overview of the emergence of this concept and its utilisation for the practices of delineating science from non-science.

³⁸ It is important to note that some of the medico-legal literature admits as much. Rogers suggests that clinicians may unintentionally take on the theory a lawyer uses to build their case and Homant and Kennedy’s studies described the possibility of political ideation may influence expert evidence (Homant & Kennedy, 1986, 1987a, 1987b; R Rogers, 1987). These studies will be drawn on later in the thesis (p. 140) during the presentation and discussion of the results of this study.

Within sociology there has been a large body of research that has focused on demarcation processes that occur within and between professions. Indeed, this research began with a focus on what made professions different from other occupations (Gieryn, 1995). The notion of “professions” itself was a demarcation tool that drew boundaries between “special” and “ordinary” occupations (Lamont & Molnar, 2002).

Following this work, sociologists began to focus on how certain practitioner’s work came to acquire more resources, power, authority and control, while others failed to attain such standing (Gieryn, 1995). One example of this is the ‘professionalization project’, where social scientists argued that professionals utilise particular strategies to “define and institutionalize the boundaries of the profession against outsiders” (Lamont & Molnar, 2002).

In the late 1980s Abbott’s research shifted the analytical focus from the demarcation processes at an organisational level to detailing the struggles professionals have among and between themselves (Lamont & Molnar, 2002). Abbott (Abbott, 1988, 1995) argued that professions should be seen as an ecological system whereby individual professions are constantly competing for control of their jurisdiction and legitimisation of their claimed expertise. Professions, in this sense, were conceptualised as constantly changing systems (Abbott, 1995) that are interdependent on the practices and claims of other professions.

Gieryn’s work has extended the research completed by those outlined above, conceptualising “territories” or “borders” as objects of sociological interpretation (Gieryn, 1995). His work has embraced their messiness, contentiousness, and practical significance in everyday life. He has interrogated the borders between science and non-science focusing on analysing the practices involved in marking knowledge as scientific.

In stark contrast to essentialist notions that argue science is defined by unique qualities that set it apart from cultural practices and products (such as Kenny's list of qualities or the legal rules outlined in *Daubert*, see chapter two. p. 27), Gieryn argued for a constructivist argument that there are no 'universal principles' that demarcate science. Instead, what is accepted as 'science' is contextually contingent and driven by interests (Gieryn, 1995). Like other STS researchers, he contended that:

...[e]ssentialists *do* boundary-work; constructivists *watch* it get done by people in society – as scientists, would-be-scientists, science critics, journalists, bureaucrats, lawyers, and other interested parties accomplish the demarcation of science from non-science (Gieryn, 1995, p. 394, emphasis in original text).

The cartographical metaphor of 'boundary-work' is central to Geiryn's work. Focusing on episodes of boundary-work Geiryn sought to investigate the:

...attribution of selected characteristics of the institution of science (i.e., to its practitioners, methods, stock of knowledge, values and working organizations) for purposes of constructing a social boundary that distinguishes some intellectual activity as non-science (Gieryn, 1983, p. 782).

Geiryn has suggested that boundary-work is particularly noticeable when the cognitive authority (credibility, prestige, power and material resources attached to science) of science is being challenged. Therefore, it follows that boundary-work is driven by a desire to claim, increase, defend, monopolise, appropriate, deny or restrict access to cognitive authority. The courtroom, therefore, offers a unique opportunity to see boundary-work *in action*.

He described four types of boundary-work: monopolization, expansion, expulsion and protection. *Monopolization* explains contests for the authority to define what is truly real and how to go about determining it. *Expansion* refers to contests between two or more oppositional 'epistemological authorities' to gain control of a contested ontological domain. The objective of expansion is to distinguish science from other sources of knowledge by relegating them as less reliable, less truthful, and less relevant. *Expulsion* explains strategies aimed at marginalising rival authorities who claim to be or are "posing" as scientific. Often such rivals are termed pseudoscientists, amateur scientists, deviant or fraudulent scientists in an attempt to gate keep (Gieryn, 1999). Although the boundary-work under the heading

expulsion involves allowing some work to count as science, the basis for this is not in dispute as “[n]either side wishes to challenge or attenuate the epistemic authority of science itself, but rather to deny privileges of the space to others who – in their pragmatic and contingent judgement – do not belong there” (Gieryn, 1999, p. 16). *Protection* is the genre of boundary-work that includes attempts to maintain autonomy from external efforts to exploit the epistemological authority of science in a manner that compromises the “material and symbolic resources of scientists inside [the boundary of science]” (Gieryn, 1999, p. 17).

In summary, Gieryn has effectively argued that what is defined and accepted as ‘science’ is the result of good boundary-work. This means he defines science as:

Nothing but a space, one that acquires its authority precisely from and through episodic negotiations of its flexible and contextually contingent borders and territories. Science is a kind of spatial “marker” for cognitive authority, empty until its inside gets filled and its borders drawn amidst context-bound negotiations over who and what is ‘scientific’ (Gieryn, 1995, p. 405)

Boundaries between good and bad science are never fixed, rather as new competitions for credibility arise, new boundaries, and the space within and outside them, boundaries are drawn and redrawn. At times what is considered good science may become murky, as Nader argued “[b]orders are contentious, and as any scientist knows, science is not a revealed and unambiguous truth - today’s science may be tomorrow’s pseudoscience or vice versa” (Nader, 1996, p. 2). What is considered science presently may not be so as time passes – science is not a fixed entity.

The boundary-work in legal proceedings

Edmond (1998b) used Geiryn’s four types of boundary-work to make sense of science-law interactions in legal proceedings. He described how lawyers’ practices can be described using boundary-work. In the courtroom, Edmond illustrated how lawyers contrast *ideal* images of science with *contingency* or *social* factors to make some expert knowledge appear ‘scientific’, while relegating others as ‘unscientific’. One example of lawyers doing boundary-work that Edmond provided is the practice of emphasising the differences between professional realms within science in the courtroom. Lawyers use this technique, he explained, as one way to disestablish the credibility of experts, showing up how a particular expert does not “belong” to the relevant scientific community or does not have the necessary

familiarity or formal training required to be accepted as an expert in the relevant scientific community (Edmond, 1998b). The boundary-work practices of lawyers, therefore, can go beyond demarcating ‘bad’ from ‘good’ science as Geiryn used the concept.

Boundary-work has also been used to describe fact-finders decisions as to what is valid and invalid evidence. Jasanoff illustrated how judges do boundary-work in their decision-making regarding the admissibility of scientific experts: “[j]udges are swayed by their perceptions of what “science” is and who is a “scientist” when they certify an expert’s credibility” (Jasanoff, 1995, p. 59). By closely examining cases where judges do boundary-work, she argued that it allows us to get a glimpse of what judges see as science and this is often related to the existence of a *named* discipline, the availability of *specialised* training, and the use of *specialised* equipment. These types of understandings embrace idealised understandings of science that upholds the fact/value distinction described above.

One example of judicial attempts of boundary-work is the case of *Daubert*.³⁹ In their detailed analysis of this decision and amicus briefs,⁴⁰ Solomon and Hackett (1996) used the concept of boundary-work to investigate how this case exemplifies the way courts attempted to build and maintain a boundary between legal values and value-free science (i.e. the fact/value distinction). They found two different acts of boundary-working exhibited in the amicus briefs for either side of case (*Daubert vs Merrell Dow*). On the one hand, the amicus brief for Merrell Dow argued that scientists, rather than legal professionals, should draw their own boundaries between valid and invalid science which could be achieved through peer review processes. On the other hand, amicus briefs in favour of *Daubert* accepted the idea that the

³⁹ As chapter two (p. 27) briefly explored, in *Daubert vs Merrell Dow* the court had to consider the admissibility of evidence indicating a linkage between a particular drug and a medical condition. Prior to *Daubert*, the case of *Frye* set the precedence and interpreted admissible science as a body of knowledge that was ‘generally accepted’ in the community in which it belonged. Another set of admissibility standards, the Federal Rules of Evidence (FRE) used in the United States framed up the ‘helpfulness’ test (which New Zealand has taken on recently with the Evidence Act 2006) which accepts the expert’s evidence if it would be helpful to the case in question. This test is more inclusive than *Frye* and has been criticized for letting “junk science” into the courtroom (cf. Huber, 1993). In *Daubert*, the Supreme Court was asked to clarify the viability of *Frye* in light of FRE. In particular they were concerned with (Solomon & Hackett, 1996, p. 137): What judges should consider when deciding if scientific evidence should be presented to the jury; what criteria should govern this decision; how one should decide what is helpful; and what role peer review should take in these decisions.

⁴⁰ Amicus curiae is a legal Latin phrase that can be directly translated as “friend of the court” and refers to an individual, group or organisation not directly involved in a case voluntarily offering information on a point of law or another aspect of the case to assist the court in making a decision regarding the matter before it. In this case assistance was given in the form of a brief. The court has the discretion to accept/admit this information in its decision making.

legal system should evaluate scientific evidence without the need to consult scientists. This form of boundary-work, the authors argued, determined that the legal system needs an objective system for reviewing evidence and that cross-examination provides more in-depth scrutiny than peer review processes. In the end, the *Daubert* decision theoretically incorporated both repertoires, with the validity of scientific knowledge to be identified through a series of criteria (the criteria were discussed above) (Solomon & Hackett, 1996, p. 144).⁴¹

Edmond (1998b) has also explored how expert witnesses may also practise boundary-work, whereby together with their counsel they pre-empt the possible limitations of their testimony. In doing this, Edmond argued that they appear to the court as informed and impartial. This lives up to the idealised conceptions of science thereby producing a more credible expert witness (Edmond, 1998b).

Shifting focus: practising fact/value distinctions

In summary, STS researchers have illustrated how boundary-work is used by lawyers, fact-finders and expert witnesses as a means not only to disestablish, but also to establish the credibility of experts. Viewing their practices in this manner means that credibility is actively ‘deconstructed’ and ‘reconstructed’ by lawyers and expert witnesses—a proposition discussed further below. Mercer (2002b) suggested that in this way acts of boundary-work illustrate the similarities in practices of lawyers and scientists in that they both utilise methods of maintaining ideal images that parallel each other.

Boundary-work describes the practices in the legal setting that embrace the fact/value distinction. Boundary-work, therefore, often illustrates that naïve realist and positivist images of science remain resilient in the legal setting (Mercer, 2002a). Lawyers and expert witnesses draw on ideal images of science to construct their case or maintain credibility (Edmond, 1998a). At a broader level, legal rules for admission of expert evidence stipulate the requirement for testimony that is objective in nature (Edmond, 2003). Objectivity in this

⁴¹ Bal (2005) illustrated that even in inquisitorial settings, science is constructed through techniques such as boundary-work. In the case he discusses how although the court utilised a court appointed expert, adversarial tactics were utilised in an inquisitorial system. The judges had to question which experts should be trusted, which methods are reliable, and what kinds of expertise should get more weight. In doing this, the judges had to perform boundary-work.

context is generally associated with the qualities of ‘independence’, ‘impartiality’ and ‘neutrality’. ‘Good’ science is not that which embraces subjectivity, personal interests, partisanship and bias. STS have understood this as an idealised view of science that ignores science’s exposure to economic, political and social pressures, funding arrangements, ethical considerations, varying methodologies, and competition (Edmond, 2003, p. 134, 2005; Jasanoff, 1995).

DECONSTRUCTION & RECONSTRUCTION

The concept of boundary-work introduced the idea that the credibility of experts and their evidence can be *deconstructed* and *reconstructed* by lawyers and the expert witnesses throughout the duration of court proceedings. This is done through various practices that can be understood as boundary-work. The way in which lawyers use boundary-work, however, is flexible. At one point they may be aiming to build up a picture that the expert’s evidence is reliable and adheres to all the ideals of ‘good’ science. While at another point a lawyer may use the same ideals of ‘good’ science to pull apart another expert’s evidence who they are aiming to make look unreliable and untrustworthy. Another boundary-work tactic used by lawyers may be to question these ideals of science completely. This technique can be captured by what STS scholars have coined legal ‘deconstruction’.

Legal deconstruction of expert evidence

The aim of legal deconstruction is to call into question the foundations of this idealistic notion of science. Edmond has explained,

...[d]econstruction involves challenging the facticity or empirical representation of knowledge claims. It includes: Ironising and constructing inconsistencies within and between knowledges, as well as demonstrating *interests* and *flaws* in the production of knowledge claims (Edmond, 1998a, p. 402, emphasis in original).

Deconstruction is used as a method by lawyers to show up the value, tacit, and interpretive laden characteristics of science. For example, deconstructive techniques of lawyers may focus on showing up the contingencies and human factors involved in the testimony of an expert.

Lynch and Cole (2005) have illustrated how often the techniques of deconstruction used by lawyers have involved scientists' work being deconstructed by their own positivistic evaluative structures. Edmond (1998a) described this kind of legal deconstruction as 'boundary re-ordering', whereby lawyers use the boundaries upheld within science to demarcate reliable as opposed to unreliable expert testimony in an attempt at deconstruction. He also used the term 'boundary re-ordering' to explain how lawyers may use boundaries not found in science to deconstruct testimony. Again this emphasised how the practices of boundary-work within the legal setting are varied and how techniques are used in a flexible manner by lawyers to aid in their case construction.

Lynch (1998) provided a good example of the legal deconstruction of evidence in his consideration of the defence's treatment of DNA evidence in the OJ Simpson trial. He closely examined the OJ Simpson trial transcripts analysing how the defence "undertook sustained investigations of the local practices, organizational contingencies and technical controversies associated with the construction" of DNA profiling evidence (Lynch, 1998, p. 830). In short, there were two methods for data collection used in the OJ Simpson trial. These included 'Restriction Fragment Length Polymorphism' (RFLP) and 'Polymerase Chain Reaction' (PCR). The scientists used these methods to compare samples of blood found in OJ Simpson's vehicle, his house and on himself. The prosecution and defence differed as to whether these methods were 'generally accepted'⁴² in their scientific community:

Where the people [prosecution] stress that RFLP and PCR are normal forensic tools, based on accepted scientific principles and backed by authoritative scientific voices, the Motion [defence] presents an unsettled history of innovation in which key scientists continue to remain doubtful about the reliability and credibility for the forensic practices in question (Lynch, 1998, p. 834).⁴³

⁴² In doing this the lawyers are referring to the *Frye* test outlined in medico-legal literature in chapter two (p. 27). To reiterate, the *Frye* test holds that to be admissible the testimony of scientific experts must be based on a discovery or principle that has gained general acceptance in the particular field it originates from (Gatowski et al., 2001).

⁴³ There is a certain amount of background important to the lawyer's deconstructive techniques. Lynch explains that there are two debates presented in the professional literature over forensic DNA analysis which were central to the admissibility hearing for the OJ Simpson trial of 1994 – 1995. The first debate relate to the reliability of procedures for collecting and analyzing samples of blood and other bodily materials (for example, semen). The second debate related to the accuracy of quantitative estimates of random matches between DNA profiles and unrelated profiles in the community population (for example the probability for wrongfulness).

Like the boundary-work practices discussed by Soloman and Hackett, the trial showed up the use of ideals of science to frame good, valid and credible evidence. Lynch explained that the prosecution took a realist perspective arguing that DNA profiling is historically stable, consensually accepted and trustworthy. In contrast, using deconstructive techniques, he interpreted that the defence took on a constructivist position showing that interests, practical difficulties, and institutional barriers have a role in the construction of DNA profiling. What is interesting to note is that these positions upheld by the lawyers are not “rock-solid metaphysical commitments”; rather, Lynch explained that lawyers used them in a flexible way in order to make their argument at a given point of time in the case. This means that throughout the trial or between different trials they may flip between each position.

Interestingly, Timmermans’ study (2006) illustrated the way in which expert witnesses themselves consider potential deconstructive techniques that could be used within the courtroom when they are preparing forensic reports. The forensic pathologists in his study thought about the questions they may be asked under cross-examination relating to their compilation of evidence while constructing their reports. In this way they anticipated the deconstruction that may occur in court, actively conducting boundary-work as they wrote their reports. He concluded that it is the legal standards and the potential questions a forensic pathologist may be subjected to that determine how they collect and interpret evidence. This study suggested one way in which legal standards and procedures may shape forensic expertise. This notion is discussed further below.

Reconstruction of expert evidence

Edmond (1998b) extended the analytical focus solely on *deconstruction* to the simultaneous inclusion of *reconstruction* of scientific knowledge that takes place when science and law interact. He found limitations with the notion of ‘legal deconstruction’ utilised by STS because its tendency to have a limited focus on how scientific knowledge claims – after having their social origins exposed – are reconstructed into legitimate narratives from which decisions can be based.

At the end of the day judges and administration are required to provide convincing reasons for their decisions. Even if these participants were cognisant of some type of deconstruction which was equally applicable to all knowledge claims, their commitment to the existing legal structures and their need to

regularly maintain a “firm” epistemological basis for decisions effectively requires them to adopt a register which often incorporates simplistic images of scientific knowledge (Edmond, 1998b, p. 140).

In undertaking this interpretation, Edmond provided a way to understand how law and science may interact to coproduce closure in a case. Smith (1988) has also emphasised the importance of cooperation between experts and lawyers. He concluded that the end result of a trial is not just down to one person’s competency or incompetency, it is the effect of cooperation between the experts, prosecution, defence and the court (R. Smith, 1988). Edmond (2008) has taken this proposition further suggesting that such cooperative practices can make the lines between science and law murky, to the point that law and science occasionally coalesce to produce law-science hybrid knowledge. This proposition is discussed further below.

Shifting focus: practising deconstruction/reconstruction

By focusing on the interactions that take place during cross examination, STS scholars have described instances where scientific authority becomes doubted through the deconstructive techniques employed in the adversarial setting. The sceptical context of the legal setting and methods of deconstruction expose science as unstable. As Wynne suggested, the legal system “can be described as institutionalized pure mistrust” (Wynne, 1989, p. 33). The fragility of science is especially explicit in cases where there is complexity or conflicting opinions. In these cases qualifications and status become increasingly important as they become the basis of tactics employed by legal players to undermine the credibility of the expert. Other examples may revolve around the restriction of discussion between experts occurring and introducing new information to an expert to make them look unprepared (R. Smith, 1985). This deconstructive process takes place as experts and legal professionals interact; “the adversary setting of investigation and cross-examination” can be seen as a “discursive site at which crime scenes and allegedly air tight chains of custody are deconstructed into ‘impure’ web-sites – places of knowledge in which authorized and hidden agendas converge and mingle” (Lynch, 1998, p. 854).

THE LEGAL SHAPING OF SCIENTIFIC KNOWLEDGE

In the late 1980's Smith discussed how forensic experts are distinctive occupational groups that combine their scientific knowledge with expertise that satisfies the requirements of the legal setting. In doing this, forensic experts accepted that it is the 'legal' not 'scientific' needs that structure their application of knowledge and it is the judge or jury who decide what is reliable knowledge (R. Smith, 1988). The main method of this legal shaping of scientific expertise is the way in which case law sets precedents for what it means to be an 'expert' in the court of law. In other words, case law tells us that the role of scientific experts is to aid factual discovery in court which – by way of their special training, knowledge, or expertise – they do by assisting the legal system in a) determining the facts or b) offering opinion about facts and their role in determining an outcome. The legal process, not the expert, determines the factual question that the expert may answer.

Smith and Wynne (1989) have further described how a 'good' expert witness is one that can acknowledge their subservience to legal processes. It is this subservience, they argued, that characterises forensic experts and makes them a distinct occupational group. In other words, experts may have to mould their expertise for the legal context in order to be credible witnesses (Lynch & Cole, 2005). As suggested above, this may involve a certain amount of boundary-work being done by the experts themselves.

The control over their credibility, however, is not always in the hands of the expert witness (Edmond, 1998a). As Wynne explained:

Legal processes enshrine scepticism and mistrust: cross-examination has a duty to question as fully as possible the adversary's case in front of the judge or jury. Reconstruction from the ensuing intellectual debris is not the expert's, but the judge's responsibility, which he or she must achieve using appropriate legal principles, implicit social values, experience, and so forth. Legal processes can strip away the value system of a scientific culture, leaving the scientist with no control, nor even participation in, translating expert knowledge into particular knowledge and decisions (Wynne, 1989, p. 37).

This lack of control in the courtroom is for some forensic experts a regular part of their professional culture (Wynne, 1989, p. 35). STS scholars have explored how some types of scientific knowledge and some professions are shaped by the demands of the legal setting

(Mercer, 2002b). The following reviews the case of the forensic pathologist to illustrate this point further.

Exemplar: The case of the forensic pathologist

Smith's (1989) research on the role of the forensic pathologist described in detail a profession that has accommodated the constraints of the legal setting. In particular he described some of the qualities and skills that make a 'good' expert which the pathologists have embraced as a normal part of their culture. This involved pathologists shaping their scientific expertise to fit with the legal requirements for an expert witness (R. Smith, 1989). The following summarises some of the skills Smith detailed.

Communication skills were the most important for the expert witness. Case law has stipulated that experts must be an 'expert' but most importantly, Smith explained, they must have the ability to communicate in simple lay terms and lawyers will obtain those experts who are good at this. Further, good oral evidence is not full of qualifications and limitations.

Maintaining control over the meaning of their evidence was also important. Communicating in a simplified manner can lead to a loss of scientific meaning and the forensic pathologist can lose their ability in the courtroom to give a qualified scientific statement. Although the forensic pathologists in Smith's study were willing and able to simplify, at the same time they actively monitored their evidence to ensure it retained some of its original meaning. They achieved some sort of control through a process of negotiation with lawyers instructing them as to what is relevant (R. Smith, 1989, p. 79). To be a proficient expert, therefore, involved maintaining some sort of control over how their evidence is presented.

Practising boundary-work was a skill the forensic pathologist had to manage in order to maintain their professional integrity. Such techniques included such things as: upholding intellectual identification with a scientific discipline; maintaining group solidarity among experts that overrides being pitched in opposition by the courts; working at different times for the prosecution and defence in order to minimise personal bias; viewing the expert role as a service to the court; and making sure the limits of their evidence is made up front so as to retain some control over the possible meaning of expert knowledge. These tactics, Smith

argued, “make it possible for experts to mediate between scientific and legal norms” (1989, p. 71).

Accepting the differences between procedures in the medical as opposed to legal settings was also a characteristic of a ‘good’ expert in Smith’s study (1989). He argues that this recognition sets them apart from other scientists: “This makes forensic experts into very distinctive occupational groups since, unlike their ‘purely’ medical or scientific colleagues, they agree to surrender ultimate control over the way scientific evidence becomes built into constructions of factual reality” (R. Smith, 1989, p. 71).

As referred to previously, Timmermans (2006) has also shown how the content of forensic pathologists’ evidence is shaped by legal requirements. His ethnographic work directed attention to the micro-level detail of the content of forensic pathologists’ reports and testimony. Specifically, the study showed forensic pathologists have to ensure that their inferences as to the cause of death meet the legal standards. Timmermans showed how this requirement constantly influenced the ways in which the forensic pathologists wrote their reports:

...medical examiners, however, are unable to write down a suspected cause of death without pathological proof. To have a medicolegal standing, the cause needs to be documented appropriately and comprehensively, following legally admissible, standard procedures (Timmermans, 2006, p. 50).

A valid determination of the cause of death, therefore, was the product of evidence presented in such a way that meets the locally devised medico-legal standard (Timmermans, 2006, p. 81).

Moreover, Timmermans (2006) suggested that in meeting the medico-legal standard, the forensic pathologists’ work involved the mixing of law and medicine to the point that the discrete influence of each on the production of knowledge was indistinct. He found that decisions around cause of death were not reduced to medical processes as indicated on a death certificate. Rather the conclusive decision was the result of “multiple decisions, complexities, and ambiguities that make possible authoritative tone of the autopsy report” (Timmermans, 2006, p. 70). In other words the forensic pathologists must do a lot of work to

make a report self sufficient, conclusive and rid of uncertainties. Such a report was not just the product of examining bodies and samples, but also the result of various information sources and practices, such as investigations of the scene, medical history, the credibility of relatives, collaboration with law enforcement agents and the consideration of social problems, such as alcoholism and drug abuse. In this way, a cause of death determination could not be completed without access to a variety of information, which then needs to be triangulated because it is the culmination of the sources that result in a conclusion. Timmermans' study indicated that not only are forensic pathologists' conclusions based on a variety of sources, but that these conclusions cannot be given on the basis of one source alone.

Shifting focus: Legal shaping and constraints

The STS focused research reviewed above introduced the idea that the practices of particular occupations have been shaped from their interactions with the legal setting (R. Smith & Wynne, 1989). In other words, new forms of expertise have arisen that reconcile differences and accommodate the law's need (R. Smith, 1985). Returning to Edmond's suggestion, knowledge in the legal setting can be 'co-produced' to the extent to which, at times, "the lines between what can properly be distinguished as law and science become indistinct" (Edmond, 1998a, p. 439). Timmermans' study of forensic pathologists illustrated this in the ways in which they write up their reports for legal purposes (Timmermans, 2006). Jasanoff (1995) has also argued along similar lines stating: "ideas of truth and ideas of justice are co-constructed in the context of legal proceedings" (Jasanoff, 1995, p. xiv). These kinds of professionals, and the knowledge produced in legal settings, can be understood as law-science/medicine hybrids, to which I now turn.

HYBRIDISED INSTITUTIONS AND EXPERTISE

The above research on forensic pathologists exemplified how some experts' evidence involved a mixing of law and science to the point that it is hard to maintain a sharp division between the two. Some STS scholars have suggested that the pressures or constraints created

by the legal shaping of scientific knowledge has led to hybrid formations that bring science and law together (Edmond, 2001; Mercer, 2002b).⁴⁴ Mercer explained:

In law/science encounters scientists are often called upon to answer problems that do not neatly mesh with any pre-defined body of scientific expertise, work with unfamiliar time constraints, and find that their knowledge claim will be reconstituted and strategically simplified into legally tractable terms (Mercer, 2002b, p. 266).

Hybrid experts, Edmond and Mercer contended, often experience difficulty fitting their knowledge within the professional rhetoric of solely 'law' and 'science' (Edmond & Mercer, 2002). This was clearly illustrated in Smith and Timmerman's research on the role of forensic pathologists (R. Smith, 1989; Timmermans, 2006).

Edmond (2001) has further argued that forensic experts have a symbiotic relationship with the legal system. In this way, the viability of knowledge production by forensic experts would not exist without being "displaced" within legal settings (p. 192). Conversely, the legal system would be "deprived of a source" of legitimacy if it did not incorporate this knowledge in its decision making. In this way, it is a reciprocal relationship.

Shifting focus: Hybridisation

The empirical work of STS scholars has shown that solely viewing legal professionals and scientific/medical expert witnesses as separate and competing entities ignores the ways in which these professionals come together in the courtroom producing new hybrid knowledges. It has also highlighted how other studies of forensic experts have ignored the ways in which some forensic expertise is grounded in practices that combine both worlds to the extent that it is more fruitful to explore the hybrid nature of such roles. These interpretations became significant for understanding how the defence of insanity and legal requirements for an expert witness shape the role forensic psychiatrists perform and for understanding their interactions

⁴⁴ The notion of the hybrid as a conceptual tool was initially introduced to STS by Latour in his ethnographic research on scientific knowledge production in the laboratory. He focused on the artificiality of culture/nature distinction. Latour was also critical of the ways in which the social and the object are separated in existing considerations of science and technology. He has argued that this has led to three distinct disciplines where, rather than investigating things in their hybridised form, seem intent on using naturalization, socialization or deconstruction as their lens for viewing reality (see Latour, 1993, 1999a).

with lawyers in the courtroom. Chapter four (p. 88) describes my practical application of the hybrid concept in detail.

WHY ADOPT A STS APPROACH?

This section brings together the theoretical contributions reviewed above and relates them to the focus of this study. It will consider how this thesis “shifts the focus” from that taken in the medico-legal literature to interpreting the findings of this study using a constructivist approach guided by concepts provided by STS scholars.

Rationale for a shift in focus

Chapter two reviewed the existing medico-legal literature with the aim of illustrating the current state of knowledge around the use of psychiatric expertise in criminal trials using the insanity defence. While this literature highlighted the many problems that forensic psychiatrists and legal professionals face in this context, there are several methodological limitations with the current state of knowledge presented in this literature. These limitations include:

- *Limited empirical basis.* A large percentage of the medico-legal literature presented in chapter two was conceptual or based on individual experiences of clinicians conducting insanity evaluations and/or participating in courtroom proceedings. While illuminating, there is limited empirical research that has paid close attention to the issues. The potential for research in this area has been continually discussed in the medico-legal literature. In particular, as far as I am aware, there is no in-depth or systematic qualitative research focused on the practices and experiences of those involved in trials using the insanity defence. Forensic psychiatrists have rarely been asked about the difficulties they face when performing the role of expert witness and what limited quantitative research that does exist has mainly focused on legal professionals’ views of psychiatrists who have given expert testimony.
- *By practitioners for practitioners.* Most of what has been written about the role of scientific/medical experts in the courtroom has been written by practitioners for professional consumption (R. Smith & Wynne, 1989). There is little written by outsiders researching the role of scientists as experts in the legal system.

- *A focus on problematising the role.* The medico-legal literature is largely focused on problematising the relationship between psychiatry and law, which it does in a conceptually dualistic manner. In this way, it is either psychiatry or law that is to ‘blame’ in certain ways for the problems that occur in cases of legal insanity. This approach ignores the intricate and interesting ways in which law and medicine are brought together in this context. Seeing the expert witness or the legal system as the ‘problem’ in the relationship between psychiatry and the law does not attend to the ways in which these disciplines interact. Resorting to blaming either law or psychiatry without any real close empirical investigation can be alleviated by using a socio-legal approach. It is the contention of this study that the STS work allows for a way to unpack the ‘problems’ in a different manner, attending to ways in which the interactions between law and medicine create ways of ‘lawyering’ and ‘doing psychiatry’ that are characterised by hybridised features.
- *Idealised versions of ‘science’.* Some of the medico-legal literature understood science and scientific knowledge production in an idealised manner. This is best illustrated in the work of Kenny (1983, 1984) in his assumption that the essence of science can be defined by a pre-defined set of criteria. STS have shown how what constitutes ‘science’ and ‘expertise’ are relational and constructed in practice. The concept of ‘boundary-work’ exemplified the different techniques that professionals may use to maintain their control over a domain considered scientific. Moreover, because what counts as science is a result of practices, definitions of science can change and expertise is relative to how one is positioned. This is particularly relevant in this thesis because in the courtroom these very definitions can become challenged, making boundary-work practices highly visible and illustrating how fixed notions of science and expertise are not useful.
- *Idealised version of scientific knowledge production.* In viewing science and expertise in this way, the medico-legal literature also suggested that scientific knowledge production should ideally be based on facts only. Such understandings assume that this is possible. STS research has illustrated the ways in which facts are constructed, drawing attention to varied social processes that take place in practise by scientists to produce stable representations assigned as ‘facts’. In the courtroom, such practices can become highly visible as lawyers and expert witnesses practice deconstruction

and reconstruction, showing up not only the constructed nature of knowledge production, but also the legal shaping of expertise. Taking an STS approach, therefore, allows for a way to interpret the practices of knowledge production within the courtroom.

CONCLUSION

In conclusion, this chapter has reviewed STS of law-science interactions in order to develop the rationale for adopting a constructivist approach to the study of the role of forensic psychiatrists and legal professionals in cases involving the insanity defence. Aligning with the research questions for this thesis, this shifted the focus from problematising the role of expert witness in this context, to exploring: the *practices* of forensic psychiatrists and their instructing lawyers; the blurring of legal categories and requirements that occur *in action* within the courtroom setting; and the role of broader contexts in *the shaping* of psychiatric expertise in the legal setting and in the construction of an insanity defence. As chapter four outlines, this involves an analytical framework that allows for the interpretation of the practices of key actors and a method for navigating the ways in which the hybridised nature of the insanity defence leads to a blurring of ideal boundaries (legal categories and requirements) when these key actors interact within the courtroom. This study contends that this analytical focus provides a fresh look into the role of psychiatric expertise in the courtroom.

CHAPTER FOUR: RESEARCH METHODS

This chapter outlines the methods of data collection and the interpretive framework used to answer the research questions for this study. It also details the methodological and ethical issues experienced while conducting the research.

DESIGN OF THE STUDY

In his ethnographic study *Science in Action*, Latour (1987, p. 21) suggested that to explore the practices of scientists “...we merely have to follow the best of all guides, scientists themselves”. In stating this, he described the relationship between theory and method, creating a linkage between the current and last chapter of this thesis. The research aims to investigate a specific area of the law *in practice*. It explores how a defence of insanity is constructed as psychiatric experts and legal professionals interact within the courtroom. In Latour’s words, the study aims to “be there *before* the box closes and becomes black” and observe “efforts to close one black box and to open another” (Latour, 1987, p. 21).

While the STS of law-science interactions significantly shaped the use of particular research methods, this study also drew on the work completed by social scientists generally. STS researchers have used eclectic methods for data collection. Most often studies have employed an ethnographic approach. This method allows for close attention to be paid to the details and content of scientific practices as they are played out by scientists in their ‘natural’ setting. For obvious reasons, the traditional methods of ethnography could not be employed in this study. This meant that at times the study drew on other sources to help guide methodological choices.

This study has used a qualitative research design that was sympathetic to ethnographic research strategies. A quantitative approach would not have been appropriate to assist in the answering of the research questions for this study. It was perceived that qualitative research methods would allow the participants in the research to detail their experiences and enable observation of their practices to the depth required. The data collection methods included the use of interviews, collection of various legal documents and observation of courtroom practices. Data was collected between July 2006 and July 2008. The following section

provides an overview of the processes involved with the interviews, the collection of legal texts and records and the courtroom observation.

QUALITATIVE INTERVIEWS

Sample

The study aimed to seek interviews with forensic psychiatrists, prosecution and defence lawyers, and judges who had experience in criminal cases specifically involving the defence of insanity. Potential participants were identified through reported and unreported cases of insanity between 1995 and 2006. These were accessed via the electronic legal databases of Brookers Online and LexisNexis NZ. Every case reported details of the names of the presiding judge, the defence and prosecution team, and the psychiatrists called as expert witnesses.

Through this process 23 judges who had presided over criminal cases involving insanity were identified. In some instances the same judge had presided over two or more cases over the period 1995-2005. Six of these judges had since retired or resigned from legal practice. On advice from my doctoral advisor, this list was expanded to include all High Court judges in New Zealand as most would have experienced cases involving forensic psychiatrists acting as expert witnesses. Further, not all cases of insanity are reported. The inclusion of all High Court judges gave me a final sample of 53 judges.

The sampling of forensic psychiatrists and lawyers was approached differently to the judges. An initial list included forensic psychiatrists and lawyers drawn from the reported cases but this list was truncated to only include those professionals who had been involved in two or more cases between 1995 and 2005. This ensured the forensic psychiatrists and lawyers had *relevant* and *recent* experience in cases involving legal insanity.

An initial sample of 30 lawyers was determined using this approach. It was difficult to identify an even mixture of defence and prosecution lawyers. Because the insanity defence is rarely used in New Zealand courtrooms (see chapter one, p. 8), defence lawyers do not have much experience of such cases. Prosecution lawyers are more likely than defence lawyers to be involved in cases of insanity, even if this only occurs infrequently. Consequently the initial

sample was comprised of more prosecution than defence lawyers (18 prosecution lawyers to 12 defence lawyers). On advice from my doctoral advisor, the numbers of defence lawyers were increased to include lawyers who had experience with the insanity defence but who may not have been identified through the initial search of legal databases. A final sample of 38 was determined that comprised 18 prosecution lawyers and 19 defence lawyers. The lawyers' contacts were identified using a legal directory which is publically available (Brookers Ltd, 2007).

Due to the fact that forensic psychiatry is a relatively new profession in New Zealand, there are only a few experienced forensic psychiatrists who regularly give evidence in cases of insanity. Statistics on the medical workforce in New Zealand suggest that between 1995 and 2005 there were on average 27 psychiatrists who identified as working in the sub-speciality of forensic psychiatry. Further, not all forensic psychiatrists are involved in giving expert evidence in trials. This meant I had the opportunity to interview most of the forensic psychiatrists who regularly give evidence in cases of insanity. The initial sample gained from the cases reports totalled 19. This sample was reviewed by a practising forensic psychiatrist and a final sample of 18 forensic psychiatrists was determined.

Access to judges

The judges were sent a letter that formally invited them to take part in the study. An information sheet (see appendix one, p. 223) and consent form (see appendix two, p. 225) accompanied the letter.

Shortly after receiving positive feedback from some judges, I received a letter from the Chief Justice of New Zealand detailing her concerns about judicial participation in the study. The letter explained that the correct approach would have been to contact the Chief Justice initially before formally contacting judges (for a copy of the letter from the Chief Justice see appendix three, p. 226).

In response, the Chief Justice was sent a letter that detailed the aims of the study and addressed her concerns (for a copy of this letter, see appendix four, p. 227). A proposal outlining the study and the interview questions for judges was attached to the letter. The letter focused on how the study was not aimed at providing an evaluation of the adequacy of the

defence but rather the role of expert witness during the court trial process. The letter acknowledged that the study did aim to seek the viewpoints of the judges on the expert witnesses' role and the possibility that evaluative statements about the insanity defence could arise during the interviews. The need for the study was emphasised by stating there is no research in New Zealand that has considered the insanity defence in the manner indicated. The letter also detailed the processes that research projects are subjected to before they are accepted as ethically safe by the University of Auckland. It contended that at no stage had my research been considered not to have assured the anonymity of the participants. Finally, the letter addressed the assumption that permission should have been obtained from the Chief Justice. It was noted that wide consultation had taken place during the development phase of the study and at no stage was it mentioned that this would be a requirement. As some judges had already consented to take part in the study, it was also clear that they were not aware of this requirement. Based on the statement on the government website (see www.courtsofnz.govt.nz/about/judges/contacting, accessed 2 March 2010) that: "It is at the discretion of the judge whether it is appropriate to respond to any communication", the letter explained that it was presumed that individual judges would indicate if inappropriate questions were being asked during the interview.

The Chief Justice denied access to the judges due to the study's inappropriate aim of seeking the personal opinions of judges on the operation of the law. Appendix five (p. 229) provides a copy of the Chief Justice's letter of response. All the interviews with judges that had been previously organised were cancelled.

Since this process, the Courts of New Zealand website has guidelines for submitting research requests to a judicial committee (see www.courtsofnz.govt.nz/business/guidelines, assessed 2 March 2010). The guideline outlines the limits of judicial participation in research. It is difficult not to interpret two points detailed in the guideline as direct responses to this study. The guideline firstly states:

Research proposals that seek judicial comment on the existing law, options for law reform or the role or function of court participants are more difficult to approve as responses from the judiciary in these areas will usually be made formally through the Chief Justice.

This prohibits any research involving judges as proposed in this study. It would not be possible to have interviewed judges without discussions relating to ‘court participants’ or the law of insanity. Secondly, the guideline suggests:

The decisions (judgments) Judges make must speak for themselves. Judges cannot add reasons or provide an explanation for a decision they have made. Discussion of individual cases is consequently very difficult for Judges to participate in.

This point is interesting because judicial decisions are edited versions of what occurs in practice. This study was concerned with the processes that occur in action as a defence of insanity is being constructed.

Access to the forensic psychiatrists

The 18 forensic psychiatrists were sent a letter formally inviting them to take part in the study. The letter was accompanied by information sheets and consent forms (see appendix one and two on pp. 223-225). Most forensic psychiatrists responded quickly. Reminder letters were sent out to those who did not respond initially. Three forensic psychiatrists did not wish to be interviewed due to their perceived inexperience with the defence of insanity. A total of 15 forensic psychiatrists consented to take part in the study and were interviewed.

Access to the lawyers

The 38 lawyers were invited to take part in the study using the same methods as the forensic psychiatrists (see appendix one and two on pages 223-225 for copies of information sheets and consent forms). It was difficult to gain access to the lawyers for an interview and many follow-up phone calls were made after lawyers did not respond to the formal letter. The lawyers would often be unavailable due to their involvement in criminal cases. Email became a crucial method of communication as the lawyers could respond to my requests after-hours. ‘Gatekeepers’ (for example, personal assistants) were also useful to speak with in regard to scheduling interviews with the lawyers (Aberbach & Rockman, 2002). Three lawyers who originally consented to participate in the study were unable to be contacted for scheduling of the interview. Three lawyers also chose not to participate due to their perceived inexperience with the defence of insanity. Sixteen lawyers did not respond to follow-up contact after the original letter of invitation to participate in the study. In total 16 lawyers (7 defence and 9

prosecution lawyers) consented and took part in the study. This gave a response rate of 42%. I was comfortable, however, that the interviews with the lawyers adequately assisted in answering the research questions for the study.

Interview design

As this is an exploratory study, the interview design used open-ended questions in a semi-structured format. Literature has suggested that using open-ended questions allows one to “probe for information” while “giv[ing] respondents maximum flexibility in structuring their response” (Aberbach & Rockman, 2002, p. 673). In under-researched areas, ensuring participants can respond to the interview questions using their own frameworks of understanding is important. At the same time, specific topics had to be covered in the interview. The semi-structured format meant that these topics were covered, while it also allowed for flexibility within the interview process. This flexibility was a key strategy used to make the participant feel comfortable and gave a conversational rather than interrogative feel to the discussions. In sum, the interviews included open-ended questions that were semi-structured around key issues related to the insanity defence and expert testimony of psychiatrists.

