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Depressed but not legally mentally impaired

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ABSTRACT

This article examines the mental impairment (insanity) defense in the Australian state of Victoria and argues that the defense is successful only when offenders suffer from psychotic mental illnesses. This raises the question about how non-psychotic offenders are dealt with by the courts when they claim 'mental impairment' for serious acts of violence such as homicide, particularly when a relatively large number of perpetrators involved in homicide suffer from non-psychotic illnesses like depression. The analysis shows that depressive illnesses do not reach the threshold for mental impairment (legal insanity) such that they mitigate violent criminal behavior, although they can, arguably, diminish culpability. This article draws upon existing literature, qualitative analysis of two court cases and semi-structured interviews with four legal representatives to make its conclusions.

1. Introduction

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*), major depressive disorder, more commonly known as depression, is a clinical disorder characterized by one or more major depressive episodes (American Psychiatric Association [APA], 2000, p. 369). A major depressive episode is in turn defined as 'a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities' (APA, 2000, p. 349). The criminal law does not treat individuals with a diagnosis of depression in the same manner as those with psychotic mental illnesses, such as schizophrenia, when assessing an offender's mental impairment. The current study explores this issue (in Victoria) and attempts to determine why this may be so. The findings will be applicable to other Australian states as well as all other liberal democratic societies that practice the common law based on the M'Naghten elements, and have similar legal systems and criteria for what constitutes 'mental impairment'.

2. The current legal framework in Victoria

In criminal law, the concept of criminal responsibility assumes that individuals have the ability to make rational choices and are able to differentiate between right and wrong. In order to find a defendant guilty of a crime or criminally responsible, the prosecution must prove beyond reasonable doubt that the act is committed voluntarily and intentionally. That is, the required *mens rea* (intent to harm) and *actus reus* (volition to harm) must be present. If one of these elements is not satisfied beyond reasonable doubt, the accused is fully acquitted. Both the *actus reus* and *mens rea* can be challenged under different circumstances. The defense may bring evidence of automatism to negate voluntariness, which may occur without the volition of the accused in circumstances of an accident, a reflex action, or while in a state of impaired consciousness (Bronitt & McSherry, 2010, p. 187). The concept of *mens rea* can also be challenged when it comes to individuals suffering from psychiatric illnesses, because these individuals may lack the required intent for culpability and the law can make an exception in these cases by exculpating the concerned defendants from criminal responsibility.

Outside this framework, the law can exculpate mentally ill offenders – under the mental impairment defense – on the basis that they did not know the nature and quality of their conduct or whether the conduct was wrong. Mental impairment – which is a legal term that refers to legal insanity rather than a medical condition – can be considered at two distinct stages of the legal system. At law in Victoria, mental impairment can be considered before trial, in terms of whether the offender is fit to be tried (or fit to plead), and raised during trial, in relation to the time at which the offense was committed. Mental illness, on the other hand, can be relevant after trial and during sentencing considerations because the law recognizes an offender's mental health state at the time of sentencing regardless of culpability.

The purpose of a trial in which mental illness is an issue is to determine whether the offender was mentally impaired at the time of their alleged crime due to a disease of mind (a legal term with no medical relevance). The basis for the modern English law (and therefore the Australian common law) of 'mental impairment' derives from the M'Naghten case in 1843, in which Daniel M'Naghten shot and killed the Prime Minister of England's private secretary, mistakenly thinking he was the Prime Minister. M'Naghten was under the delusion that he was being persecuted by the British Government. The M'Naghten[1]

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[1] 8 ER 718, [1843] UKHL J16 (http://www.bailii.org/uk/cases/UKHL/1843/J16.html).

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rule states that to establish a defense on the ground of insanity, it must be clearly proven that at the time of committing the act:

a) The party accused was laboring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act being committed or
b) If the accused did know it, that he or she did not know that the act was wrong.

The Crimes (Mental Impairment & Unfitness to be Tried) Act 1997, 1997 (CMIA) of Victoria replaced the common law defense of insanity with the defense of mental impairment in 1997. Section 20 (1) states that the defense is raised if, at the time of the crime, the person was suffering from a mental impairment so that:

a) He or she did not know the nature and quality of the conduct or
b) He or she did not know that the conduct was wrong.