Interview questions

Due to the requirements of an ethics application, the interview questions were initially designed early on in the research process. This meant that they were largely shaped by the issues arising from the review of medico-legal literature and case law. The interview questions were adapted after they were reviewed by analysts at the New Zealand Law Commission and piloted with a forensic psychiatrist. At the time this study was designed, the New Zealand Law Commission was proposing to explore the efficacy of the defence of insanity. It was important to have their views incorporated into the interview questions to ensure the possibility that the questions generated information useful for the purposes of future reform. This process also ensured the correct legal vernacular was used in the interviews. The piloting of the interview questions with a forensic psychiatrist also ensured the study used the correct psychiatric terminology (see appendix six on p. 231 for a copy of the interview questions).

The interview questions focused on the components that make up the insanity test, followed by various questions on the role of expert witnesses, common issues that arise in these trials and how they manage those issues. In particular, the thematic areas covered in the initial interview schedule included:

- *Insanity defence specifically.* This series of questions aimed to generate participant's interpretations of the legal constructs that comprise the defence, such as disease of the mind and moral wrongfulness. A related question here focused on the problems relating to particular circumstances involving drugs and personality disorders.
- *Translation of terms.* A series of questions focused on gaining insights into how the participants deal with the mixing of clinical, legal and lay terminology in the courtroom.
- *Expert witnesses specifically.* This series of questions aimed to generate information on how the participants viewed the role and function of psychiatrists when acting as expert witnesses. This question was left broad to allow for the participants to discuss the problems *they* perceived occurred during the course of a case involving legal insanity.
- *Criminal defences and mental illness.* This aimed to examine how the participants viewed the legal system's response to defendants with mental illness. Room for discussion over alternatives to the status quo were allowed for here.

The questions were used as a guide and allowed for those being interviewed to expand in depth while maintaining some degree of structure to be able to compare the material between interviews. At the end of the interview schedule there was also a last question which allowed participants to discuss a point not covered in the interview.

Interview process

The interviews took place at the location of the participants' choice. All the interviews took place face-to-face. The method of face-to-face interviews allowed for rapport to develop during the interviews. It also had the benefit of facilitating access to documents, such as

articles the participants had authored or case reports that I would not have accessed otherwise.

All the interviews were recorded with the permission of the interviewees. By not having to worry about taking notes throughout the interview, the recording of the interviews allowed me to focus on ensuring all the necessary questions were covered. It also allowed for the interview to proceed in a manner logical to the interviewee. This meant that participants could describe their experiences as they saw them using their own language without leading them to answer questions based on my determinations. Notes were taken following the interviews to record any important issues. This helped later analysis in determining the core themes that were repeated across interviews.

An important aspect of effective interviewing is the researcher's ability to have adequate understanding of the language and culture of the participants (Fontana & Frey, 2000). As I worked part-time as a researcher in the field of mental health while completing the study, I had gained the necessary background understandings to be well informed for the interviews. The research experience in the field of mental health also helped in establishing rapport through an ability to see the situation from the participant's point of view, rather than superimposing the "world of academia and preconceptions upon them" (Fontana & Frey, 2000, p. 655).

The interviews with the forensic psychiatrists lasted on average 50 minutes, with the shortest interview lasting 24 minutes and the longest one hour and 20 minutes. The interviews with lawyers were slightly shorter in duration, with the average interview lasting 28 minutes, the shortest being 23 minutes and the longest 54 minutes.

Transcription of interviews

All the interviews were transcribed before the analysis of the data took place. Because of the sensitive nature of the interview material, the transcriber completed a confidentiality form that required they maintain the confidentiality of information and anonymity of interviewees (for a copy of the confidentiality form, see appendix seven, p. 241). The interviews were transcribed verbatim, however, close attention was not paid to including every break in speech. Rather there was an attempt to capture the 'spirit' of the original speech. As Good has

argued this “provide[s] a sounder basis for detailed analysis than a paraphrase or summary, since the very act of paraphrasing would introduce a further element of interpretation” (Good, 2007, p. 46).

Participants were given the opportunity to review the record of the interview. This acted as an additional check that the transcript was a correct record of the interview and gave participants an opportunity to disguise any potentially harmful or identifiable information. It also allowed for the participant to give further details regarding a particular issue if needed. The large majority of participants indicated at the interview that they did not want to receive a copy of the transcript and were happy for me to go forward with my analysis without them reviewing the transcript. The small majority that did make changes sent their interview material via email.

LEGAL TEXTS AND RECORDS

Legal texts

‘Legal texts’ collected included both the official case reports (reported and unreported cases) and the legal commentary on cases which have significant implications for legal practices. The case reports and legal commentary gave a picture of past and current judicial thinking around legal insanity and psychiatric expert testimony in the courtroom. This information became particularly important when access to interviewing judges was prohibited. These documents were used as ‘data’ and were analysed alongside the interview, court transcript and courtroom observation material.

Accessing case reports

As described earlier in this chapter, legal texts are available through the University of Auckland’s library’s legal databases of Brookers Online and LexisNexis NZ. These databases were used to access any ‘reported’ and ‘unreported’ cases relating to the defence of insanity. ‘Reported’ judicial decisions are those which are published in the *New Zealand Law Reports* or the *Criminal Reports of New Zealand*, thereby becoming precedent for future decisions. There are also many judgments that go ‘unreported’ but which are available through the two legal databases. A decision is not published when it has little significance for legal practice. However, this does not mean that unreported cases are not important for the purposes of this

research. Access to both reported and unreported cases allowed for insights into the insanity defence regardless of their importance for legal procedure. Thirty-eight case reports (for 35 cases)⁴⁵ were accessed from the period 1958 to 2007. Further information about these cases is outlined in table format on page 83.

Accessing legal commentary

Legal commentary was accessed through the same online databases. In particular, the legal commentaries of *Adams of Criminal Law*, *Cross on Evidence*, *Garrow and Turkington's Criminal Law in New Zealand* were accessed. Legal commentaries are continually updated as new editions and are largely written for law students and practising lawyers. They discuss different legal theories relating to defences that make up criminal law or law of evidence while referencing specific cases pertinent to the discussion. The collection of legal commentary allowed for further explanations of the legal theory behind the law and international cases that may have shaped the way the law has been interpreted by the judiciary in New Zealand courtrooms (Cross, 1958, p. 6). The legal commentary led to the identification of further relevant reported cases. It also allowed for correlations to be made with the material generated through the interviews.

Court records

A selection of relevant court records of recent cases between 2000 and 2006 was also accessed. The reported and unreported judgments are limited in the way that they are carefully constructed documents that occur after the legal closure. The term 'court records' is used in this study to refer to the court transcripts and other material that may be contained within a file relating to a case, such as psychiatric reports or legal notes.

Sample

Brookers and Butterworths online databases were used to identify the cases for which the court records were sought. A purposive method for inclusion was used. Transcripts of court trials were sourced if they: used 'insanity' as a defence (successfully or unsuccessfully), were High Court trials (not District Court or Court of Appeal), took place between 2000 and 2006,

⁴⁵ Three of the cases have two court reports because the defendant appealed their conviction.

and related to charges that were serious in nature (murder and attempted murder, serious assault).

An initial search of the online databases identified 20 court trials. In order to make the analysis of the court transcripts manageable, this initial sample was culled to a total of 13 cases. This sample comprised of three cases in which the defendant was found NGRI and three cases where the defendant was found guilty. One case was included where, the defendant was found NGRI on one charge but guilty on another. These court trials were selected from the original sample based on the characteristics of each case (for example, because of the experts involved or the nature of crime) in order to ensure a mixture of content between cases. All six court trials that took place under the new legalisation of the Criminal Procedure (mentally impaired persons) Act 2003 were accessed. This allowed for comparisons to be made between these hearings and jury based trials.

Accessing court records

To access the 13 court records an application was made to the Ministry of Justice (hereafter ‘the Ministry’).⁴⁶ The application detailed the overall objectives of the research project and specified the cases I wished to access. The Ministry granted approval and notified each of the courts that held the information. Dates for viewing of the records were then set up with the individual courts. The court records were accessed throughout 2007. A total of nine cases were eventually accessed. There was insufficient information to access four of the court records.

The information made available in the different courts varied. In most instances, the courts provided the notes of evidence to be viewed. Notes of evidence are the transcriptions of all the evidence given by witnesses. Some of the courts provided the psychiatric reports in addition to the notes of evidence, particularly in cases that operated under the Criminal Procedure (Mentally Impaired Persons) Act (2003). Other court records provided by a minority of the courts contained legal judgments made during the case that related to

⁴⁶ At first it was difficult to navigate the correct process for submitting an application to the Ministry. The report *Access to court records* authored by the New Zealand Law Commission has critiqued the lack of information available in relation to accessing court records for research purposes (Law Commission, 2006).

evidential issues or police files pertaining to the case. The data presented in the findings chapters largely draws on the notes of evidence and the psychiatric reports.

In most instances only notes could be taken from the court records at the courts throughout New Zealand. This created serious limitations because determining what should and should not be noted was difficult. As a consequence, the notes were overly inclusive. Photocopies of sections of the court records would have been ideal. Due to financial (and context) constraints, however, all notes were taken by hand. An electronic copy of the notes of evidence was provided for the trial observed in 2008 (described in detail below). For future research purposes, it would be most beneficial to be able to access all notes of evidence in electronic format, subject to the usual ethical obligations of confidentiality and anonymity.

DIFFERENTIATING CASE REPORTS FROM COURT RECORDS

The next four chapters (five, six, seven and eight) rely simultaneously on both the ‘case reports’ and ‘court records’ relating to particular cases. At times it may be difficult for the reader to differentiate between the two when the chapter is referencing extracts taken from a case report as opposed to a court record. In some instances, both the case reports and court records of the same case may be used. Figure four outlines each case accessed for this study in order to simplify the process of differentiating between two sources of data when reading the next four chapters. Figure four also outlines the name and year of the cases. The legislation referenced in the court reports and court records are included to highlight when a case proceeded through the jury or judge alone hearing (see chapter one, p. 8, for an overview of these pieces of legislation). When a case is being directly referred to in the following chapters, a further reference within the text is given that correlates to the table of cases found on page xi.

Figure 4. Characteristics and sources for cases

Case name	Year	Verdict	Legislation referenced	Court report		Court record
				<i>Unreported</i>	<i>Reported</i>	
R v Cottle	1958	Guilty	Crimes Act, s 23	✘	✓	N/A
R v Lorimer	1966	Guilty	Crimes Act, s 23	✘	✓	N/A
R v Tobin	1978	Guilty	Crimes Act, s 23	✘	✓	N/A
R v Clark	1983	NGRI	Crimes Act, s 23	✘	✓	N/A
R v McAllister	1984	NGRI/Guilty	Crimes Act, s 23	✘	✓	N/A
R v McKeown	1984	Guilty	Crimes Act, s 23	✘	✓	N/A
R v Munro	1986	Guilty	Crimes Act, s 23	✓	✘	N/A
R v Williams	1988	NGRI	Crimes Act, s 23	✓	✘	N/A
R v Jane	1988	Guilty	Crimes Act, s 23	✓	✘	N/A
R v Misimoa	1991	Guilty	Crimes Act, s 23	✓	✘	N/A
R v Green	1993	NGRI	Crimes Act, s 23	✘	✓	N/A
R v Rotana*	1994 1995	NGRI	Crimes Act, s 23	✘	✓	N/A
R v Smith*	1994 1995	NGRI	Crimes Act, s 23	✘	✓	N/A
R v Summerfeldt	1995	NGRI/Guilty	Crimes Act, s 23	✓	✘	N/A
R v Campbell	1996	Guilty	Crimes Act, s 23	✘	✓	N/A
R v Hamblyn	1997	Guilty	Crimes Act, s 23	✘	✓	N/A
R v Anderson	1997	NRGI	Crimes Act, s 23	✓	✘	N/A
Police v Wihongi	1999	NGRI	Crimes Act, s 23	✓	✘	N/A
R v Simpson	2001	Guilty	Crimes Act, s 23	✘	✘	✓
R v Gates	2001	NGRI	Crimes Act, s 23	✘	✘	✓
R v Lipsey-McCarthy	2004	Guilty	Crimes Act, s 23	✓	✘	✘
R v Moore	2004	NGRI	CP (MIP) Act, s20	✓	✘	✓
R v T	2004	NGRI	CP (MIP) Act, s20	✓	✘	✘

Case name	Year	Verdict	Legislation referenced	Court report		Court record
R v B*	2004 2005	NGRI	CP (MIP) Act, s20	✓	✗	✓
R v Barnes	2004	NGRI/Guilty	Crimes Act, s 23	✓	✗	✗
R v Yee	2005	NGRI	CP (MIP) Act, s20	✓	✗	✗
R v Macrae	2005	NGRI	Crimes Act, s 23	✓	✗	✗
R v Johansen	2005	NGRI	CP (MIP) Act, s20	✓	✗	✓
R v Rathod	2005	NGRI	Crimes Act, s 23	✓	✗	✓
R v Yesler	2006	NGRI	Crimes Act, s 23	✗	✓	✗
R v Rangi	2006	NGRI	CP (MIP) Act, s20	✓	✗	✗
R v KTK	2006	NGRI	CP (MIP) Act, s20	✓	✗	✓
R v Clarke	2006	NGRI	CP (MIP) Act, s20	✓	✗	✓
R v LM	2007	NGRI	CP (MIP) Act, s20	✓	✗	✗
R v Manuele	2007	NGRI	CP (MIP) Act, s20	✓	✗	✗
R v NHM	2007	NGRI	CP (MIP) Act, s20	✓	✗	✗
R v 'X'	2008	Guilty	Crimes Act, s 23	✗	✗	✓
Total cases**				22	12	9

* There were two court reports for this one case due to an appeal of conviction.

** As there were two court reports for some cases, the total for unreported and reported may not equal that which was discussed above (p. 80).

COURTROOM OBSERVATION

Further insights into courtroom interaction between psychiatric expert witnesses and legal professionals were gained through observation of a case using the defence of insanity. The courtroom observation allowed for the forensic psychiatrists and legal professionals to be viewed “in action” as they played out their roles. As Blanck (1987) has explained “the overriding purpose of this method is to gain an in-depth understanding of a real, ongoing, and complex social setting” (Blanck, 1987, p. 339). At times throughout the interviews, I gained the impression that some participants tended to respond to particular questions with answers that correlated with expected norms. For example, participants responded to questions

regarding the insanity defence that amounted to verbatim renditions of reported cases rather than reflecting on what may have happened in practice. The unobtrusive method of courtroom observation (and collection of court records) allowed for the generation of information that was not affected by such variables.

Courtroom observation also provided an opportunity to triangulate data sources. Triangulation refers to the process whereby the researcher, rather than relying on one single form of evidence or perspective as the basis of analysis, employs mixed methods to gather a wide variety of evidence which is used to check the consistency of the research results. Although the same biases in data collection may still be present, because there are more types of evidence being analysed, there are more reference points to check the consistency of the overall results. The courtroom observation allowed for the legal terms and practices detailed in legal texts and by interview participants to be viewed *in action*. This firmed up some of the initial analysis that had already been undertaken. Triangulation is discussed in further detail on page 90.

The method of non-participation observation also provided the opportunity to familiarise myself with the courtroom and its procedures. Interestingly, this method quickly dispelled some assumptions I had regarding the interactions between professionals in the courtroom and the general atmosphere of the legal setting.

Identification and access to trials

Due to the small number of trials that use this defence, the opportunity to observe trials was limited. Additionally, most cases now proceed using the judge alone hearing under the Criminal Procedures (Mentally Impaired Persons) Act 2003 (described further on p. 8) which is not as open for public viewing as other trials.

Permission was granted from the Ministry of Justice to observe courtroom proceedings. Further, when an appropriate case to observe was identified, consent was also gained from the relevant court. Due to financial constraints, observation took place at the High Court in Auckland only. Staff at the Auckland High Court assisted in the identification of any trials using the insanity defence in advance of the dates when they were due to take place. When I was advised of an appropriate case an application was made to the judge presiding over the

criminal trial. Although the general public are allowed to view any criminal trial, gaining prior approval from the presiding judge meant he/she had prior knowledge of my presence in the courtroom. This led to many benefits, which are discussed in further detail below.

Observation process

A relevant trial using the insanity defence was identified and observed in July of 2008.⁴⁷The context for the case is detailed in chapter eight (p. 180). The defence put forth several defences one of which was insanity. The case was observed over six weeks.

Due to the presiding judge's prior knowledge of my research, I received permission to make notes during the course of the case and received special viewing privileges. One day early on in the trial, the judge directed that I stay while the remaining public left. After explaining to counsel and court staff the purposes of the study, with permission of counsel, I was allowed to sit in on closed chambers for the duration of the hearing. This afforded an insight into the proceedings that I would not have gained otherwise. The discussions that took place in closed chambers often involved legal debates over the admissibility of psychiatric reports, whereby the defence and prosecution would submit their arguments as to why or why not particular evidence should be admissible.

Note taking

Notes were taken throughout the trial. This allowed for 'first impression' notes to be taken as the court trial was being played out. The court staff also advised that they would make available the full transcript of the notes of evidence. Thereafter, only notes were made when psychiatric testimony was given to capture first impressions that I had in "real time". The notes complemented the more in-depth analysis of the full transcript.

⁴⁷ Another trial was identified before the completion of this thesis. Due to unforeseen circumstance, this case could not be viewed.

INTERPRETATION OF DATA

At the end of the data collection phases there was an overwhelming amount of raw data. A careful strategy had to be developed that integrated the various sources and reduced the large amounts of data.

The interpretation of data involved a tenuous balance between allowing themes to emerge from the data and using the analytical tools described in chapter three to guide my analysis. In some instances, the interpretation of data drew on the medico-legal literature detailed in chapter two or social science literature outside of STS. At times new areas to explore arose that needed to be unpacked without the use of existing literature. The interpretive process was flexible. It used the analytical tools developed around what was emerging from the raw data. The analytic toolkit described in chapter three was the result of this interpretive process.

Throughout this interpretive process a continual process of self-reflection took place (Charmaz, 2003). The limitations of the scope of this analysis was taken into account, which meant accepting that the study could not address every interesting finding that emerged from the raw data. This was managed through constant referral back to the three research questions for the study.

Three layers of analysis

There were three layers of analysis applied to the interviews, legal texts and records and the courtroom observation. Initially each data source was attended to separately. The focus was to reduce the data into a manageable size for the analytical chapters presented in this thesis. The initial analytical ideas that emerged from the interviews were particularly influential in the reduction of other data. Further, the themes that emerged from the interview material were also used to guide the analysis of other data sources.

The qualitative software package NVIVO was used to assist in the organisation of the raw material under emerging themes. NVIVO allows users to import interview material into a folder within the software interface that can then be subjected to various thematic coding. The NVIVO interface displays hierarchical 'tree nodes' that allow users to organise their interview material under major themes, with sub-themes branching off these major themes.

The software also allows for considerable flexibility in terms of shifting ideas and this was invaluable for the three layers of analysis that were undertaken in this study.

Memos were made that kept track of the meanings behind the development of various themes. These memos are a built-in feature of NVIVO, which meant they were conveniently linked to the original transcript for later access. Influenced by the work of grounded theorists, 'memoing' allowed for the recording of the relationships established amongst themes, how this related to theoretical ideas and the meaning of each individual theme (Ryan & Bernard, 2000).

The first layer of analysis used the 'auto-coding' function provided by NVIVO. This function collates and combines material using the headings system contained in Microsoft Word documents. All the raw data for this study was imported into NVIVO as Microsoft Word documents using these headings. Each heading revolved around the themes contained in the interview guide, such as 'the insanity defence', 'translation of terms' and so on (see p. 77). The legal texts and courtroom observation transcripts were also coded according to these broad themes. This allowed for a general sense of the data to be obtained. Further on through this process themes began to be repeated and themes that went across many of the headings were identified. At this point, it became less useful to use the interview guide as the main organiser of themes. Different labels that adequately described the content were assigned to larger pieces of data. At the end of this first layer of analysis, major themes were beginning to be conceptualised.

In the second layer of analysis, the raw data was approached by collating it under the major themes using my own labels that had emerged from the above process. This process allowed for the analysis to be shaped by what had emerged from the interviews rather than the interview guide developed before the data collection began. This state of the analysis drew on the medico-legal literature, which guided the development of labels for sub-themes. The second layer of analysis also led to some material which was not applicable to the research questions this study sought to answer being put to one side. It was not difficult throughout this process to see repetitive topics and issues being talked about by all participants. What was important was to ensure that subtle differences and contradictions in the ways participants conceptualised these issues was explored through the analysis.

In the third layer of analysis, the data was distilled into four core themes. These themes were labelled: ‘producing boundaries’, ‘blurring boundaries’, ‘hybrids’ and ‘symbiotic relationships’. Each of these core themes ended up shaping the focus for the separate findings chapters presented over the next four chapters. The labels for each theme were analytically driven by the tools described in chapter three. Under each of these four themes was a series of sub-themes that were the result of a tenuous balance between what had emerged from the interview material and that which was interpreted using the analytical toolkit. In this way a reciprocal relationship developed between the analytical focus provided by the toolkit and the themes that were emerging from the raw material. This allowed for the aim to analyse the raw data in terms of the particular issues important to the participants to be maintained. The analysis continued to describe the situation using the words and understandings of the participants. At the same time the analytical toolkit helped interpret the data and answer my research questions. The use of analytically driven labels assisted in distilling the material but this was balanced with a commitment to ensuring they were effective descriptions of the field. Again this meant the analytical toolkit had to be flexible. It shifted as more literature was read and further data interpreted.

VALIDITY, REFLEXIVITY AND TRANSPARENCY

The ‘validity’ of data is a controversial issue within qualitative inquiry (Maxwell, 1992; Patton, 2002; Steale, 1999; Strauss & Corbin, 1990). Many authors have argued that issues of validity and reliability are not applicable because they align with positivistic rather than constructivist paradigms which are embraced by qualitative researchers. Other authors have stated that a different set of criteria should be applied to qualitative research to ensure research rigour and trustworthiness (Davies & Dodd, 2002; Lincoln & Guba, 1985; Stenbacka, 2001). Member checking, audit trails, confirming results with participants, peer debriefing and corroboration have been suggested as practices researchers should consider to ensure the trustworthiness of their studies. Moving away from these discussions, Clarke (2005) has suggested that researchers should be accountable for the methods they use rather than ‘hiding behind’ them. Using Clarke’s approach to research methods, this section reflects on the strategies that were used throughout research process to ensure reflexivity and consistency in the use of methods and interpretation of data. The limitations of the study are described in chapter ten.

The process of reflexivity involved being transparent about my place in the research. Throughout this thesis I have been transparent about the way the aims of the research and the way I approached the research methodologically were shaped by my background as a sociologist. In chapter one, for example, the ways in which the research focus emerged from readings of the medico-legal literature and STS of forensic expertise was discussed (pp. 14-18). Although the strength of the research lies in its sociological focus, a careful balance had to be struck between using a sociologically inspired analytical lens and approaching the selection and interpretation of raw data on its own terms. The previous section of this chapter (p. 88) explored the evolving processes of the interpretation of the data that took place in this study (Charmaz, 2003). Throughout this phase a continual process of self-reflection took place that involved the continuous re-reading of raw data after making interpretations and assigning labels. This ensured a balance was maintained between theorising about the raw data and letting ‘themes’ emerge from the raw. However, it is important to be clear that the interpretation of data included in this study is inseparable from the context in which it emerged (Clarke, 2005).

Triangulation of data was another strategy used to ensure consistency in the analysis (Creswell & Miller, 2000; Patton, 2002). This chapter has described how the data were collected from various sources, through interviews, legal texts and courtroom observation. Comparisons were made between these sources when interpreting the data, which strengthened the theoretical ideas over time. In some instances contradictions were found between sources. At this point, the raw data would be returned to in order for this contradiction to be explored further to see if an existing interpretation needed to be adjusted.

Peer review was used as a strategy to have the choice of research methods evaluated and for ‘testing’ the analysis of data. In the early stages of the research, I presented at two doctoral schools and received feedback on my intended methodologies. The findings of the research were presented at five international conferences in Australia (Thom, 2007), England (Thom, 2008b, 2008c), Scotland (Thom, 2008a), and the United States (Thom, 2009). All of these conferences were multi-disciplinary in nature and focused on the broad areas of STS, socio-legal studies, medical sociology or within the field of mental health generally. The findings described in chapter eight were also subjected to peer review and published as a chapter (Thom, 2009) in an edited book entitled *Configuring madness: Representation, context and*

meaning. This peer review was integral to firming up ideas and gaining feedback from scholars specialised in a wide variety of disciplines.

ETHICAL ISSUES

Before I commenced the research, I submitted an ethics application to the University of Auckland's Human Participants Ethics Committee. This required the ethical issues of informed consent and confidentiality to be considered in relation to all the data collection methods.

In terms of the interviews, the ethics application described how the subject of this research was a highly sensitive area. This meant that the confidentiality of all legal and medical participants was of paramount importance to the study. The study set out to maintain the anonymity of participants by not using their names. Pseudonyms were assigned for each participant and these were utilised throughout the research process. It was acknowledged, however, that it may not be possible to prevent insiders from within the 'field' from recognising particular participants by the inclusion of quotes in the thesis. The limitations in the use of pseudonyms were openly explained to each participant when gaining informed consent.

The processes that were going to be used to identify and approach potential participants were also outlined in this application. It was emphasised that the names and contacts of the lawyers and forensic psychiatrists were readily available through public sources. Informed consent was to be obtained from all participants before the interviews commenced. This included providing each participant with an information sheet outlining the purposes of the research, the methods of data collection, and any possible risks. This was accompanied by a consent form that was required to be completed by all participants before the interview commenced. This insured that each participant was openly informed about the "nature and consequences" of the research they were to be involved in (Christians, 2000, p. 133). At this stage the participants were required to consent to the interview being recorded by audio-tape and they were assured that any individual employed to transcribe the interviews would be required to sign a confidentiality form. All participants were instructed that they could withdraw their information at any time throughout the data collection process.

All information—including signed consent forms, audio tapes, transcripts and any notes taken during the interview—were to be kept in locked filing cabinets or on a password protected University of Auckland computer. After six years following the completion of this research, all raw data has to be destroyed.

Following the submission of the application, approval from the University of Auckland's Human Participants Ethics Committee was received (2006 #248). Appendix eight on page 242 provides a copy of the approval letter from this Committee.

SUMMARY

This chapter has discussed the research methods used to collect and interpret the data. It has also discussed the various methodological and ethical issues that were experienced during the research process.

The findings for this study that follow this chapter are developed thematically over four chapters. Chapter five is focused on developing the ideal interpretations of 'insanity' and the role of psychiatrists in its construction. It also paves the way for an exploration of how these boundaries become murky, messy and blurred in practice, which is the topic of chapters six and seven. Chapter eight uses the data collection from the courtroom observation to bring together the themes of boundaries and blurring of boundaries, focusing on the symbiotic relationship that occurs as lawyers interact with forensic psychiatrists in the courtroom.

CHAPTER FIVE: BUILDING BOUNDARIES

The role forensic psychiatrists perform as expert witnesses in New Zealand courtrooms is for the most part uncontroversial. Consequently, decision-making regarding insanity has appeared uncomplicated. In a minority of cases, however, decision-making around the legal constructs that comprise a defence of insanity can become difficult and complex. Not only are decisions around what constitutes ‘insanity’ contentious in some cases, the exact role a psychiatric expert witness should play in these determinations has been disputed within the legal context and the wider literature on the topic (cf. Chapter two, p. 21-42). An overarching argument put forward in this thesis is that the boundaries that ideally aim to separate the responsibilities of the fact-finders, legal professionals and the expert witnesses become blurred in the context of insanity trials. Before discussing instances of blurring of these boundaries, this chapter describes how they are built.

The chapter considers how the legal texts and participants in this study interpret the defence of insanity and the role psychiatric expert witnesses play in its construction. The overall aim of the chapter is to provide a rather *idealised* account of the legal test for insanity and the role of the expert witnesses in order to provide a foundation for an analysis of the blurring of boundaries that can occur *in practice* when these cases become contested. The chapter will achieve this aim using the material generated from the interviews with lawyers and forensic psychiatrists as well as legal texts, including case law and legal commentary. It will conclude by drawing on Geiryn’s notion of boundary-work (1995), as described in chapter three (p. 54), to explore how the ideal interpretations of the legal test for insanity and the role of the expert witness attempt to build two boundaries in order to define the territory that is under the jurisdictional control of legal professionals. These include boundaries that aim to maintain a separation between (1) lay and expert knowledge and (2) facts and values, with facts being something for experts to give opinion on and values for fact-finders to consider.

Chapter five begins by detailing the components that comprise the test of insanity and the legal requirements that guide the role of the expert witness. The latter part of the chapter uses specific cases of legal insanity to illustrate further the characteristics that neatly fit with the ideal interpretations of these legal constructs. The chapter will conclude with an analysis of the boundaries that emerge from the material discussed in the first two sections. These

boundaries will reappear throughout chapters six, seven and eight and will form much of the discussion in chapter nine.

THE LEGAL TEST FOR INSANITY

The legal test for insanity under the New Zealand Crimes Act 1961 involves a two stage⁴⁸ process. To qualify for the verdict of NGRI, the defendant must first have been found to be labouring under ‘natural imbecility’ or ‘disease of the mind’. Following this, it must be found that one of these two afflictions affected the defendant to such an extent as to render him (sic) incapable of a) understanding the nature and quality of the act or omission, or b) knowing that the act or omission was morally wrong having regard to the commonly accepted standards of right and wrong. The concepts ‘natural imbecility’ and ‘nature and quality’ are rarely used in New Zealand courtrooms considering a defence of insanity.⁴⁹ It is most common, therefore, for a forensic psychiatrist to assist the court in determining whether firstly the defendant has what the court defines as a ‘disease of the mind’ and secondly, whether this disease of the mind affected the defendant to such an extent that they were incapable of knowing the moral wrongfulness of their actions. This two stage process is illustrated rather simplistically in the figure below.

Figure 5. Two stage process



⁴⁸ This was referred to as a two ‘stage’, two ‘prong’, or two ‘limb’ test by the lawyers and FP’s I interviewed, all signifying that there are two related steps in deciding whether a person may meet the criteria for legal insanity.

⁴⁹ ‘Natural imbecility’ (sub-normality or mental retardation) and ‘nature and quality’ are terms that are not often used in cases of insanity in New Zealand. I could find no references to the use of these terms in any New Zealand cases nor did any of the participants in this study remember or have experience in any case that utilized them. It was explained to me by one forensic psychiatrist (#1) that a person who meets the standard of natural imbecility and is affected to such an extent as to render them incapable of understanding the nature and quality of the act would undoubtedly be found unfit to stand trial and would therefore never be considered under section 23 in court. He suggested that the inclusion of this ‘limb’ under section 23 dates back to when there was no adequate law to deal with fitness to stand trial. In this thesis, therefore, only ‘disease of the mind’ and ‘moral wrongfulness’ will be considered.

STAGE ONE: 'DISEASE OF THE MIND'

The first stage of the test aims to decipher whether the defendant has a disease of the mind. There is no precise definition of a disease of the mind provided by the court through case law, although commonly accepted mental disorders amounting to a disease of the mind are those that fall under the umbrella of “psychoses” (this term will be discussed in further detail below). It is argued that the term ‘disease of the mind’ has purposely been left open by the court for interpretation, as suggested in the case of *R v Cottle* (1958).⁵⁰ In this case Justice Gresson interpreted a disease of the mind as:

...a term which defies precise definition and which can comprehend mental derangement in the widest sense whether due to some condition of the brain itself and so to have its origin within the brain, or whether due to the effect upon the brain of something outside the brain, e.g. arteriole sclerosis” (*R v Cottle*, 1958, p. 1011).

What may not be considered a disease of the mind, Justice Gresson explained, are adverse effects upon the mind due to “a blow, hypnotism, absorption of a narcotic, or extreme intoxication” (*R v Cottle*, 1958, P. 1011). *Adams on Criminal Law* further explains that psychological disturbances which are common amongst the general population are not considered a disease of the mind. These may include extreme anger or loss of self-control. What we can take from this short introduction is that a disease of the mind is something to do with the *brain*, cannot be due to an *external* source, and has to be *severe* in nature.

There are several other factors that assist in the defining of a disease of the mind. These are discussed in the sections below.

⁵⁰ This case involved Cottle appealing against his conviction of six counts under the Crimes Act 1908. This included breaking and entering a warehouse and committing theft, mischief, and having in his possession certain implements for housebreaking. A defence of automatism was put forth and medical evidence was given concerning Cottle’s epileptic fits. A guilty verdict was returned. Cottle appealed his conviction on the basis that the trial judge misdirected the jury in relation to four matters: 1. Failure to give the usual warning to the jury regarding the evidence of an accomplice; 2. Failure to direct the jury regarding the probative content of certain evidence of an accomplice; 3. *Failure to direct as to the nature of the defence raised as to automatism; and 4. Misdirection that the onus of proving the state of automatism rested on the accused* (*R v Cottle*, 1958, p. 1000). The Court of Appeal found that the first two points were established and quashed the conviction and ordered a new trial. The Court explained their reasons for this decision while also detailing the defence of automatism with regard to the appellant’s argument in points three and four (emphasised in italics). In doing so, the judges explained the differences between a defence of insanity and sane/insane automatism – allowing for clarification over the wording and its meaning in the legal context. This case set precedence for the future use and interpretation of disease of the mind and other terms that make up the insanity defence.

‘Disease of the mind’ is a legal term

Along with the legal texts, the lawyers and forensic psychiatrists interviewed emphasised first and foremost that the term ‘disease of the mind’ is a legal term. This term does not have any direct medical relevance and is not a term used by psychiatrists in their clinical settings (FP #1). In practice this means that the final decision as to what is to be considered a disease of the mind is for the court to decide.

... [it] is a question of law for the Judge. It is his [sic] duty to instruct the jury what constitutes a "disease of the mind", and then it is for the jury to say whether the prisoner was suffering from a disease of the mind... Surely it cannot be left to a medical witness to apply his own definition? I would think it not unlikely that individual doctors might interpret these words in different ways, and it seems to me altogether wrong that the course of the trial should depend on the opinion of a doctor (*R v Cottle*, 1958, p. 1028).

This means that forensic psychiatrists acting as expert witnesses can state whether they regard a person to be suffering from the causes and symptoms best explained by a mental disorder that could be interpreted in law as a disease of the mind, but their opinion is not final (Adams et al., 2008, p. CA23). Chapter seven (p. 171) discusses how ‘assisting’ only in the decision-making about whether a mental disorder should be accepted as a disease of the mind becomes difficult for the forensic psychiatrist to manage in practice.

The notion that what constitutes a disease of the mind is not to be decided by a medical professional was emphasised in the British case of *R v Kemp* (1957), a case often cited in New Zealand legal commentary. The presiding judge in this case explained: “The law is not concerned with the brain but with the mind, in the sense that ‘mind’ is ordinarily used, the mental faculties of reason, memory and understanding” (*R v Kemp*, 1957, p. 254). Although this seems to contradict Justice Gresson’s proposition mentioned above where he referenced the ‘brain’ as the most important element in considerations of the disease of the mind, the main proposition to be taken from *R v Kemp* is that the law is interested in *common understandings* rather than medically driven inferences as to what constitutes a disease of the mind. As Justice Potter explained, fact-finders are not required to “perform a neurological or psychiatric assessment of the defendant’s brain or its workings” (*R v Dixon*, 2007, para. 32).

This is emphasised by the fact that what comprises a disease of the mind is not necessarily exclusive to disorders traditionally accepted by the psychiatric profession as mental disorders. Some physical conditions have been found by courts in other jurisdictions to be diseases of the mind even though medical witnesses may not agree. These include diseases such as epilepsy and arteriosclerosis which may create temporary mental states and involuntary acts that could be described as a mental disorder (Adams et al., 2008, p. CA23:07). In *R v Sullivan* (1984), for example, it was held that epilepsy does equate to a disease of the mind despite medical witnesses giving evidence at the trial that it was not. This reinforces the claim in *R v Kemp* that the law is interested in wider interpretation of the ‘mind’ (memory, reason and understanding) rather than psychiatric conceptualisations of disorders resulting from a dysfunction of the brain (Adams et al., 2008).

In conclusion, the term disease of the mind is interpreted as a legal rather than a medical concept and it is the role of the judge – a legal professional – to determine. This rule is something that the forensic psychiatrists are ready to accept and abide by when they are acting in the expert role:

I suppose disease of the mind is firstly a legal term and we [expert witnesses] are acutely aware of that and we are also acutely aware that is an undefined term (FP #2).

As quoted, a disease of the mind is an undefined term driven by case law, whereby prior important judgments or ‘reported’ cases give precedent to future decisions (FP #3). This will always be qualified by taking into account the other characteristics of a disease of the mind set out in legal texts. The following section outlines these other characteristics.

Serious in nature

A disease of the mind must be due to a condition that is serious in nature. The lawyers and forensic psychiatrists interviewed often referred to Lord Denning’s articulation of the test for insanity which he gave in *Bratty v Attorney-General for Northern Ireland* in 1963. This case is commonly cited in New Zealand case law and legal commentary with regard to determining whether a disease of the mind is present and the mental disorders that qualify for a disease of the mind. Lord Denning argued for a rather broad definition:

It seems to me that any mental disorder which has manifested itself in violence and is prone to recur is a disease of mind. At any rate, it is the sort of disease for which a person should be detained in hospital rather than be given an unqualified acquittal (Bratty v Attorney-General for Northern Ireland, 1963, p. 534).

Lord Denning's explanation is said to cover organic brain disorders, all the psychotic illnesses and mood disorders that effect a person's thinking and reasoning and are serious in nature (FP #1, FP #11). In other words, a disease of the mind must be due to a major mental illness:

I believe that is a major mental illness and...it just highlights that they're [the court] really talking about a really *serious* thing to do with the mind, meaning a *major mental illness*. Not just stress or common features that affect the mind anyway (FP #13).

The seriousness of the mental illness is emphasised by the courts having stipulated that the malfunctioning of the mind must be attributable to 'disease' (Garrow et al., 2007, para. CR123.4). The prosecutors and defence lawyers in this study also suggested a disease of the mind is something one is born with or acquires and manifests itself as a disease causing sickness or illness.

Disease of the mind I've always interpreted as a *sickness*, which affects your normal function, so some of the syndromes that you're born with (DL #12).

[A defendant found to have a disease of the mind is] Someone who gets *sick* [or] mentally *unwell*...People are *unwell mentally*, not functioning (PL #13).

Minor mental illnesses, therefore are not understood to be serious enough condition. In this way, it has to be a "pathological condition", not something "that is within the canon of understanding of the jury as a normal response or reaction" to a situation (FP #3). This suggestion that a disease of the mind is something that is caused by illness that is serious in nature also leads to another important characteristic of a disease of the mind: the internal/external distinction.

Internal/external distinction

Another factor important for establishing a disease of the mind is the “direction of causality” (Memon, 2006, p. 242). This means that the law requires a disease of the mind to be the result of an *internal* rather than an *external* cause. External causes include such things as a blow on the head, the absorption of drugs, alcohol, or an anaesthetic, or hypnotism (Adams et al., 2008).

A disease of the mind has to be something that is inherent or internal to the person (McSherry, 1993), and this internal process must not be transient but persistent, lengthy in duration and recurrent.

I think we would look at it [disease of the mind] as obviously encompassing the major mental illnesses and other aspects where there is clearly an *internal* change of process going on which is of at least some duration rather than transient. I think there needs to be some sense of durability to it and some *internal* mechanism to it (FP #2).

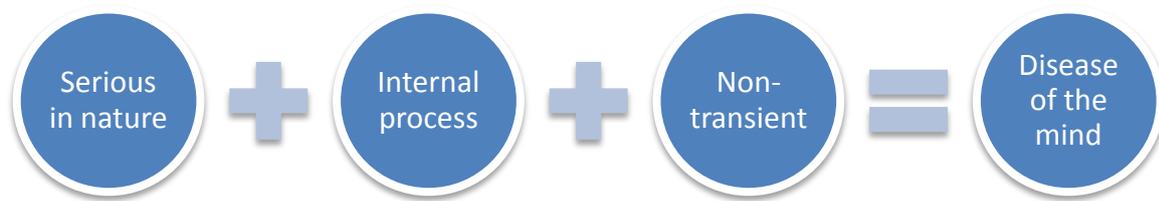
In this way, disease of the mind must have permanency or an established history.

I think anything [mental illness] that’s well established, that has a recognised history and that is permanent and not just transitory (PL #4).

Psychosis, for example, is generally accepted as an internal and non-transient process and is therefore, generally accepted by the court as a disease of the mind. The concept of pathology is emphasised in legal texts whereby a disease of the mind must be the result of an underlying condition and not the result of an external stimuli.

In summary, the characteristics that make up a disease of the mind as set out in case law, legal texts and by the participants in this study can be displayed in a simple equation such as figure 4.

Figure 6. Constructing a disease of the mind



STAGE TWO: ‘MORAL WRONGFULNESS’

The second stage of the test for insanity involves assessing whether a person afflicted with a disease of the mind was affected to such an extent that they did not know the moral wrongfulness of their actions. Section 23(2)(b) of the Crimes Act (1961) stipulates that this part of the test should be focused on determining whether the accused was “incapable of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong”. As with the term ‘disease of the mind’, moral wrongfulness is determined by the fact-finders, not medical witnesses. In this way, standards of morality are decided by the fact-finders (as lay representatives of society) in accordance with the addition of the term “commonly accepted” to the second stage of the test of insanity (PL #8). The following outlines the legal definitions of what is meant by moral wrongfulness in this context.

‘Moral’ versus ‘legal’ wrongfulness

The inclusion of ‘morally wrong’ departs from the strict M’Naghten rules (see chapter one, p. 8) and was not contained in New Zealand’s Criminal Codes of 1893 and 1908. The M’Naghten rules intended the term ‘wrong’ to mean *legal* rather than *moral* wrongfulness. This meant that to meet the test for insanity the accused must have been incapable of knowing the act or omission was illegal, or that “one ought not to do it” according to the standards adopted by “reasonable men” (Adams et al., 2008; Memon, 2006). Whether the law of insanity should consider legal wrongfulness only or whether it should be expanded to include moral wrongfulness has been debated across several jurisdictions for some time. *Adams on Criminal Law* cites the English case of *R v Windle* (1952) and the Australian case of *R v Stapleton* (1952) which made arguments in direct opposition to one another. These cases have been influential in the shaping of the current case law in New Zealand.

The issue of defining “wrong” was directly addressed in the appeal of *R v Windle*. The defendant had put forth a defence of insanity for administering an overdose of aspirins to his alleged mentally ill wife leading to her death. The medical witness for the defence testified that Windle suffered from a “form of communicated insanity known as folie à deux” which occurs when a person has been in “constant attendance on another of unsound mind...so that, for a time at any rate, the attendant might develop a defect of reason or of mind” (*R v Windle*, 1952, p. 827). All the medical witnesses on both sides agreed that when Windle administered the dose of aspirins he knew what he was doing was wrong in the eyes of the law. On addressing the jury, the presiding judge stated that there was no defence of insanity under the M’Naghten rules for them to consider. The appeal considered whether the presiding judge was correct in addressing the jury in this way, specifically focusing on whether ‘wrong’ under the M’Naghten rules should be interpreted as encompassing only legal wrongfulness or whether moral wrongfulness should also be considered. It was found that the law of insanity cannot consider whether a particular act was morally right or wrong.

In the opinion of the court there is no doubt that in the McNaghten rules “wrong” means contrary to law and not “wrong” according to the opinion of one man or a number of people on the question whether a particular act might or might not be justified (*R v Windle*, 1952, p. 834).

Because the defendant knew what he was doing was contrary to the law, the appeal was dismissed.

In *R v Stapleton*, however, it was decided that the defendant may be found insane even if they knew that what they did was illegal. This has been interpreted in legal texts as a clear rejection of the decision made in the case of *R v Windle* (Adams et al., 2008). There was no question as to whether Stapleton did commit the murder, rather the question was whether he was insane at the time he did so. At the trial there was evidence that his family had a history of ‘mental deficiency’ and ‘abnormality’. On the night Stapleton committed the offence he had been drinking large quantities of alcohol and claimed the next day that he did not remember committing the offence. Expert evidence was given by a highly respected medical witness for the defence and although another medical expert did examine the defendant for the Crown, they chose not to call him to the witness stand. The defence expert witness gave his opinion that Stapleton was a ‘schizoid psychopath’ and that he had inherited this disorder

from his family. Alcohol in combination with this abnormality, he suggested, would have made Stapleton unaware of what he was doing, although he stated that Stapleton may have had the ability to “walk, hold a conversation and give apparently sensible responsive replies and do an act like shooting” (*R v Stapleton*, 1952, p. 364). The presiding judge explained to the jury that to find the accused insane they must be satisfied that he did not know what he was doing was against the law. Part of the appeal⁵¹ included considering whether the judgement in *R v Windle* was correct. The appellant judges thought not.

The truth perhaps is that, from a practical point of view, it cannot often matter a great deal whether the capacity of the accused person is measured by his ability to understand the difference between right or wrong according to reasonable standards, or to understand what is punishable by law, because in serious things the two ideas are not easily separable. But in certain cases, where the insane motives of the accused arise from complete incapacity to reason as to what is right or wrong (his insane judgment even treating the act as one of inexorable obligation or inescapable necessity) he may yet have at the back of his mind an awareness that the act he proposes to do is punishable by law (*R v Stapleton*, 1952, p. 375).

According to Robertson (1967), New Zealand common law has adopted the Australian rather than English view of ‘wrong’, with judges preferring the viewpoint given in *R v Stapleton*. The inclusion of moral wrongfulness was formally acknowledged with the 1961 Crimes Act (Adams et al., 2008).

‘Subjective’ versus ‘objective’ criteria

Linked in with debates are discussions outlined in legal texts over whether the test for moral wrongfulness should be founded on *subjective* or *objective* criteria. It has been argued that the inclusion of “commonly held standards of right and wrong” in the Crimes Act (1961) indicates the test for moral wrongfulness is an objectively based test. This is because the test signals that a defendant must be incapable of perceiving that their actions would be considered morally wrong in the eyes of *other people* (Adams et al., 2008). A subjective test, in contrast, would take into account the ways in which a disease of the mind may create an

⁵¹ This appeal also considered several other aspects including: (1) whether the verdict went against the evidence given at the trial; (2) whether there was a misdirection by the trial judge in regards to evidence given by several witnesses; (3) whether evidence was wrongly admitted; (4) whether the trial judge directed the jury correctly as to the proper use to be made of the evidence referred to under the previous point; (5) whether there was a miscarriage of justice in that the accused’s legal advisers were given no proper opportunity by the prosecution to consider the eligibility of the persons constituting the jury panel summoned for the trial (*R v Stapleton*, 1952).

irrational state of mind where the defendant may know what they are doing would be seen as morally wrong by others but regardless felt justified in committing the act. This issue was discussed by Justice Turner in *R v MacMillan* where he argued:⁵²

The question is whether he was able to appreciate the wrongness of the particular act he was doing at the particular time. Could this man be said to know in this sense whether his act was wrong if through a disease or defect or disorder of the mind he could not think rationally of the reasons which to ordinary people make that act right or wrong? If through the disordered condition of the mind he could not reason about the matter with a moderate degree of sense and composure it may be said that he could not know that what he was doing was wrong (*R v MacMillan*, 1966, p. 621).

This judgement rejected the idea that the second stage of the test for legal insanity is an objectively based test. Consequently, in New Zealand courtrooms this has meant that a defendant may be found to be insane if they believed the act or omission was justified in *his/her own case*. While a defendant may have perceived the act would be considered morally wrong by the wider public, they may still be able to establish a defence of insanity if, as a result of their mental disease, they believed they were morally justified in committing the offence. For example, in *R v Green* (1993) the court commented that there was expert opinion from psychiatrists that the accused made a correct moral and legal judgement based on a mistaken perception of the facts due to delusions. This argument was confirmed in the cases of *R v Smith* and *R v Rotana*.

In summary, the above case precedent has meant that the test for insanity has been broadened to include a generalised lay understanding of wrongfulness rather than just the strict legal wrongfulness. What this means in practice was described by one lawyer who participated in this study:

...well I mean under the English Common Law, at least as I understand it, the word 'morally' was never in there, so when I address juries I simply use the word morally wrong, but I tell them that if the offender knows that what they have done is legally wrong it will be morally wrong. It will meet the test. As long as they

⁵² Justice Turner gave his judgement in the appeal case of *R v Macmillan* where he considered (1) whether the trial Judge wrongly directed the jury as to the meaning of s. 23 (2) (b) of the Crimes Act 1961; (2) whether there was a miscarriage of justice in that the trial Judge did not direct the jury as to the nature of the defence as far as insanity was concerned; (3) whether the verdict was unreasonable considering the medical evidence called by the defence.

know it's wrong. It's difficult to know quite why the word 'morally' was put in there. I think it was to make a distinction between knowledge of legal wrongfulness so that someone needs to know that it's wrong and just leaving it as 'wrong', possibly the law makers felt was going to make it too confusing and everything, but what I say to juries, and what I understand by the term 'morally' wrong, is essentially an understanding that what they did was unacceptable, unacceptable within the community and certainly if they know that it was legally wrong then it necessarily meets that test...it's a test below knowledge of legal wrongfulness (DL #12).

This participant suggests that when addressing the fact-finders the term 'morally' wrong is seen to encompass 'legal' wrongfulness as well as right and wrong actions as accepted by the general public.

This could also be construed as including the question: would a person without such afflictions as the accused have reacted to the set of circumstances in the same way?

The issue is whether they understood that it was morally wrong for them to do it...The importance of that test is that the jury is told "morally wrong for them to do it" and that is often what a case will turn on. Did they understand that it was morally wrong for them to do it? That doesn't mean legally wrong, but was a wrong thing to do. Was it the wrong thing or the right thing to do given the circumstances that were going on in their head? (DL #10).

Morally wrong? I think the way I interpret it is more that's the individual's internal construct. Did they think that what they were doing was morally justified or not because when you look at most insanity acquittees, what most of them have actually done is something that they thought was right to do. So it's actually not so much that they didn't know that it was wrong, but that they thought it was right (FP #12).

What this last quote points to is that most defendants who are found NGRI may have had the capacity to understand the legal wrongfulness of their actions but for some reason at this time they thought what they were doing was morally right in their context:

...either because of grandiosity (that they are greater) or that they believe the world is horrendous and they are saving this person from something or that that person is horrendous and they are not who they are and have been invaded by aliens or reptiles or evil and they have to expunge them to save the world...most people that meet the insanity standard believe what they are doing is morally right, they believe there is a moral imperative to act as they are" (FP #1).

So what becomes important is that the defendant may at the time have understood that what they were doing would be considered wrong in the eyes of the general public, but felt compelled to act in the way they did because they had no choice in the matter based on a particular psychoses or delusion (FP #2).

Basically the issue of moral wrongness and rightness is quite important because in a sense it goes to the heart of delusions. Because of course if a person does not understand that it is morally wrong, it is because they think they are doing a good thing because of the basis of delusions (FP #7).

This idea that a person may come to think they made a correct moral and legal judgement based on a mistaken view of the facts, because of the delusions they were experiencing at the time, has been criticised somewhat by the court. *Adam's on Criminal Law* (Adams et al., 2008, p. para. CA23.19) cited the appeal of *R v Green* (1993) where the court stated: "Whether delusions as to factual matters, which if true would make an act morally justifiable, can be sufficient to show that a person is incapable of knowing that an act or omission is morally wrong, may be doubted". *Adam's on Criminal Law* has noted, however, that this proposition has been widely accepted based on international precedents in Canada (Adams et al., 2008).

This does not mean however, that the actions to be considered 'morally wrong' are always relative to an individual's circumstance. Rather it is always what the general public would consider it to mean.

Morally wrong is also qualified by regard to generally accepted standards, so what the population at large would see as being wrong. Not just, so that takes away the fact that someone may have their own moral standards that differ from most other peoples. So it is not relating the person to themselves because you may have somebody who is an habitual offender, burglar whatever...and to them that is not wrong and in their own world it may not be considered wrong but in the eyes of everybody else it would be (FP #4).

Some of the lawyers debated the subjective basis of the test for insanity.

I would have thought it would have to be tested objectively rather than subjectively. You know, the commonly accepted standard of morally right or

wrong seems to me to imply that it's the objective standard rather than the subjective standard...Is what this person is displaying at this particular time, when this event happened, something that would be normally accepted in terms of the commonly accepted standard of morality? Or is it outside what society would accept as a common, reasonable, acceptable standard of morality? So I suppose it has to be assessed objectively...The delusional state could be causing them to believe it is morally right but that's a morality which of course would be removed from the commonly accepted standard of morality because it's almost like a de facto morality when you compare it with that standard, because it's something that's peculiar to them at the time. It's their subjective morality, it's not the community based objective morality (DL #6).

While the use of 'morally wrong' broadens the meaning of 'wrong' to include more than a defendant's knowledge that the act they committed was illegal, the exact understanding of 'commonly accepted standards of right and wrong' still remains uncertain.⁵³ Legal texts appear to accept there is the existence of such uncertainty:

The introduction of "morally" before "wrong" is a clear rejection of *Windle* (above), but the additional qualification, "having regard to the commonly accepted standards of right and wrong", requires further consideration (Adams et al., 2008, p. CA23.15).

It appears that the law makers' attempt to strike a balance between individual and collective understandings of moral wrongfulness in a manner that can be easily understood may have added another layer of complexity to decision-making in cases of insanity. While expanding the test for insanity to encompass moral understandings of 'wrong', the additional inclusion of community standards in the Crimes Act (1961) have lead to difficulties in the delineation of the objective/subjective criteria.

⁵³ This is not a problem limited to the insanity defence. Good (2007) has discussed the problems associated with objective/subjective tests in terms of professionals' differences in understandings. Speaking about anthropologists who give expert evidence in asylum seeking cases, he stated: "For anthropologists, 'objective' and 'subjective' simply mean external and internal to the observer, respectively". Citing Gluckman, he explained that in contrast, "when a jury is told to apply a 'subjective' test it means to apply the test of what the person on trial thinks...[and] when a jury is told to apply an 'objective' test, it means the jury should apply the standard that the jury thinks the community or average person subscribes to..." (Good, 2007, p. 130). Good further stated that the task of the expert is to "assess matters as any reasonable person sharing in their expertise would assess them, rather than to provide an account that is 'true' in any absolute metaphysical sense" (Good, 2007, p. 130).

The relationship between the two stages of the test

Whether the mental disorder – accepted to be a disease of the mind – is so severe that it affected a person’s ability to know right from wrong becomes most important in cases of insanity. This means that discussions around whether the law should only consider ‘legal’ or ‘moral’ wrongfulness or both becomes less important for making a case for insanity in practice.

...you have to be so ill that you don’t appreciate that what you are doing is wrong. Whether it’s morally wrong or legally wrong, I don’t think cases turn on that. If you’re stabbing someone or punching them or hitting them with a softball bat the issue is whether you’re capable or whether you have the capacity of knowing it’s wrong. To me they merge as one (PL #13).

The relationship between the defendant’s disease of the mind and their ability to morally reason is what is important in this context. As this forensic psychiatrist explains, a defendant may be found to have a disease of the mind but it does not necessarily equate that they automatically meet the second part of the test.

So I think when they are really suffering from a really serious illness and it’s really at a severe extent, their whole judgement and how they perceive can be so clouded and in that sense they don’t have a sense of moral wrongfulness. But moral wrongfulness is about what is okay and what is seen as what is wrong and right by even me, is that how they are operating when they get mentally ill. And it’s only a real minority of people who will fit into that. Otherwise just because somebody has a mental illness doesn’t automatically mean that they don’t have a sense of moral wrongfulness. They are quite capable of that kind of judgement (FP #13).

In other words a person may suffer from a serious mental disorder that may be considered a disease of the mind but this may not have affected their ability to morally reason at the time they committed an offence.

ENTER THE EXPERT WITNESS

This chapter has detailed the accepted understandings of the test for insanity with brief reference to the role psychiatric expert witnesses have in its determination. This section will explore legal expectations for the role of the expert witness as described in legal texts and by those who were interviewed for this study.

The Evidence Act 2006 stipulates that to be admissible in court, the forensic psychiatrist must be accepted as an *expert*—they must assist the court in providing independent scientific information that is outside the experience and knowledge of the judge or jury (France & Pike, 2007). The key word here is *independent*. The expert witness's first duty is to the court and their evidence should be neutral (Adams et al., 2008). An ideal expert must also take note of the legal requirement for them to *assist* the court by furnishing it with information that may be needed in the determination of a verdict. The following sections unpack these ideals in further detail.

Providing 'expert' evidence

An 'expert' is defined under sub-section 4(1) of the Evidence Act 2006 as a person who has specialised knowledge or skills based on training, study or experience. Specialised knowledge has been described as a body of knowledge that has "some validity" and *Cross on Evidence* acknowledges that what this means in practice has been left to the courts to work out (Cross et al., 2005, para. EVA25.4). The example often used of what is not considered expert evidence in this context is 'astrology'; an expert in this field would not be accepted as an expert in the courtroom. There are cases, however, where definitions of an expert within the legal context have become highly contested (see chapters two and three) in American litigation. In New Zealand, legal commentary cites the case *R v B* (1987), where it was argued expert opinion should be admissible if it draws from a discipline that is recognised as a branch of science.⁵⁴ The Evidence Act 2006 attempts to move away from these discussions by considering the overall helpfulness of the information an expert can provide to the court. Legal commentary has suggested that this shifts attention to the ways in which the information an expert provides is relevant and reliable rather than whether it is adequately scientific (Cross et al., 2005).

The information forensic psychiatrists provide in court is admissible because it is considered specialised knowledge in the way that it falls outside of a jury's normal understandings. The purpose of the expert evidence is to help fact-finders make their decisions by providing them with insights that they may not have otherwise. For the forensic psychiatrists such insights

⁵⁴ As discussed in chapters two and three the possibility of distinguishing between what is and what is not science is contentious. This will be discussed further in relation to psychiatric evidence in chapter nine (p. 194) where this literature will be revisited in relation to the research findings of this study.

are achieved by their ability to furnish the court with their expertise in medical, specifically psychiatric knowledge. In cases considering the defence of insanity, this involves expert knowledge around diagnosing mental illness and understandings of how a person's behaviour may be related to their mental state (FP #5).

My understanding of the role is that I am appearing as a medical specialist and I am meant to be dealing with issues beyond the ken of the average person. Therefore my role is to address those issues on which I am instructed, so that is a formal role, and there needs to be a basis for me doing that. It is a legal process and therefore, I answer questions as best I can using that knowledge and try to convey that in a way that is useful, acknowledging that I am working within a legal domain (FP #3).

The end of this quotation also suggests that the role does not merely involve the forensic psychiatrists educating the court in the basic principles of psychiatry, it involves more than this. They require communication skills that involve a complex translation process, whereby the forensic psychiatrist draws on their psychiatric knowledge to give an opinion that is shaped to fit constructs to be determined in the legal context. The ability to communicate with a lay audience and a thorough knowledge of the law are integral to the translation process. This entails a certain shaping of practices that differentiate the role of expert witness from a clinical psychiatric role which will be discussed in further detail in chapter seven (p. 148).

At the same time, the court does not require a forensic psychiatrist to give evidence that is not comprised of 'expert' knowledge. A careful boundary needs to be maintained between psychiatric expertise and the responsibilities of the fact-finders. In *R v Turner*, for example, it was stated the "jurors do not need psychiatrists to tell them how ordinary folk who are not suffering from a mental illness are likely to react to the stresses and strains of life" (*R v Turner*, 1975, p. 841). This can be interpreted as an attempt to maintain a boundary between what decisions are for the fact-finders [laypersons] and the expert witness to make. As Good (2007) has explained, the court does not want the forensic psychiatrist to give an opinion that involves knowledge a lay juror may already possess. This reinforces the argument above that judgements about insanity are founded on social not just expert knowledge.

Providing ‘independent’ information

The overriding duty of the expert witness is to assist the court impartially on relevant issues within that expert’s area of expertise (Adams et al., 2008, para. 2.14.01). Being ‘impartial’, ‘neutral’ or ‘objective’ was something the lawyers interviewed emphasised when discussing the role of expert witnesses. An expert opinion should, above all, be independent recognising that their first duty is to the court, not the defendant or the party who employed them. Both the forensic psychiatrists and lawyers, however, suggested that this legal requirement was not always met. In some cases, participants suggested that psychiatric expert witnesses have not maintained neutrality. This is not an uncommon suggestion and is central to the tensions found between psychiatry and the law (see chapter two, p. 21). As such this issue of independence will be discussed further in chapter seven.

‘Assisting’ the court

When acting as an expert witness, the forensic psychiatrist’s role is to *assist* the court in making a determination. As suggested in the discussions of the constructs that comprise insanity, this is particularly important in cases where the expert witness does not have the final say in what may be considered a disease of the mind nor whether it affected the defendant’s ability to know the moral wrongfulness of their actions.

The forensic psychiatrists who participated in this study recognise that the law requires them to *assist* the court in their decision making, rather than making legal points and determining the outcome of the criminal trial.⁵⁵ As chapter seven (p. 157) will show, the forensic psychiatrists in this study were cautious as to their role in the court. They stated that it is important for forensic psychiatrists to ensure a boundary is maintained between the job of a lawyer and a psychiatrist. This involves the forensic psychiatrist’s sticking to their expertise of psychiatry.

The requirement to only *assist* the court and not determine the ultimate issue of the case becomes particularly difficult in cases involving the defence of insanity. Chapter seven (p. 148) will also described how in practice the boundaries between the forensic psychiatrists and

⁵⁵ Being bound by legal requirements is a distinct characteristic across many fields of forensic expert work, not just within forensic psychiatry (R. Smith, 1989; R. Smith & Wynne, 1989), a characteristic that will be explored further in chapter seven.

the responsibilities of the fact-finders become blurred in cases involving insanity. This was alluded to in the medico-legal literature reviewed in chapter two and will be discussed in further detail in the next four chapters. It is important to mention this here because it is a recurring theme throughout the findings chapters.

ILLUSTRATIVE EXAMPLES: 'IDEAL' CASES OF INSANITY

Following the ideal interpretations described above, this section will explore the characteristics of cases where insanity is found to be the verdict. The focus will be on the elements of an 'open and shut' case as described by the lawyers and forensic psychiatrists who took part in this study. This section will not only provide illustrations of the characteristics coming together to form 'ideal' cases, but also describe the characteristics beyond the legal constructs that need to be present to produce an 'ideal' case. These include: agreement between experts, 'official' psychiatric documentation, and corroborative sources.

This chapter has already described how case law has provided examples of psychiatric diagnoses that could be accepted as a disease of the mind. Commonly accepted mental disorders amounting to a disease of the mind are those that fall under the umbrella of "psychoses". *Adams on Criminal Law* explains that with the legal setting 'psychoses' are characterised by loss of appreciation of reality, delusions and hallucinations. Brookbanks has further suggested conditions qualify when they meet a minimum set of criteria. This includes the requirements that the conditions are: a) a recognised mental disorder, b) severe and enduring, c) known to have effects on the cognitive functioning and/or volition of the individual, d) likely to cause significant morbidity or risk to others; and e) requires ongoing psychiatric treatment (Brookbanks, 2007, p. 136). This set of criteria provides a useful linkage for moving on to discuss the content of evidence that characterises ideal cases of insanity.

The following section draws on cases that have come under section 20 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 to illustrate further the characteristics that are readily accepted as meeting the test for insanity. These cases in particular are used for this section because they involve cases where insanity was not in dispute. As described above, they are 'open and shut' cases. In this sense, they are 'ideal' cases for insanity. It is important

to consider these types of ‘ideal’ interpretations and cases prior to looking more closely at instances where issues of insanity become contested.

Agreement between experts

Agreement between experts is crucial for making a case for insanity. In contested cases, conflicting psychiatric opinion can become a problem and has led to severe criticism from commentators from both the psychiatric and legal community.⁵⁶

It is unusual for evidence to be contested when it comes to cases involving the insanity defence in New Zealand. In the past, cases of insanity have been put to the jury with agreement from the prosecution and defence. In these cases, the defence would offer psychiatric expert opinion supporting insanity without the prosecution providing opposing evidence in rebuttal (Grieve, 1998). As briefly discussed in chapter one (p. 8), recent changes in legislation have also introduced a new procedure whereby a verdict of insanity may be found by a judge alone in a hearing characterised by an inquisitorial rather than adversarial approach. These hearings arise where, based on the evidence of two psychiatric experts, the prosecution and defence agree that a finding of NGRI is the only possible verdict. This new procedure has been used in most cases of insanity before the court since its enactment in 2004 (see chapter one for statistical overview). This is an important development illustrated in the increased numbers of successful cases of NGRI since 2004.

In the case of *T* the presiding judge stated that her decision for a finding of NGRI was made after reading several medical reports and listening to two experts under oath. She concluded: “the psychiatric opinion expressed in this case has been overwhelming and there is no disagreement whatever between the medical experts” (*R v T*, 2004, para. 8). The lack of disagreement between the experts for the defendant’s plea of insanity strengthened her decision making. A prosecution lawyer in this study explained that in practice forensic psychiatrists acting as expert witnesses do not usually dispute the mental disorders that equate to a disease of the mind, and these, he suggested, are generally accepted by the court (PL #7). A defence of insanity is further strengthened when the agreeing expert witnesses

⁵⁶ Some of these criticisms were highlighted in chapter two, p. 25).

have experience in giving evidence and conducting forensic evaluations (*R v Rangit*, 2006). This usually implies that the experts are trained and experienced forensic psychiatrists.

‘Official’ psychiatric documentation

Making a case for insanity is strengthened when defendants have received an official psychiatric diagnosis and/or had previous admissions to mental health services. Before using cases to illustrate this point, it is important to briefly describe how the diagnostic manuals used by mental health professionals become important to making a case for insanity.

The lawyers interviewed for this study spoke specifically about mental disorders recognised in psychiatric diagnostic manuals, such as the DSM-IV-TR, being acceptable for the determination of diseases of the mind:

...it’s got to be a diagnosable and recognisable psychiatric illness, so it’s got to be something that a psychiatrist will recognise as something that comes from DSM-IV (PL #9).

...if it’s in DSM-IV it’s likely to be a disease of the mind. If it’s not it’s not (DL #15).

I wouldn’t accept it unless it was recognised in a DSM (PL #4).

Generally it would be an identifiable, recognised, psychiatric illness starting from depression right up to schizophrenia (PL #9).

These quotes suggest that disorders accepted by the court are more likely to be those that are supported by the wider psychiatric community and this is ensured by containment of the disorder within the DMS-IV-TR manual.

The ease with which the law can accommodate psychiatric classification reflects its reliance upon categorisation. Following this logic, “Diagnosis A may be compensable or potentially exculpatory, while diagnosis B may not be” (Strasburger et al., 1997, p. 451). In other words, diagnosis A may equate to a disease of the mind and potentially legal insanity while diagnosis B may not meet the requirements of a disease of the mind and therefore not legal insanity. Although, it is important to note that this notion of a disease of the mind as being

attributed to mental disorders contained in the DSM-IV-TR was not taken without criticism by some forensic psychiatrists:

Largely speaking it [disease of the mind] would be the major mental disorders. That is always difficult because with the DSM, people think that anything in the DSM could be a mental disorder and therefore, qualify. But that is not my own view as I think there are many disorders in the DSM-IV that should not qualify. Practically, it [disease of the mind] is largely limited to the psychoses and depression and outside of that probably not..." (FP #2).

As suggested by the prosecutor (PL #9) and forensic psychiatrist (FP#2) above, a disorder that falls under Axis I⁵⁷ of the DSM-IV-TR, the most serious mental disorders, correspond to those mental disorders which are commonly accepted as a disease of the mind. As one FP explained a disease of the mind "has to be an axis one disorder" (FP #1).⁵⁸ This is because Axis I includes psychosis, which as for the legal interpretations included above, is characterised in this manual as a "break from reality". Schizophrenia is the most common psychosis diagnosed by mental health professionals that is used in cases of insanity.⁵⁹ This disorder fits neatly within the legal requirements for a disease of the mind because common symptoms may include delusions (highly unrealistic belief systems treated as true) and hallucinations (relating to the senses of smell, hearing, sight, touch, taste). Major mood disorders, sometimes referred to as affective disorders, also fall under Axis 1 and are accepted as a disease of the mind. Diagnoses such as major depressive or bi-polar disorder with psychotic features or mania may also be included (FP #9).⁶⁰

In *R v NHM*, for example, the defendant had a strong history of engagement with mental health services prior to the offence having been committed. The defendant had previously

⁵⁷ Each psychiatric diagnosis contained in the DSM-IV is organised into levels, called axes. There are five axes that are related to different aspects of the mental disorders and/or disability. Most important to the discussion in this chapter is Axes one and two. Axis one includes major mental and learning disorders, such as schizophrenia depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, and phobias. Axis two includes personality and other developmental disorders.

⁵⁸ Although not all disorders under this axis would meet the threshold unless they coexisted with another serious disorder.

⁵⁹ There can be different sub classifications that fall under schizophrenia such as: undifferentiated, disorganized, catatonic, and paranoid schizophrenia.

⁶⁰ It is important to note, of course, that any condition that may be described with the psychiatric profession as a mental illness could be considered disease of the mind however, it must meet the severity threshold of the second limb of moral wrongfulness.

been officially diagnosed with a psychiatric disorder and received treatment. The defendant was diagnosed with ‘schizo-affective’ disorder that was characterised “by signs and symptoms of an elevated and irritable mood and psychosis” (*R v NHM*, 2007, para. 24). This is essentially a hybrid diagnosis that involves both psychotic and mood symptoms that if experienced separately would be characteristic of schizophrenia and bi-polar disorder respectively. In this case, however, they were experienced together warranting the hybrid diagnosis.⁶¹ The evidence of the forensic psychiatrist, acting as an expert witness, was that the defendant was suffering from a relapse of his pre-existing schizo-affective disorder which led to him, through his experiences of psychosis, losing touch with reality to such an extent that he was unable to know that his actions were morally wrong. It was accepted that this was a case for NGRI under the agreed verdict procedure.

Similarly, in *Manuele* (2007) and *Johansen* (2005) the defendants both had a psychiatric history and had been diagnosed with schizophrenia early on in life. In evidence put forward to the court, *Johansen* indicated that he had been admitted several times to mental health services for negative symptoms, such as delusional beliefs related to his diagnosis of schizophrenia. The family had also confirmed that the defendant had persecutory beliefs regarding them, corroborating the psychiatric opinion. The presiding judge stated that “it is beyond doubt that the opinion of the two psychiatrists, reinforced by actions or symptoms which were occurring, or had occurred, over the past seven or eight years, established that the accused was insane within the meaning of s23 of the Crimes Act 1961” (*R v Johansen*, 2005, para. 13). An ideal case of insanity therefore, involves evidence of a psychiatric history and an official diagnosis of a serious mental illness.

This is not dissimilar to the findings of international research that has sought to quantify the ‘predictors’ of cases resulting in a finding of NGRI.⁶² Several studies have indicated that defendants with a psychiatric history and diagnosis of a serious mental illness prior to the trial are more likely to receive a verdict of NGRI (Pasewark, Jeffrey, & Bieber, 1987; Roberts

⁶¹ *NHM*’s defence of insanity was strengthened by the fact that he had been under compulsory treatment when he assaulted another patient resulting in her falling to the ground and dying from a subdural haemorrhage.

⁶² The ‘generalizability’ of these research findings to the context of New Zealand is somewhat limited in that defences of insanity around the world differ in their requirements. It does indicate, however, that the content characteristic of “open and shut” cases of legal insanity in New Zealand may be very similar to those internationally.

& Ffrench, 1994). A series of studies by Warren et al (Warren, Fitch, Dietz, & Rosenfeld, 1991; Warren, Murrie, Chauhan, Dietz, & Morris, 2004) have reviewed the content of insanity evaluations in the United States and found that a primary diagnosis of an Axis I disorder (including diagnoses of psychosis, organic, and affective disorders and mental retardation [sic]) and prior hospitalizations were commonly associated with findings of insanity. These findings are similar to those of other American studies which found that schizophrenia or another major mental illness was associated with a verdict of NGRI (Cochrane, Grisso, & Frederick, 2001).⁶³

Studies have also indicated that certain characteristics relating to defendants are less likely to result in a finding of NGRI. These include the occurrence of an Axis II disorder as a primary diagnosis in instances of co-morbidity, or the presence of substance abuse and personality disorders (Cochrane et al., 2001; Pasewark et al., 1987; Warren et al., 2004). Literature has particularly noted that cases can become complicated when both a diagnosis of mental disorder and drug use is involved, arguing there may be a fine line between deciding on a diagnosis of schizophrenia and drug induced psychosis (Freeman, 1998): A defendant who has no history of drug abuse or drug offences is more likely to meet the test for legal insanity (Warren et al., 2004). In cases involving these characteristics the decision-making becomes more contested; this complexity will be discussed in the next chapter (p. 123).

Corroboration of expert evidence with lay observations

Corroboration of psychiatric evidence with the observations from lay witnesses is also important in strengthening a case (*R v Manuele*, 2007). The family members of Johansen, for instance, had observed that the defendant's behaviour had changed and that he had indeed had a lengthy history of mental health problems. In *Moore* (2004) all evidence given by the psychiatric expert witnesses were corroborated by lay witnesses. The importance of evidence from lay witnesses for the construction of a defence of insanity cannot be underplayed. The observations from family and friends of the defendant's behaviour become increasingly important in cases that are not 'ideal'. The next chapter discusses the interviewing of lay

⁶³ These types of studies have also shown how the employment history and a particular ethnicity (white) or gender (male) of the defendant may be more likely to be associated with a finding of NGRI. The seriousness of the offence has been discussed in such research too, with those cases involving sexual, drug or kidnapping offences less likely to found insane (Cochrane et al., 2001; Warren et al., 2004). These findings, however, have been contradicted by other research that has come out of the United States that has found no significant relationship between these variables and a finding of NGRI (Pasewark et al., 1987).

people to assist the forensic psychiatrists to tease out the relative contributions of external and internal influences. Further chapter seven (p. 149) will show that not speaking with family or friends of the defendant may be used as a technique to deconstruct a forensic psychiatrist's expert evidence thereby making them look less credible to the jury.

Overall, the data show that evidence becomes strengthened when information regarding the defendant's state of mind at the time the offence was committed, can be triangulated with different sources of data. In all the cases subject to the new procedure that were accessible, there was information from various sources – lay witnesses, official documentation, mental health professionals - which the expert could triangulate and draw on to justify their opinion. Interviewing family and friends can be seen as an essential part of good practice in forensic evaluation.

BUILDING BOUNDARIES

The preceding sections have explored ideal interpretations of the defence of insanity and the role that psychiatric expert witnesses have in its construction. This section will illustrate how such interpretations attempt to forge and maintain a boundary between the place of legal, lay and expert knowledge in the construction of insanity. Using Geiryn's (1983, 1995) notion of boundary-work, this section explores how the setting up of these boundaries can be seen as attempts by legal professionals to maintain ownership over a cognitive territory, highlighting their control over medical professionals in the courtroom.

Drawing boundaries between expert and lay knowledge

This chapter has drawn attention to the way in which the ideal interpretations of insanity emphasise the importance of lay knowledge in the final construction of both stages of the test. According to legal texts and the interview material, a disease of the mind is clearly interpreted as a legal not a medical term. Yannoulidis (2003) has surmised that final decisions around what constitutes a disease of the mind are the result of social judgements which draw on medical diagnoses rather than being direct reflections of them. In this way, the term may be founded on medical knowledge but what constitutes it is ultimately a social judgement that a judge, a lay person, will determine. The second part of the test for insanity—moral wrongfulness—also emphasises the importance of lay knowledge. The inclusion of 'moral wrongfulness' suggests the test is interested in a person's capacity to know not just what they

were doing was wrong in the ‘eyes of the law’, but also within the ‘eyes of the public’. Even though it has been accepted in New Zealand courtrooms that this is a ‘subjective’ rather than an ‘objective’ test—in that there may be consideration of the person’s own moral justification for their actions—it still indicates that subjective reasoning should be relative to community understandings of right or wrong.

Loughnan (2007) has surmised that insanity has been understood in many jurisdictions as something that is observable to lay people. This helps explain the reasoning behind the emphasis in legal texts on decisions regarding a defendant’s insanity (or sanity) being something that fact-finders can make based on their observations. They may be assisted in coming to this decision by the testimony of medical expert witnesses, but any final decision-making is for the fact-finder – a lay person – to decide. Additionally, in the later illustrations provided above, the process of triangulation was shown to be important in ‘ideal’ case construction. This involved the combination of medical and lay knowledge. In this way psychiatrically based evidence (official diagnosis, previous psychiatric history for example) had to align with lay observations and accounts of a person’s behaviour to strengthen the case for insanity.

The importance of lay knowledge is also reinforced in the way several jurisdictions have developed another boundary which emphasises the ‘mind’ over the ‘brain’ in determinations of a disease of the mind. In this context, the mind is understood using notions common to lay persons, such as reasoning, memory and understanding, while the workings of the brain are understood to be within cognitive territory of science and medicine. Legal interpretations have indicated a disease of the mind may be result of a physical condition. This reinforces the claim in *R v Kemp* that the law is interested in wider interpretation of the mind, rather than psychiatric conceptualisations of disorders resulting from a dysfunction of the brain (Adams et al., 2008). A disease of the mind may be based on psychiatric knowledge but it is interpreted in law as something that involves more than medical inference alone.

This analysis was influenced by Gieryn’s notion of boundary-work. If a disease of the mind was interpreted by the courts as encompassing diseases of the brain, it would allow for

psychiatrists, who use biological determinism,⁶⁴ to have more jurisdictional control in deciphering legal decisions related to insanity. The way in which case law has attempted to move the focus away from the brain allows for a certain amount of legal ownership to be maintained over interpretations of diseases of the mind. This resembles how members of other professional groups undertake particular rhetorical practices that are aimed at upholding ownership over a profession's jurisdiction (Gieryn, 1995). Overall, such interpretations reinforce that medical expert witnesses do not have the final say as to whether a person should be found NGRI.

Drawing boundaries between expert opinion and value judgements

As the court does not require a forensic psychiatrist to give evidence that is not comprised of 'expert' knowledge (cf. *R v Turner*), this can be understood as another attempt to preserve the boundary between decisions for lay people versus experts to make. As Good (2007) suggests, the court does not require a forensic psychiatrist to give an opinion that may fall within knowledge a lay juror may possess, rather they must give scientifically based expert evidence. A border must also be maintained, therefore, between facts which are in the vicinity of scientifically based expert knowledge and values which are for lay persons to consider (Jasanoff, 1995; Solomon & Hackett, 1996; Wynne, 1989).

The reliance on medical opinion that has a factual basis in the construction of a defence of insanity cannot be underemphasised. In the ideal cases illustrated above, the agreement between experts strengthens the case for psychiatric evidence aiding the court in maintaining the boundary between fact and values. Further, the interview material suggested that the court generally accepts the opinion of experts when there are no disagreements. This adheres to the idealised view of scientific knowledge as being founded on fact that should be comprised of content that experts agree on. Varying points of view by experts within the same scientific field suggests uncertainty and arouses suspicion that they may not be talking about facts any longer. Wynne (1989) has suggested that this way the legal system see conflicting opinion as an indication that values may have come into play.

⁶⁴ I am referring to psychiatric understandings of mental illness as a biologically determined phenomenon.

A careful boundary needs to be maintained between opinion that has a factual basis and social judgements, with the former being for the domain of the expert witness and the latter for the fact-finders. As discussed in chapter three (p. 53), the fact-value boundary illustrates how the legal requirements for an expert witness rely on rather romanticised understandings of medical knowledge production. Jasanoff (1995) has argued this boundary is based on the assumption that medical professionals and scientists produce knowledge that is stable, objective, and free from values.

While insanity is a social judgement, it draws on medical knowledge to ensure fact-finders' decisions have a legitimate basis. This chapter has illustrated how ideal interpretations of insanity revolve around the idea that a disease of the mind equates to the concept of a 'disease', a 'sickness' or a 'pathology'. It is conceptualised as a condition that should have arisen from an underlying internal process that is serious in nature and non-transitory. This is emphasised in the way in which the disease of the mind has to be so severe that it disrupts a person's ability to know right from wrong. The internal/external criteria illustrate the legal system's reliance on medical knowledge as a method for ensuring fact-finders' decisions are valid and reliable. A focus on 'internal' causation allows for an appearance of 'fact', with the focus being on mental afflictions that are the result of a biological or genetic cause resulting in something commonly understood as a disease of the mind. Schizophrenia, the more accepted mental illness to meet this requirement, is commonly understood in this context as something that has a biological basis that arises regardless of the external factors influencing a person. In this way, final determinations of a disease of the mind may fall within the jurisdictional control of the legal professionals, but it is something that requires medical evidence to be validated (Edmond, 1998a).

CONCLUSION

This chapter has explored how the components that comprise the legal test for insanity and the legal requirements of the expert witness have been interpreted in legal texts and by the participants in this study. This was done to provide the necessary backdrop for the analysis of the *murkiness* that can occur in practice when cases of legal insanity become contested and the boundaries that separate the responsibilities of the fact-finders, legal professionals and expert witnesses become *blurred*. Two overarching boundaries that attempt to reinforce the role of both expert and lay knowledge in the construction of a defence of insanity were

explored. These included a boundary that separates expert and lay knowledge and a boundary that maintains a separation between opinion based on facts and values. Making up these two boundaries were 'sub-boundaries' that further highlight the importance of one factor over another in decision-making regarding insanity and the use of expert witnesses. These included: internal over external causes, mind over brain, and objectivity over subjectivity. Maintaining the boundaries built by the idealised interpretations of legal insanity described in this chapter is particularly difficult for the forensic psychiatrists and lawyers to uphold in practice. The next three chapters aim to explore different areas where the boundaries have become blurred.