Knowing the 'nature and quality' of the conduct refers to the physical element of the conduct or the estimation and understanding of the consequences of the conduct; this includes, for example, having the capacity to know and understand the significance of killing (Bronitt & McSherry, 2010, pp. 245–247). The second alternative applies to circumstances in which the accused did not know the conduct was wrong. Under section 20(1) b of the CMIA, this is explained as: 'he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong'.

At a national level, the Model Criminal Code was formalized in 1995 and was intended to serve as a model for all Australian jurisdictions (McSherry, 1997). In addition to the two elements of the defense described above, the Model Criminal Code has a third limb (a volitional component) not adopted in Victoria:

c) The person was unable to control his or her conduct.

Because this third limb is not part of the Victorian legislation, in the state of Victoria, mental impairment is determined upon satisfying one of the first two cognitive-based limbs of the defense. The question of mental impairment may be raised by the defense or prosecution [s 22 (1)], and is determined by a jury on the balance of probabilities [s21 (2)], rather than on the criminal standard of 'beyond reasonable doubt'. If the defense is successful, the person is found 'not guilty because of mental impairment' [s20 (2)]. Under this verdict, the defendant may be liable to supervision orders or may be released unconditionally [s23 (b)]. Once the court finds an accused liable to supervision, it can, under s26 of the CMIA:

a) Make a custodial supervision order (where treatment takes place in a secured place).
b) Make a non-custodial supervision order (where treatment takes place while living in the community under the conditions of the order).

The Victorian legislation does not offer a definition of mental impairment. In this regard, it is the only Australian state that employs the defense without a definition of the components of mental states that amount to mental impairment. In Queensland and Tasmania, the defense can raise 'mental impairment' or 'insanity' on the basis of an offender having had a 'mental disease'. In the Northern Territory, Western Australia, the Australian Capital Territory and South Australia, 'mental impairment' (or 'mental incompetence' in South Australia) may be raised on the basis of mental illness, brain damage, intellectual disability or senility. In New South Wales, the defense is called 'mental illness' and can be raised on the basis of a 'disease of mind' (Bronitt & McSherry, 2010, pp. 240–241). If an offender is tried in New South Wales, Queensland, the Northern Territory or the Australian Capital Territory, mental illness may also be taken into account through the defense of diminished responsibility, which is available only for homicide cases (Bronitt & McSherry, 2010, p. 315). If this defense is successful, the offender is convicted of manslaughter rather than murder, leading to a determinate sentence instead of indefinite detention at a psychiatric facility. Victoria does not recognize the partial defense of diminished responsibility. This bears certain implications for mentally ill offenders tried in this jurisdiction because if the courts consider their illness to fall short of mental impairment, these offenders cannot employ this alternative defense. Consequently, rather than the option of a determinate sentence for manslaughter through this partial defense, mentally ill offenders in Victoria are faced with either the possibility of indefinite detention with a nominal sentence of 25 years if found 'not guilty because of mental impairment', or a conviction of murder with a maximum term of a life sentence.

To examine the operationalization of the defense in Victoria, two case studies were selected: the Donna Fitchett and Arthur Freeman cases.

3. Methodology

The author qualitatively examined court transcripts of the two cases as the first method of collecting data, analyzing the main legal principles, arguments and procedures involved in the prosecution of violent mentally ill offenders. Because the Fitchett and Freeman cases were recent and high profile, and both offenders claimed mental impairment due to their depression, they were selected as suitable for examining how the defense has operated since the introduction of the CMIA in cases in which violent offenders with depression employ it, and what amounts to the legal test of 'mental impairment'.

To add contextual insight not available from documentary analysis, the author (who is also experienced in interviewing crime reporters and parliamentarians) conducted one-on-one interviews with legal representatives as the second method of gathering data. As such, the findings obtained from the interviews are examined in the 'Discussion' section below. Participants were informed by way of an explanatory form of the purpose of the study without detailed elaboration, so that they were not led in any particular direction when answering questions. A prosecutor and three defense lawyers were interviewed. They were selected based on their experience, knowledge and/or expertise in dealing with matters relating to mentally ill offenders. The interviewees had extensive experience either prosecuting or defending mentally ill offenders, including Freeman and Fitchett. Both the participants' experience in their professional roles and their involvement in the selected case studies facilitated a range of responses that were both general and specific to the case studies in question. Two participants agreed to be identified by name: Chief Crown Prosecutor Gavin Silbert and Defense Counsel Patrick Tehan. The two other defense lawyers who did not want to be identified will be referred to as Lawyer1 and Lawyer2.