CHAPTER SIX: BLURRING BOUNDARIES

When making a case for insanity, it is important for the defence to persuade the fact-finders that the defendant's mental state at the time they committed the offence was the result of a *natural* rather than *environmental* cause. This is because a cause that occurs naturally aligns with the ideal interpretations of legal insanity discussed in chapter five which stipulate that a disease of the mind must be the result of *internal* factors. A defendant's mental state must be something that would have resulted regardless of any *external* factors influencing the defendant's behaviour. Strengthening this type of causation are the other criteria discussed in chapter five that specify a disease of the mind as serious in nature and non-transient. The law for insanity presumes that a distinction between internal and external causative factors can be made.

Chapter six describes how in practice internal/external boundary-drawing (R. Smith, 1981) becomes murky.⁶⁵ It uses cases when pure methamphetamine (henceforth 'methamphetamine') is an issue as an exemplar of the difficulties forensic psychiatrists face when giving opinion that does not fit within the internal/external binary.⁶⁶ In exploring this murkiness, the chapter will illustrate how a further boundary outlined in chapter five which aims to ensure expert opinion is based on facts, becomes blurred. In focusing on how the role of expert witness translates into practice, particularly in controversial cases, the data shows how blurred this boundary becomes.

⁶⁵ This chapter focuses on the first part of the insanity test – disease of the mind – rather than the defendant's capacity to understand the moral wrongfulness of their actions. The second part of the test will be the focus of chapter seven, p. 140).

⁶⁶ Personality disorders also create murkiness in the courtroom in terms of internal/external boundary-drawing. These disorders are generally accepted by the psychiatric community as involving a psychological or behavioural process. Accordingly case law has stipulated that disorders with a behavioural component, such as personality disorders *alone* may not meet the criteria for a disease of the mind because such disorders have no underlying internal quality. In this way behavioural conditions are accepted by the Court to arise from a person's reaction to their environmental setting (FP #14). The external factor, therefore, brings about the disruptive features of a personality disorder (FP #2). This becomes difficult in practice in cases where the internal versus external quality of personality disorders has been contested. Due to space limitations, this chapter is solely focused on the issues that arise from methamphetamine use, but personality disorders are another example that appropriately illustrates the difficulties with internal/external boundary-drawing (see for example Greig, 2002; Manning, 2000; McDowell, 1997; Ruffles, 2004).

The analysis weaves together information generated from court records, interviews and courtroom observation to explore the difficulties that arise when forensic psychiatrists are faced with the challenge of giving expert opinion that cannot be simplified to allow internal/external boundary-drawing. The medico-legal literature reviewed in chapter two and clinical research on methamphetamine and psychosis will also be drawn on in the analysis. This chapter will move beyond the ideal interpretations of legal insanity outlined in chapter five. As Finn has argued: “The statutes tell us what Parliament wanted the law to be; the law reports tell us what judges said the law was; only court records tell us how the law worked in practice” (cited in Law Commission, 2006, p. 159). The aim of this chapter is to extend this to not only include court records but also observations of courtroom practices and the viewpoints of lawyers and forensic psychiatrists with experience in trials using the defence of insanity.

METHAMPHETAMINE AND INSANITY

The vast majority of lawyers and forensic psychiatrists interviewed suggested the use of drugs by defendants was a common occurrence in cases involving the insanity defence. As one forensic psychiatrist put it: “I think that you would find that it is the rule rather than the exception that people with serious mental illness in New Zealand are likely to have abused substances” (FP #5). With the recent increased use of the drug (Wilkins, Girling, Sweetsur, & Butler, 2005), methamphetamine has created difficulties in the way it can induce, exacerbate, or precipitate psychotic symptoms (Gordon, 2004; Tapsell, 2004).

It is generally accepted in case law that a disease of the mind caused by the ingestion of drugs or alcohol (an external factor) will not be accepted for consideration of insanity. On the surface this seems clear. If a defendant has chosen to take a drug that has brought about a mental state,⁶⁷ external in origin, that could be characterised as a disease of the mind, they cannot be excused of any crimes they committed while in this mental state. This is because the mental state was brought about by the drug that the defendant chose voluntarily to ingest rather than a biological cause originating from within the person.

⁶⁷ In this chapter I use the term ‘mental state’ to connote lay rather than clinical understandings of person’s cognitive state or state of mind.

Cases that involve methamphetamine use are often highly contested and controversial. This means the characteristics described in chapter five that give ideal cases their strengths become weakened. Agreement between experts does not often occur, for example, or there may be little or no ‘official’ psychiatric documentation on the defendant. Psychiatric diagnoses may be disputed and there may be difficulties with corroboration and the ability to triangulate different information sources. This sort of situation creates ‘murkiness’ manifested by the culmination of clinical uncertainty and the complexities associated with diagnosing mental disorders. This “result[s] in judicial ambivalence as to how to locate phenomenon[a] within legal categories” (Brookbanks, 2007, p. 139), which illustrates the limits of the use of psychiatric knowledge within the legal context.

In practice, drawing boundaries between external and internal causative factors is a nearly impossible task for forensic psychiatrists to complete when methamphetamine is an issue. As a forensic psychiatrist and prosecutor summarise,

The relation between drugs and alcohol and mental illness is a complicated one. Sometimes the drugs of abuse can cause a mental illness that otherwise would not have existed, sometimes they can cause a state of intoxication that wouldn’t be called a mental illness, sometimes they can exacerbate a pre-existing condition, sometimes they can prolong the resolution of a condition that occurred without the drugs and alcohol in the first place or the relapse of a pre-existing condition. So there is a complex range of possibilities (FP #5).

I think that’s a tricky area, trying to establish whether it’s simply an effect of a drug or whether the effect of the drug has either created a disease of the mind or unleashed something that is quiescent (PL #5).

These quotes begin to describe three overlapping areas in which decision-making relating to insanity becomes murky for the forensic psychiatrists, lawyers and fact-finders. These involve instances of: (1) drug-induced psychosis, (2) drug use in combination with mental disorder, and (3) mental disorder following drug use. It is important to note that these areas are not always distinct, rather in many cases they overlap, indicating just how complex this area is.

Drug-induced psychosis

Psychosis is a state, people with mental illness can experience psychosis but psychosis is not ipso facto a mental illness, there are a number of other things that can cause people to experience psychotic symptoms. The most significant of those in this case is drugs...methamphetamine is well described as causing psychosis in users (Expert A, *R v 'X'*, 2008).

In this extract, the expert witness describes a mental state, psychosis, which is brought about by the ingestion of methamphetamine. This term is not used to describe a simple state of intoxication one may experience from drinking too much alcohol, rather it is suggestive of the symptoms one may experience from psychosis associated with particular mental disorders. Psychosis alone, however, does not automatically lead to a psychiatric diagnosis within the clinical setting.

Methamphetamine mainly affects the central nervous system, stimulating dopamine pathways and creating an initial sense of euphoria, heightened sense of energy and hyperactivity. Some people, however, may become increasingly irritable, easily agitated, highly guarded and impulsive after using the drug (Hunt, Kuck, & Traitt, 2005; Tapsell, 2004). In others, an occurrence of psychosis following drug use may occur and it is this state that psychiatrists have labelled drug-induced psychosis:

...drugs produced an altered mental state called a drug-induced psychosis which is simulating a mental illness but is short lived for hours or a few days (FP #4).

One of the questions central to the construction of insanity in the courtroom is whether psychosis arising from methamphetamine use alone can amount to a disease of the mind. Current legal precedent becomes important when considering this issue. Both the lawyers and forensic psychiatrists explained that they were guided by case law when constructing their case.⁶⁸ They interpreted current case law as stipulating that drug-induced psychosis, although more likely to result in people carrying out dangerous acts, does not result in a finding of insanity because it is considered a *self induced* state (FP #4). It was suggested that case law in this area is “very squarely trying to insure that voluntary intoxication[s] are not available as

⁶⁸ This also points to the way in which the forensic psychiatrist practices are shaped by legal requirements and knowledge, which will be discussed in chapter seven (p. 139).

defences” (FP #2). This notion appears to have been confirmed in the case of ‘X’ (discussed in detail in chapter eight, p. 179) with the judge, when summing up to the jury, emphasising the fact that “temporary mental disorder caused by some factor external to the accused such as the taking of drugs” does not amount to a disease of the mind (Jury handout, *R v ‘X’*, 2008). Drug-induced psychosis, therefore, does not meet the requirement for disease of the mind not only because it is the result of an external factor but also because it is a transient mental state rather than permanent and recurrent in nature.

Drug use in combination with mental disorder

What may be more likely to be accepted by the court as a disease of the mind are psychoses resulting from the use of methamphetamine in combination with a pre-existing mental disorder. This occurs in cases where the defendant (prior to the trial) had been diagnosed with a serious mental disorder and the use of methamphetamine may have exacerbated the psychotic symptoms of that mental disorder. In these situations the court may accept the defendant was suffering from a disease of the mind if the ideal characteristics of official psychiatric documentation and corroboration of evidence described in chapter five (pp. 114-117) are present.

In other cases, the situation differs and involves the use of methamphetamine that coincides with the relapse of an existing mental disorder. Although closely linked to that described above, it involves cases where a defendant has been diagnosed with a mental disorder by a psychiatrist but stopped taking their medication and commenced taking illicit drugs culminating in a relapse of their existing condition.⁶⁹ The forensic psychiatrists explained that in these circumstances where the mental state of the accused conforms to the “known pattern of a schizophrenia relapse” and the use of drugs in this period was inconsequential to that relapse, they may be accepted as having a disease of the mind (FP #5). This was illustrated by a forensic psychiatrist when discussing a particular case:

In the end I said, that in my view, it actually didn’t matter. There was clear enough evidence over the years and subsequent to the offending, there was clear

⁶⁹ The implications of the acceptance of these circumstances in cases of insanity require further exploration. There appears to be differential treatment of defendants who voluntarily take illicit drugs and become unwell compared with those who voluntarily stop taking their medications and (with or without using illicit drugs) become unwell. Mitchell has explored this philosophical proposition in detail (1999, 2003)

enough evidence that this guy had a psychotic disorder without there needing to be drugs involved. So if in fact he had taken some drugs prior to the alleged offending, it really didn't make much difference because all it would do was destabilise what I thought was a mental disorder. So I guess those were the kind of issues I think you were looking at so taking drugs is not fatal in my view to an insanity defence, as long as you can identify a pattern that suggests illness as well (FP #15).

Again the presence of a history of a mental disorder and official psychiatric documentation assists the forensic expert in demarcating internal from external causes.

When considering if a disease of the mind is present in the cases described above, the court requires the *primary cause* of the mental state of the accused to be identified. Justice Fisher stressed that the primary cause of the "abnormal mental condition" was the most important factor in considering whether a disease of the mind was present (*Police v Bannin*, 1991). The task of determining the primary cause can create difficulties for the forensic psychiatrists because it cannot always be identified. This will be discussed in further detail below.

Mental disorder following drug use

In some cases the effects of methamphetamine may be thought to have contributed to the existence of an *underlying* mental disorder that could be defined as a disease of the mind. This occurs when a defendant is diagnosed with a mental disorder following the offence they committed, but this disorder was not officially documented prior to the use of methamphetamine. A prosecution lawyer suggested that in these circumstances the courts are more likely to accept the defendant had a disease of the mind,

My understanding of the legal position is, and this is probably too simplistic, but if say a psychosis which is entirely induced by drugs arises, it may not be a disease of the mind, but where you have got an underlying mental illness, which may be sitting in a sub-clinical level but which is exacerbated by drug use, then I think that most people would agree that that would amount to a disease of the mind (PL #2).

This extract also describes an assumption that the lawyers in this study commonly referred to regarding the notion that some people are predisposed to some mental disorders and that certain drugs have the potential to bring on the symptoms of these disorders. A defence lawyer further illustrates this point using the example of cannabis and methamphetamine:

Commonly you know you hear and I've seen what appear to be mental illnesses either brought on or exacerbated by a drug usage. [It] could be cannabis, could be P [methamphetamine] or whatever and there's always a big debate about whether someone's got a mental illness because they are genetically predisposed to it or whether or not it's a mental illness that's been drug-induced or activated (DL #6).

The 'big debate' as this defence lawyer puts it, can be extended to include the assumption that if the defendant had not used a certain drug, the mental disorder they were diagnosed with would have remained dormant. This contention assumes that an external source such as methamphetamine has the potential to bring about the negative symptoms associated with a diagnosis of schizophrenia, which in turn, may be accepted by the court as a disease of the mind.

Legal precedent appears to confirm to some extent these arguments expounded by the lawyers who participated in this study. Past decisions have supported the idea that the effect of some drugs may result in a disease of the mind when there is evidence that the defendant may have an underlying mental disorder that has been 'activated' or 'exacerbated' by the drug use. Legal decisions have indicated that a drug-induced disordered mental state may be accepted as a disease of the mind if the disordered mental state is lengthy in duration and liable to recur regardless of the external factor. In other words, to be accepted as a disease of the mind, the mental disorder has to continue to exist *independently* or *autonomously* from the external factor (the drug), even if it was initially activated by the external factor (the ingestion of the drug).

MURKINESS

All three areas described above create murkiness for decision-making around internal/external causation and what constitutes a disease of the mind. The following details the murkiness that can occur within the context of cases involving methamphetamine, specifically reflecting on how this creates difficulties for the forensic psychiatrists in their role as expert witnesses. This includes the problems relating to the provision of evidence that differentiates symptomatology, identifies the primary cause, and quantifies relative contributors to mental states.

Differentiating symptomatology

In many cases it may be difficult for the forensic psychiatrists to classify the defendant as suffering purely from methamphetamine induced psychosis. Symptoms resulting after heavy methamphetamine use may be similar to the psychosis a person may experience from acute paranoid schizophrenia.

I have been involved in a number of cases where 'P' [methamphetamine] is an issue and where 'P' [methamphetamine] is an issue, the symptoms, the effects of the 'P' intoxication, can be much more closely aligned to, and indistinguishable to, schizophrenia (FP #5).

Clinical studies that have researched the effects of methamphetamine support this proposition. Patients who present with psychosis related to their use of this drug can experience auditory and visual hallucinations that are almost identical to those experienced by patients⁷⁰ diagnosed with schizophrenia (Fabian, 2007; Sato, 1992).

The court, however, requires the forensic psychiatrist to assist the fact-finders in determining whether the symptoms the defendant is experiencing are self-induced or the result of some internal process out of their control. This is crucial for the construction of a defence of insanity, as this prosecution explained:

...if you're prosecuting and you're rejecting the issue of insanity or trying to say 'no, there's no insanity here', you will be looking for all the strands in the evidence of the vein [where] psychiatrists' say: 'Well the underlying disease of the mind would have just remained dormant were it not for his drug abuse. His drug abuse, his 'P' [pure methamphetamine] trip that he [was] on at the time that actually caused him to act this way, not his disease of the mind'... [However] there obviously is a tension there because the defence will be trying to whip up a sort of 'the 'P' was just the icing on the cake, it was an episode that would have been a part of his life anyway'. (PL #8)

In an ideal situation, the forensic psychiatrist describes how they use drug screening to determine if the mental state of the defendant around the time of the offence was due to

⁷⁰ I use the term 'patient' here to correspond with the language used in these studies.

methamphetamine intoxication as opposed to mental disorder.⁷¹ In the case of ‘X’, for example, Dr B explained that if the psychotic symptoms the defendant was experiencing continue beyond 10 days and drug screens are clear of methamphetamine, an alternative psychiatric diagnosis should be considered (Expert B, *R v ‘X’*, 2008). In other instances it is relatively easy for the forensic psychiatrist to assess that the mental state of the defendant is due to methamphetamine intoxication because the psychotic symptoms desist in the time period expected with the known effects of this drug:

...see that this individual is perfectly well. They took amphetamine, they became really aroused, a bit mad, a number of psychotic phenomenon, offended, then that phenomenon went away in accordance with the sort of time frame you’d expect with the use of that drug (FP #12).

In both cases—either from the results of drug screening or discontinuation of psychotic symptoms after a short period—a forensic psychiatrist would feel more certain of their ability to diagnose a defendant as suffering from a drug-induced mental state and not a disease of the mind.

In practice this set of circumstances does not always occur. Methamphetamine induced psychoses does not always play out in the traditional time period of other drug-induced states. It was explained by one forensic psychiatrist that methamphetamine may cause long term or irreversible damage to an individual that may or may not require psychiatric treatment.

So if the person takes an excessive quantity of ‘P’ [methamphetamine] and becomes floridly psychotic and kills someone and then doesn’t recover for a year...this becomes quite complicated as to whether this is a disease of the mind (FP #5).

In such cases, a defendant’s psychotic symptoms could be diagnosed as drug-induced by a forensic psychiatrist and this could be the most appropriate explanation at the time they

⁷¹ The forensic psychiatrists also use particular methods to distinguish methamphetamine induced psychosis from the diagnosis of schizophrenia. In the case of ‘X’ a psychiatric expert witness stated that certain symptoms are more likely to be associated with amphetamine induced psychosis than with a diagnosis of schizophrenia. With amphetamine-induced psychosis, Dr B explained, psychiatrists would be more likely to observe the person was experiencing visual hallucinations and tactile hallucinations (to a lesser extent). With people experiencing symptoms commonly associated with schizophrenia, auditory hallucinations are more likely to be observed and auditory hallucinations are less likely to be present with amphetamine induced psychosis (Expert B, *R v ‘X’* 2008).

prepared their expert testimony. Further down the track, however, the same defendant may have developed or continued to experience symptoms best explained as a mental disorder (Brookbanks, 2007). This intimates that some individuals who use excessive amounts of methamphetamine may continue to experience psychotic symptoms long after the drug has left their system.

Several clinical studies have suggested that long-term use of methamphetamine may produce a lasting ‘vulnerability’ to relapses of psychotic symptoms (Hiroshi & Sato, 2004; Iwanami et al., 2007; Sato, 1992).⁷² Sato et al., (1992) concluded that their clinical studies have indicated there is a biological component (which could be understood as *internal* in legal language) of the psychotic states experienced by some long-term users of methamphetamine. Rather than having a transient effect directly resulting from the use of the drug (an external factor) these studies suggest, like the descriptions from the forensic psychiatrists, that an internal process can develop that continues without the ongoing use of methamphetamine. It has been asserted that over time, this could include ongoing experiences of psychoses (Leong, Liesenring, & Dean, 2007).

These sets of circumstances create a temporal aspect to decision-making around appropriate diagnoses that conflict with the short time frames and fixed decisions associated with legal decision-making related to insanity. In chapter two (pp. 37-41), several authors suggested that the idea that mental states change over time is not often acknowledged in the courtroom and the temporal complexity associated with such states is not discussed because of its misalignment with black and white legal decision-making (Allnutt & Chaplow, 2000; Zemishlany & Melamed, 2006). Boundary-drawing between whether the symptoms a defendant experiences are the result of methamphetamine use or are an indication that a mental disorder is present cannot always be achieved in the short-term.

These temporal problems are further compounded by the lapse in time that can occur from the date the defendant committed the alleged offence to the date the forensic assessment took place. When these lapses in time occur, reconstructing the mental state of a defendant when

⁷² In this clinical study, the long-term ‘vulnerability’ only applied to a small number of people who were heavy intravenous users of methamphetamine and this finding was also dependent on many other variables such as: the amount of methamphetamine used, the routes of intake (e.g. where the drug is injected by the user), and the use of other drugs in combination with methamphetamine (Sato, 1992).

methamphetamine is involved becomes difficult for the forensic psychiatrists in terms of working out when the defendant began using the drug, when he/she began to experience symptoms, and when the symptoms he/she was experiencing desisted after methamphetamine was no longer being used. A forensic psychiatrist explains:⁷³

I think where it is extraordinarily difficult is where the person cannot give you an idea of that chronology and maybe particularly where there is some delay between the event itself and the person being apprehended, so you don't see them close to the event. You are going back sometimes six weeks in time saying 'what do you remember?' and you start to get into very difficult territory (FP #11).

Some of the forensic psychiatrists referred to this as a 'chicken and egg' situation in terms of trying to determine which influencing factor—the drug or the internal process—came first.

Basically the implications are chicken and the egg, and most authorities say what you need to do is take a very careful history and determine whether the resulting illness is actually solely due to drugs, such as intoxication, and, as you know, while there is a defence of intoxication under certain circumstances, it doesn't normally run under a defence. So a lot of apparent psychoses, if it stops when they cease taking the drug within 8 to 24 hours, it's fair bet it is due to intoxication or side effects...If [on the other hand] the clinician determines that you do have a disease of the mind because the symptom profile persists for a good length of time after the cessation of the substance, you may opine that a disease of mind exists and therefore the argument may be the drug has precipitated an illness which was already there. So you have to tease out *cause* and *effect* (FP #7).

The uncertainty that forensic psychiatrists face in trying to reduce a complex picture in order to answer legal questions makes their role of giving expert opinion difficult.

Identifying the 'primary cause'

It also becomes difficult in practice for the forensic psychiatrist to identify the *primary cause* of the mental state of the defendant at the time the alleged offence took place. As this prosecutor explains,

⁷³ This description provided by a forensic psychiatrist applies to other circumstances also where methamphetamine may not be involved. Many of the forensic psychiatrists commented on how a difficult aspect of the forensic interview is developing a chronological description of the events with the defendant who may be at the time suffering symptoms of their mental disorder. This study did not closely focus on the forensic psychiatrists practices in terms of forensic interviewing and report writing, although this is a topic worthy of further qualitative investigation. The concluding chapter (p. 209) of this thesis discusses this issue.

The problem then arises if the drug use contributes to the psychotic condition...What if someone is psychotic, if they're suffering from schizophrenia but the particular psychotic episode was perhaps triggered by smoking dope or some other hallucinogenic? That is a very difficult issue (PL #10).

From the defence's point of view, it is important to build a narrative of the defendant's illness as being the result of a *natural* occurrence. As discussed in chapter five (p. 100), this is because the defence of insanity is more likely to be successful if the jury can be persuaded that the behaviour exhibited by the defendant was the effect of a disease of the mind caused by a *naturally* occurring (internally caused) mental illness:

...if the jury thinks that the guy is nuts, but he's nuts because he's been using 'P' all the time, you are going to get less sympathy than if he...[is] just 'naturally' nuts...you've got to make sure your psychiatrist makes it plain to the jury that the drugs or the alcohol might have been the trigger for the mental illness, but it's a mental illness nevertheless. It's there and measurable and demonstrable (DL #14).⁷⁴

The clinical picture, however, may not allow for the identification of one primary cause. In contrast, the clinical picture may suggest the mental state was the result of both the drug use and a mental disorder. A psychiatrist giving verbal evidence in the case of 'X' emphasised this:

It's important to remember that persons with mental illness also use drugs, that doesn't mean that the drug use has caused the mental illness, it's simply two things that are occurring together (Expert B, *R v 'X'*, 2008).

This proposition was mimicked by a prosecution lawyer when he was discussing the impossibility of separating out the behaviour caused by drug use and that caused by a mental disorder:

...how do you separate them out? Someone that's used cannabis for 20 years, drug-induced psychosis but for the cannabis they'd be fine. But the reality is they're unwell, they're unwell. They are unwell because of the drugs. So that's the problem and I think the psychiatrists must find that really, really hard because they're being asked to separate out the causes of the behaviour...is it a symptom

⁷⁴ This also points to the idea that the mental illness has to be measurable and demonstrable, this will be discussed further in chapter nine (p. 198).

of disease of the mind or is it a symptom of overuse of drugs. Who knows? I don't think you can separate them out (PL #13).

Leong et al., (2007) have argued that the aetiology of psychoses may be the result of a variety of factors such as recent excessive use of a substance and pre-existing neurobiological vulnerabilities. The authors argue that forcing dichotomous decision-making in the legal setting may not accurately reflect clinical reality (Leong et al., 2007).

These difficulties can also occur with a defendant who has experienced a relapse of their officially recognised mental disorder following the use of methamphetamine. In these cases, it is difficult to know whether the mental state of the defendant was solely a relapse of the existing illness or the effect of the drug use in combination with this disorder (Fabian, 2007). Again internal/external boundary-drawing becomes murky as this prosecutor describes,

They often are interlinked. Usually if the person who has committed the homicide has a history, they've been on medication and they are either – they've either stopped taking it or they've self-medicated...They're not taking their normal medication. They're put into situations, because of their drug usage, where they are having to mix with people that adversely affect them and they basically aren't getting care. So I think that there's a very strong link between the two and there are real difficulties for psychiatrists in trying to work out what is really a *genuine* disease of the mind and what is something that has just been exacerbated by alcohol or narcotic intoxication (PL #4).

'Genuine' in this extract can be interpreted as referring to the internal nature that characterises legal descriptions of a disease of the mind.

Corroboration of different sources of information becomes important for identifying the primary cause. As this forensic psychiatrist explains, the corroboration process becomes a valuable method for the forensic psychiatrists in testing evidence during the process of identifying the core cause of the mental state:

Then it gets slightly tricky because you have got to decide the nexus, so someone might have a mental illness and drug misuse but one or other or neither might be related to their offending behaviour. So the nexus is important as well; trying to see what the nexus is and understanding that. Now in doing that, it relies on solid evidence, going back and seeing whether the person has done this before, trying to corroborate information from other people. So you are testing the information

and all those sorts of things; trying to make sure the information is as accurate as it can be (FP #3).

Official psychiatric documentation backed up by lay observations of the deterioration in the mental health of the defendant in the period leading up to the incident is crucial in constructing a defence of insanity (FP #6). This corresponds to the ideal characteristics of case construction discussed in chapter five where official psychiatric documentation and lay accounts were deemed crucial in assisting the forensic psychiatrist's corroboration of evidence. In *R v Rangit*, for example, the importance of corroborated evidence relating to the defendant's psychiatric history became important in identifying whether the drug use exacerbated a pre-existing condition. Both forensic psychiatrists acting as expert witnesses in this case explained that the defendant was legally insane⁷⁵ based on the evidence that included a diagnosis of schizophrenia and a history of psychiatric illness which was complicated by alcohol and cannabis use. It was also explained that the offending was the result of the defendant not taking his prescribed medication. All of this contributed to him having marked delusions that were of such intensity that he was unable to consider the moral and legal consequences of his actions (*R v Rangit*, 2006). Corroboration of evidence becomes extremely important in relation to working out relevant contributions to a defendant's behaviour when methamphetamine is involved.

Insufficient collection of data from various sources to test evidence can lead to forensic psychiatrist's inferences in the courtroom being susceptible to lawyer's deconstructive practices. Such deconstructive techniques used by lawyers (and sometimes other forensic psychiatrists themselves under cross examination) aim to challenge the credibility of the expert opinion and the methods used to obtain the evidence (see chapter three, p. 60). This process of deconstruction will be examined in chapter eight (p. 179) where the interactions between lawyers and forensic psychiatrists will be in focus.

⁷⁵ Whether or not this is the job of the forensic psychiatrist to give evidence as to the legal insanity of a defendant is not the topic of this chapter. It will be discussed, however, in chapters seven (p. 139).

Quantification of relative contributions

The difficulties associated with identifying the primary cause become further highlighted when the expert witnesses are pressured to quantify relative contributions to a defendant's mental state and behaviour. This was exemplified in *R v Lipsey-McCarthy* (2004).⁷⁶ The case involved two forensic psychiatrists giving expert evidence on behalf of the defence. The Crown did not call expert evidence in rebuttal. One of the forensic psychiatrists explained that the defendant had a history of drug use and that prior to when the offences took place she had ingested large quantities of methamphetamine and had not slept for three days leading up to the day in question. The forensic psychiatrist explained that the culmination of these factors—drug use and sleep deprivation—gave rise to a psychotic state which involved delusions and paranoia. Prior to her use of methamphetamine, however, the defendant had not experienced similar psychosis, so she had no pre-existing official psychiatric documentation showing she had previously experienced a mental illness.

Following the day in which she committed the offences, the defendant was treated in hospital with sedatives and anti-psychotic medication over three days. After these three days no symptoms remained so she was transferred to a remand prison. She was diagnosed with 'methamphetamine induced psychotic disorder with delusions'. In the period between her initial arrest and the court case, she had two more admissions. By the third admission the psychiatrists charged with her care began to consider a diagnosis beyond symptoms that could be understood as drug-induced. This complicated the matters before the court in terms of whether the mental state operating at the time the defendant committed the acts amounted to a disease of the mind or whether it was the result purely of her ingestion of pure methamphetamine. In other words the factor—external or internal—that was the primary cause of her behaviour was in issue.

This case also illustrated the problem forensic psychiatrists' face when they are asked to give opinion on the relative contribution of each factor. This effectively forces the simplification of a complex clinical picture and may even call for the quantification of factors that cannot be

⁷⁶ In this case the proposition that an external factor could cause a disease of the mind to occur was not accepted by the court. This was a complex case in which the difficulties associated with demarcating internal from external factors were demonstrated. It also exemplified the important link between disease of the mind and moral wrongfulness discussed in the last chapter—that although a defendant may be accepted as having a disease of the mind that was the result of drug use in combination with an underlying mental disorder, this still may not have affected that person's ability to reason morally.

subjected to this sort of analysis. As the following extract taken from *R v Lipsey-McCarthy* shows this may be difficult for a forensic psychiatrist to explain in terms that are relevant to the legal line of questions that require dichotomous answers. The presiding judge pressed the forensic psychiatrist to clarify his opinion as to what level of severity the factors, external and internal, were operating on the night in question.

Court: Doctor, I've got a question. You've talked about two factors affecting the events on the 9th of May. There's the internal factor and the external factor. Would you agree with that?

Expert: Yes.

Court: Well, you've talked about the proportions of which the external factor may have influenced the internal factor. If you were to leave aside the external proportions, the external influence, do you have an opinion, or what is your opinion of the level of disability or disease that operated on the 9th of May?

Expert: I think that if Ms Lipsey-McCarthy had not taken any amphetamines, that she would not have been particularly unwell on the 9th of May. However, the reason why she became so unwell, I think is in part because she's vulnerable to developing a mental illness which has subsequently been much more clearly defined than was the case at the 9th of May (*R v Lipsey-McCarthy*, 2004, para. 11).

Although the initial diagnosis of the defendant was considered to be the effect of an external factor, this forensic psychiatrist is suggesting that she may have been vulnerable to developing a mental disorder. While this claim may create murkiness between what factor (external or internal) produced the defendant's mental state, the forensic psychiatrist argued that the drug use made the defendant's underlying vulnerabilities more severe.

Court: So the level at which the disease affected her on the 9th of May, from what you say, were mild symptoms?

Expert: Those mild symptoms were made dramatically worse by the amphetamines. Lots of people take amphetamines. Very, very few have symptoms like she had. The reason why she had such severe symptoms is because she's a very vulnerable person who has an underlying mental illness.

This implies that had she not ingested methamphetamine she may still have become just as unwell, while at the same time it is suggesting that had she not been so vulnerable to developing a mental illness, she would not have become so unwell having ingested the drug. The expert opinion of this forensic psychiatrist is slightly conservative towards supporting a defence of insanity, implying that although the defendant had been experiencing the effect of an internal process, the external factor was the primary contributor.

The second forensic psychiatrist called on behalf of the defence provided a simplified answer to legal questions regarding the relative contributions. He gave the opinion that methamphetamine brought the defendant's predisposition to developing schizophrenia "out to the surface", as this extract illustrates:

Ah, so in...my opinion the methamphetamine then was, ah, was a...cause. It, it wasn't, ah... the condition she was in, the condition that the methamphetamine led to, helped that it came to the surface, the symptoms were characteristic of abnormal mental state. There were delusions, hallucinations, no insight, ah, impaired judgment. There was an abnormal mental state, and that was by itself that led to behaviours and can lead to behaviours that it alters judgment and can lead to, ah, consequences. However because subsequently she had a schizophrenia and she was diagnosed, and clearly led me to believe, yes, there was a condition there, this lady has a disease of the mind (*R v Lipsey-McCarthy*, 2004, para. 12).

The defendant's behaviour, according to this forensic psychiatrist's expert opinion, was the result of an abnormal mental state, a condition he diagnosed as schizophrenia. The initial cause of this condition may have been due to an external factor but the primary driver of her behaviour was due to the symptoms of schizophrenia.⁷⁷ As already discussed, the symptoms of schizophrenia of delusions and hallucinations are commonly accepted as amounting to a

⁷⁷ The defence of insanity was not accepted by the jury and the defendant was found guilty. The jury's decision, however, was appealed with the defence arguing that based on the unanimous expert opinion of the forensic psychiatrists called by the defence, the verdict was unreasonable. The second limb of the insanity test became important in the Court of Appeal's decision in that whether a condition amounted to a disease of the mind only becomes important for the test if the defendant is rendered incapable of understanding the nature and quality of the act or knowing that it was morally wrong. They argued that there was evidence that the defendant, regardless of her mental state, knew the moral wrongfulness of her actions. The fact that the forensic psychiatrists agreed she may have been suffering from a disease of the mind was not enough to find a verdict unreasonable: "The appellant's actual behaviour and the psychiatric evidence supported a possible conclusion of legal insanity but were not determinative of it. This is because the term "disease of the mind", as we have mentioned, is not a medical expression but a legal concept, which embraces more than medical science" (*R v Lipsey-McCarthy*, 2004, para. 18). In making their decision, the Court of Appeal reinforced the fact that the forensic psychiatrists' role as expert witnesses is to assist the court, not determine decisions.

disease of the mind (see chapter five, p. 112). Therefore, the forensic psychiatrist opined that the defendant did have a disease of the mind at the time she committed the offences.

Acknowledging the existing precedent as found in *R v Lipsey-McCarthy*, the forensic psychiatrists explained that this area of the law is still open to further interpretation on a case-by-case basis (FP #6). It is difficult for the forensic psychiatrists to weigh up the biggest contributor to the defendant's behaviour at the time they committed the offences:

...it is important to be clear that at the time of doing what the person did was a function of the disease of the mind rather than intoxication from drugs...that's an important determination to make. The difficulty with that of course is because of the nature of co-morbidity of psychiatry many people who suffer from mental illness also have used and abused drugs. It is very important to try as best we can to give a sense about whether we think it was a primary intoxicated state or whether the drugs contributed but were not a major factor in the commissioning of the act (FP #8).

It may be possible for the forensic psychiatrists to give a general opinion as to what factor (the drug or the mental state) contributed to the defendant's behaviour but they cannot quantify the relative contributions. Regardless, they described instances where they have been pressured to provide a statement that quantifies the relative contributions of the drug and the mental disorder. To avoid over-simplification, some of the forensic psychiatrists described how they use the 'but for' test to avoid the quantification of unquantifiable information:

One of the big issues is the issue of quantification...So you know, I think it is probably impossible to quantify exactly in percentage terms. But it is important to be able to, you know, use phrases like 'what is the determining factor'. For instance, one rule of thumb is the 'but for' this contribution would they have still behaved in this way and that is one way to see if something is substantial or not (FP #3).

Forensic psychiatrists cannot give testimony which states that the mental state of an accused was, for example, 20% caused by methamphetamine and 80% the result of a mental disorder. At the same time, they are required to assist the court in determining the relative contributions of the defendant's behaviour. This task is impossible to complete given the current state of psychiatric knowledge on this topic and would amount to "testimonial

dishonesty” (Perlin, 2000) if an opinion of this sort was given in court. This proposition will be explored further in chapter nine (p. 207).

As illustrated in *Lipsey-McCarthy*, cases involving internal/external boundary-drawing can become further implicated when the defendant has no prior history with mental health or other health services (FP #5). It is in this situation that another limb of the insanity defence becomes helpful for the forensic psychiatrists when making decisions around identifying the possibility a disease of the mind was present at the time the offence was committed. Part three of the section 23 of the Crimes Act 1961 states:

...insanity before or after the time when he did or omitted the act, and insane delusions, though only partial, may be evidence that the offender was, at the time when he did or omitted the act, in such a condition of mind as to render him irresponsible for the act or omission.

Given the length between when an accused allegedly committed the act and the commencement of the trial (sometimes up to a year), the forensic psychiatrists have the time to observe whether the defendant’s possible disease of the mind was a transient or more permanent mental state.

I think the job of the expert in this case is to try and tease out what came first and of course part of section 23, sub-section 4, talks about looking at what happened...the importance of looking at what happened after the act or omission...so evidence of mental illness after the act or omission is important evidence to establish that at the time the person may have been insane. So we know roughly speaking what happens when people take substances [in terms of] normal people or people without a serious mental illness and if the person who smokes cannabis is still crazy in a week’s time, we know that this is not what happens with most people who smoke cannabis, this is something else (FP #5).

Lipsey-McCarthy, for instance, was admitted to mental health services three times after the index offence took place allowing for a different diagnosis to be given by her treating physician. This more longitudinal view is also important for the problem forensic psychiatrists face with distinguishing drug-induced psychosis and a psychotic episode associated with the diagnosis of schizophrenia. A forensic psychiatrist succinctly summarised these points:

...when it is the person's first episode; where there is not history of pre-existing mental illness and the person smokes cannabis and becomes psychotic in a way which is indistinguishable from schizophrenia; they come into hospital and a week later they are still psychotic. So now we are in the situation where this is not straight forward cannabis intoxication, this is something else, and yet it is quite clear that up until the day of the offending the person had not had any mental illness or taken a large amount of cannabis and it might be that these things take a year or so to come to trial, the person may have been in hospital for a year, so by that stage you have quite a lot of time to sort out whether or not this person has now developed a mental illness. Again there is this issue of looking at what happens afterwards, how long does it take the person to recover? And I would say in those kinds of cases what becomes evident is that this person had an underlying vulnerability to developing a mental illness and the drug abuse caused the expression of, or caused the condition to emerge, a condition that would have otherwise not emerged or may not have emerged (FP #5).

In sum, this still leaves the question as to whether in some situations a mental disorder would have emerged had the accused not ingested the methamphetamine (an important point of contention in *Lipsey-McCarthy*). One forensic psychiatrist explained that some mental disorders "may not have emerged in that way, at that time" (FP #5). Therefore, can a mental state brought about by drug use although more permanent in nature, be considered a disease of the mind? It was suggested by forensic psychiatrists that if the effects of the drug ingestion lead to,

...chronic or sustained symptoms for longer than several days particularly for a number of weeks, whatever their ingestion of substances, they are moving towards a disease of the mind (FP #6).

For now it seems that this area of the law is open to negotiation on a case-by-case basis.

BLURRING BOUNDARIES

The sections above have described three situations involving methamphetamine use which may create difficulties for the fact-finders, lawyers and forensic psychiatrists in drawing boundaries between internal and external factors and in turn, for determining whether a defendant was suffering from a disease of the mind at the time they committed an offence. This section will summarise the findings of this chapter and explore their implications for the blurring of the boundary that ideally separates expert opinion from value judgements.

Determining the aetiology of the defendant's behaviour is important in constructing a defence of insanity and ideally it should be the direct result of an internal factor. This aligns with the assumption that insanity is concerned with *diseases* of the mind, effectively pathologising mental states accepted under this defence. In cases involving methamphetamine use, this involves interpreting whether the drug (an external factor) or a mental disorder (an internal factor) caused the defendant to commit the offence. This chapter has illustrated how boundary-drawing between internal and external factors is very difficult, meaning that in practice a blurring not only of these factors, but also the boundaries that assign defendants and their behaviour as 'mad' or 'bad' occurs.

The internal/external binary distinction relies on the premise that one cause can and should be isolated in cases of insanity with the assistance of the forensic psychiatrists. The lawyers in this study understood that it is part of the forensic psychiatrist's role, as an expert witness, to draw boundaries between the effects of drugs as opposed to mental disorder on the defendant's behaviour at the time of the offence:

Well, again it's a matter of in the end [for the] expert...and you rely on the experts to sort out that problem. You can't sort it out, it's for your experts to sort it out...If you're wanting to advise your client to plead the insanity defence, then you're going to have to get your expert to be able to say, "well yes, he was a druggie but this had nothing to do with it" or "while it might have been an influence, it wasn't a crucial or critical one etc." So it comes back to the evidence. The lawyer can't make the facts...So you've got to ask your expert for a report and ask the expert to take into account the fact that the evidence shows this person was a habitual drug user, or an alcoholic, or whatever [who] might have been drunk at the time and so forth (DL #15).

The assertion that an expert witness can provide a *primary cause* of a defendant's behaviour creates significant difficulties for the forensic psychiatrists because the clinical picture that they are faced with in these cases is often complex. As many clinical studies have shown, the aetiology of psychoses arising after methamphetamine use is extremely difficult for psychiatrists to determine (for overview see Fabian, 2007). Further complicating the picture are research findings that indicate that psychotic symptoms arising from persistent methamphetamine use may mimic symptoms experienced by people with schizophrenia. This makes it difficult to differentiate between psychoses arising from drug use or from a mental

disorder. Other research has suggested that psychotic reactions may occur after one dose of methamphetamine (Hartel-Petri, Radler, Schmeisser, Stienmann, & Wolfersdorf, 2005).

Importantly, the overall contention that emerges from these clinical studies that heavy methamphetamine use may leave a person vulnerable to future episodes of psychosis (in clinical language “residual methamphetamine psychosis”) with or without the continued use of the drug, directly implicates the internal/external boundary-drawing (Sato et al., 1992).⁷⁸ In some situations an internal process may have developed that repeatedly occurs independently of an external factor, suggesting the “permanency” needed for building a defence of insanity.

Reflecting on the complex situation they are faced with, the forensic psychiatrists conceptualised the clinical picture presented in these sorts of cases as operating across a “continuum, not clearly delineated categories” (FP #1). As one forensic psychiatrist surmised, these cases often involve a series “knotty determinants” rather than behaviour which can easily be placed in the ‘bad’ (external) as opposed to ‘mad’ (internal) category (FP #3).

In opposition to this, the insanity test privileges categorical answers and this leads to practices whereby lawyers pressure the expert witnesses into making such simplifications, reducing the complexity of their opinions,

The issue of mutual exclusivity comes up and I have been involved in situations where it is almost as if it was either ‘this’ or ‘that’. And I think you are caught, either that is the jury or the way the questions have been asked and they have tended to see it like that...Things can become over distorted into a simplified, for instance, a dichotomy – is it is this or this? (FP # 3)

This situation becomes even more complicated when methamphetamine is used by a defendant who has been identified with a mental disorder. In the case of ‘X’ this was illustrated when a psychiatrist explained that the defendant had a “very complex history of presentation” and that there were more likely to be “multiple explanations”, rather than a

⁷⁸ This research also suggested the relapses of psychoses may be related to further methamphetamine use or environmental stresses – both of these factors could be conceptualised as external factors influencing an internal process. This is also the case with people who may be diagnosed with a mental disorder commonly accepted as a disease of the mind, such as schizophrenia. However, this is not often discussed in court cases. The implications of this will be discussed in chapter nine in further detail.

single “unifying diagnosis”. This psychiatrist stated, “I don’t think this is a situation where it has to be A or B or C. It seems more likely that there are several things going on at the same time” (Expert B, *R v ‘X’*, 2008).

Chapter five described how ideal interpretations of the role of the expert witness build a boundary that assigns expert opinion to that based on scientific evidence. This ensures that any social judgements, which may encompass facts but also values, are designated for fact-finders only to consider (Jasanoff, 1995; Solomon & Hackett, 1996; Wynne, 1989). In cases involving the murkiness summarised above, the boundary that divides facts and values becomes explicitly blurred.⁷⁹

Firstly, due to the clinical uncertainty and often impossibility associated with boundary-drawing between internal and external factors, agreement between experts does not often occur in cases involving psychosis arising from methamphetamine. This disrupts the romanticised views of science implicit in legal understandings that see agreement between experts as an illustration that they are speaking only to the facts (Wynne, 1989). Such views were illustrated in chapter two (cf. Kenny, 1983, p. 28) and in the analysis of legal texts and interview material in chapter five (pp. 112-120). Conflicting opinion in cases involving methamphetamine, therefore, creates a situation in which the forensic psychiatrists may find it difficult to live up to the expectations legal professionals have of an expert witness.⁸⁰

Secondly, chapter five (pp. 118-120) detailed how the internal/external binary distinction illustrates the legal system’s reliance on medical knowledge as a means for ensuring fact-finders’ decisions are valid and reliable. In cases where methamphetamine is involved, however, the reliability of expert evidence becomes questionable. The clinical studies mentioned above give some indication as to the possibility that methamphetamine intoxication can lead to short-lived psychotic symptoms and that it can create a relapse of an

⁷⁹ In chapter nine (p. 199), I argue that this exemplifies the limits of psychiatric knowledge in meeting the criteria for ‘science’ that is demanded within the legal context. This is apparent, not only in controversial cases but also in all cases of insanity. Controversial cases these limits become more apparent. The implications of the ways in which these limits appear to be largely ignored in most cases of insanity will be explored thoroughly in chapter nine.

⁸⁰ Gutheil (1999) notes that conflicting opinion is often the result of psychiatrists having to apply complex clinical pictures into narrow legal constructs, this was also discussed by some of the forensic psychiatrists. The next three chapters will explore the tensions arising from the legal shaping of psychiatric knowledge in-depth.

existing mental disorder. In a small number of people heavy use of the drug may also lead to the development of a ‘vulnerability’ or a relapse of psychosis with or without the continued use of methamphetamine. They do not however, provide any answers for the forensic psychiatrists or the fact-finders on the definite *cause* of the psychosis. Forensic psychiatrists cannot be certain as to whether methamphetamine “triggers” a disorder such as schizophrenia that has been laying dormant, or whether psychotic symptoms arising from methamphetamine are just very similar to that which is observed with people diagnosed with schizophrenia. Such opinion does not meet the legal standard for scientific fact,⁸¹ as Carroll et al., (2008) have argued:

...when considering individual causes...the scientific evidence does not yield a reliable framework for teasing apart the relative magnitude of the aetiological contributions of the external agent of drug use versus other possible factors such as psychosocial stressors and pre-existing, internal ‘vulnerability’ (Carroll, McSherry, Wood, & Yannoulidis, 2008, p. 638).

Unlike the mental disorders that are understood to have a biological cause and thereby are more acceptable to the court as amounting to a disease of the mind (such as schizophrenia),⁸² psychoses that involve methamphetamine use, at least in part, may not provide the validation needed for legal closure.

Despite the difficulties, the law for insanity requires assistance from forensic psychiatrists when making decisions relating to the ‘direction of causality’ (Memon, 2006, para. 12). When the forensic psychiatrists are pushed into giving testimony of absolute certainty, the implications are far reaching introducing the possibility of evidence being given that does not match the current state of psychiatric knowledge on this topic.

It could be argued that such testimony would be based on a social judgement. As Brookbanks (2007) has argued, this proposition becomes extremely important in cases considering

⁸¹ Here I am not suggesting that I agree with the way in which the law understands science or scientific facts, rather I am illustrating how the murkiness involved with making internal/external distinctions shows up the difficulties psychiatrists have in meeting the romanticised standards for scientific facts that the law embraces.

⁸² Although the biological basis of schizophrenia is highly debated and has been subjected to significant amount of criticism, intriguingly this aetiological assumption does not often become questionable or used as a deconstructive device by lawyers in cases of insanity. The implications of this not only for defendants but also for public understandings of madness will be discussed in chapter nine.

controversial issues such as the use of methamphetamine “existing as they do on the borders of clinical and legal toleration” because value judgements may lead such cases being automatically “discarded simply because they are associated with dangerous behaviour and offenders that evoke little personal sympathy” (Brookbanks, 2007, p. 137). Research carried out in North America reflects this proposition suggesting that the verdicts of insanity are more likely to be found when the defendant has no substance abuse related disorders and/or no history of drug offences (Freeman, 1998; Warren et al., 2004). Clinical studies have pointed out that chronic users of methamphetamine are more likely to have a history of mental illness and diagnoses of “dual diagnosis” or “co-morbidity” which reflect this complex picture (Lin et al., 2004). When compared with the findings of these studies, the contention put forward by Brookbanks has the potential to pose significant implications for a large number of defendants using the insanity defence.

CONCLUSION

This chapter explored the varying difficulties that arise when forensic psychiatrists are faced with the challenge of giving expert opinion on mental states that do not easily fit with the internal/external binary distinction that comprises the test for insanity. By focusing on the murkiness which evolves in practice, this chapter moved beyond the ideal interpretations of legal insanity outlined in chapter five. In doing this the wider implications of these ideal interpretations were highlighted in terms of the limits of psychiatric knowledge in meeting legal understandings of science. It was also suggested that the boundaries which define and contain the role of the expert witness become blurred in this context. This theme of blurriness will be continued in chapter seven, which will focus on the hybridised nature of the role of expert witnesses.

CHAPTER SEVEN: THE LEGAL SHAPING OF PSYCHIATRIC EXPERTISE

When expert witnesses enter the courtroom they are expected to abide by particular legal rules and provide testimony on issues determined by legal professionals. This chapter explores how these legal needs shape the way forensic psychiatrists conduct their forensic evaluations, write reports and give verbal testimony. Using data generated from interviews with lawyers and forensic psychiatrists, it shows how forensic psychiatrists have to mould their psychiatric expertise to meet the legal expectations of an expert witness (Lynch & Cole, 2005; R. Smith, 1988, 1989; R. Smith & Wynne, 1989). Overall the chapter will aim to provide ‘thick descriptions’ (Geertz, 1973) of the ways in which the forensic psychiatrists’ practices are inseparable from the legal processes that shape them when they undertake the role of expert witness. It draws on Edmond and Mercer’s (1998) use of the trope ‘hybrid’ to interpret the expertise that forensic psychiatrists provide in the context of insanity trials⁸³ and concludes that their practices can be seen as a hybrid composed of legal, lay and psychiatric knowledge.⁸⁴

The chapter is divided into two sections. The first section builds a picture of the ways in which the legal needs for the *defence of insanity* shape the forensic psychiatrists’ practices. The section focuses on the ‘forensic’ tasks that the forensic psychiatrists must complete when preparing their reports and giving verbal testimony. Section two considers how the forensic psychiatrists shape their practices to meet the legal expectations of an *expert witness*. It also pays particular attention to the difficulties that arise from the legal requirement that an expert witness’s foremost duty is to the Court. Both these sections seek to highlight the hybrid nature of the expertise the forensic psychiatrists provide as expert witnesses by exploring the legal shaping of their practices.

⁸³ The hybrid notion can be extended to understand the symbiotic relationship (Edmond, 2008) between lawyers and psychiatrists in the context of the use of this defence. This will be explored in chapter seven. This chapter is solely focused on understanding how the expert witness role is accommodated and managed by the forensic psychiatrists in this study.

⁸⁴ Although the implications of this proposition for the maintenance of the boundaries that separate and contain the role of the expert witness, fact-finders and legal professionals will be discussed in the conclusion of this chapter, they will be considered in more depth in chapter nine (p. 197).

SECTION ONE: ACCOMMODATING THE LEGAL TEST FOR INSANITY

When describing the role of forensic psychiatrists in cases of insanity, a prosecution lawyer stated that they are not really “doing normal psychiatry” (PL #1). This section explores this notion further by describing the ‘forensic’ tasks that forensic psychiatrists undertake as expert witnesses in cases of insanity. In doing this the section shows how the role differs from that which psychiatrists assume in the clinical setting. This further demonstrates how the *legal test for insanity* and the *legal expectations of an expert witness* shape how they perform the role.

The following provides examples of the legal shaping of psychiatric expertise in relation to the data the forensic psychiatrists collect, corroborate and interpret for the purposes of a forensic evaluation. It also describes the communication skills they must master as an expert witness in cases of insanity.⁸⁵

Data collection, corroboration and interpretation

The legal test for insanity requires the forensic psychiatrists to reconstruct the mental state of the defendant at the time the offence was allegedly committed (Bowden, 1995). The process of providing this reconstruction involves a combination of psychiatric and legal knowledge. As Gunn and Taylor (1993) have described, it entails making medical diagnoses shaped by the court’s needs. In particular the practices of collecting, corroborating and interpreting information are essential ‘forensic’ tasks the forensic psychiatrists must complete when reconstructing the mental state of the defendant. This section will describe these practices and show how the ‘forensic’ tasks extend beyond the clinical skills assumed by a psychiatrist in a therapeutic setting.

To reconstruct the factors that affected the mental state of a defendant at the time they committed the offence, information is required beyond what is required for psychiatric diagnostic procedures. A typical report completed by a forensic psychiatrist entails the collection of various sources of information, as well as data generated from interviews with the defendant. This can include: police and witness statements; copies of documents that can

⁸⁵ By stating that I am using these two examples, I am acknowledging that there may be several other examples of the legal shaping of forensic tasks. Due to the size restrictions of the PhD thesis, however, I cannot address all the practices a forensic psychiatrist undertakes when conducting the expert witness role. Chapter 10 (p. 213) of this thesis states how future research could consider the practices forensic psychiatrists undertake pre-trial to further explore the hybridised nature of the expertise they provide.

later be used as exhibits; photographs from the scene investigation; records of the defendant's previous offences; medical notes; and material generated from interviews with the family and friends of the defendant (Bluglass, 1995).⁸⁶

Although some of these information sources may be used by psychiatrists as part of their diagnostic procedures, the importance placed on certain sources over others varies in the forensic reports. A forensic psychiatrist explained:

...it is not your diagnostic brilliance at all, it is your willingness to just patiently go through old notes, corroborate history and police statements and every bit of information that you can get your hands on to get the best picture you can of what was happening at the time (FP #14).

This extract describes how the collection, corroboration and interpretation of different sources of information can be more important than the diagnostic picture. This is because sources of information, other than the data gathered from interviews with defendants, are considered to be 'independent' (free from subjectivity) in the legal context (Bluglass, 1995). The forensic psychiatrists assess whether the defendant's statements correlate with these 'independent' sources of information. These practices ensure forensic psychiatrist's reconstruction of a defendant's mental state meets the legal standards of accuracy and reliability. As chapter five (pp. 114-117) illustrated, the corroboration of psychiatric assessments with other sources of information and lay witness statements characterised 'ideal' cases of insanity.

Corroborative practices become extremely important in cases where insanity is contested. In these cases the forensic psychiatrist's reliance on interviews with the defendant alone has become a means of demolishing the credibility of an expert witness.⁸⁷ The potential for legal

⁸⁶ An important part of initial discussions a forensic psychiatrist has with the lawyer instructing them may include processes for accessing this documentation. Failure to secure sufficient documentation can lead to substandard expert opinion (Galpin, 2007) and may be used as a source of legal deconstruction via cross-examination when the forensic psychiatrist gives testimony (Jones, 1994). This implicates the lawyers in ensuring effective expert opinion. Chapter eight (pp. 173-196) draws attention to the symbiotic relationship between the lawyers and forensic psychiatrists.

⁸⁷ Chapter three (p. 58) defined 'deconstruction' using the work of STS of law-science interactions to illustrate. Chapter eight (p. 177) illustrates the legal deconstruction strategies of lawyers in relation to the notion of malingering.

deconstruction places a different emphasis on how forensic psychiatrists go about collecting and interpreting data:

Clinically, it is not as important, it is not as much an issue as to whether the person has been accurate with their description. Here you are trying to corroborate and test that the best you can clinically. So it is the weight that you would place on different sources of information, in particular you would give that more weight (FP #3).

The focus of the forensic investigation, therefore, is very different to the focus of a psychiatric assessment in the therapeutic setting where the ‘truthfulness’ of a patient’s description may not be as important. In summary, the information collected and the weight placed on different information sources is shaped by legal needs.

The practices forensic psychiatrists perform as expert witnesses, however, are not independent of the therapeutic setting. The role may entail a very different set of skills due to the legal shaping described above, but the forensic tasks can only be completed by a forensic psychiatrist because he/she is a doctor with clinical expertise:⁸⁸

So I see it ultimately as a public service through that process, which is different than the role of a clinician, but one can only do it because one is a clinician. That is the irony and you can’t escape that; you are still there because you have got medical or psychology qualifications that mean you link to a body of literature and scientific understandings that bears on the issue before the court. So you cannot, you are not there as some independent process of a clinician (FP #1).

This forensic psychiatrist describes how he is called upon as an expert witness by the court because of his clinical training and skills. The extract also illustrates how a forensic psychiatrist must draw on their medical skills to provide the necessary information for the court. Fact-finders are not expected to possess the required knowledge to diagnose mental disorders, nor is it assumed that they have the ability to determine how a defendant’s behaviour may be related to a particular mental state. Forensic psychiatrists are considered by the court to have the necessary medical, specifically psychiatric, expertise to address these issues.

⁸⁸ This extract also draws attention to the fact that other clinicians may be used as expert witnesses in the courtroom. In cases of insanity this is rare and, as this chapter will soon show, the lawyers in this study almost exclusively use forensically trained psychiatrists as expert witnesses.

Forensic psychiatrist #1 also suggested that there is not a firm boundary which separates clinical from forensic expertise. This reflects the hybrid nature of the insanity defence itself, which draws on medical as well as legal understandings. In practice, this means that forensic psychiatrists are required to mix various information sources and then by drawing on their clinical knowledge, apply this to the test of insanity.

My role and function is to give the court the benefit of my expertise, which is in the area of diagnosing mental illness, trying to understand how a person's behaviour may be attributable or partially attributable to their mental state, to try to give the court insights into the person's conduct or behaviour, acts or omissions that they may have otherwise not have...and I guess too, help the court with some medico-legal tests, which do require the application of some science in terms of mental illness to those particular tests (FP #5).

Forensic psychiatrist must formulate a clinical view of the mental state of the defendant and determine if this mental state amounts to a disease of the mind and lack of moral reasoning. As chapter five stated, a disease of the mind is a legal construct that draws on medical knowledge, rather than being determined by it. This means that the forensic psychiatrist must give expert opinion as to whether a psychiatric diagnosis amounts to a disease of the mind, taking into account all the characteristics of this legal construct (serious disorder, internal process, non-transient). The second part of the test involves an assessment of not only how a mental disorder may have affected a defendant's behaviour, but also their ability to know the moral wrongfulness of their acts. This means the forensic tasks involve making inferences as to what behaviour is morally or legally excusable (Galpin, 2007).⁸⁹

The ability to manage the hybrid skills required for giving expert opinion in cases of insanity has been described as the 'art' of forensic psychiatry (Gunn & Taylor, 1993). This was reflected in the perceptions of the lawyers in this study who preferred to employ the services of psychiatrists trained in the sub-specialty of forensic psychiatry.⁹⁰ The lawyers explained that they find this particularly important because most cases involving insanity relate to

⁸⁹ This contention is not without criticism as it effectively blurs the role of the expert witness with that of the fact-finders. The second section of this chapter (pp. 151-169) will discuss this issue in further detail.

⁹⁰ There is no legal requirement in New Zealand to use forensic psychiatrists as expert witnesses in criminal trials involving the insanity defence.

serious charges; usually murder. In these cases the lawyers stated that they required an expert witness well versed in both psychiatric issues and the law of insanity.⁹¹

...if you are talking about a major crime or alleged crime and you want an expert, you need to get a genuine forensically trained expert psychiatrist. So the bottom line is—if it's a homicide then you just can't go in with a psychiatrist, you really need someone that knows that area and knows that area of law really, really well (PL #13).

In cases where the defence of insanity was being used the lawyers required assistance from the forensic psychiatrist in matters that were specifically focused on 'forensic' issues. The lawyers perceived 'forensic' issues as different to the 'psychiatric' issues that arose in other cases,

Well in a forensic sense, whenever I call a forensic psychiatrist in the forensic sense, I'm wanting them to given an opinion to a jury about issues relating to psychiatry. I will always call a forensic psychiatrist. There are occasions when I will call psychiatrists in a context other than that so they are psychiatrists being called about a psychiatric issue, but in the context of a forensic psychiatrist giving an opinion. Usually it will be a psychiatrist who has operated as a clinician in a particular case (PL #2).

This extract also suggests that from the lawyer's point of view the role of a forensic psychiatrist in cases of insanity involves giving an opinion that is comprised of more than clinical issues. The lawyer's assumption relies on the definition of 'forensic',⁹² which describes the application of scientific and/or clinical expertise to legal issues and criminal investigations. A forensic psychiatrist further described what he perceived 'forensic' to mean in relation to his work:

It is a particular form of work that is intellectually stimulating and intriguing to do. You are entering the theatre of the court with all the drama of human life that those courts are. It links back to what 'forensic' is: it is a forum where social discourse and justice meet, and in some ways it is the ultimate form of that. [It is

⁹¹ The lawyers also discussed how they expected forensic psychiatrists to perform better under cross-examination in contested cases and appear more credible than non-forensically trained psychiatrists. See chapter eight for a discussion of how these understandings can be used as tactics in the courtroom by both the lawyers and forensic psychiatrists to disestablish or build credibility of expert witnesses.

⁹² See chapter one (p. 3) for further discussion of this term.

the] coming together of law, of various aspects of the human condition, and the needs of justice (FP #1).

As chapter one detailed forensic psychiatry is described in psychiatric textbooks as a subspecialty in which scientific and clinical expertise is applied to legal issues in legal contexts (American Academy of Psychiatry & the Law, 1995).

Communication skills

The ability to communicate complex information in a way fact-finders can easily understand is an important aspect of the 'art' of practising forensic psychiatry. The forensic psychiatrists described a three-way translation process. They must be able to translate psychiatric terminology into lay language, while also speaking to the legal constructs that comprise the defence of insanity (FP #10). This forensic psychiatrist argued that the translation process becomes an essential skill in effectively performing the role of expert witness.

The ability to manage the translation process is a skill that the forensic psychiatrists develop over time (FP #7). The specialist training they undergo as clinicians, and the experience they gain through their involvement with cases, hones their translation skills. As one forensic psychiatrist explained:

I think if you practise it enough it is not difficult [to do] (FP #10).

A very experienced forensic psychiatrist illustrated this when discussing how he found the translation process to be relatively easy to achieve in practice and something that he enjoyed doing:

No I don't actually. It's one of the things that I try to concentrate on and one of the things I actually enjoy about forensic psychiatry and that is developing a certain degree of expertise around legal issues as they pertain to psychiatry, so that you can show the counsel that has instructed you and the judge that you are well aware of what the legal tests are, you are well aware of the rules around evidence, you know how to behave in court and the things you can and can't say....I like to try and keep things simple, to reduce them down a bit so you're not using jargon. If you do use technical words, explain them. So your role in court is very much one of working as hard as you can to get your message across in a professional way... (FP #14).

The communication skills required for the role of expert witness involves the shaping of psychiatric knowledge to effectively manage the translation process. One forensic psychiatrist explained that they use lay language as the mediating factor:

It is not just a translation from psychiatry and the law it is actually psychiatry as it pertains to law in common lay language. In fact, sometimes it is actually best to just leave out the middle bit or to just make it a two stage test, which is...for me to think from a psychiatric perspective – these are some of the psychiatric concepts, how might I describe that to my wife or to my family or to my friends and use the language I might use otherwise...remembering that a courtroom with juries, judges and others are really just interested, some of them semi-educated, lay people (FP #8).

Forensic psychiatrists develop communication skills that leave psychiatric terms behind in the therapeutic setting and replace them with lay terms. The lay terms and understandings are then applied to the legal constructs being discussed. If they do use psychiatric terminology, the forensic psychiatrists explained, they would define these terms using everyday language (FP #2).

It is important to note that this can be difficult to achieve in practice and the forensic psychiatrists suggested that at times, they were not always able to translate terms effectively:

It can be particularly difficult if you cannot break out of speaking in psychiatry speak and I think often at times we lose many more people by that than our inability to apply psychiatry speak to the law...” (FP #8).

Again the ‘art’ of forensic psychiatry was something that was learnt over time with experience in performing the role in the courtroom.

Lay communication and thorough knowledge of the law are integral to this translation process. This means that forensic psychiatrists are required to have adequate knowledge of current case law and statutes relevant to the criminal case in question. They must have this level of understanding of the law to complete the translation process. In terms of the defence of insanity this means:

[a]ny experienced expert witness should know what the court accepts as a disease of the mind and how to explain the symptoms and how the symptoms affect ones behaviour in a way that anybody can understand (FP #5).

Mastering the translation process was perceived to be a skill that sets forensic psychiatrists apart from their clinical colleagues:

...you are going into legal land; the same word may have different meaning than in the clinical land. If you don't get that you can wind up in all sorts of trouble and non-forensic experts tend to do this – she has got schizophrenia and therefore she is insane – Well no, you have to go through a rationale of thinking and so I think one of the forensic skills is being able to do that (FP #1).

The forensic psychiatrists were also considered by the lawyers in this study to perform well in the courtroom in contrast to expert witnesses who were not forensically trained. Academically based psychiatrists or practising clinicians with little experience with giving expert testimony were not considered to be able to communicate clearly and without jargon to the fact-finders.

...they are well used to the forum of talking to juries and they are well able to communicate with juries in the main and those I find who are less able are the ones that have been brought in to give evidence in a criminal trial for the first time. They need time to just work through it because they're just not used to the forum...they may be fantastic in the lecture room but not necessarily to the jury (PL #8).

This section has shown that effective communication skills involve a complex translation process. Further, such communication skills are a quality that expert witnesses were expected to possess. During the translation process, the forensic psychiatrists draw on their psychiatric expertise to give expert opinion that is shaped to fit legal requirements. Further, a thorough knowledge of statutes and relevant case law was an essential aspect of the 'forensic' task. For many of the forensic psychiatrists, mastering the translation process was a core part of their role and a challenge that they enjoyed:

I think it is also very good for us. It makes us consider what we are saying all the time...if I cannot translate this into something that makes sense to a juror then it is probably bullshit! If it is only language that is used amongst a group of special experts it is probably meaningless, it ought to be translated in such a way that an

average person can understand...so I think it is a healthy challenge for us all (FP #11).⁹³

Section one: Summary

This section has shown that the ‘data collection and interpretation’ involved in forensic assessments and the ‘communication skills’ an expert witness must possess, involve the forensic psychiatrists using expertise that extends beyond what may be expected of a clinician working in a therapeutic setting. The forensic psychiatrists explained that they draw on their psychiatric skills to perform ‘forensic’ tasks while accommodating the legal needs required for cases of insanity. This illustrated how they perform a hybrid expertise when practising the role of expert witness.

SECTION TWO: ACCOMMODATING LEGAL EXPECTATIONS

The following section explores three ways in which the legal expectations of an expert witness shape the practices of forensic psychiatrists. The section focuses on the legal expectation central to the conduct of an expert witness, which stipulates that their overriding duty is to the Court. How this legal expectation becomes difficult in practice for the forensic psychiatrists to achieve, and how they manage these difficulties, is also discussed. The section suggests that this highlights how the forensic psychiatrists practise a hybridised expertise when performing the role of expert witness.

Assisting the court, impartiality and sticking to expertise

Chapter five described how the law of evidence stipulates the primary duty of an expert witness is to the Court. Briefly returning to this legal expectation, this requires an expert witness to acknowledge that they have an overriding duty: to assist the *court* in providing relevant evidence; to give evidence in an *impartial* manner, and to give evidence within *their area of expertise*.

The following describes how all three of these legal expectations pose difficulties for the forensic psychiatrists in this study. How they manage these difficulties and accommodate

⁹³ This quote alluded to the way in which the challenge of being scrutinised in court may shape how forensic psychiatrists write their reports or give testimony (Timmermans, 2006), a proposition discussed in the conclusion of this chapter (p. 169).

these legal expectations will highlight the legal shaping of psychiatric expertise that occurs in practice. This will further illustrate the usefulness of the ‘hybrid’ as a metaphor for describing their practices in this context.

The problem of wearing ‘two hats’

When acting as an expert witness a forensic psychiatrist must accept the legal expectation that their first duty is to the *court*. This expectation immediately poses a problem for the forensic psychiatrists in the way it conflicts with the duty of a doctor to the welfare of their patient.⁹⁴

A forensic psychiatrist explained that this legal expectation creates a situation that is remarkably different from that which would take place in a therapeutic setting:

...probably the hardest thing [to do] is to step out of your clinical role, so that when you see a client for the court you are not seeing them with your clinical hat on. When you are working with someone clinically you want their best interests, you might see yourself advocating for them. In the court you have to step away from that, you are not necessarily there for the person’s best interest, you are not there as their advocate and you are not engaging in any therapeutic activity with them (FP #2).

This forensic psychiatrist described that the alliance between ‘patient’ and ‘doctor’ as opposed to ‘defendant’ and ‘expert witness’, is different in the forensic context. The former is focused on the psychological well-being of the individual. The latter is focused on meeting the requirements of social justice, a situation in which the forensic psychiatrist may be allied with, or opposed, to the defendant.

In this way,⁹⁵ this legal requirement for an expert witness conflicts with the Hippocratic Oath that drives medical practice. As one forensic psychiatrist explained:

⁹⁴ Forensic psychiatrists are faced with various ethical dilemmas in their usual clinical practice because of the legal constraints their area is subjected to. In this context, however, their clinical practices are still geared towards the assessment, care and welfare of the patients. The expert witness role changes this focus with the legal expectation that their overriding duty is to the Court.

⁹⁵ Traditionally medical professionals’ ethical framework is concerned with the issues that emerge from the doctor-patient relationship (Allnutt & Chaplow, 2000). The New Zealand Medical Association (2002) describe four principles that apply across healthcare settings. These include: respect for autonomy, beneficence, non-

I think it is a very different role...the clinical role is quite sacrosanct in the sense that it is bound by Hippocratic principles, it is bound by doctor-patient confidentiality; you put your patient first. In the forensic role you take that hat off and in theory at least it is an objective role, it is a societal role, your first loyalty if you like is truth and objectivity that the court needs from you. Sometimes that might not be in the patients perceived best interests (FP #10).

The expert opinions provided by forensic psychiatrists, when acting as expert witnesses, may have a negative impact on the defendant and this implicates the ethical principles of beneficence and non-maleficence central to medicine (C. Evans, 2007). The clashing of this legal requirement for an expert witness and the duty a doctor has to their patient's welfare has been referred to in the medico-legal literature as the problem of wearing "two hats".

Confidentiality

When conducting a forensic assessment, the forensic psychiatrist also has to recognise that the issues of confidentiality are very different than in usual psychiatric assessments for therapeutic purposes (Kalmbach & Lyons, 2006). In short, private information gathered during the forensic investigation is made public during legal proceedings (Simpson & Evans, 2005).

The forensic psychiatrists explained that they have to ensure the defendant undergoing the forensic investigation is clear about the limits of confidentiality. The ability of the forensic psychiatrist to ensure the defendant is clear on these issues can become difficult in practice. The forensic psychiatrists suggested that some defendants, who have had regular experiences as a patient under the care of psychiatrists prior to the forensic evaluation, may not understand the difference between the assessments. They may still see the forensic psychiatrist as their doctor and someone interested in their welfare. They may also understand that any information they provide to this doctor is guarded from public consumption.

The big thing is the lack of confidentiality in that someone may, if they have a history of psychiatric care, they may have this engrained conscious expectation if you like, that what they tell me is sacrosanct, secret and I won't disclose it to

maleficence and justice. Autonomy emphasises the rights of patients to make their own decisions. Beneficence refers to the doctor's aim of providing the best possible outcome for the individual while under their care, taking into consideration the constraints of the environment in which they are working. Non-maleficence describes a doctor's duty to do no harm, and justice refers to their duty to facilitate equality and fairness within the setting where they provide services.

others, even though I have given them a Miranda warning at the beginning of the assessment, and then in court they have their health information spelled out, cross-examined, blow by blow... (FP #10)

Even after providing several explanations regarding the limits of confidentiality, the forensic psychiatrists explained that a defendant may not realise that *any* information they provide to the forensic psychiatrist will be used in reports and presented publically in the courtroom. This means that forensic psychiatrists have to repeatedly make it clear to the defendant throughout the forensic evaluation that the process is very different to therapeutic situations which they may have experienced through previous interactions with a doctor (Simpson & Evans, 2005).

Advocacy and empathy

The legal expectation that the duty of the expert witness is to the court rather than the defendant, also means that forensic psychiatrists should approach their assessment impartially. Again this emphasises a focus on questions of law and not what may be in the best interests of the defendant. Strasburger et al., (1997) have explained that this difference in alliance minimises the empathic identification the forensic psychiatrist would usually have with the patient in a clinical setting, favouring neutrality over advocacy (Strasburger et al., 1997). The problems associated with impartiality are discussed using the interview data in further detail below.

Managing (hybrid) ethics

The role of being an expert witness creates an ethical dilemma for forensic psychiatrists that they need to manage. The ethical implications of the role of being an expert witness have been debated widely in the medico-legal literature (Kalmbach & Lyons, 2006; R. Rogers & Shuman, 2000; Simpson & Evans, 2005; Strasburger et al., 1997). Adshead and Sarkar (2005) have surmised that forensic psychiatrists face a clash between the paradigms of 'welfare' and 'justice' when acting as expert witnesses. They have described how balancing the welfare and justice paradigms become difficult for them:

The values of justice and welfare clash in complex ways for the forensic psychiatrist in the courtroom. It is undeniably in the public good for the courts to have access to expert knowledge that supports and enhances justice. In theory, such evidence benefits everyone, rather in the way that public health physicians

contribute to public welfare through their expertise. However, the psychiatrist who acts as an expert will usually have to carry out an examination of an individual person, and have a professional relationship established (Adshead & Sarkar, 2005, p. 1016).

Because of these ethical issues, other commentators have argued against psychiatrists being involved in the forensic area altogether. Stone (1984, 1994) has argued that the blurring of ethical boundaries that occurs when psychiatrists use their therapeutic skills for forensic purposes is unethical. To illustrate this point, he used an example from his time as an officer in the military where he was required to give psychiatric evidence in a court martial proceeding. While conducting his assessment, Stone developed a rapport with the sergeant which led to the sergeant disclosing incriminating evidence. Stone's testimony then became integral to proving the guilt of the sergeant. Stone suggested that this role as a 'double agent' was unethical. He concluded that a psychiatrist should not use their therapeutic skills to extract damaging information for the purposes of justice. He argued that this disrupts the principles of beneficence and to 'do no harm' embedded in medical ethical frameworks.

In contrast, Appelbaum (1990, 1997a) has contended that the role of psychiatry in the forensic setting departs from the paradigm of the treatment setting. According to his argument traditional medical ethics do not apply in the forensic context. In other words, the primary role of the expert witness is as an 'assessor' for the legal professional who instructed them, not as a 'therapist' charged with the care of the defendant. From this, Appelbaum interpreted traditional medical ethical principles as of secondary importance to the legal requirements of an expert witness. He concluded that the primary role of the forensic psychiatrists in this context is to assist the court in the advancement of justice by drawing on their psychiatric expertise.

Appelbaum (1990) provided an ethical framework to guide forensic psychiatrists, or in his words the 'forensicists', as they assist the court. He explained that the practices of a forensicist can be guided by an ethical framework, which is distinct from medical ethics:

Society values highly—and in many respects increasingly—the application of psychiatric expertise in legal contexts. But to apply that expertise is not to practice psychiatry, at least not in any ethically meaningful sense of the term. Perhaps it would be better if we even used a different term to denote the role played by the evaluator who applies knowledge of psychiatric diagnosis and

psychological functioning to assist the legal system in reaching legally useful conclusions. Were we to call such a person a "forensicist," or some similar appellation, it might more easily be apparent that a different-nonmedical-role with its own ethical values is involved (Appelbaum, 1990, p. 252).

This different set of ethical principles encompassed in Appelbaum's framework includes 'truth-telling'. This involves both 'subjective' truth-telling (the expert's genuine belief in their testimony) and 'objective' truth-telling (the acknowledgement of limitations of the testimony and limits of scientific knowledge) (Appelbaum, 1997a, 1997b).⁹⁶ Another principle of 'respect for persons' necessitates that the forensic psychiatrists clarify their role with defendants when conducting insanity evaluations, honour defendant's decisions, and maintain confidentiality within the constraints of the law (R. Rogers & Shuman, 2000). In summary, Appelbaum's ethical framework can be seen as an attempt to balance the ethical obligations of his medical profession with the legal requirements of an expert witness.

Some medico-legal literature has accepted Appelbaum's approach to the ethical dilemma forensic psychiatrists face when acting as expert witnesses. Bloche (1998) has argued that the tension between the ethical obligations of individual welfare and society's need for social justice is healthy. Adshead and Sarkar (2005) have also emphasised the need to balance the paradigms of justice and welfare.

Stone (1994), however, rejected Appelbaum's thesis. He contended that a forensic psychiatrist cannot maintain a meaningful distinction between the ethics of practising as a clinician and an expert witness. He argued that regardless of special practices to maintain an ethical situation when conducting forensic investigations, the 'psychiatrist-patient' relationship can still lead to unguarded disclosure on the part of the defendant. Moreover, Stone suggested that in situations where the forensic assessment is deemed to be beneficial to the plight of the defendant, the 'psychiatrist-patient' relationship may continue to develop therapeutically. In these cases, Stone noted the expert can enter the courtroom:

...deeply involved in a transference/countertransference, wearing both hats and bound by both kinds of ethics, but without any sense of the conflict between

⁹⁶ The issue of truth telling will be discussed in further detail towards the end of this section.

them. The experts believe they are serving justice and helping their patients at the same time” (Stone, 1994, p. 83).

For Stone, the continued use of forensic psychiatrists as expert witnesses is an untenable situation.

The New Zealand medico-legal literature has agreed to some extent with Appelbaum’s ethical framework. The practical limitations of the forensicist concept have been noted and, as in the work of Adshead and Sarkar (2005), New Zealand authors have described how there is the need for the forensic psychiatrist to balance the individual needs of the patient with the societal demands for protection:

...although clinicians may believe they are operating with different, forensicist ethics when carrying out a medico-legal assessment, they do so by using clinical techniques and interactions. It seems that some clinicians operate as ‘conditional forensicists’, preferring a combination of clinical interviewing conditions while claiming forensicist ethics (Simpson & Evans, 2005, p. 354).

The idea of ‘conditional forensicists’ was also described by the forensic psychiatrists interviewed for this study. The polarisation of ‘therapist’ versus ‘forensicist’ was perceived by many of the forensic psychiatrists as unhelpful for understanding the expert witness role. Rather, the forensic psychiatrists described how the role may involve a different set of ethics while simultaneously using the practices they learned through their medical training:

This sort of thing has been polarised into the therapist versus forensicist dichotomy. Where I sit somewhere inside of that. I do agree with what a lot of what Appelbaum states ‘forensicist’ means, what those principles are and the differences between abandoning beneficence and confidentiality structures, and you are certainly there for objectivity, for truth and to provide the best information on the human condition that the jury and judge, from common understandings, would not otherwise know. So I see it ultimately as a public service through that process, which is different than the role of a clinician, but one can only do it because one is a clinician. That is the irony and you can’t escape that; you are still there because you have got medical or psychology qualifications that mean you link to a body of literature and scientific understandings that bears on the issue before the court (FP #1).

This extract exemplifies the perception many of the forensic psychiatrists had that related to the way in which they do not completely ‘leap out’ of their therapeutic role when they act as

an expert witness. Indeed they are instructed by lawyers to perform this role because of the expertise they have as a medical professional. As it has been discussed so far in this chapter, the forensic psychiatrists combine some of these skills with their knowledge and experience of the legal system, and specifically the requirements of the defence of insanity. Their skills as a psychiatrist are used to generate information to assist in answering legal questions and it is these legal needs that constrain their practices. This was reinforced by both the lawyers and forensic psychiatrists interviewed for this study when they described the expert witness role as a 'public service'. Again this highlights the usefulness of understanding their role as one that is founded on a hybridised expertise, which mixes psychiatric with lay and legal knowledge.

To further balance the ethical obligations of their profession with the legal expectations of an expert witness, the forensic psychiatrists argued that a clinician should never simultaneously act in a therapeutic and expert witness capacity. As this forensic psychiatrist explained in relation to the forensic mental health service he works for:

We try and separate those roles here, so we have one psychiatrist who treats the person who's committed an offence and one psychiatrist who will interview them for the purposes of writing a report for the court. So the two roles are separated (FP #4).

The Royal Australian and New Zealand College of Psychiatrists has also stressed the importance of psychiatrists avoiding being the therapeutic agent for a patient for whom they are simultaneously assessing for medico-legal purposes (The Royal Australian and New Zealand College of Psychiatrists, 1980). International codes of ethics for forensic psychiatrists also state that situations where the forensic psychiatrist is conducting the forensic evaluation while at the same time is treating the defendant, should be avoided (Kalmbach & Lyons, 2006; R. Rogers & Shuman, 2000; Simon & Wettstein, 1997).

The practice of separating the two roles was also seen by the forensic psychiatrists as adding to their ability to maintain a certain level of neutrality. A particularly important part of meeting the legal expectations for an expert witness is achieved through the provision of objective evidence, which is not shaped by the needs of the defendant.

...if you have a therapeutic relationship with the patient your objectivity could be skewed. This particularly happens when you merge the two, if you are treating someone and providing expert evidence. I think that is much more common a problem” (FP #10).

By maintaining a divorce between the role of therapist and forensic evaluator, the forensic psychiatrists argued that they would be less likely to give an expert opinion that may be seen as advocating for the defendant. It also ensures that an opinion is not based on previous therapeutic interactions with the defendant:

...you shouldn't confuse the boundary by having been the therapeutic caregiver prior to that...If I have treated you for whatever I might know, because of that relationship, that you are an alcoholic and you have a rotten mother and three husbands and that may confuse my assessment because I have preformed judgement (FP #7).

This can be difficult in practice to uphold in some jurisdictions, particularly in small countries like New Zealand, where it may be impractical within inpatient forensic psychiatric services to separate the roles (Allnutt & Chaplow, 2000). This means that at times the psychiatrist may be the therapist and the forensic evaluator for the defendant. The following section considers further management of issues related to impartiality of expert witnesses.

Neutrality and truthfulness

The forensic psychiatrists in this study recognised the impossibility of an expert witness being completely impartial. One forensic psychiatrist explained that there will always be bias due to the value basis of psychiatry and the social judgements required for decisions regarding the sanity of a defendant.

...in psychiatry in particular, there are far more value judgements and the weight is more on that. Add to that the situation where you are talking about insanity...in a courtroom setting involving social situations you are really tapping into value areas that judgements are based on (FP #3).

The hybrid nature of the expert witness role accentuates this. As the above discussions have detailed, their role entails completing ‘forensic’ tasks that involve social processes shaped by

legal needs.⁹⁷ The medico-legal literature reviewed in chapter two (pp. 22-41) showed that although forensic psychiatrists may recognise the subjective nature of their psychiatric interpretations, the legal system still relies on positivistic frameworks that seek objective knowledge. In practice this can create problems for the forensic psychiatrists in terms of their ability to meet the legal expectation of 'neutrality', which this section will consider shortly.