The methodological approach allows for a comprehensive understanding of how the law deals with violent offenders affected by depression. That is, it allows for the analysis to progress from documentary and interview analysis to identifying what occurs in the courts when mentally ill individuals perpetrate serious violence; the key legal procedures, principles and concepts employed in the context of these cases; and the implications that may follow from the use of these principles for offenders affected by depression.

4. Results

The following sections examine how the mental impairment defense was used in the Fitchett and Freeman cases. In doing so, they explore the application of the two limbs of the defense in the Victorian legislation: not knowing either the nature and quality or the wrongness of a criminal act.

4.1. The Fitchett case

The agreed facts of the case taken from Lexis-Nexis CaseBase database, R v Fitchett [2009] VSCA 150, were as follows. On the morning of Tuesday 6 September 2005, Donna Fitchett ran a few errands, returned

home, drugged her sons with large amounts of benzodiazepines and put them to bed. After the drugs failed to take the effect she had anticipated, she used a sock to strangle one of the children. The other woke up groggy and delirious, and wet himself. Fitchett changed him into clean clothes, put him back to bed and then placed a pillow over his face to stop him from breathing. The family dog tried to intervene, but Fitchett took it outside before returning and strangling her second son with a sock. Approximately 3 h after killing her children, she swallowed a number of benzodiazepine tablets and wrote a suicide note to her husband. Two days prior, another suicide note had been mailed to her psychologist whom she was seeing in relation to her marital difficulties. Mr David Fitchett returned home at about 6:30 pm to find her drugged and the children dead in bed. He did not realize that they had died some hours earlier and attempted resuscitation. At around this time, Fitchett went into the kitchen and inflicted some wounds on her arms, neck and groin. She then went to bed and stayed there until ambulance officers arrived. She was later admitted to the Thomas Embling Hospital as an involuntary patient.

Fitchett detailed her actions to emergency, ambulance and hospital staff. She explained that she had killed her children to protect and spare them from what would be a harsh life with their father (R v Fitchett transcript, 2008, pp. 69–72). In her mind, she 'had moved them to a safer place' where 'all [was] peaceful [and] no one could ever hurt them' (2008, pp. 68–69). At her first trial, Fitchett claimed that she suffered from mental impairment at the time of killing her children. Her defense was rejected, and she was found guilty on 22 May 2008. Fitchett was sentenced to an 18–24 year custodial order at a psychiatric hospital. This decision was based on the judgment that she was mentally ill during sentencing because the law recognizes an offender's mental health state at the time of sentencing regardless of culpability. Claiming that a miscarriage of justice had occurred because the trial judge had failed to explain the outcome of a 'not guilty because of mental impairment' verdict, she successfully appealed her conviction and a re-trial began on 12 April 2010. Mental impairment was again raised as an issue at the second trial. Fitchett was found guilty for a second time, on 18 May 2010. On 1 September 2010, she was sentenced to 18–27 years in prison. This time she was sentenced to prison because, according to psychiatric opinion, her mental condition had improved and was manageable in a prison environment.

At the first trial, the prosecution argued that Fitchett set out to kill her sons in order to punish her husband for their unsatisfactory marriage. The Crown called expert psychiatrist Dr Yvonne Skinner to negate the defense's claims of mental impairment. It put forward that Fitchett's actions were motivated by spousal revenge and that she had carried out the murders 'in cold blood, consciously [and] voluntarily' (2008, pp. 59–60). At the second trial, the prosecution argued that the murders were a consequence of Fitchett's suicidal tendencies, although she was not mentally impaired to the extent that she did not know her conduct was wrong. During both trials, the defense conceded that the first limb – that 'he or she did not know the nature and quality of the conduct' – did not apply in this case. The argument put by the defense was that, at the time of the alleged crime, Fitchett 'could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong' (CMIA, s20[1] b). The 'guilty' verdict following both trials suggests that, although Fitchett was mentally ill (clinically depressed) at the time of the crime, the degree of mental illness did not reach the threshold to satisfy the defense of mental impairment to the extent that it impaired her knowledge that her conduct was wrong.