The forensic psychiatrists detailed instances where they had experienced the problem of another expert witness being a 'hired gun'⁹⁸ in the courtroom. The following extract shows how it may not only be financial incentives that impact on an expert's opinion. Rather the information they were provided when constructing their reports or testimony was important in shaping their opinion:⁹⁹

I don't think any expert witness is neutral. I think they strive to be neutral and the extent to which they achieve that is proportionate to their professionalism but ultimately I think it is impossible. I say that having tried very hard in every case I have been involved in to be neutral but I am aware all the time of all those biases that come into play. The information you are fed, you know if you are representing one side...but I know that some of my colleagues do tend to be what is called a 'hired gun' and these are people who will give any opinion you want and try and find the best possible argument to support it. Of course there are financial incentives to some of my colleagues having a reputation for being a 'hired gun'. Lawyers know that if they phone up this particular psychiatrist they will get a favourable opinion (FP #4).

The lack of 'professionalism' referred to by this forensic psychiatrist was often perceived to be associated with expert witnesses not specifically trained in forensics. This included general psychiatrists who have no training and little experience in forensic psychiatry. This problem was suggested by some of the forensic psychiatrists to be exasperating due to the fact that training specifically for forensic psychiatry has only recently been introduced in New Zealand.¹⁰⁰

⁹⁷ Chapter nine (pp. 197-211) will consider the consequences of this claim.

⁹⁸ See chapter two (p. 22) for further descriptions of this term.

⁹⁹ This is where the interaction between forensic psychiatrists and the lawyer instructing them becomes important in reducing the appearance of bias, as will be discussed in chapter eight (pp. 197-211). As Jones (1994) has argued the lawyer controls the process of case construction throughout the legal proceedings.

¹⁰⁰ Chapter one briefly described the relatively recent development of forensic psychiatry in New Zealand.

If you are thinking about New Zealand particularly, I guess one of the big issues is the fact that until recently there wasn't training in forensic psychiatry so people who became forensic psychiatrists weren't trained in forensic psychiatry. Most of them did not have the opportunity to do things like expert witness training courses and stuff like that. So there probably are some people who are practising in forensic psychiatry who do not have a grounding and experience in medico-legal process...you trot along to your general psychiatrist training, you might have a bit of an attachment in forensics as a registrar, you get your exams and bang you are a forensic consultant, without really having a lot to do with appearing in court and have had no training in appearing in court...so I think not everyone is as balanced as they could be... (FP #2).

It was suggested that these expert witnesses come to court with a "view" that they are intent on sticking with regardless of any evidence that may indicate the contrary.

I have seen at times, both junior and senior psychiatrists, adopting a particular position they cannot shift from and don't understand when they come to cross [examination] how they come to look biased. When you get too rigidly attached to a position and don't take in new evidence and look at it in a balanced way, so occasionally you do see a lack of objectivity, particularly if new information comes to light or testimony alters (FP #1).

Often this position described by the forensic psychiatrists did not equate to the extremist view of the 'hired gun' developed in Chapter two. Instead it relates to a psychiatrist's inability to step outside of their role as an advocate for their patients. These expert witnesses do not meet the requirement that stipulates their duty is to the Court, not the patient. Ultimately, the forensic psychiatrists interviewed for this study, emphasised the need to be independent from the outcome of the case:

I am amazed when I go into court and here is someone who is trying to fight the case and trying to win the case; it is absurd, it is not what our job is. Even though we are called by the Crown or the defence, our job is to assist the jury to make a better decision than they would otherwise do without the experts (FP #7)

In line with Appelbaum's approach detailed above, this means that an expert witness must be committed to 'truth-telling'. The forensic psychiatrists explained that expert witnesses should take new information into account and alter their testimony in response if they think it is more valid. It was suggested that if they were not prepared to do this they may be seen as less credible as an expert witness.

Referring back to the value basis of psychiatry, 'truth-telling' also includes being honest about the limits of psychiatric knowledge:

Psychiatry has theories that are immensely powerful explanatory theories...but they are not theories with powerful predictive capacity. When I was working at clinic B [de-identified] there were reports that advanced developmental theories and psychodynamic theories as if they were the same scientific reasoning as saying this person has all the symptoms of schizophrenia and he has a strong family of schizophrenia and I can be 99% certain that this disease is what we call 'schizophrenia'. To say that this man hated his mother and was abused by his father and therefore offended against elderly women I think is a different order of reasoning all together. It might be a helpful way of thinking with that person but it is not something to be advanced in court. "You have to think about...whether you could defend your notion against a colleague" (FP #11)

At the same time forensic psychiatrists are faced with a situation in which 'truth' does not always mean providing the 'whole truth'. The differences between how the legal system and forensic psychiatrists denote the meaning of 'truth' can become difficult in this respect. Their obligation to the court includes only providing information that is *relevant* to the proceedings. The forensic psychiatrists explained it is not their role to include any information, even if incriminating that is not related to the charges facing the defendant (FP #10). Allnutt and Chaplow (2000, p. 982) have also suggested:

...care must be taken when adding information that implicates another person in an unreported crime or information that may be damaging to a third person. In doing so, the forensic psychiatrist becomes an agent of the State, potentially establishing grounds for charges against the individual or another party.

As chapter six (pp. 129-147) illustrated, the ability of the forensic psychiatrist to make the appropriate concessions regarding their evidence can be limited in practice. This is because the testimony of an expert witness is largely directed by the lawyers questioning them. The expert witnesses are only required to answer the questions they are asked by the defence or prosecution lawyer.

...it is a really important issue and people actually do not tell the truth and of course you will know there are many forms of truth telling; there is exaggeration, minimisation, and there are white lies and great lies and half truths. What I am saying is that it is quite difficult in that context...[because]...expert witnesses are bound to answer the questions that have been asked, so what I am saying is you

are not sworn to tell the whole truth, you are actually sworn to tell the whole truth about what you are being asked (FP #7).

The forensic psychiatrists also described instances where lawyers would interrupt them mid-sentence while they were giving their testimony. They explained that this often occurred in situations where the forensic psychiatrists were attempting to describe the complexities of a case, while perhaps taking too much time to do so in the eyes of the lawyer. This situation makes it difficult for a forensic psychiatrist to ensure that complex concepts and diagnoses are effectively communicated to the fact-finders. Although they may be able to provide more justifications and qualifications in their written report, the information that is put to the fact-finders is restricted in the courtroom (Champagne, Shuman, & Whitaker, 1991). As Jones (1994) has described, from a lawyers perspective a ‘bad’ expert witness brings up evidence that the lawyer did not want presented in court. When giving testimony in the courtroom therefore, the forensic psychiatrists have to recognise and accept that the construction of ‘truth’ is not in their control (Edmond, 1998a). Wynne (1989) has suggested that the acceptance of this lack of control over their knowledge construction has become a central task for a forensic expert.

The forensic psychiatrists’ management of ‘truth-telling’ also illustrates the ways they ‘perform credibility’ (Hilgartner, 2000).¹⁰¹ The expert witnesses ‘perform credibility’ by allowing for adjustments of their expert opinion in light of new information thereby appearing balanced and neutral. A prosecution lawyer illustrated this in relation to the testimony of an expert witness in a trial he observed:

He was terrific because he really did understand the role and he answered the questions without any perspective at all as to who was calling him. I expect my experts to be robustly independent and to make concessions where concessions are due. It’s very important, and they’re not credible as witnesses unless they do. So that’s without a doubt the most important thing about expert witnesses (PL #2).

¹⁰¹ When preparing their reports the forensic psychiatrists also described how they consider the potential questions they may get asked in court when writing their reports. In this way, the sceptical nature of the adversarial courtroom actively shapes the content of their forensic reports (Timmermans, 2006). Again illustrating how the practices of the forensic psychiatrists are inseparable from the legal requirements for an expert witness. Chapter eight (p. 186) will further highlight such self-deconstructive techniques practised by the forensic psychiatrists.

Practices such as these, when they are offered up front in evidence-in-chief, also render any techniques of legal deconstruction utilised by the lawyers on cross-examination redundant. The lawyers also explained that the impartiality of an expert witness was apparent with forensic psychiatrists who gave the same opinions regardless of whether it meets the needs of the lawyer who instructed them:

They have to be neutral, they're experts. That's the bottom line. In my experience there are shades of grey but in the main the people I've dealt with, that's their role. There have been plenty of times where a psychiatrist has come back and said no, there's no defence of insanity here (PL #13).

Additionally, a forensic psychiatrist who has given expert evidence for both the Crown and the defence in the past was considered by the lawyers to be impartial. The notion of the 'hired gun' or advocate witness was described as most obviously displayed, and exploited by legal professionals, when a forensic psychiatrist had only been employed by one 'side' previously.

Clearly there are some people who are particularly renowned for working for one side or the other. Like they only do defence work or Crown work and there are people out there who have an awareness that they are a 'hired gun'. There is a sense that people do change their opinions depending on who is paying the bill (FP #2).

The research reviewed in chapter two also indicated that attorneys view mental health experts who have worked for both sides as less biased and more balanced in their testimony. They consider them more trustworthy and loyal (Dattilio et al., 2006).

In summary, this section has reinforced the idea that forensic psychiatrists' reports and verbal testimony are shaped by legal expectations to the point that they can be seen to be practising a hybrid expertise. Viewing their expertise as a 'law-psych' hybrid has implications for the impartiality of expert testimony that is far more complex than the 'hired gun' notion discussed in the medico-legal literature. The above findings suggest that any 'bias' may be the product of the constraints produced by the requirements of a defence of insanity that lead to hybrid practices and particular interactions between the forensic psychiatrists and their instructing lawyers within the courtroom. Chapter eight (p. 179) will explore this last point using a specific case to illustrate.

The 'ultimate issue' dilemma

While recognising the unique hybrid nature of their role as expert witnesses, the forensic psychiatrists were also cautious as to their position in the courtroom. Although forensically trained, they explained that they are careful to ensure they do not encroach on the role of the lawyer or the fact-finders. The data presented above illustrated how they carefully ensure their psychiatric roots remain intact, while ensuring legal needs are met. This situation is highlighted further when considering the legal expectation of an expert witness to *assist* the fact-finders in their decision-making.

As chapter five (p. 118) suggested, ideally a boundary should be maintained between matters that are for the forensic psychiatrists to provide expert opinion on, and decisions that are for the fact-finders to decide. The forensic psychiatrists recognised that the law requires them to assist the fact-finders in their decision-making, rather than arguing legal points and determining whether the defendant meets the criteria for 'insanity'.

It is your role to try and help the court understand the interaction or the interface between psychiatry and psychiatric disorders and the effect of psychiatric disorders on people's mental state, behaviour and the law. It is not your role to make ultimate decisions about legal tests (FP #8).

At the same time however, the role is not as simple as when practising in a therapeutic setting:

I think your role is absolutely as a psychiatrist, not as a lawyer. I think that it is a trap for forensic psychiatry...to decide that you are an expert in the finer parts of law...So I am clear that I am there as a psychiatrist, that is my expertise, not the law...having said that, you are there as a psychiatrist with the responsibility of translating psychiatry into terms that can be understood by a judge and/or jury. So you are not there to talk psychiatry as you would talk psychiatry amongst a bunch of psychiatrists. You are there to make your psychiatric expert opinion comprehensible to whoever it is that you are talking to, either the judge or the jury (FP #11).

It also becomes particularly difficult in practice to uphold a boundary between matters for the expert witness and the fact-finders to discuss. The forensic psychiatrists explained that the lawyers will often push expert witnesses into providing ultimate issue opinions because it is in their best interests to do so.

There is an ethical issue around whether you deal with the ultimate issue. We tend not to like to go to the ultimate issue but in insanity if you don't they say: "Dr F, you were asked to write this report, why did you not give your opinion?" So in a sense they actually force you to give your opinion (FP #7).

This is particularly common in cases of insanity, and the Evidence Act (2006) does not make such evidence inadmissible if found to be helpful for the fact-finders. Some of the lawyers acknowledged the hybrid effects of the insanity defence on the expert witness role. They discussed how it is impossible in practice for forensic psychiatrists to give evidence without speaking to the ultimate issue:

In cases of insanity, yes they do [give opinion as to the ultimate issue] and the courts have long allowed experts to do that...The ultimate issue...It's artificial to prevent the psychiatrist addressing the ultimate issue when he can't really give that opinion without addressing the ultimate issue (Lawyer 8).

This mimics Wynne's (1989) contention that critics have always "wrestled with the unacknowledged problem that any factual statement about mental states always embodies interpretation, which inevitably implies evaluation of responsibility. It has proved impossible to make statements about mental conditions which do not imply something about moral responsibility" (Wynne, 1989, p. 50).

Regardless, as discussed earlier, it was still considered important for the forensic psychiatrists to maintain a conceptual boundary between their role as forensic psychiatrists and that which is for the role of lawyers and fact-finders.¹⁰² They acknowledged the medico-legal literature presented in chapter two that was critical of psychiatric expert witnesses stepping outside of their expertise and into the area of law. Further, giving verbal testimony that amounts to opinion as to the insanity of the defendant was discussed in significant detail by the forensic psychiatrists, particularly because of the contention that this involves moral rather psychiatric judgements:

¹⁰² It must be noted that the interviews with forensic psychiatrists took place before the implementation of the Evidence Act (2006). This could mean that any statements made by the forensic psychiatrists reflected a time when the 'ultimate issue rule' was theoretically in place. However, it was still common practice in New Zealand courtrooms prior to the implementation of this Act for forensic psychiatrists to give their opinion on whether or not a defendant meets the criteria for insanity.

I think that psychiatrists are going out on a limb when they purport to be experts in morality and I think whenever we do that we run the risk that we will be challenged in terms of what training we have had in the understandings of morality. I very much doubt that many of my colleagues would be able to say that they have any real training in the understanding of moral issues – this is about philosophy. However, what we do have is genuine expertise in understanding mental illness, understanding the symptoms and I think what we can do is try and describe for the finder of fact the likely state of mind of the person and how that might impact on their ability to morally reason (FP #5).

Because judgement around morality becomes central, this was also seen to disrupt the forensic psychiatrists' ability to give opinion that is scientifically grounded. The expert witnesses are employed by the court to give 'scientific' opinion, emphasised by the requirement of this opinion to be 'objective' and 'neutral'. In other words, the law requires a clear separation between facts and values, with science providing the former and the law taking responsibility for the latter. In short, giving opinion as to the ultimate issue relates to legal and/or lay knowledge rather than scientific expertise. The attempts by forensic psychiatrists to maintain "professional boundaries" resemble an act of boundary-work. The forensic psychiatrists, by resisting giving direct opinion on the ultimate issue, attempt to maintain their jurisdictional control over psychiatric (scientific) knowledge.

In the courtroom, semantic methods may be used to maintain a conceptual boundary between the role of the expert witness and the fact-finders. For example, rather than asking the forensic psychiatrist to give definitive answers as to the sanity of a defendant, a prosecution lawyer explained that they focus on elucidating their opinion as to all the criteria that comprise the defence:

Well, I think that that is a legal principle that particularly in the area of forensic psychiatry is observed more in the breach because expert witnesses are asked in psychiatric cases whether somebody has a natural imbecility, whether they have a disease of the mind, whether they understood the nature and quality of the act, or whether they knew the act or the issue was morally wrong having regarded the common use of the standards of right and wrong. Right? So we do actually directly address those issues in forensic psychiatry and Section 23. So when it comes to asking experts [about] whether the questions on the ultimate issue, I suppose no defence counsel or prosecutor would sum up a series of questions based on those essential elements of Section 23 and therefore say "On the basis of that doctor, tell me was this person insane or not." You wouldn't do that but you would do everything short of that and I don't think that...I certainly haven't encountered it where counsel has objected and the court has upheld the objection

when we get into the ultimate issue, because how can an expert give a jury assistance on disease of the mind for example, without saying really whether or not a particular series of symptoms or presentations amounted to a disease of the mind (PL #2).

This extract reinforces the importance of the instructing lawyers in assisting with the maintenance of the boundary between the role of the expert witness and the fact-finders. In this way, the management of the boundary between the responsibilities of the expert witness and the fact-finders is also part of the lawyer's role. A defence lawyer described how the expert witness should be briefed by their instructing lawyers as to how far they can go in their testimony:

...if a lawyer is briefing an expert, then if the expert has never given evidence before and you do come across that sometimes, if they have never given evidence before in a tribunal setting, you need to make sure that they understand the evidential process. That they can go to that point but they can't then say "Therefore this is why I believe the person is guilty, or therefore this proves that he did such and such." Because that ultimate decision...is for the fact-finder to then decide. I've never had a problem, I can't recall cases where I've ever had a problem with experts knowing where to stop or how far they can go, but I think it does have a lot to do with making sure as counsel calling a witness, that you've properly briefed them so that they know what the rules are (DL #6).

Chapter eight will detail how the credibility of an expert witness is the result of both the practices of lawyers and forensic psychiatrists in the courtroom.

This section has illustrated the ways in which the forensic psychiatrists interviewed manage the boundary between 'assisting' and 'deciding' the ultimate issue of the case. It has indicated that in practice this border becomes less meaningful, further highlighting the effect of the hybridised nature of the insanity defence on the role that forensic psychiatrists undertake. The messy reality of what occurs in practice means the forensic psychiatrists testify as to the effect of mental afflictions on a defendant's ability to know the moral wrongfulness of the act they committed. Rather than "potentially", the legal demands for an expert witness in this context always blur "the lines of responsibility and boundaries between the forensic psychiatrist and the legal system" (Allnutt and Chaplow, 2000, p.986). A defence lawyer described such blurriness:

...experts have to tread carefully and I don't blame them if they step slightly over the mark because the mark isn't all that well defined (PL #7).

Viewing the role as comprised of hybridised expertise provides one way of capturing the blurring of boundaries and messiness that occurs in practice.

Section two: Summary

Section two has illustrated how in meeting the legal expectations for the role of an expert witness, the forensic psychiatrists must manage various ethical dilemmas. It showed how they must accommodate the legal needs of the expert witness role and balance them with the ethical obligations of their profession. In particular, it was highlighted that on the one hand the forensic psychiatrist's duty is to the court and this shifts their focus from advocating for the patient and involves the abandonment of traditional medical ethical principles. On the other hand, they explained that they can only undertake the expert witness role by virtue of their qualifications and training that they acquired at medical school. In addition, when acting as an expert witness, they must also utilise their clinical expertise to gather the necessary information to assist the court. To master the expert witness role therefore, a forensic psychiatrist must recognise that in practice the ethical boundaries between legal and medical realms are not clear. Rather, they have to accept and manage a version of ethics that combines a little of both worlds. Overall these findings suggest that the forensic psychiatrists embrace a different set of the ethical principles that acknowledge the hybrid nature of the role they perform as expert witnesses.

THE 'ART' OF FORENSIC PSYCHIATRY = MANAGING A HYBRID EXPERTISE

The practice of providing psychiatric reports and testimony for the court involves making ordinary diagnoses based on a somewhat differently focused inquiry that is shaped in a way that acknowledges the court's needs. When considering the sanity of a defendant, the evidence a forensic psychiatrist provides combines their psychiatric expertise with lay understandings imposed by the legal test for insanity and the legal expectations for an expert witness.

This chapter has illustrated how forensic psychiatrists' practices can be described as something different to what a psychiatrist undertakes in their usual clinical settings. Like the forensic pathologists in Timmerman's study (2006, p. 90), the expertise forensic psychiatrists

provide is “mediated by their twin roots in the area of medicine and criminal justice”. In other words, the hybrid nature of the insanity defence and the legal expectations of the expert witness shape the forensic psychiatrist’s practices to the extent that it becomes a very different role than what they undertake as a clinician. As Smith and Wynne (1989) have noted, the legal shaping of some forensic expertise does not only occur within the courtroom but also at an institutional level, where specific expert knowledge has emerged and continue to be shaped through their interaction with the legal setting. Institutionalised law-science hybrids emerge from such interactions (Edmond & Mercer, 1998).

The forensic psychiatrists therefore, are not merely ‘doing’ psychiatry as they may do in their clinical setting, when they write forensic reports or give verbal testimony in the courtroom. Rather, as Smith (1988, 1989) has argued in relation to the work of forensic pathologists, it is the demands of the legal setting that characterise what forensic psychiatrists ‘do’ when they act as expert witnesses. This involves forensic psychiatrists combining their medical knowledge with expertise that satisfies the requirements of the legal setting. This was a characteristic that they perceive sets them apart as a distinct occupational group (R. Smith, 1989).¹⁰³

Similar to the forensic psychiatrists’ discussions of the translation process, Smith (1989) has discussed how forensic pathologists must have good communication skills which include above all, an ability to describe scientific terms simply. He suggested that this shows how forensic pathologists are willing to accept that it is lay, rather than scientific, considerations that structure particular legally sanctioned outcomes. The data in this study suggest that the forensic psychiatrists also accept this is “...the essence of the forensic task” (FP #1).

Miller (2001) used the metaphor of hybridisation to describe the process of combining political and scientific knowledge in a way that meets the requirements of all parties involved. This process, he argued, involves the careful management of the integration of

¹⁰³ This idea of combining psychiatric knowledge with expertise around legal precedent becomes explicit when considering courtroom deliberations. The way in which the legal players in the courtroom have control over accepted and valid knowledge and the way this shapes forensic psychiatrists’ practices is overtly displayed to the extent that the boundaries between what can be considered legal and medical knowledge become blurred. This will be illustrated in further detail in chapter eight (p. 173).

different epistemological commitments and normative assumptions. He noted boundary-work is an important aspect to managing hybrids. The above discussion has explored how the forensic psychiatrists interviewed attempt to balance the legal requirements for an expert witness with the expectations of their clinically based profession. The ethical situation the forensic psychiatrists describe can be interpreted using the concept of ‘hybrid’. The legal requirements for the expert witness, whereby their foremost duty is to the *court*, blurs the boundaries between expertise traditionally seen as belonging to law and psychiatry. Returning to the lawyer’s comment used in the introduction of this chapter, the forensic psychiatrists are not really “doing normal psychiatry” when they are appearing as expert witnesses.

The findings indicate that the legal constraints provide the parameters within which the expert witnesses have to work. The legal constraints also stipulate the ways the forensic psychiatrists should apply their psychiatric knowledge. This was illustrated in the ways they shape their ethical principles around the constraints imposed on them by the law. Edmond (2004, p. 3) has described a similar process when discussing how forensic experts in other fields “balance a range of expectations and obligations which may be in tension” in order to effectively maintain their duty to the court. Forensic psychiatry textbooks also state that reports and verbal testimony should demonstrate ‘objectivity’, ‘detachment’, ‘humanity’ and ‘professionalism’ (Bluglass, 1995). A core challenge in undertaking the expert witness role is managing these somewhat conflicting obligations in order to meet their duty to the court.

Overall, the constraints imposed upon forensic psychiatrists when they practise as an expert witness can be understood as leading to the development of a hybridised expertise, whereby the ‘psychiatric’ and ‘legal’ component of their role cannot be easily demarcated (Mercer, 2002b). The ways in which some of the forensic psychiatrists manage the difficulties when the different boundaries become blurred—both pragmatically and conceptually— serves to further illustrate how the trope of ‘hybrid’ usefully captures how the expert witness role translates in practice.

CONCLUSION

In chapter five it was illustrated that an ‘ideal’ expert witness must acknowledge the legal boundaries within which they work. These boundaries are determined by legal texts and

procedures and aim to confine the limits of the expert role. Chapter six explored how these boundaries can become blurred when decision-making about insanity becomes murky. This chapter has extended the theme of blurring boundaries in its focus on the ways in which the practices of the forensic psychiatrists are inseparable from the legal requirements that shape them. The chapter achieved this by demonstrating how the role forensic psychiatrists undertake as expert witnesses is very different from that which they carry out in the therapeutic setting. The chapter highlighted the usefulness of interpreting the forensic psychiatrists' practices as comprised of hybridised expertise that reflects the hybrid nature of the insanity defence itself and the legal expectations of an expert witness.

CHAPTER EIGHT: ‘LAW-PSYCH’ SYMBIOSIS IN THE CASE OF ‘X’

Chapter eight uses the specific court trial of *R v ‘X’*¹⁰⁴ to explore the interactions between forensic psychiatrists and lawyers as they build a persuasive narrative ‘for’ or ‘against’ a verdict of insanity. It will bring together the findings of the last three chapters through its referral to the recurrent theme of blurring boundaries, while also extending this interpretation to include the practices of lawyers. The lawyers’ acts of boundary-work portrayed in the Case of ‘X’ will be closely examined. This will involve providing examples of the strategic techniques employed by the lawyers, together with the expert witnesses they instructed, to show the alignment (or misalignment) of a particular forensic psychiatrist’s testimony with the legal expectations¹⁰⁵ for an expert witness. In doing this, the chapter will seek to illustrate two points. Firstly, it will suggest the forensic psychiatrist’s ability to display the expected qualities of an ‘ideal’ expert witness is in part dependent on their relationship with the lawyer instructing them. Secondly, this chapter will serve to reinforce the blurring of boundaries that can occur within the context of insanity trials between the responsibilities of not only the expert witnesses and the fact-finders, but also the lawyers.

The chapter begins by briefly contextualising the case of ‘X’. This will be followed by an analysis of the prosecution’s case construction, where the strategic use of the concept of ‘malingering’ is used to explore the boundary-work practices of the prosecution and their expert witnesses. Extracts from the case are used to exemplify the prepared dialogue the prosecution used to build the credibility of their expert witnesses. The defence’s inability to build a persuasive narrative will follow. In this section it will be shown how the defence displayed a lack of knowledge around the limits of psychiatry and misunderstood the psychiatric diagnostic processes. Coupled with unpreparedness and lack of interaction between the defence and their expert witnesses, it will be demonstrated that this led to a less persuasive narrative in favour of legal insanity. The chapter concludes with a discussion of how these kinds of interactions resemble Edmond’s (2008) contention that a symbiotic relationship occurs between forensic experts and lawyers in the courtroom. This inevitably

¹⁰⁴ The title of this case has been renamed to protect the anonymity of the participants in this study.

¹⁰⁵ By legal expectations I am referring to the ideal interpretations of the insanity defence and role of the expert witness described in chapter five and explored in further detail in chapter seven.

implicates the lawyers, as well as the forensic psychiatrists, as enablers or hinderers of proficient expert testimony.

THE CONTEXT

This section will briefly detail the charges laid against Mr X and the characteristics that made the case extremely complex. The case of 'X' was high profile due to the nature of the crimes and the curiosity the public had about Mr X. The circumstances involved Mr X travelling from one location to another over a 12 hour period leaving, as one journalist commented, a trail of "death and destruction" in his wake (Gay, 23rd June 2008). Mr X's actions resulted in eight charges:

- Two counts of wounding and intent to cause grievous bodily harm
- One count of murder
- Two counts of discharging a firearm with intent to cause grievous bodily harm
- One count of using a firearm against police
- One count of kidnapping
- One count of aggravated burglary

The defence of insanity was put forth and rejected in the initial trial of Mr X. However, due to issues related to the presiding judge's summation in this trial, a retrial took place in 2008. In the retrial, on which this chapter is focused, the defence put forth several defences, one of which was insanity.¹⁰⁶

There were several factors that made this case particularly complex. Firstly, because of the horrific and unusual nature of the offending, this case received extensive media coverage. Mr X was also very interesting to the public who were grappling for answers as to how he, or any

¹⁰⁶ Other defences were also put forth, these included: Lack of intent, self defence, and provocation. While these defences may only have been relevant to some of the charges, insanity was to be considered by the fact-finders for all eight charges.

human being, could have committed such offences. Secondly, the defendant had been diagnosed with several mental disorders by different psychiatrists since the time of his arrest and throughout his period of incarceration (five years approximately). The psychiatrists and forensic psychiatrists,¹⁰⁷ called as expert witnesses, all agreed Mr X suffered from a serious personality disorder and they did not consider this disorder to be a disease of the mind. What was in contention, however, was whether he suffered from a serious mental disorder on top of this severe personality disorder, which could then be considered a disease of the mind. As a consequence, the retrial involved complex and conflicting psychiatric testimony. Thirdly, there were notions that Mr X was manipulating legal processes in his favour so as to receive a medical, rather than legal, disposition. ‘Malingering’ was a term brought up and strategically put forth by the prosecution. This added another layer of complexity to the case. Lastly, Mr X was a user of methamphetamine and this created murkiness akin to that detailed in chapter six in terms of decision-making around whether he suffered from a disease of the mind caused by an internal factor.

As summarised in Thom (2009), the prosecution’s case construction hinged on the theory that the accused was *in control* of his actions the day he allegedly committed the offences. Regardless of his use of methamphetamine, he still knew what he was doing and therefore had the capacity to know the moral wrongfulness of his actions. The prosecution accepted that Mr X had a severely disordered personality with anti-social features that may have been exacerbated by his use of methamphetamine. However, the personality disorder was not considered by the prosecution to be a mental disorder. They also did not accept that this affected Mr X’s ability to know the moral wrongfulness of the acts he committed.

In contrast, the defence argued that the accused suffered from the serious mental illness called ‘schizo-affective disorder’ in addition to a personality disorder (Thom, 2009).¹⁰⁸ The defence argued that this mental disorder should be accepted as a disease of the mind. Mr X’s use of methamphetamine was also argued to have seriously affected his ability to form an

¹⁰⁷ There were five psychiatric expert witnesses in total called, one of which was a psychiatrist while the remaining four were trained in forensic psychiatry.

¹⁰⁸ The DSM-IV’s diagnostic criteria for schizo-affective disorder requires a person to have experienced “an uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet the Criterion A for Schizophrenia” (American Psychiatric Association, 1994, p. 323). This means that the disorder describes circumstances where a person simultaneously experiences the presence of hallucinations or delusions and mood symptoms.

intention to commit the offences and realise the moral wrongfulness of the situations he faced. The defence attributed Mr X's lack of personal responsibility to the fact that he was *not in control* of his actions. His inability to control his actions was said to be driven by delusions, severe paranoia and suspicion. His childhood, which was established to have involved extreme physical and sexual abuse, coupled with intense religious coaching, "never gave him a chance"—the jury was asked the day of the defence's closing to give him that chance.

The following sections focus on how the lawyers interacted with their expert witnesses to construct their theories in a persuasive manner. Although in a case where the defence of insanity is contested the defence initially puts forth their case followed by rebuttal from the prosecution, this analysis begins with the prosecution's case construction. It does this in order to then be able to contrast the defence's case construction with the prosecutions. This structure will seek to accentuate the importance of these two professionals working together to construct a case of insanity.

THE PROSECUTION'S CASE CONSTRUCTION

There were several factors that had the potential to work against the prosecution's attempt at building a plausible theory using psychiatric expert opinion. Mr X did not allow the prosecution's psychiatric expert witnesses to interview him or any of his family or friends. This was a choice he was legally permitted to make. Also, the defence did not allow the prosecution open access to some of the official documentation relating to Mr X's ongoing mental health status and treatment during his incarceration. Interviewing the defendant, his family and friends, and accessing important background material are all 'best practice' components of a forensic psychiatrist's expert opinion (cf. chapters five, p. 112 and seven, p. 149).

Interestingly these issues did not completely disrupt the prosecution's ability to build a persuasive case against a verdict of NGRI. Rather, the prosecution, together with their expert witnesses, used evidence gathered from the crime scenes and by lay and other expert witnesses in the courtroom to strategically construct a case against a finding of insanity. The following section shows how the prosecution succeeded, in part, due to the way in which they worked with their forensic psychiatrists to build a carefully crafted narrative. This will

illustrate the ways in which these two professionals rely on one another to not only create a convincing narrative, but also effective and credible expert witness testimony.

The strategic use of the concept of ‘malingering’

One of the ways in which the prosecution built up their case persuasively was with the strategic use of the concept of malingering. The prosecution relied substantially on the concept of malingering to create an image of Mr X, and any statements he made, as unreliable, untrustworthy and shaped in a way as to project himself as ‘mad’. Mr X feigned his symptoms, the prosecution argued, in order to receive a disposition in a forensic mental health unit which he considered more lenient and comfortable than a jail cell.

The prosecution’s construction of Mr X as a malingerer began when their first forensic psychiatrist took the stand. Their expert witness was questioned as to the ‘comfortableness’ of a secure mental health unit as opposed to a correctional facility.

Prosecutor: Just as far as the clinic A [de-identified] is concerned and while we’re on that topic, in terms of the nature of the facilities at the clinic A and in terms of respective comfort of those facilities versus say prison, how would they compare?

Expert: One is a hospital and one is a prison.

Prosecutor: And it's probably self-evident but are you saying a hospital’s more comfortable than prison?

Expert: Yes.

This dialogue aimed to suggest to the fact-finders that the end result of being found NGRI would ensure a more comfortable disposition than a conviction would. There were several other characteristics of the case used to conjure up this image of Mr X as a malinger. These related to Mr X’s childhood upbringing and the ways in which the defence limited access to Mr X and his medical documentation.

Mr X's childhood upbringing

Mr X had been exposed during his childhood to several people who had been mentally unwell. It was established by the court that his mother ran a 'half-way' house for outpatients from a local psychiatric institution. The prosecution, together with their expert witnesses, suggested that this exposure to the outpatients enabled Mr X to develop an ability to feign the symptoms of mental disorders:

Prosecutor: In the context of this case, do you attribute or attach any significance to Mr X's exposure in his earlier years to those people suffering mental disorders?

Dr A: The most significant issue there I think, is that in a case where there has been the suggestion of malingered symptoms, that is the jury will remember feigned symptoms for the purposes of secondary gain, one of the things that is very important for the person feigning the symptoms is to have either had access to people who are in fact suffering those symptoms, allowing the opportunity to observe them and or the opportunity to talk to others about how symptoms might appear to others.

The features that characterised Mr X's childhood were important for the prosecution's construction of a persuasive narrative that relied on the concept of malingering.

Access to Mr X's medical notes

The prosecution also emphasised the ways in which their psychiatric expert witnesses were denied access to the defendant for a forensic assessment. In doing this, they highlighted the unusualness of this in cases of insanity:

Prosecutor: In those cases which are contested cases like this one, is it usual that both the prosecution and the defence have equal access to the accused in terms of the ability to examine and question and essentially test the account given by an accused person?

Expert: That is my experience of all of the insanities that I have done. Either agreed or contested.

Prosecutor: Well this one isn't. Is this the only one that you've undertaken where it hasn't happened?

Expert: Yes.

Prosecutor: Having said that you're obviously aware that it's a right of an accused to decline to be examined if that is an accused's wish, you'd accept that?

Expert: Absolutely.

Prosecutor: But despite that this is the first time that it's happened to you?

Expert: Yes.

In this extract, the prosecutor implied that there may have been underlying factors motivating the lack of access the prosecution's expert witnesses had to the defendant. He did this without overly stating that this was a wrong action for the defendant to do because, as stated above, it was well within Mr X's legal rights to refuse to be examined. These factors were suggested to have been purposive actions by the defendant to limit the prosecution's expert witnesses from being able to critically assess the defendant in person where they may have developed the impression that the defendant's statements were not reliable.

This was only accentuated when the prosecution further explained how the defence also limited access to medical notes on Mr X's treatments while he was incarcerated. Using the expert witnesses to confirm the point, the prosecution explained to the fact-finders that in the first trial access to notes received, relating to the medical treatments of Mr X, were not provided until the court proceedings had begun. It was suggested that this lack of access had been repeated in the retrial when the notes were provided to the prosecution and their expert witnesses well into the proceedings. The following excerpt details how the prosecution's expert witnesses only had access to a selection of Mr X's medical notes three days prior to giving evidence:

Prosecution: Are you aware then that since Mr X's appeal, the Prosecution as a result of a request from you has sought to obtain the medical notes which cover the period from the conclusion of the last trial up to the beginning of this trial? So it's the next period on from the last set of notes?

Expert: Yes.

Prosecution: And are you aware that those were not provided to you until Wednesday of this week, the Prosecution having received them only just before on the previous evening of the day before?

Expert: Yes.

Prosecution: And is it apparent to you that those notes, even those notes are not complete and contain only the papers which were copied by Dr B from the original file?

Expert: Whilst I haven't seen the original file, I would be surprised if they were all of the notes.

Prosecution: Is that apparent from the notes themselves...that it would appear that there are other papers which you don't have but which there is reference to?

Expert: Well again my assumption of that is based on the fact that they cover quite a long period of time and they are relatively few notes. And there are reasonably large periods of time during which there are no notes made.

Again this dialogue served the purpose of implying that withholding of medical notes was part of a wider plot by Mr X to reduce the ability of the prosecution experts to build an adequate and credible forensic assessment.

Malingering as a catalyst

The construction of Mr X as a malingerer helped the prosecution insinuate to the fact-finders that there were wider issues at stake. Implicitly the prosecution tapped into existing concerns some of the public have towards the insanity defence and insanity acquittees. It could be suggested that this allowed the fact-finders to place the case within 'commonsense' frameworks (Perlin, 1990a, 2000), which provided an avenue for them to make sense of Mr X's actions.¹⁰⁹ More explicitly, the use of the concept of malingering gave the prosecution the opportunity to deconstruct the usefulness and reliability of psychiatric expertise in this case. This strategy was an act of boundary-work that highlighted the need for the fact-finders to pay more attention to other evidence available to them. The following sections elaborate on these two points further.

¹⁰⁹ As will be shown shortly, this can be contrasted by the defence's reliance on lengthy and complex psychiatric testimony which may have been difficult for the fact-finders to comprehend in its entirety.

Public concerns over insanity and Mr X

The use of the concept of malingering by the prosecution correlated with the views that had been expressed in the media and by some of the New Zealand public. For example, in the initial trial Mr X's behaviour in court was broadcast on television, and photos were published in New Zealand newspapers. The images depicted Mr X's strange hair-cut and wide-staring eyes which appeared to capture the feigned nature of the defendant's gestures. Soon after the completion of this trial, individuals reconstructed these images depicting Mr X in a way that implied his attempts at feigning madness were laudable.¹¹⁰

The use of the concept of malingering also correlated with concerns that have been expressed by societies all around the world. Research has suggested that the public commonly view the defence as being used too frequently by defendants seeking an acquittal and quick release into the community (Wheatmann & Shaffer, 2001). These concerns are further implicated by wider conceptions of mentally unwell people as intrinsically violent, unpredictable and, since deinstitutionalisation, not adequately supervised by mental health professionals. Simpson et al., (2003) have argued that media coverage of high profile homicides involving mentally abnormal offenders fuel these perceptions by creating an impression that the public is in danger from violent mentally ill people living freely in the community (Simpson, McKenna, Moskowitz, Skipworth, & Barry-Walsh, 2003). It has been argued that such misconceptions result in public concern over the insanity defence being used as a 'loop-hole' in which criminals escape punishment for illegal acts (Silver, Cirincione, & Steadman, 1994). The prosecution's strategy tapped into these popular notions of insanity defences being used by the defendants as a method to 'escape punishment' (Perlin, 1990b).

The reliability of expert evidence

The concept of malingering was used by the prosecution not only to conjure up images of Mr X as untrustworthy, but was also used to deconstruct the reliability of any psychiatric assessments of him. The key question the prosecution put forth to the fact-finders was: if the defendant was inherently a liar, then how could psychiatrists rely on his statements in the

¹¹⁰ Due to my commitment to ensure the anonymity of participants in this study, I cannot provide examples of these images.

construction of their forensic assessment of his mental state at the time the offences were committed? After all, a large majority of a psychiatric assessments for forensic purposes relies on what the defendant has to say about circumstances leading up to the offence. The prosecution developed this idea with their expert early on in their rebuttal,

Prosecutor: I know this is a topic that's been discussed a good deal and I hope I can move through it reasonably quickly Dr A, but there's been a lot of evidence about this topic of malingering or feigning symptoms. In terms of this feigning of symptoms, what effect does that have on the ability of clinicians no matter what their role is, to be able to diagnose what it is that Mr X has?

Expert: An important part of diagnosis is being able to describe a very clear pattern of signs and symptoms. In the case of mental illness many of those signs and symptoms one either observes of a person or asks of a person in terms of their account. Implicit in that process is the ability to be able to rely on, that what the person is saying or doing, is actually a function of their mental functioning or malfunctioning as opposed to put-on or feigned. I'm sure the Court can understand that if it is not possible to know what one can and can't rely on in terms of the signs and symptoms which one sees and hears about, it's very difficult to make an accurate diagnosis of any sort.

The prosecutor continued to discuss with this expert witness how the observations that other clinicians treating Mr X made could be interpreted as examples of him feigning symptoms in an attempt to manipulate legal processes. This included various descriptions of symptoms that according to the forensic psychiatrists called on behalf of the prosecution, were highly unlikely to have occurred, such as Mr X's visions of dancing goblins and gremlins, vampire bats with red mouths, and God represented in a triangular shape. It is important to note that the defence's psychiatric expert witnesses also confirmed that these symptoms may not have been experienced. Whether this potential untruthfulness amounted to malingering, however, was questioned by the defence's expert witnesses.

By addressing the reliability of expert opinion based on psychiatric assessments of Mr X, the prosecution legitimised other non-psychiatric evidence. The prosecution's case construction relied heavily on the proposition that information collected at the time the offences were committed was more reliable than any psychiatric assessment. Of particular importance to the prosecution were the audio and video recordings and lay witness observations of Mr X on the night he allegedly committed the offences. For example, Mr X rang the police several times during the 12-hour period the offences took place. He also talked to negotiators for hours

while allegedly taking a person hostage. Lay witnesses corroborated the issues Mr X spoke about to police, and his behaviour was also captured by various retail outlets' recorded footage (such as petrol stations). The prosecution emphasised the importance of this evidence over any information collected after the offence by the defence's expert witnesses (of significance here were the psychiatric reports).

The prosecution's strategy aligned with the ideal aspects of an insanity case explained in chapter five, whereby it is best practice for the forensic psychiatrists to corroborate their assessment of the defendant with other sources of information. In emphasising 'other' sources of information as important in this case, the prosecution attempted to highlight how the defence's psychiatric expert witnesses failed to adequately corroborate data. This can be seen as a technique of boundary-work. The prosecution contrasted ideal practices with the short-comings of the expert testimony for the defence in an attempt to relegate this testimony as less reliable and credible (Edmond, 1998b).

At the same time the prosecution drew on official psychiatric documentation to construct the image of Mr X as a malingerer. Several psychiatric reports that were written while Mr X was in the care of a forensic mental health service and when forensic psychiatrists visited him while he was incarcerated, referred to the possibility that he was feigning his symptoms. In this way the prosecution carefully downplayed the need for psychiatric expertise in deciding Mr X's sanity without completely discrediting this expertise when it came to supporting the prosecution's claims of Mr X's feigning of symptoms. This illustrates the flexibility in the prosecution's use of boundary-work practices (Edmond, 1998a).

The prosecution went as far as to facilitate discussions with the prosecution expert witnesses as to how the fact-finders may address the legal issues they must decide on.¹¹¹ This included questioning the expert on the particular areas of evidence the fact-finders may want to pay attention to in making their decisions. In doing this, the prosecution downplayed the need for the fact-finders to consider reports and testimony by forensic psychiatrists, while highlighting the need to consider certain evidence gathered at the time the offences were committed:

¹¹¹ The blurring of boundaries that ideally separate the responsibilities of the fact-finders and expert witnesses was discussed in chapter seven. This section shows the blurring that can occur between the role of the expert witness and the lawyers in this context. How this emphasises the symbiotic relationship that occurs between lawyers and forensic psychiatrists is further detailed in the conclusion to this chapter.

Prosecutor: So we've got the evidence of what happened at location 1, what happened over the night through to and including what happened in location 2 and going through to the various comments that the accused made to the police after his arrest. Would you agree that that's one body of evidence?

Expert: Yes.

Prosecution: And then there's another body of evidence that we've heard which is largely drawn from things which the accused said about these events after he had been charged, including and after his time in the Clinic A?

Expert: Yes.

Prosecution: Standing back and looking at those two bodies of evidence, what in your view is going to be the most likely indicator of the accused's real state of mind at the time of these acts?

Expert: Given the difficulties in the reliability of the information that I think the defendant has given the people that he has talked to, that is as you say particularly the experts, the inconsistencies, the apparent inaccuracies, I think that that body of evidence that was gathered at the time within minutes if not hours of the offending must be given significant weight – ultimately, obviously, that's an issue for the jury, but that is my view.

As already noted, by drawing attention to the reliability of 'other' evidence over psychiatric evidence the prosecution reinforced their strategy of focussing on malingering as described above. The extract demonstrates the forensic psychiatrist's interpretation of Mr X's statements as unreliable, thereby emphasising the ways in which 'other' evidence is independent and more reliable. In this way, video footage of Mr X and statements he made to the police were put forth as objective and free from Mr X's manipulation.

The tactical use of dialogue

Accompanying their strategic use of malingering, the prosecution and their expert witnesses constructed a narrative that was clearly articulated and which effectively incorporated lay understandings. This kind of narrative ensured the fact-finders understood the legal aspects crucial to the prosecution's case. For example, the prosecution carefully defined the legal constructs that constitute the insanity defence and clarified which parts of this test were relevant to the case of 'X'. This line of questioning did not necessarily involve the expert

witnesses giving their opinion about the ultimate issues, rather it required them to confirm the prosecutor's statements.¹¹² The following dialogue illustrates this:

Prosecutor: What has been circulated Dr A is an extract taken from section 23 of the Crimes Act and that is a section which deals with insanity. His Honour in his summing up will direct the jury on what the law to be applied is, and what these various terms mean when applied to the facts of this case, but I just ask you please to help us with a couple of notions in relation to section 23. We won't worry about the (1) which is in brackets, subsection (1), I will deal with that in a minute, but it's really subsection (2) which we are concerned with in this case, would you agree?

Expert: Yes I would.

Prosecution: What [this] section provides is that "No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable, (a) of understanding the nature and quality of the act or omission, or (b) of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong." Now, am I correct then that, getting back to my original question, that the enquiry under subsection (2) involves two steps. First, determining whether the accused at the time of the commission of the offences was labouring under a natural imbecility or a disease of the mind, that is step one, is that right?

Expert: Yes.

Prosecution: And step two, of either – or to such an extent that they were incapable of either understanding the nature and quality of the act or know the act or omission was morally wrong having regard to the commonly accepted standards of right and wrong, is that right?

Expert: Yes.

Prosecution: I just want to see if we can refine that further in this case. I think we have already heard from Dr B and Dr C, if not both certainly one, that in their view, as far as natural imbecility is concerned, it doesn't apply in this case. Would you agree with that?

¹¹² This can be seen as another act of boundary-work by the prosecution lawyer. In doing this, the prosecution was careful not to step into areas which were for the presiding judge to direct the fact-finders on.

Expert: Yes.

Prosecution: So as far as you are concerned and at least as far as I understand the defence experts are concerned step one is just an enquiry into whether or not, at the time of the commission of these offences, the accused was labouring under a disease of the mind?

Expert: Yes.

This dialogue continued with the prosecution narrowing the legal issues to be considered by the fact-finders to two points: (1) whether, on the balance of probabilities, the defendant had a disease of the mind at the time the events took place and (2) whether this disease of the mind affected his ability to know the moral wrongfulness of his actions. The prosecution provided the fact-finders with a clear outline of the issues they should focus on in their deliberation, while simultaneously building the prosecution's narrative that the defendant was not insane.

In chapter five (p. 118) it was shown that insanity, and the legal constructs that comprise it, have been construed as a lay rather than medical terms. The dialogue created by the prosecution and their expert witnesses exemplified how important this point is within the courtroom context. This can be contrasted to the defence's practices that did not allow for clear dialogue and heavily used medical language, this will be explored further below.

Pre-empting deconstruction

Further accompanying their strategic use of malingering and carefully managed dialogue, the prosecution and their expert witnesses pre-empted possible deconstructive tactics. For example, the prosecution anticipated the defence would attempt to show-up biased aspects of their expert witnesses' testimony. Given that this was a retrial, the prosecution could pre-empt issues that had been raised in the cross-examination of their expert witnesses in the original trial. In particular the prosecution sought to dismantle the defence's accusation that two of their forensic psychiatrists were biased because of their close affiliation with one another as members of the same private organisation that provides access to forensic services. Even if the fact-finders thought this accusation had no factual basis, the prosecution addressed this proposition by replacing one of these forensic psychiatrists with another who

was independent of the private organisation. As this extract shows, they made certain the fact-finders understood this:

Prosecutor: At the last trial, were you and Dr D [de-identified] cross examined by the defence on the basis that you were both members of an organisation or an association called organisation ABC [de-identified], is that organisation ABC?

Expert: Organisation ABC, yes we were.

Prosecutor: And was organisation ABC a collegial group of forensic psychiatrists who I think shared a website and provided a service or a forensic service in psychiatry?

Expert: As individuals, yes.

Prosecutor: And is it correct that both in cross examination and also in final submissions to the jury, counsel for Mr X questioned your objectivity and the objectivity of Dr D because of your joint association with organisation ABC?

Expert: That is certainly my memory of cross examination and I understand that that was the case in closing submissions, although I did not witness them myself.

Prosecutor: And in fact I think the accused in his evidence made a reference, may have been quite a brief one, to that issue. You were present, is that right?

Expert: I was and yes I understand there was a brief reference.

By bringing up this in evidence-in-chief the prosecutor addressed the potentially detrimental cross-examination by the defence. Again the prosecution and their expert witness can be understood to be practising an act of boundary-work. By pre-empting the possible limitations of their testimony, the expert witness appeared to the court as informed and impartial. As chapter seven suggested, this lives up to the popular conceptions of science and thereby seemingly a credible expert witness (Edmond, 1998b).¹¹³

¹¹³ At the same time the extract above shows how the prosecution reinforced the unusual response from defendant when they did replace one of the expert witnesses with another. The defence had communicated to the prosecution that Mr X would allow one of their expert witnesses to assess him if he/she was not one of the forensic psychiatrists called in the previous trial. So the prosecution replaced Dr D with another forensic

THE DEFENCE'S CASE CONSTRUCTION

This section will contrast the prosecution's and defence's approach to case construction. In doing this the importance of the interaction between lawyers and their expert witnesses will be illustrated.

As suggested, the defence's evidence-in-chief did not include the traditional 'question and answer' format and this created major limitations for their case construction. Rather than this traditional format, each of the three expert witnesses called for the defence were given permission by the court to read from their report. This meant that the court sat through several days of expert witness testimony that included the reading of their lengthy psychiatric reports. From my observations of the trial, the ramifications of this strategy for the defence were apparent, with some jury members falling asleep while a psychiatrist read two very long reports over two days. The prosecution's use of clear dialogue using the question and answers format held the fact-finders interest and was far more informative than the defence's approach.

Deconstructive attempts were made by the defence's expert witness while he was reading his forensic report. For example, the defence psychiatrist brought up several limitations with the prosecution expert witnesses' forensic reports. However, in the little time devoted to the 'question and answers' with their expert witnesses, these limitations were not picked up by the defence. Nor were these limitations covered in the defence's cross-examination of the prosecution's expert witnesses. This meant that the jury did not have the critiques introduced in the defence psychiatrist's report reinforced; the expert witness's attempt at boundary-work was not successful.

In contrast, the defence did demonstrate acts of boundary-work, particularly in the way they attempted to highlight the unreliability and lack of credibility in the prosecution experts' testimony. The defence sought to show how the forensic psychiatrists employed by the prosecution did not adhere to best practice methods of conducting forensic assessments. Further, the defence attempted to attack the reliability of psychiatric diagnostic processes in general. The following sections review these strategies utilised by the defence.

psychiatrist. The defendant, however, maintained his refusal and would allow this forensic psychiatrist to assess him. This again emphasised the possibility of the manipulation of evidence being undertaken by Mr X.

Lack of adherence to best practice methods

As the above discussion has shown, the defence had a ‘window of opportunity’ to attack the reliability of the expert witnesses’ testimony called on behalf of the prosecution. The forensic assessment these expert witnesses conducted was not founded on any clinical examination of Mr X or any interviews with his family members and friends. This does not adhere to best practice notions of what an ideal forensic assessment should include (see chapter five). The defence cross-examined one of the prosecution’s expert witnesses on the reliability of their opinion considering such information sources were omitted from their forensic assessment:

Defence: It’s important, just as a general proposition, isn’t it Doctor, when trying to make a psychiatric opinion about somebody, [its] important to look at the evidence as a whole?

Expert: Absolutely

Defence: It would not be fair to cherry pick bits out that suited would it?

Expert: No I believe that is right.

This strategic line of questions, however, was quickly met with responses from the expert witness that dismantled any affect the deconstructive tactic may have had on the fact-finders. The prosecution’s expert witness emphasised that access to particular people and documents could have occurred had the *defence* permitted it. During this section of the cross-examination, the defence sought to highlight the rarity of this occurring in insanity trials. Rather than assisting in the defence’s case, this appeared to assist in ‘firming up’ the prosecution’s case construction that relied on malingering, as the following extract shows:

Defence: So in this case you haven’t had the opportunity to engage the patient?

Expert: No

Defence: You haven’t had the opportunity to get a full history?

Expert: No

Defence: Dr B mentioned that it's important if possible to speak to friends or close associate[s] or family members and they can also assist in providing relevant information, do you agree with the proposition?

Expert: Yes, I do

Defence: Did you do that?

Expert: I asked at the time of the first trial to have access to all of the people that might've been able to give me exactly that history, but I understood that along with exercising his right to withhold his consent to be interviewed by me, Mr X was also not keen for me to interview any of his relatives or those close to him. And so the answer is not, I did not.

...

Defence: ...you've never given evidence in court before where insanity's at issue and you haven't spoken to the subject, person?

Expert: I've never been involved in an insanity [trial] where the defendant has withheld their consent to be interviewed.

In summary, the defence's tactics of deconstruction were often met with carefully crafted answers by the prosecution's expert witnesses. It appeared that these expert witnesses were well prepared for the line of questioning the defence were presenting. This is similar to the forensic pathologists in Timmerman's study (2006) who also prepared for potential techniques that could be used in the courtroom from the time they wrote their reports through to when they took part in courtroom proceedings. The experienced forensic psychiatrists who were instructed by the prosecution showed comparable anticipation of the defence's tactics in the case of 'X'.

Reliability of psychiatric diagnostic processes

The defence tried to undermine the credibility of the prosecution's expert witnesses by attacking the reliability of psychiatric diagnostic processes. Again the defence struggled to successfully deconstruct the prosecution's expert witnesses' credibility using this technique because of their carefully constructed responses. The following section exemplifies this using extracts taken from the defence's cross-examination of one of the forensic psychiatrists.

The defence's attempt at deconstruction was apparent in the cross-examination of one forensic psychiatrist in particular. The expert witness in question had extensive experience in assisting in the writing of the DSM-IV-TR. Regardless, attacking the foundations of the DSM-IV-TR became the focus of the defence's deconstruction. In response, the forensic psychiatrist turned the deconstructive techniques offered by the defence 'on their head' by describing the limitations with psychiatric diagnoses being relied on for decision-making in court. In short, the prosecution expert witness was only happy to testify as to the limits of psychiatric diagnostic processes. The following extract provides a snapshot of this:

Defence: Of the 400 [disorders] in the DSM, how many do you say are arbitrarily shoved in there then?

Expert: Well if you look at what psychiatrists use, most studies have shown that psychiatrists use—the average psychiatrist may use about 20 of the 400 categories. So you know that illustrates something...

.....

The DSM you remember is widely spoken of as the Chinese cookbook approach to diagnosis, not as a rude comment about Chinese but as a comment that people trying to do Chinese cooking need a sort of checklist they can go down. It's not actually how the textbooks think of diagnoses. They work more on the concept and characteristics, but I understand that you're thinking of the DSM A, B, C, D type criteria.

Defence: When you say it's useful and practical, what purpose in Court is it useful for do you think?

Expert: Very little I think in Court, I mean clinicians use it as a shorthand form of communication so that if they say X, the somebody listening to them knows which particular characteristics they're talking about...Now in terms of the Courts, I think it's a distracter in the Courts because in the ultimate sense, the Court's concerned with a different set of rules....

This extract also illustrates that the defence appeared to have a lack of understanding of psychiatric diagnostic processes. This was exhibited in their troubling cross-examination of both of the prosecution expert witnesses.

The discussion of the defence's failed attempts at deconstruction highlight the importance of pre-trial conferences between lawyers and their expert witnesses. Pre-trial interactions allow lawyers to gain insights into the meaning of certain diagnoses and the limits of the forensic psychiatrist's expertise. This is crucial for conducting effective evidence in chief, cross-examination and re-examination. It is also an important practice to ensure the fact-finders have a good understanding of the characteristics of certain psychiatric diagnoses, psychiatric understandings of how they may affect a defendant's behaviour, and how this may implicate the legal constructs that comprise the defence of insanity. Wheate's (2008) research that surveyed forensic experts (it did not include forensic psychiatrists) in Australia explored similar issues. Her participants stated that:

Poor comprehension of how forensic science is organised, how forensic practitioners are trained, the fundamental principles of forensic disciplines, and the significance of results, have created a situation in which lawyers are not utilising expert evidence effectively. Not only are poor questions asked of expert witnesses, but misuse of scientific concepts, jargon and results reportedly leads to evidence itself being misrepresented, omitted and even misused (Wheate, 2008, p. 132).

Wheate's findings have significant implications not only for the situation in which the expert witnesses faced, but also for potential fact-finders' decisions to be based on incomprehensible and unreliable information. This contention is taken up in chapter nine in relation to the findings of this study.

In contrast to the defence, the prosecution and their expert witnesses constructed a clearly articulated narrative that ensured the fact-finders understood the diagnoses the defendant had received and how these *did not* meet the test for insanity. This included ensuring the fact-finders knew that personality disorders and the psychoses arising from methamphetamine use do not amount to a disease of the mind or an inability to know the right from wrong.

To summarise, this section has shown the importance of lawyers understanding the limits of the knowledge that underpins their experts' testimony. This allows for more effective cross-examination. At the same time this section has also highlighted the ability of experienced expert witnesses to practise self-deconstruction so as to not only make themselves appear

impartial, but also to prevent further deconstructive attempts by the opposing lawyers (Edmond, 1998a; Mercer, 2002b).

THE SYMBIOTIC RELATIONSHIP

The above discussion has illustrated how the fulfilment of the legal ideals for an expert witness and the defence of insanity in the courtroom arise through effective interaction between the lawyers and their expert witnesses (Jasanoff, 2008a). In the case of 'X' the prosecution had clearly worked pre-trial with their experts to prepare their evidence-in-chief and for potential cross-examination. This allowed them to build a convincing and well articulated narrative for the fact-finders to draw on in their decision-making. In contrast, the defence did not provide such a clear narrative. Their expert witnesses proceeded to read their reports to the fact-finders over several days and they appeared unprepared when conducting cross-examination of the prosecution expert witnesses.

This chapter has not been able to consider all the ways in which the prosecution and defence constructed their cases. Rather, this chapter has focused specifically on the use of the concept of malingering and attempts aimed to undermine the reliability of the expert witnesses testimony. This focus allowed for an exemplification of the importance of interactions between lawyers and expert witnesses in building a defence for or against insanity.

This reliance upon one another that is exhibited when lawyers and forensic psychiatrists interact resembles Edmond's (2008) notion of symbiosis. Both professionals require one another to produce plausible case construction and credible expert testimony. The analysis of the case of 'X' has illustrated the ways in which a persuasive narrative and effective expert testimony is the result of carefully constructed dialogue between the lawyer and forensic psychiatrists. This aligns with Wheat's (2008) research that showed a lawyer who has inadequate understanding of an expert witness's expertise may ask inappropriate questions or alternatively fail to ask the appropriate ones. Adequate knowledge of their witnesses' expertise is crucial for the lawyer's ability to ensure the credibility of their experts and for the provision of effective cross-examination (Wheate, 2008). 'Good' expert witness evidence, therefore, is as much facilitated by a lawyer—who is well versed in insanity law and in the knowledge of what forensic psychiatry can provide for the court—as it is the result of a

forensic psychiatrist who is experienced in undertaking the role and a good performer in the courtroom.

This chapter has relied on the analysis of court transcripts and observations of a highly contested trial. Although most trials involving insanity are uncontested, this case was used because it illustrated the symbiotic dynamics that occur in practice between the lawyers and forensic psychiatrists. In agreed verdict cases (such as those discussed in chapter five), these dynamics may not be so apparent. In Latour's (1993) words they may have become black-boxed or hidden from view. It is important to focus on the unravelling of symbiotic practices in contested cases because they have implications for the role of the lawyers and the expert witness in cases of insanity, and for defendants using the defence. These implications will be discussed in detail in chapter nine.

BLURRING OF BOUNDARIES

If we accept that the symbiotic relationship adequately describes the ways in which lawyers and expert witnesses work together to build a persuasive narrative, the boundaries discussed over the last few chapters again become blurred. This section focuses on this blurring of boundaries.

In some of the extracts taken from the case of 'X' above, the forensic psychiatrist stepped into areas that are for the fact-finders to decide. For example, during the prosecution's evidence-in-chief, their expert witness directed the fact-finders to evidence they should focus on in their decision-making around Mr X's sanity. The prosecution managed the blurring of boundaries between what is for the expert witness and the fact-finders to decide, by limiting their expert witness's ability to talk to specific evidence the fact-finders may want to consider. Together the prosecution and their expert witness drew attention to broad areas of evidence while giving such qualifications as:

Expert: Obviously I'm not in a position to say what that actually was but I do believe that there are a wide range of bits of evidence that give the jury some guidance in that regard.

Further, the management of this boundary was 'muddled through' with the presiding judge having to interject twice to question the way the prosecutor was interacting with his expert

witness. The presiding judge argued that the prosecution was asking the expert witness questions that were ‘legally’ rather than ‘psychiatrically’ significant. From then on, it appears the prosecutor ‘got around’ this by questioning the expert on evidence that was “psychiatrically relevant”.

The prosecution responded with a rhetorical method to allay the judge’s concerns while simultaneously facilitating the psychiatrist in answering questions that had legal significance:

Prosecution: What about the negotiation tapes...

Judge: Are those psychiatrically significant?

Prosecution: Are they psychiatrically significant?

Expert: I think that there are a number of things that were said in the negotiation tapes that gives us suggestions about the way in which Mr X, at the time, might’ve been thinking about the offending – some of which I think have psychiatric relevance.

Prosecutor: Are you able to give examples of those which may have psychiatric relevance which would assist the jury?

Expert: I think particularly in the tapes where Mr X appeared to display a degree of understanding about what he had done when he said that he was sorry that he’d – by memory I think – chopped the girls and also with regards to the other offending where I think he said – and again from memory – something about shooting an innocent man. Both of those things I think give us some indication of the extent to which, on reflection, he accepted that was wrong.

The presiding judge brought this issue up again later in the same expert witness’s testimony.

The presiding judge stated:

I think Dr B once again can only give us his psychiatric view as to the respective weightings. The actual weightings are matters for the jury.

The prosecutor and expert witness continued with providing similar evidence while couching it within the boundary of what was ‘psychiatrically relevant’. However, the focus of their dialogue persisted to select ‘other’ evidence that illustrated how the defendant knew what he

did was morally wrong. This is a requirement of the test for insanity. As this thesis has continually pointed out, this is a legal test.

CONCLUSION

This chapter used the case of 'X' to closely examine the interactions between forensic psychiatrists and lawyers as they work together to make a case (or not) for insanity. Boundary-work was a feature that reappeared as these professionals interacted. In doing this it sought to highlight the symbiotic relationship that occurs between the lawyers and their expert witnesses in cases of insanity. This implicates the lawyers in the production of effective expert witness testimony. It also brought together the findings of the last three chapters by returning to the theme of blurred boundaries.

CHAPTER NINE: DISCUSSION

The broad aim of this study was to examine the role forensic psychiatrists undertake as expert witnesses in criminal trials involving the insanity defence. It intended to closely focus on the forensic psychiatrists' management of the problems they commonly face when assuming this role and their interactions with lawyers as they assist in the construction of a defence of insanity. Influenced by contemporary socio-legal studies of forensic expert witnesses, the overall aim was to examine how the role translates into practice. This led to the development of three foci that provided the parameters for this research, these included investigating:

1. The practices that comprise the role of expert witness with specific reference to the processes forensic psychiatrists are involved in when assisting in the construction of a defence of insanity;
2. The difficulties associated with the role that forensic psychiatrists face; and
3. The interactions between the forensic psychiatrists and lawyers within the courtroom context.

To achieve these aims, data were collected through qualitative research methods. These included data accessed from multiple sources, including interviews with forensic psychiatrists and lawyers, observation of a high profile murder trial using the insanity defence, and close readings of legal documentation (court transcripts, reported and unreported case reports). Recent socio-legal focused research, particularly within the interdisciplinary field of STS, was used to make sense of the data collected through these methods. This led to an analytical focus on the building and blurring of boundaries, the hybridised practices of forensic psychiatrists, and the symbiotic relationship between the lawyers and expert witnesses they instructed that occurs in insanity trials. This chapter will highlight the contribution of this study to existing research in this area. It will do this by demonstrating how the research aims have been achieved, while simultaneously identifying the theoretical and practical significance of the research.

The chapter begins by drawing together the research findings and correlates them with existing literature on the topic. In this section, the synergies found between this study and STS of law-science interactions, as well as the medico-legal and other social science literature, will be explored. The chapter will then demonstrate the theoretical and practical

implications of the findings of this study. The advantages of using a STS approach will be described. It will be argued that this approach allowed for new and fresh ways to theorise about the use of psychiatric expertise in the legal setting and the relationship between psychiatry and law. It will also be contended that this study moves beyond existing STS of law-science interactions through its consideration of the repercussions of the findings for the continued use of forensic psychiatrists as expert witnesses in cases of insanity and for public understandings of ‘madness’.¹¹⁴ In making such claims, it will draw on Perlin’s thesis (2000) to unpack the acceptance, and provision, of ‘sanist’ testimony in cases of insanity. It will be suggested that the findings of this study, when viewed through this lens, have profound implications for public understandings of madness.

DRAWING THINGS TOGETHER

This section demonstrates how the research aims for this study were achieved by drawing together the findings of this study. As the research aims for this study were interlinked, the following shows how they were achieved thematically rather than attending to the accomplishment of each aim individually. This will avoid repetition of content. The section also highlights the study’s contribution to the creation of new knowledge. It does this by discussing the synergies that were found between the findings of this study and STS of law-science interactions and the medico-legal and/or social science literature.

Building boundaries and doing boundary-work

Chapter five described two boundaries that emerged from the data which set out to manage *ideally* the role of the expert witness in the courtroom. These included:

- (1) A boundary that is aimed at maintaining a separation between lay and expert knowledge, and
- (2) A boundary that is aimed at maintaining a separation between facts, which are for experts to give opinion on, and values which are for fact-finders to consider.

¹¹⁴ Perring (2009) has noted that the use of the ‘language of madness’ can have different agendas and varies in meaning. I use ‘madness’ to avoid medicalised language that conceptualises mental states as ‘illnesses’ while minimising the moral and social judgements involved in diagnostic procedures. Medicalised language also marginalises the social contexts in which these states occur and/or the role of individuals in the construction of a diagnosis (cf. ‘looping effect’ in Hacking, 1999). At the same time, I use ‘madness’ in a way that allows for the incorporation of many knowledges so as not to also marginalise the role of psychiatric expertise in identification and alleviation of suffering.

The chapter concluded by illustrating how these boundaries can be understood using Geiryn's (1983, 1995, 1999) notion of 'boundary-work'. It was shown that the setting up of these boundaries can be seen as attempts to mark out the cognitive territory that is under the control of legal professionals and fact-finders rather than expert witnesses.

Legal definitions of insanity

In describing how the law defines 'insanity' in chapter five, synergies were found with literature outside of STS of law-science interactions. The legal interpretations of insanity outlined in this chapter suggested that insanity is something that is *observable to lay people*. Loughnan (2007) has similarly noted how legal texts have emphasised that decisions regarding a defendant's insanity is a process that lay people can make based on their observations. Taking this notion further, the chapter argued that this was another act of boundary-work, which aimed to emphasise that fact-finders make the final decision, not the medical expert witnesses.

In similar vein to Yannoulidis (2003), chapter five also showed how the legal texts sought to reinforce the legal expectation that decisions regarding insanity are *social judgements*, which involve the consideration of more than medical inferences alone. Chapter seven showed how this proposition is reflected in the information that forensic psychiatrists collect and corroborate when making their forensic assessment. This chapter described how the forensic psychiatrists must correlate various forms of psychiatrically relevant information (hospital records, psychiatric reports, prison notes) with 'other sources' of material generated through police procedures and interviews with lay observers.

Finally, chapter five concluded that legal definitions of insanity are focused on mental states that are the result of a *disease process*. The reported cases and interview data for this study supported the idea that a disease of the mind has to be something that is serious in nature and attributable to a 'disease'. This was highlighted further in chapter six, which showed the importance of a disease of the mind being the result of an internal process. This chapter concluded that this finding can be seen as another act of boundary-work that aimed to ensure that legal decisions are legitimized through being founded on facts, rather than values.

Chapter three discussed that STS of law-science relations have showed how acts of boundary-work are based on idealised assumptions regarding the nature of expertise. The following section discusses these assumptions in relation to this study's findings, further illustrating the synergies found with STS.

Legal understandings of expertise

The assumptions on which the insanity defence is founded favour the *medical model* for understanding mental *illnesses*. The medical model, which pathologises mental disorders, equates well with both the test for insanity (cf. Gerard, 1999) and the legal expectation that an expert witness provide 'expert' opinion that has a 'factual' basis. The findings of this study have illustrated how forensic psychiatrists are accepted as expert witnesses by the court based on their expertise, which is considered to be beyond the abilities of the fact-finders. While the insanity defence may require forensic psychiatrists to apply commonsense understandings of 'insanity', and use lay sources to build their evidence, they are still expected to provide opinion that is based on knowledge a layperson is not expected to possess. Influenced by STS of law-science relations, chapter five concluded that *ideally* a border must be maintained between facts, which are in the vicinity of scientifically based expert knowledge, and values which are for fact-finders (lay persons) to consider (Jasanoff, 1995; R. Smith, 1989; Solomon & Hackett, 1996).

The 'ideal' cases of insanity described at the end of chapter five also illustrated the romanticised notions of scientific expertise the legal texts embraced. This provided further synergies with the work of STS scholars. Agreement between experts was an apparent characteristic of the 'ideal' cases. This emphasised the courts reliance on the idea that scientific knowledge is founded on facts, which should be comprised of content that experts agree upon. Jasanoff (1995) has argued that such assumptions presume medical professionals and scientists produce knowledge that is stable, objective, and free from values.

It is important to note, however, that the overall theme in chapter five was that '*the ball is squarely in the legal professional's court*'. Although legal definitions of insanity may rely on medical models of mental disorders to ensure the legitimisation of fact-finders' decisions, the *mind* is emphasised over the *brain* in this context. This was shown to be another act of

boundary-work that sought to reinforce that the court has control over decision-making regarding what constitutes insanity (Gieryn, 1983, 1995, 1999).

BLURRING BOUNDARIES AND SHAKING-UP ASSUMPTIONS

Chapters six, seven and eight illustrated that *in practice* the boundaries that should ideally separate the responsibilities of expert witnesses, the lawyers, and fact-finders (as well as the assumptions upon which they are based) become blurred when cases are contested and decision-making becomes murky. These chapters showed how the maintenance of the boundaries built by the idealised interpretations of legal insanity becomes difficult for the forensic psychiatrists to uphold in practice.

Answering ‘unanswerable’ legal questions

Chapter six used the example of methamphetamine use to explore the way in which the use of this drug has created difficulties not only for the construction of insanity, but also for a forensic psychiatrist’s ability to meet the legal expectations of an expert witness. The forensic psychiatrists described complex clinical pictures that arise in cases involving the use of methamphetamine. They explained that methamphetamine facilitates psychosis on its own and/or in combination with pre-existing mental disorder. Further, the forensic psychiatrists stated that methamphetamine induced psychosis can vary in length, from a temporary through to a long-term state of mind. In many instances, they noted, a person was already mentally unwell when they began to use the drug or they may, following the use of the drug, be diagnosed with a mental disorder.

Regardless of the complex clinical pictures the forensic psychiatrists faced at times, they described instances where they have been required by the court to differentiate symptomatology, identify a primary cause, and quantify relative contributions to a mental state. The findings of this study demonstrated how the forensic psychiatrists interviewed have difficulties in completing these three tasks. Firstly, the characteristics of methamphetamine induced psychosis and psychosis relating to mental disorders, such as schizophrenia, can be indistinguishable. It was shown that methamphetamine induced psychosis may last longer than traditional drug induced states, which further complicates differentiating symptoms. Secondly, it was demonstrated that with the use of methamphetamine it becomes difficult in practice for the forensic psychiatrist to identify the *primary cause* of the mental state.

Forensic psychiatrists cannot reliably provide evidence as to whether the primary cause was the result of a ‘naturally’ occurring ‘internal’ process. This is a direct consequence of the cause being inseparable from the use of methamphetamine. Thirdly, chapter seven illustrated that from the forensic psychiatrists’ viewpoint, the quantification of relative contributions cannot be achieved.

As this chapter has repeatedly implied, in these situations the forensic psychiatrists are faced with the impossible task of answering “unanswerable” legal questions (Gunn & Taylor, 1993). Leong et al., (2007) has also illustrated that forcing dichotomous decision-making in the legal setting may not accurately reflect the clinical reality. The findings of this study correlated with this medico-legal literature by illustrating how the complex clinical picture cannot be reduced for the legal purposes of boundary-drawing between internal and external factors required in cases of insanity (Fabian, 2007; Hartel-Petri et al., 2005; Sato, 1992; Sato et al., 1992).

The limits of psychiatry

The findings of this study also drew attention to a lack of understanding some legal professionals have regarding the limits of psychiatric knowledge. In this way, there were synergies found between these findings and some of the medico-legal literature reviewed in chapter two (Appelbaum, 1987-1988; Chaplow & Peters, 1996; Freckelton, 2007; Perlin, 1990b; T. Rogers, 2004; Shuman, 2002). This was particularly apparent in the case of ‘X’, where the importance of the lawyers having some understanding around the limits of the knowledge that underpin expert witnesses’ testimony was highlighted. Chapter eight showed how a good knowledge of forensic psychiatry allowed for more effective evidence-in-chief and cross-examination on the part of the prosecution. Wheate (2008) also found similar results in her study of forensic scientists. She argued that this has profound implications for fact-finders’ decision-making.

Chapter six also illustrated how the legal system and legal professionals may not understand the limitations inherent in psychiatric knowledge. It described how the determination of the aetiology of a defendant’s behaviour is important for constructing a defence of insanity. In practice, this chapter indicated that forensic psychiatrists cannot always provide adequate answers to questions regarding the aetiology of mental states. In cases involving

methamphetamine, there were often multiple explanations rather than a single unifying diagnosis. The wider medico-legal literature has described the limitations of psychiatry being able to provide reliable evidence as to the aetiology of all mental disorders (Coles & Veiel, 2001; T. Rogers, 2004). The psychiatric manual, the DSM-IV-TR, is marketed as ‘a-theoretical’ in that it is not focused on the aetiology of mental disorders (American Psychiatric Association, 2000).

The findings of this study also illuminated how in many instances psychiatric knowledge fails to meet the legal system’s romanticised understandings of ‘science’. This was particularly evident when the boundaries between facts and values became blurred. Chapter six provided two illustrations of this. Firstly, it showed that conflicting expert opinion creates problems for the forensic psychiatrists in terms of their ability to meet the legal understandings of ‘science’. This finding correlated with some of the medico-legal literature that has argued that conflicting opinion is often the result of psychiatrists having to reduce complex clinical pictures into narrow legal constructs, rather than a sign that psychiatry is ‘bogus’ (Gutheil, 1999). Secondly, the findings illustrated the legal system’s reliance on medical knowledge being ‘valid’ and ‘reliable’. The clinical research drawn on in chapter five indicated that the current state of psychiatric knowledge cannot provide reliable answers for legal decision-making on methamphetamine induced psychosis (Fabian, 2007; Hartel-Petri et al., 2005; Sato, 1992; Sato et al., 1992). The medico-legal literature has similarly argued that there is no scientific evidence that can “tease apart the relative magnitude of the aetiological contributions” of external verses internal factors (Carroll et al., 2008).

Chapter seven further illustrated the blurring of boundaries that can occur between facts and values as forensic psychiatrists and lawyers interact in the courtroom. There were strong synergies between the blurring of facts and values found in this study and discussions over the ‘ultimate issue rule’ described in the medico-legal literature (Buchanan, 2006; Golding, 1990; McSherry, 2001; R Rogers & Ewing, 1989). The case of ‘X’ highlighted several ways the forensic psychiatrists stepped into areas that are, in theory, for the fact-finders to decide. Even with attempts by the lawyers, together with their expert witnesses, to manage this boundary it was still ‘muddled’ through in practice. This reinforces the idea that in practice there is a fine line between moral, legal and psychiatric questions (Allnutt & Chaplow, 2000; R Rogers & Ewing, 1989). Perhaps as some of the medico-legal literature has stated, “it may

be that this difficulty in separating matters of fact and value has led to the erosion of the ultimate issue rules in practice” (McSherry, 2001, p. 15). Indeed the Evidence Act (2006) has abandoned the ultimate issue rule. What remains is a complex situation in which the boundary that *ideally* separates the role of expert witnesses and fact-finders is not just blurry, but completely dissolved in practice. As Perlin (2000, p. 60) has stated, it still remains that this effectively places expert witnesses in a position where they become “moral” experts.

The relationship between law and psychiatry

The findings of this study also showed the blurring of boundaries that occurs in practice between the role of forensic psychiatrists and the legal professionals. Significant synergies were found between this part of the study and the work of STS researchers (Edmond, 2001, 2008; Edmond & Mercer, 1998; Miller, 2001; Timmermans, 2006). Specifically, the concepts of the ‘hybrid’ and ‘symbiosis’ became useful methods for interpreting the legal shaping of psychiatry, and the relationship between legal professionals and the forensic psychiatrists in this context.

Chapter seven described how the forensic psychiatrists’ practices were inexplicably linked to the context in which they were practising. This was illustrated by following the different ways the forensic psychiatrists shaped their practices in order to perform effectively as expert witnesses. The chapter concluded by demonstrating that the ‘art’ of forensic psychiatry involved managing the hybrid nature of the expertise they provide in cases of insanity. It did this by using the example of how they approach the ethical issues that rise from performing the role of expert witness. This was similar to Edmond’s (2004) review of the hybrid expertise that other forensic experts undertake where they too have to balance expectations and obligations that are in tension to effectively manage their role in court. In exploring such ‘hybrid management’ (Miller, 2001), it was argued that it is difficult to define that what the forensic psychiatrists are doing is comprised of purely psychiatric knowledge. Instead, it was argued that the forensic psychiatrists perform a hybrid expertise in this context, managing a mixture of legal, psychiatric, and lay knowledge.

The theme of blurred boundaries was extended in chapter eight with a focus on the symbiotic relationship that occurs between the forensic psychiatrists and lawyers in cases of insanity. Using the case of ‘X’ to illustrate, it was shown that the fulfilment of the legal ideals for an

expert witness and the insanity defence are accomplished through effective interaction between lawyers and their expert witnesses. The interpretation of these findings were also influenced by STS research that has explored how expertise is not a 'given' in the courtroom (Jasanoff, 2008b), and in the case of 'X', it was the result of well rehearsed interactions between lawyers and psychiatrists. Edmond's (2008) notion of symbiosis was useful in understanding the ways in which both professionals required one another to produce plausible case construction and credible expert testimony.

Summary

This section has drawn together the findings of the study. In doing this, it has shown how the research aims for this study were achieved through the focus on the *practices* of forensic psychiatrists and the *difficulties* associated with undertaking the role of expert witness in cases of insanity. In particular, the last three chapters (six, seven and eight) have explored in detail the various ways in which the hybrid nature of the defence, along with the legal rules for expert witnesses, shape forensic psychiatrists' *practices*. This was interpreted as leading to a blurring of the boundaries that should ideally separate the responsibilities of fact-finders, lawyers and the expert witnesses. Not only was the insanity defence found to be a hybrid construct, but the expertise the forensic psychiatrists provide in this context was also interpreted as hybridised. The way in which forensic psychiatrists *practised* their role and managed the *difficulties* associated with accommodating the legal shaping of their psychiatric expertise illustrated the hybrid features of their expertise.

The findings related to the second aim of this study (to explore the interactions between the forensic psychiatrists and lawyers in cases of insanity) were also described in this section. The findings illustrated the ways in which lawyers and forensic psychiatrists work together in cases of insanity. It was argued that this exemplified the symbiotic relationship that occurs in action between these professionals as they construct a defence of insanity.

The blurriness that occurs in practice has significant theoretical and practical implications. The next section details these implications as they relate to the continued use of forensic psychiatry in cases of insanity and for public understandings of madness.

CONTRIBUTION TO KNOWLEDGE

This study has contributed to the existing medico-legal knowledge by providing a platform for exploring the *practices* of forensic psychiatrists and the insanity defence *in action*. Influenced by STS of law-science interactions, the findings of this study have implications for current understandings of the relationship between law and psychiatry detailed in the medico-legal literature. As well as using an innovative analytical approach, the study used qualitative methods of data collection and sought information from multiple sources. Using qualitative research methods, this study contributes considerably to existing knowledge of forensic psychiatrists and their role in the insanity defence. This section will demonstrate the contributions of this research to existing knowledge on the topic.

The study has shown that viewing ‘law’ and ‘psychiatry’ as two separate knowledge systems ignores the way the forensic psychiatrists and lawyers are brought together in cases of insanity. The findings summarised above illustrated the symbiotic relationship that occurs between these two professionals. The focus on the practices of forensic psychiatrists has highlighted how what they do is inextricably linked to the legal context. The concept of the ‘hybrid’ assisted in describing the ‘psych-law’ mixture that occurs when the forensic psychiatrists undertake the role of expert witness. Overall, the study’s findings have highlighted that the existing medico-legal literature at times has simplified the complex interactions between legal professionals and forensic psychiatrists, and downplayed the ways in which the insanity defence creates a situation in which psychiatric and legal knowledge production cannot be easily separated.

The core contribution this thesis makes to existing medico-legal research is in its provision of a fresh approach to researching the role of forensic psychiatrists in the courtroom. STS of law-science interactions provided the avenue to explore the topic in innovative ways. At the same time, this study contributed to the existing STS literature on forensic expertise through its focus on the implications of the findings for the continued use of forensic psychiatrists. The following section details these implications further.