4.1.1. Proof of mental impairment during the Fitchett trial

When it comes to the issue of the impact of mental illness upon criminal responsibility, the courts require expert opinion from mental health professionals about an offender's state of mind at the time of the crime. Expert witness for the defense, forensic psychiatrist Professor Paul Mullen, gave evidence that insight into the mental health state of an offender at the time of the crime is usually derived from information gathered immediately before and after the crime (R v Fitchett transcript, 2008, p. 340). Information related to the extant circumstances before the crime would ideally be obtained from a psychiatric evaluation of the offender, but no such evaluation was available in this case. Therefore, based on the accounts provided by Mr Fitchett, Donna Fitchett's sister and Fitchett's neighbor of the circumstances prior to the offense, all of which attested to Ms Fitchett's distress and bizarre statements about conspiracy theories, she was said to be affected by a mental illness in the days leading up to the murders (2008, pp. 341–342). In trying to establish an offender's state of mind at the time of a crime, accounts obtained as soon after the offense as possible carry more weight than those obtained prior to it. Mullen explained that 'perhaps the most important thing . . . is what the person said in the hours and sometimes days after the offence [and] what their statements were to others' (2008, p. 340). The accounts given by mental health professionals within hours of and a few days following the offense indicated that Fitchett 'had a disorder of mind . . . and that was a depressive illness' (2008, pp. 341–342).

Mental impairment at the time of a crime is thus usually determined by piecing together elements of the events that occurred before and after the offense. However, in this case, Mullen gave evidence that there was 'unusual insight' into Fitchett's state of mind because she wrote a suicide note on the day of the offense, hours after the crimes had been committed (2008, p. 340). This note gave a closer insight into her possible state of mind while she was committing the crimes. If suicide attempts and depression can be taken into account as evidence of mental impairment at the time of an offense, then this 'unusual insight' was a strong piece of evidence for the defense.

Once mental illness at the time of an offense is determined, and in this case it was a non-disputed depressive illness, the next step is to determine how (or whether) it affected the accused. According to Mullen, Fitchett's rationalization about the murders was evidence of a mental illness that impaired her reasoning at the time. The fact that she believed that her actions were 'an act of love . . . a necessary act' because her children could not have a decent life without her, and that they were better off dead than being left in the care of family, friends or their father, suggested that the depressive illness had 'perverted her understanding of the world to such an extent that she actually believed . . . what she was doing was right' (2008, pp. 341–342). Mullen's further evidence was that, because Fitchett was undisputedly a loving and caring mother, the only explanation for her 'dreadful and absurd conclusion' was the depressive disorder that affected her reasoning, which was possibly aggravated by the sudden withdrawal of the antidepressants and thyroid hormones she was taking on and off, thus adding to the 'disorganization of her thought' (2008, pp. 341–342).

Mullen testified that Fitchett clearly knew the nature and quality of her conduct because she carefully prepared for the homicide and suicide, and had said goodbye to loved ones. So the first leg of the defense, as set out in section 20 of the CMIA, did not apply in this case. The question revolved around her reasoning or appreciation of right and wrong. Based on psychiatric evidence, the defense argued that Fitchett was mentally impaired at the time of the crimes such that she did not know what she was doing was wrong and therefore should not be held criminally responsible (2008, p. 348). Whether she knew her actions were legally or morally wrong was not the issue; rather, it was whether she was able to reason, as reasonable, 'normal' people would, that her actions were wrong. The defense argued, during both trials, that she was not able to reason in this way.

There were some differences between the two trials. At the first trial, the Crown contended that Fitchett's suicide attempts were not genuine. At the second trial, the prosecution no longer argued 'spousal revenge' as the motive; the only possible motive put forward by the Crown was that Fitchett was suicidal and wanted to take her children 'into death' with her (R v Fitchett [2010] VSC 393, p. 14), though not mentally impaired at the time of the crimes. Furthermore, the Crown sought

the imposition of a life sentence at the second trial, which was not a submission made at the previous trial. Nonetheless, the principal issue in question – mental impairment – was the same in both trials. The prosecution held that Fitchett committed the murders while legally sane, and well able to reason right from wrong, whereas the defense contended that Fitchett was mentally impaired at the time of the killings.