PRACTICAL CONTRIBUTIONS

This section explores the implications of this study's findings for the continued use of forensic psychiatrists as expert witnesses in cases of insanity. To do this, the section draws on literature outside of STS. As already discussed, STS of law-science relations was useful in the interpretation of the *practices* of expert witnesses and analysing legal processes *in action*. This set of literature, however, was not as helpful for considering the implications of such 'thick descriptions' (Geertz, 1973). This has been noted in several of the contributions to the third edition of *The handbook of science and technology studies* (Hackett, Amsterdamska, Lynch, & Wajcman, 2008b). Briefly, Evans and Collins (2008, p. 619) argued that STS research may have provided a platform for exploring "what is going on, making visible what has traditionally been invisible" but the ramifications of these studies' findings have not been adequately explored. They explained that this is because such consideration may involve scholars making normative statements about expertise. A normative approach conflicts with the relativist constructivist agenda of STS: "it is difficult to assert that STS knowledge about knowledge can be seen as more than one account among many" (R. Evans & Collins, 2008, p. 620). Speaking directly to STS of law-science relations Jasanoff (2008a, p. 781) continued this theme, stating:

Relentlessly concerned with the law's epistemic authority, STS students of science, technology, and the law have been on the whole less attentive to the law's magisterial role in constructing and maintaining justice, legitimacy, and constitutional order—and, of course, in holding at bay the disruptive forces of injustice, illegitimacy, and disorder...To an inquiring mind, these are not omissions but openings. Through them, future STS research can be expected to push forward to new levels of insight, by bringing within its investigative reach not only law's fabrication of knowledge but also its power to establish order and justice in the world.

The following section aims to "push forward to new levels of insight" through a consideration of the consequences of the findings of this study for public understandings of madness. For this study, it was important to consider how the constructions of 'insanity' and 'expertise', created through the interactions between legal professionals and forensic psychiatrists, establish ways of thinking about madness. What constitutes 'madness' is legitimized in cases of insanity, meaning that the forensic psychiatrists and legal professionals have a major role in constructing the public's understandings of madness.

The impact of legal constructions of insanity & expertise

This study has repeatedly shown how legal definitions of insanity prefer mental afflictions that are the result of a ‘disease’ process, and that this privileges medical models of understanding mental illness. Outside of the courtroom, the aetiology of mental afflictions is a contentious topic and has been widely debated across disciplines (selected examples include: Boyle, 2002; Foucault, 1973, 2006; Horwitz, 2002; Read, Mosher, & Bentall, 2004; Scheff, 1999; Wakefield, 1992) and by people that have been subjected to psychiatric diagnoses, with the extremists questioning the existence of mental ‘illnesses’ altogether (Szasz, 1962). It is outside of the scope of this thesis to consider all of this literature. For the purposes of this discussion, however, the core argument to be drawn from these works relates to the idea that processes of medicalisation have led to unquestioned and taken-for-granted assumptions that mental illnesses are biological, ‘natural entities’ (Horwitz, 2002). The experiences of madness as related to social contexts are marginalised. Psychotic symptoms, for example, have been found to be inextricably linked to “psychological or emotional reactions to life events” (Read, 2007, p. 123) and the aetiology of schizophrenia the effect of interactions between biological, social and psychological factors.¹¹⁵ Legal definitions of ‘insanity’ marginalise the notion that madness may be relational to the defendant’s environment. This is particularly emphasised in its acceptance of ‘internal’ over ‘external’ factors. This means even when external factors are considered, they must be separated from internal factors in a dualistic manner to make decisions regarding insanity. It is largely accepted in legal texts reviewed in chapter five that the cause of mental disorders can be established, when in practice this study has shown that the forensic psychiatrists find it difficult to assist in such decisions.

When the forensic psychiatrists give expert opinion that adheres to the legal understandings of insanity, they are not providing evidence based on ‘fact’.¹¹⁶ Before they even enter the courtroom, psychiatrists undertaking diagnostic procedures with defendants inevitably make professional judgements based on their clinical experience (Szmigiero, 2009), education and training (Bernstein, 1995). These judgements may be more important than the processes the legal system upholds as ‘scientific’. The medico-legal literature in chapter two discussed the

¹¹⁵ The DSM-IV suggests this in its introduction when mentioning the biopsychosocial models of understanding mental disorders.

¹¹⁶ Read et al., (2006) have further indicated that the information provided to the public by well meaning advocacy groups also embrace causative understandings that are not evidence-based.

value basis of psychiatric diagnostic procedures. For example Rogers (2004) argued that psychiatry has little 'construct validity'. The forensic psychiatrists in this study also described the value basis of their decision-making.

In cases of insanity the value basis of psychiatric expert evidence becomes even more explicit. In achieving the 'neutrality' required in the legal context, the forensic psychiatrists interviewed for this research shaped their practises in ways to meet the norms and expectations required by the legal system. Further, the moral foundations of their inferences were particularly evident in the way they gave evidence on the 'ultimate issue' of the case. When acting as expert witnesses their practises will never be entirely divorced from normative assumptions, expectations and morality (Wynne, 1989).

Interestingly, this research did not find many examples of the value basis of the forensic psychiatrist's expert opinion being vigorously questioned in New Zealand courtrooms. When attempts at legal deconstruction were used in the case of 'X' they were hindered by the legal professional's lack of understanding of psychiatric knowledge. This was very different from the dynamic and clearly crafted deconstruction described by Lynch (1998) and Jasanoff (1995) that has taken place in North American courtrooms. Good (2007) has noted that in English courtrooms the status of expert is ascribed rather than achieved during legal proceedings as in North American courtrooms. Edmond (2008) has surmised that in the Australian context this is the consequence of the symbiotic interaction between forensic experts and the lawyers because it is a relationship based on trust rather than "scrutiny and accountability" (Edmond, 2008). The lack of cross-examination aimed at showing up the socially constructed nature of the psychiatric expertise in the New Zealand context could also be associated with the legal professionals' reliance on forensic psychiatry underpinned by an unquestioned trust in medical professionals (Hiday, 1981; Sjostrom, 1997).

This study has also illustrated how legal professionals can have a lack of understanding of the questions forensic psychiatry can answer in relation to the influence of a defendant's mental state on their behaviour. It showed that the forensic psychiatrists were often put into positions where, based on the current state of psychiatric knowledge, they were compelled to answer unanswerable legal questions. This has serious implications for the forensic psychiatrists' ability to give testimony that adequately reflects their professional abilities. At its extreme,

some forensic psychiatrists have provided evidence that is “intellectually dishonest” (Perlin, 2000) and the court appeared to be willing to accept this dishonesty.

This discussion has been influenced by Perlin’s thesis (2000) which suggested that the insistence of biological determinism, the lack of understandings of the limits of psychiatric knowledge, and the unquestioned acceptance of psychiatric expert testimony by the court can be attributed to ‘sanism’. He used sanism to describe the ways in which the legal system and legal professionals selectively accept evidence that meets their objectives. Perlin has labelled the process of selectivity as “pretextuality” and argued that it can be two-sided. Firstly, the courts’ unquestioned acceptance of psychiatric evidence can be seen as intellectually dishonest. Secondly, the court ensures the maintenance of barriers to prevent certain people from “misusing” the system.¹¹⁷ In Perlin’s words, “...the courts accept (either implicitly or explicitly) testimonial dishonesty and engage with dishonest (frequently meretricious) decision-making” (Perlin, 2000, p. 60). This implicates the expert witnesses in the continuation of sanism as they provide testimony that is shaped to fit the legal system’s sanist objectives.

The favouring of medical models of mental illness in laws of insanity in New Zealand, despite the research that has questioned its reliability and suggested different ways of understanding madness, can be attributed to sanism (Perlin, 2000). The legal professionals continue to reinforce sanism through their insistence of testimony that is not subjected to adequate scrutiny. The “bad lawyering” described in this chapter illustrated the way some lawyers do not understand the limits of psychiatry and this can be attributed to sanist practices. Perlin has strongly summarised the effects of sanism:

Insanity defense decision-making is often irrational. It rejects empiricism, science, psychology, and philosophy, and substitutes myth, stereotype, bias, and distortion. It resists educational correction, demands punishment regardless of responsibility, and reifies medievalist concepts based on fixed and absolute notions of good and evil and right and wrong. In short, our insanity defense jurisprudence is the jurisprudence of sanism (Perlin, 2000, p. 237).

¹¹⁷ Perlin (2000) further explained that this second process of pretextuality is based on several mythical assumptions the legal system (and the public) has of the frequency of the use of insanity as a defence. Similar to that discussed in chapter eight, this revolves around fears that people feign symptoms in order to escape punishment.

Finally, the shaping of psychiatric knowledge to meet the pretexts of insanity and the objectives of the legal system can lead to forensic psychiatrists giving sanist evidence. Viewing the findings of this study through this lens, the continued use of forensic psychiatry to meet the legal objectives of insanity has the potential to reinforce sanist attitudes and practices.

The findings of this study have significant implications for public understandings of madness when viewed through the lens of sanism. As *R v 'X'* illustrated, controversial cases of insanity are often high profile and closely watched by the public through reports by the media. The evidence of forensic psychiatrists inevitably affects the ways in which people understand and give meaning to mad or bad behaviour (Timmermans, 2006). The legal shaping of psychiatric evidence, however, means the public receive a constrained and simplified view of madness based on the pretexts (Perlin, 2000) which constitute the insanity defence. These pretexts, based on biological determinism, do not take into account studies that have consistently shown different ways of understanding how people may come to be mentally unwell. Some researchers have indicated that the continual drive to solely focus on biogenetic causes of mental 'illnesses' reinforces stereotypes and fuels fear and prejudice (Read, 2007). In consideration of the reality that it is the public who fill jury boxes, this has profound implications for the decision-making of fact-finders.

CONCLUSION

Chapter nine highlights the contribution of this study to existing knowledge in the area. It does this by demonstrating how the research aims have been achieved and weaves together the theoretical and practical significance of the research. The ways this research contributes to new knowledge is shown through the chapter's consideration of the theoretical implications of the study. It is contended that the use of an STS inspired interpretive approach allows for a fresh look into the use of forensic psychiatry in cases of insanity and offers a fruitful way for theorising about the relationship between psychiatry and law. In particular, the study shows that a blurring of boundaries occurs in practice as a defence of insanity is being constructed. A focus on the hybridised practices of forensic psychiatrists and the symbiotic relationship between the lawyers and forensic psychiatrists has illuminated this blurriness. The chapter also considers the ways the study simultaneously contributes to existing STS of law-science interactions through its focus on the practical implications for the

continued use of forensic psychiatrists as expert witnesses in cases of insanity. This section has relied on Perlin's thesis (2000) to unpack the acceptance and provision of 'sanist' testimony in cases of insanity. It is argued that the findings of this study, when viewed through the lens of sanism, have profound implications for the public's understanding of madness.

CHAPTER TEN: CONCLUSION

This research constituted the first New Zealand study to closely examine the practices of forensic psychiatrists and lawyers from their perspectives, and *in action*, as they participate in cases of insanity. The contribution of this research has been to provide an interpreted understanding of how the role forensic psychiatrists undertake as expert witnesses in cases of insanity, translates into practice. It gained additional insights into the interactions between lawyers and forensic psychiatrists as they work together to construct a defence of insanity. The study has drawn on multiple data sources and contemporary socio-legal studies to provide a fresh approach to the existing knowledge on the expertise forensic psychiatrists provide and the insanity defence itself.

The study found that in practice the hybrid features of the insanity defence lead to a blurring of the boundaries that should ideally separate the responsibilities and functions of the fact-finders, lawyers and the expert witnesses. At its extreme, this blurring of boundaries was shown to lead to situations where the forensic psychiatrists were forced into positions where they were required to “answer unanswerable legal questions” (Gunn & Taylor, 1993, p. 1). The study implicated legal professionals, as well as forensic psychiatrists, in the creation of this situation. This was achieved through the study’s focus on the symbiotic relationship that occurs between these professionals in this context.

This final chapter will conclude the thesis by exploring the strengths and limitations with the study. It will show how the study provides additional research opportunities, further reinforcing the contributions of this research.

The strengths in this research lay in its use of a STS approach to studying forensic expertise and in its extensive collection of data from multiple sources. The focus of this study differed to existing literature on the topic by paying attention to the *practices* of forensic psychiatrists and lawyers *in action* as they constructed a defence of insanity. Multiple data sources were collected through qualitative methods, adding significantly to the dearth of research in this

area. This allowed for data sources to be triangulated, which in turn strengthened the findings of this study.

Unlike previous research this study was conducted by a researcher from ‘outside’ the fields of forensic psychiatry and the law, providing a new approach to studying the role of forensic psychiatrists and lawyers in criminal trials using the insanity defence. The outcome contributes to the existing medico-legal literature that has largely been written by professionals for professionals.

There were some limitations to the study that could be rectified through further research and support from the judiciary in New Zealand. Judges were not permitted to take part in this study and this severely limited the ability of this research to include their experiences of working with forensic psychiatrists in the context of insanity trials. Although there were attempts to include their views by accessing case reports and notes of evidence, these documents did not provide insight into the judges’ perceptions in the depth required. Judges have a crucial role to play in the management of the boundaries that should ideally separate the functions and responsibilities of lawyers and their instructing expert witnesses. Future research, with the support of the judiciary, would allow for further understanding of judges’ ‘hybrid management’ (Miller, 2001) practices.

The methodological approach led to the collection of a significant amount of data that had to be carefully managed to meet the parameters of a PhD thesis. This meant that some data worthy of inclusion could not be presented in this thesis. In chapter six, for example, personality disorders could have also been used as an exemplar for the murkiness that can occur in practice when boundary-drawing between internal and external factors becomes difficult. Several participants also discussed in length legal reform issues in New Zealand. In addition, the lack of diminished responsibility as a partial defence was an issue for many. These topics will be explored post-doctorally and published in peer reviewed journals.

The large quantity of data collected on the case of ‘X’ for this study will also be used in a post-doctoral research project. In the second trial, Mr X testified and this is a rare occurrence in cases of insanity. The notes of evidence from this trial, coupled with non-participant observation, provide a platform for exploring how he constructed himself within the

courtroom context. Further, this thesis presented a snapshot of the second trial of Mr X. His interactions with the legal system and forensic psychiatric services began several years prior to this trial. They also ended abruptly with the death of Mr X while in custody. A Coroner's inquest has not yet been released to the public. A further project that follows Mr X as he engaged with legal and psychiatric services would provide further explorations into what can occur when these discourses interact.

Although an ethnographical approach could not be undertaken in all aspects of this research, this area of study could benefit from further use of this method. The non-participant observation of the case of 'X' allowed for close attention to be paid to participants' practices as they occur in their 'natural' setting. Further observation in less controversial cases would be beneficial and would allow for insights into the workings of 'practice as usual'. Access to hearings under s 20 of the Criminal Procedures (Mentally Impaired Persons) Act 2003 would be ideal to extend such observations. At the time this research was conducted permission to access these hearings was uncertain. Apart from the courtroom setting, an ethnographic approach could be applied particularly well in the pre-trial stages. This would allow for observations of lawyers and forensic psychiatrists as they prepare for a criminal trial. Further explorations of hybridised expertise in action could be achieved using this method. It would also allow for investigations into the interactions between defendants and their lawyers, as well as the expert witnesses.

This study did not include the experiences of defendants using the defence of insanity and this would be a valuable area to conduct further research. As Perlin (2000) has argued, research that seeks to explore the effect of the legal processes and the verdict of not guilty by reason of insanity on defendants would help to identify the non-therapeutic consequences of the defence. This could include seeking acquittees' experiences of being a 'forensic patient', which entails the individual (amongst other things) dealing with being found 'not-guilty' while acknowledging they committed a serious offence (often involving people close to them), and managing their behaviour so that it 'fits' with society's expectations of normality. In summary, there are several areas that could involve defendants and/or NGRI acquittees in order to further enhance knowledge in this area.

Finally, the approach taken in this study could be applied to other areas of mental health law within the criminal and/or civil areas. Future research could use ethnographic approaches and STS analytical tools to explore the practices of forensic psychiatrists and lawyers as they work together in ‘fitness to stand trials’, mental health review tribunals and civil commitment hearings. This would be most beneficial for furthering knowledge in the broad area of mental health law.

*

This thesis began by introducing the idea that the insanity defence is a hybrid construct comprised of legal concepts that are founded on, and validated by, psychiatric knowledge. It was proposed in chapter one that this can lead to the blurring of the boundaries that ideally separate the responsibilities of the fact-finders, lawyers and expert witnesses. This proposition has been explored in detail in this study through the provision of thick descriptions (Geertz, 1973) of the way the hybrid features of the defence, along with the legal rules that manage expert witnesses, shape the forensic psychiatrists’ and lawyers’ practices. It was shown that the legal shaping of these professionals’ practices lead to the blurring of the boundaries. The blurriness that occurs in practice has significant theoretical and practical implications, particularly in relation to the continued use of forensic psychiatry in cases of insanity and for public understandings of madness.

The blurring of boundaries will inevitably continue to occur in practice in cases of insanity. This research provides a platform for further investigations into this area of study and a basis upon which professionals from within the ‘field’ may reflect on their practices.

APPENDIX ONE: PARTICIPANT INFORMATION SHEET

Deconstructing the Insanity Defence

The role of legal and medical professionals

25th August, 2006

My name is Kate Thom, I am a PhD candidate located at the University of Auckland's Faculty of Medical and Health Sciences. I invite you to take part in this project that aims to investigate the contribution of legal and medical professionals to court trials utilising the insanity defence. I have been identified through existing case reports as a Judge/lawyer/forensic psychiatrist with experience in these court trials. You and other Judges/lawyers/forensic psychiatrists are being asked to participate in this research. Your participation would be voluntary.

Currently, there is limited information available on the experiences of Judges/lawyers/forensic psychiatrists in these trials. One New Zealand study has indicated that some legal professionals think jurors lack the necessary understanding of the role and function of the expert witness. This was argued to be extremely problematic when there was conflicting opinion between psychiatrists and where evidence was complex. In these situations, prosecutors suggested jurors make decisions based on those expert witnesses who have communicated and presented well (Brinded, 1998).

It is imperative that these issues are explored further. This project aims to gain insights into your understandings of the role you play and the perceptions you have of other legal and medical professionals who have participated in these court trials. Overall the study will deconstruct the practices, knowledge and roles of professionals who have participated in court trials that utilised the insanity defence and explore the different ways legal and medical professionals interact to contribute to the construction of the insanity defence.

The project will be supervised by a team from the University of Auckland with experience and knowledge in forensic mental health related research. This includes Associate Professor Mary Finlayson (Faculty of Medical and Health Sciences), Dr Brian McKenna (Senior Lecturer, Faculty of Medical and Health Sciences and Nurse Advisor Auckland Regional Forensic Service) and Professor Warren Brookbanks (Faculty of Law).

Your contribution would be voluntary and would involve participating in one semi-structured interview. The interview will be face-to-face or by telephone and will take approximately one hour of your time. The interview will take place at a time and venue convenient to you.

You are free to withdraw from the study at any time without giving reasons, and you may withdraw your data up until March 31st, 2007. With your permission, the interview will be taped and transcribed

verbatim by myself or an experienced transcriber who will sign a confidentiality agreement. You will be given an opportunity to review the transcript and make any changes.

All personal information will remain strictly confidential and no material that could personally identify you will be used in any reports on this study. Due to the limited number of expertise in this field, I cannot absolutely guarantee anonymity, however, every effort will be made to ensure you and the information you give remains anonymous. Pseudonyms will be used throughout the research process. Information gathered from the interviews will be used in my final thesis and academic publications. The transcriptions of the interview will be kept in a locked location at the University of Auckland and destroyed 6 years after completion of the study. Any information stored on computer files and audio-tapes will be kept on the University of Auckland server that requires a password to access.

If you agree to take part, you will be required to sign the consent form attached. It can be returned to me in the pre-paid envelope provided. Please indicate on this form the contact details that you would like me to use to follow-up this letter and organise an interview time with you.

If you have any queries regarding this study please do not hesitate to contact me on (09) 3737599 ext 89579, k.thom@auckland.ac.nz. Alternatively contact Associate Professor Mary Finlayson, (09) 3737599 ext 88508, m.finlayson@auckland.ac.nz; Assoc Prof Judy Kilpatrick, (09) 373 7599 ext. 82897 j.kilpatrick@auckland.ac.nz.

For ethical concerns contact: The Chair, The University of Auckland Human Participants Ethics Committee, Research Office, 76 Symonds Street, Auckland, (09) 373 7599 ext 87830.

This project has been granted ethical approval by The University of Auckland's Human Participants Ethics Committee from 12th July, 2006 to 12th July 2009, Reference Number 2006/248.

APPENDIX TWO: PARTICIPANT CONSENT FORM

Deconstructing the Insanity Defence

The role of legal and medical professionals

I have read the participant information sheet dated 25th August, 2006 for volunteers taking part in the above study. I agree to take part in the research. I have had the opportunity to discuss and ask questions about the study and I am satisfied with the answers I have been given.

I understand that I can withdraw from the study at any time and can withdraw any data traceable to me up until three months after the interview.

I recognize that the information gathered from the interviews will be included in a PhD thesis and academic publications and that all personal information will remain strictly confidential and pseudonyms will be used to ensure no material can identify me.

I acknowledge the interview will be recorded but that I will have the opportunity to review the transcripts of my interview.

I understand that the transcripts of the interview will be kept in a locked location at the University of Auckland for the duration of the study and destroyed six years after the completion of the study. I understand that any information stored on computer files will be kept on the University of Auckland server that requires a password to access.

I _____ (full name) hereby agree to take part in this study.

For future reference and arrangement of an interview time, I can be contacted at the following:

Phone:

Address:

Today's Date

Signed _____

If you have any queries regarding this study please do not hesitate to contact me on (09) 3737599 ext 89579, k.thom@auckland.ac.nz.

This project has been granted ethical approval by The University of Auckland's Human Participants Ethics Committee from 12th July, 2006 to 12th July 2009, Reference Number 2006/248.

APPENDIX THREE: LETTER FROM THE CHIEF JUSTICE



Chief Justice of New Zealand

[Please quote in reply] : A02/09

29 August 2006

Kate Thom
PHD Candidate
Faculty of Medical and Health Sciences
The University of Auckland
Private Bag 92019
AUCKLAND

Dear Ms Thom,

Thank you for your letter relating to 'Deconstructing the Insanity Defence' which I received on 28 August 2006. As you perhaps know, judges need to maintain confidentiality about trial processes. It is not appropriate for judges to be involved in the sort of research you are proposing without an assurance that the methodology used will be appropriate and that confidentiality will be properly maintained. I suggest that if you want judges to participate, you should write to me as Chief Justice requesting judicial participation and providing information about the research and the methodology employed in it. In that respect, the title of your project ('Deconstructing the Insanity Defence') raises some questions immediately.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Sian Elias'.

Sian Elias
Chief Justice

MAIL TO: Chief Justice's Chambers, PO Box 1091, Wellington, DX SP27009, Wellington
Telephone: 04 914 3639, Facsimile 04 914 3636

APPENDIX FOUR: LETTER TO THE CHIEF JUSTICE



The University of Auckland
Private Bag 92019
Auckland, New Zealand
www.health.auckland.ac.nz

Telephone: 64 9 373 7599 ext89579
Facsimile: 64 9 367 7158
Email: k.thom@auckland.ac.nz

6 September 2006

Rt. Hon Dame Sian Elias
Chief Justice
Chief Justice Chambers
PO Box 1091
WELLINGTON

RE: A02/09

Dear Rt. Hon Dame Sian Elias,

Thank you for your letter relating to my PhD research which I received on 6th September 2006. I understand your concerns and want to assure you that the methodology to be used in this research and the confidentiality of all judges who participate in this study has been carefully considered.

In regarding your request to write to you as Chief Justice to obtain judicial participation, I have at no time through the development of this study and the initial recruitment process with Judges, been advised that this approval was needed. As you can appreciate my background is not within the legal field, however, on taking advice from the government website (www.courtsofnz.govt.nz), I understood it was “at the discretion of the judge whether it is

appropriate to respond to any communication”. I apologise if this was the correct procedure and ask for your permission at this time.

Currently there is limited research on the use of the insanity defence in New Zealand. International research, however, indicates that the public have many misconceptions about this defence and the role of professionals who participate in these trials. In order to improve current understandings, this study aims to investigate the roles of legal and medical expert witness in court trials utilising the insanity defence. To achieve the aim of this study, I am employing a qualitative approach in order to generate insights from the perspectives of the participants. Although quantitative approaches, such as survey methods, are useful for aggregating descriptive data, they do not give us a more in-depth understanding of the experiences and/or perceptions of participants. I have attached my PhD proposal which outlines the aims and methodology of this project in more detail.

Judges who agree to participate in the study will take part in one semi-structured interview. The focus will not be on individual court cases, but rather participants viewpoints regarding the legislation pertaining to the insanity defence, and the role of medical expert witnesses in these trials. I have enclosed the proposed interview schedule to be used.

The ethical implications of this research have been carefully considered and the study gained ethical approval from the University of Auckland’s Human Participants Ethics Committee from 12th July, 2006 to 12th July 2009, Reference Number 2006/248. All personal information will remain strictly confidential and no material that could personally identify individual judges will be used in any reports on this study. Due to the limited number of expertise in this field, I cannot absolutely guarantee anonymity, however, every effort will be made to ensure their identity and the information they give remains anonymous. Pseudonyms will be used throughout the research process. All information gathered from the interviews will be used in my final thesis and academic publications. The transcriptions from interviews will be kept in a locked location at the University of Auckland and destroyed 6 years after completion of the study. Any information stored on computer files and audio-tapes will be kept on the University of Auckland server that requires a password to access.

I hope that the above detail and enclosed information addresses your concerns,

Yours sincerely,

Kate Thom

PhD Candidate

APPENDIX FIVE: THE CHIEF JUSTICE'S LETTER OF REPLY



Chief Justice of New Zealand

Our Reference: H23/11

7 March 2007

Kate Thom
PhD Candidate
Faculty of Medical and Health Sciences
The University of Auckland
Private Bag 92019
AUCKLAND

Dear Ms Thom

Thank you for the further information provided in your letter of 6 September 2006 and in particular the provision of the proposed interview schedule for the interviews with judges. I regret the delay in responding to your request but I asked my assistant, Kieron McCarron, to investigate how the judiciary has historically dealt with such requests and it has taken some time to examine the files and to also consult with the Ministry of Justice as to putting in place a proper process for consideration of research requests involving the judiciary.

I would like to make clear that the judiciary is supportive of genuine requests for research and wherever possible will cooperate with such requests. Your request highlighted the need to develop some system for processing research requests. As such, a judicial committee has now been set up to liaise with the Ministry to consider research requests in a prompt and coordinated manner.

However, in terms of your specific request, the genuine nature of your research is not questioned but the interviews will seek the individual views of judges on aspects of the existing law and options for reform, and this raises some issues of concern for me.

The questions you intend to ask seek the judges' personal opinions on legal issues that they may be required to consider in exercising their judicial functions. In addition, you seek the judges' views on law reform options and on the role and effectiveness of expert witness psychiatrists.

It is not appropriate for the judiciary to express views on such matters in the way proposed. If this is to be done at all, this should occur formally through the Chief Justice on behalf of the judiciary.

MAIL TO: Chief Justice's Chambers, PO Box 1091, Wellington, DX SP27009, Wellington
Telephone: 04 914 3639, Facsimile 04 914 3636

You may be aware that the Law Commission is currently conducting a review on criminal defences including insanity, and has approached the judiciary seeking comment on its proposals. The judiciary at this stage has not yet decided whether a response to these proposals will be made. Although I would not necessarily suggest the research you are conducting is identical to what the Law Commission is conducting, it is likely similar issues are involved. I would prefer that the judiciary as a whole consider the issues involved in the context of the Law Commission project.

I am also concerned that the number of judges who would be interviewed will be small. In the absence of a collective response from the judiciary the responses can only be individual responses from a limited number of judges. I query whether this provides a sufficient basis upon which to draw any conclusions.

I am therefore declining to agree for judges to participate in the proposed interview. I should add that the judges concerned agree with this position.

I am aware you are in contact with the Ministry of Justice concerning a request to access court records (as such I have copied this letter to Ms Lee) as part of your research.

The Ministry of Justice will consult me separately about this request. However, any application to search the court files will need to be made by you to the court or courts concerned and you will need to comply with any conditions of access the court imposes. If you wish to quote any information from the court records in your research, this will need to be made clear in your application to the court or in a subsequent application to the court.

Yours sincerely



Sian Elias
CHIEF JUSTICE

CC: Ms Angela Lee
Research Manager
Ministry of Justice
P O Box 180
Wellington

APPENDIX SIX: INTERVIEW QUESTIONS

INTERVIEW QUESTIONS: DEFENCE LAWYERS

Lawyer's details...

1. How long have you worked as a lawyer?
2. Do you work solely as a defence lawyer?
3. Approximately what proportion of your work is in the criminal jurisdiction?

My prompt: less than a ¼, about a ¼, about ½, about ¾ or all of my work.

4. Can you remember how many cases you have participated in the last 10 years where the insanity defence was used (successfully or unsuccessfully)?

The insanity defence...

The Crimes Act 1961 s23 states that 'no person shall be convicted of an offence by reason of an act done or omitted by him when labouring under 'natural imbecility' or 'disease of the mind'.

5. How do you interpret the term 'natural imbecility'?
6. How do you interpret the term 'disease of the mind'?

The legal test for insanity states that the person must be suffering from 'natural imbecility' or 'disease of the mind' to such an extent as to render him incapable of understanding the 'nature and quality of the act' or knowing that the act was 'morally wrong' according to commonly accepted standards of right and wrong.

In your opinion, is there a material difference between the 'nature' and 'quality' in this context?

7. How do you interpret the term 'morally wrong'?
8. Do you find it difficult, throughout the process of the trial, (for example when giving opening/closing addresses or cross-examining) to interpret clinical assessments and translate them into legal terms while also using language accessible to the lay jury?
9. In your view, what mental illnesses fall under these categories?

My prompt: hallucinations, psychosis but not personality disorder?

Common law states that 'insanity' has to be due to internal (organic) factors not external factors such as medication, drugs, alcohol, or a blow to the head.

10. In your experience, what, if any, tensions arise when both mental illness and drug use (or any other external factors) are involved?
11. In these trials, does the accused usually give evidence? If not, why not?

My prompt: Because an 'unbalanced' person may not do themselves justice in the witness box?

Section 20 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 states that a Judge may find the defendant NGRI if the both the defence and prosecution agree this is the reasonable verdict and the Judge is satisfied the expert evidence indicates the defendant was insane at the time the offence was committed.

12. Do you support the changes brought about by this relatively new piece of legislation?
13. Do you think current legislation – both the Crimes Act and Criminal Procedure (Mentally Impaired Persons) Act – deals affectively with major offences committed by mentally disordered persons?
 - 13a) If so, in what ways is the current legislation effective?

13b) If not, in what ways is the current legislation not effective? How could this legislation be improved?

14. Do you think the McNaghton test is outdated?

14a) If so, how would you want the McNaghton test changed?

15. Do you think NZ should introduce diminished responsibility as a partial defence to murder?

15a) If so, why?

15b) In your view, what sorts of cases give rise to a need for this defence?

Expert witnesses...

16. How would you describe the role and function of psychiatrists when acting as expert witnesses in criminal trials?

17. Do you think that psychiatrists fully understand their role and function when appearing as expert witnesses in criminal trials?

17a) If not, what are the common misunderstandings that occur?

18. Do you usually use psychiatrists trained in forensic psychiatry?

18a) In your opinion, are psychiatrists trained in forensic psychiatry readily available?

18b) If not, what effect does this limited pool of forensic psychiatrists have on criminal trials?

19. In your opinion, are psychiatric expert witnesses are neutral and the evidence they give is objective in nature?

My prompt: Does their testimony depend on who is 'paying their bills'?

20. How do you think complex or conflicting psychiatric evidence affects decision-making in these trials?

21. Have you ever experienced a case where the medical evidence in favour of insanity was clear and uncomplicated but the jury nevertheless found the person guilty?

21a) If so, can you give me an outline of the case(s)?

22. In what circumstances would it be reasonable for a jury or Judge to reject expert opinion?

My prompt: Factual basis for the opinion? Nature of offender's behaviour? Reservations and concessions in the medical evidence? Whether the mental disorder rendered offender incapable of knowing what he did was morally wrong?

Although expert evidence will invariably influence a jury by providing them with information, they are prohibited from presenting conclusive evidence as to the ultimate issue (for example, NGRI).

23. Have you any observations as to how expert witnesses manage this issue?

24. Have you ever experienced a case where an expert witness has strayed beyond their field of expertise? If so, can you give me an example?

25. Overall, what do think of the standard of psychiatric written reports and verbal testimony in New Zealand? For instance, do they use too much jargon or are their testimonies clear and concise?

26. If the standard is not good, how do you think this could be improved?

INTERVIEW QUESTIONS: PROSECUTION LAWYERS

Lawyer's details...

1. How long have you worked as a lawyer?
2. Do you work solely as a prosecutor lawyer?
3. Approximately what proportion of your work is in the criminal jurisdiction?

My prompt: less than a ¼, about a ¼, about ½, about ¾ or all of my work.

4. Can you remember how many cases you have participated in the last 10 years where the insanity defence was used (successfully or unsuccessfully)?

The insanity defence...

The Crimes Act 1961 s23 states that 'no person shall be convicted of an offence by reason of an act done or omitted by him when labouring under 'natural imbecility' or 'disease of the mind'.

5. How do you interpret the term 'natural imbecility'?
6. How do you interpret the term 'disease of the mind'?

The legal test for insanity states that the person must be suffering from 'natural imbecility' or 'disease of the mind' to such an extent as to render him incapable of understanding the 'nature and quality of the act' or knowing that the act was 'morally wrong' according to commonly accepted standards of right and wrong.

7. In your opinion, is there a material difference between 'nature' and 'quality' in this context?
8. How do you interpret the term 'morally wrong'?
9. Do you find it difficult, throughout the process of the trial, (for example when giving opening/closing addresses, cross-examining) to interpret clinical assessments and translate them into legal terms while also using language accessible to the lay jury?
10. In your view, what mental illnesses fall under these categories?

My prompt: Hallucinations, psychosis but not personality disorder?

Common law states that 'insanity' has to be due to internal (organic) factors not external factors such as medication, drugs, alcohol, or a blow to the head.

11. In your experience, what, if any, tensions arise when both mental illness and drug use (or any other external factors) are involved?

Section 20 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 states that a Judge may find the defendant NGRI if the both the defence and prosecution agree this is the reasonable verdict and the Judge is satisfied the expert evidence indicates the defendant was insane at the time the offence was committed.

12. Do you support the changes brought about by this relatively new piece of legislation?
13. Do you think current legislation – both the Crimes Act and Criminal Procedure (Mentally Impaired Persons) Act – deals affectively with major offences committed by mentally disordered persons?

13a) If so, in what ways is the current legislation effective?

13b) If not, in what ways is the current legislation not effective? How could this legislation be improved?

14. Do you think the McNaghton test outdated?
- 14a) If so, how would you want the McNaghton test changed?

15. Do you think NZ should introduce diminished responsibility as a partial defence to murder?
- 15a) If so, why?

15b) In your view, what sorts of cases give rise to a need for this defence?

Expert witnesses...

16. How would you describe the role and function of psychiatrists when acting as expert witnesses in criminal trials

17. Do you think that psychiatrists fully understand their role and function when appearing as expert witnesses in criminal trials?

17a) If not, what are the common misunderstandings that occur?

18. Do you usually use psychiatrists trained in forensic psychiatry?

18a) In your opinion, are psychiatrists trained in forensic psychiatry readily available?

18b) If not, what affect does this limited pool of forensic psychiatrists have on these trials?

19. In your opinion, are psychiatric expert witnesses neutral and the evidence they give is objective in nature?

My prompt: Does their testimony depend on who is 'paying their bills'?

20. How do you think complex or conflicting psychiatric evidence affects decision-making in criminal trials?

21. In what circumstances would it be reasonable for a jury or Judge to reject expert opinion?

My prompt: Factual basis for the opinion? Nature of offender's behaviour? Reservations and concessions in the medical evidence? Whether the mental disorder rendered offender incapable of knowing what he did was morally wrong?

Although expert evidence will invariably influence a jury by providing them with information, they are prohibited from presenting conclusive evidence as to the ultimate issue (for example, NGRI).

22. Have you any observations as to how expert witnesses manage this issue?

23. Have you ever experienced a case where an expert witness has strayed beyond their field of expertise? If so, can you give me an example?

24. Overall, what do think of the standard of psychiatric written reports and verbal testimony in New Zealand? For instance, do they use too much jargon or are their testimonies clear and concise?

25. If the standard is not good, how do you think this could be improved?

INTERVIEW QUESTIONS: PSYCHIATRISTS

Psychiatrists details...

1. How long have you been practicing as a forensic psychiatrist?
2. Can you remember approximately how many cases in the last 10 years where the insanity defence has been used (successfully or unsuccessfully) that you have given expert opinion for?
3. Have you had any other work experience in relation to the insanity defence? For example as counsel or an academic.

The insanity defence...

The Crimes Act 1961 s23 states that 'no person shall be convicted of an offence by reason of an act done or omitted by him when labouring under 'natural imbecility' or 'disease of the mind'.

4. How do you interpret the term 'natural imbecility'?
5. How do you interpret the term 'disease of the mind'?

The legal test for insanity states that the person must be suffering from 'natural imbecility' or 'disease of the mind' to such an extent as to render him incapable of understanding the 'nature and quality of the act' or knowing that the act was 'morally wrong' according to commonly accepted standards of right and wrong.

6. In your opinion, is there a material difference between 'nature' and 'quality' in this context?
7. How do you interpret the term 'morally wrong'?
9. In your view, what mental illnesses fall under these categories?

My prompt: Hallucinations, psychosis but not personality disorder?

Common law states that 'insanity' has to be due to internal (organic) factors not external factors such as medication, drugs, alcohol, or a blow to the head.

10. What are the implications when both mental illness and drug use (or any other external factors examples) are involved?

Section 20 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 states that a Judge may find the defendant NGRI if the both the defence and prosecution agree this is the reasonable verdict and the Judge is satisfied the expert evidence indicates the defendant was insane at the time the offence was committed.

11. Do you support the changes brought about by this relatively new piece of legislation?
12. Do you think current legislation – both the Crimes Act and Criminal Procedure (Mentally Impaired Persons) Act – deals affectively with major offences committed by mentally disordered persons?
 - 12a) If so, in what ways is the current legislation effective?
 - 12b) If not, in what ways is the current legislation not effective? How could this legislation be improved?
13. Do you think the McNaghton test is outdated?
 - 13a) If so, how would you want the McNaghton test changed?
14. Do you think NZ should introduce diminished responsibility as a partial defence to murder?
 - 14a) If so, why?
 - 14b) In your view, what sorts of cases give rise to a need for this defence?

On the forensic psychiatry role...

15. How would you describe your role and function when appearing as an expert witness?
16. How does the forensic assessment role vary from your usual clinical role? What would you say are the main differences?
17. Do you find it difficult to translate your clinical assessment into the legal terms, such as 'disease of the mind' while also using language accessible to a lay jury?
18. What are the ethical implications of acting as an expert witness?
 - 18a) How do you manage the ethical implications of acting as an expert witness?

19. In your opinion, do you think most psychiatric expert witnesses are neutral and the evidence they give is objective in nature?

My prompt: Does some expert testimony depend on who is 'paying their bills'?

20. How do you think complex or conflicting psychiatric evidence affects decision-making in these trials?
21. Overall, what do think of the standard of psychiatric written reports and verbal testimony in New Zealand?

On Judges and Lawyers...

22. In your opinion, do Judges presiding in these court trials have an adequate understanding of mental illness?
- 22a) Do lawyers participating in these court trials have an adequate understanding of mental illness?
- 22b) If not, what are the implications of this lack of knowledge about mental illness for these court trials?

APPENDIX SEVEN: CONFIDENTIALITY FORM



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

Deconstructing the Insanity Defence

The University of Auckland
Private Bag 92019
Auckland, New Zealand
www.health.auckland.ac.nz

Telephone: 64 9 373 7599 ext89579
Facsimile: 64 9 367 7158
Email: k.thom@auckland.ac.nz

The role of legal and medical professionals

Principal Investigator: Katey Thom

Name of transcriber: _____

- I will keep all the information on this project confidential, and will discuss the transcripts with no one other than the researcher and their supervisor.
- I will not disclose the content of the information that I have typed.
- I will protect the data files using a password, and destroy any records once they have been forwarded to the researcher Kate Thom.

Today's date _____

Signed _____

If you have any queries regarding this study please do not hesitate to contact me on (09) 3737599 ext

APPENDIX EIGHT: ETHICAL APPROVAL LETTER

Office of the Vice-Chancellor
Ethics & Biological Safety Administration



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

Level 3, 76 Symonds Street
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UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE

22 March 2010

Katey Thom
School of Nursing

Re: Application for Ethics Approval (Our Ref: 2006/248)

This letter is to confirm that the Committee met on 9 August 2006 and considered the application project titled "Deconstructing the Insanity Defence: The Role of Legal and Medical Professionals".

Ethics approval was granted for a period of three years and the approval was expired on 8 August 2009.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Lana Lon'.

Lana Lon
Executive Secretary
University of Auckland Human Participants Ethics Committee

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