The jury rejected her defense twice. It appears that the lack of definition as to what constitutes 'mental impairment' within the Victorian legislation, as well as the familiarity of people with depression or the label 'depression', affects how members of the jury deal with violent offenders claiming mental impairment as a result of this 'familiar' condition (see Discussion). Mullen explained, however, that a psychiatric diagnosis cannot determine whether Fitchett was able to think and reason about the nature of her actions at the time of the offense (R v Fitchett transcript, 2008, p. 348). What this argument entails is that psychiatric symptoms or the mental health state of an offender at the time of their offense are of greatest significance when trying to understand criminal responsibility, rather than the diagnostic label. It is the mental condition that impairs the offender's mental functioning at the time of a crime that is more relevant. Similarly, psychiatrist Dr Danny Sullivan, another expert witness for the defense in this case, explained that although the defense is frequently raised for 'significant brain injuries or intellectual disability or psychotic illnesses, the test is not specifically defined that there must be a psychotic illness present' (2008, p. 327). He argued that the test of mental impairment extends also to 'disorders of thinking'. Sullivan asserted that, although Fitchett had no overt psychotic symptoms, her behaviors and rationalizations about her crime 'were grossly irrational' (2008, p. 327). Believing that her children would be better off dead than in the care of their father was evidence of an irrational thought process that may not be psychotic but nevertheless indicates an 'inability to reason at the time' (2008, p. 327). Despite the evidence provided by both psychiatrists, the jury denied and rejected Fitchett's claims of mental impairment twice, illustrating the difficulty in employing the defense successfully to mitigate culpability on the basis of depression. The following case is another illuminating example of this issue.

4.2. The Freeman case

The agreed facts taken from R v Freeman [2011] VSC 139 were as follows. On 29 January 2009, Arthur Freeman killed his daughter who was that day to attend her first day at school. All three of his children had been in his custody overnight staying with Freeman's parents. On the day prior to the incident, Freeman and his former wife were at the Family Court resolving a dispute over custody of their children. The arrangements for custody were altered so that the previous arrangement, of each parent having an equal share of the custody, was changed such that Freeman's access was reduced. The orders were made by consent. Freeman had been upset by his experience leading up to the custody hearing. He believed that he was unfairly treated by the court psychologist, whose report formed part of the depositional material. Following the custody agreements, Freeman arrived at his parents' home in a distressed state. On the morning of the incident, while driving his children to school, Freeman engaged in a telephone conversation with a friend in the United Kingdom (UK), in which he indicated that he believed he had 'lost' his children. Not long after that conversation concluded, Freeman received two telephone calls from his former wife. In the first, he said to her, 'Say goodbye to your children', and in the second, 'You will never see your children again'. Freeman subsequently drove to the Westgate Bridge, pulled into the extreme left-hand emergency lane and turned on the hazard lights. After he stopped the car, he told his daughter to climb over into the front seat. He then reached into the car from the driver's side, pulled her from the car to take her over to the parapet of the bridge, where he lifted her up and threw her over the edge. She died as a result of the injuries she received. Freeman then drove to the Federal Court in Melbourne.

During Freeman's trial on the charge of murder, the prosecution argued that he had killed his daughter consciously, voluntarily and deliberately, with the intent to cause her death or serious injury, motivated by spousal revenge because his former wife had altered their children's custody arrangements. Based on the expert evidence provided by Dr Skinner and Dr Douglas Bell, the Crown argued that, although Freeman was suffering from depression, it was not such that it caused him to be mentally impaired. By contrast, the defense argued that Freeman was legally insane at the time of the offense, based on Professor Graham Burrow's evidence who argued that Freeman was suffering from severe depression which caused him to 'fall' into a state of dissociation so that his acts were not conscious, voluntary, deliberate or intentional; he was acting like an automaton. This case employed both limbs of the mental impairment defense in contrast to the Fitchett case. That is, Freeman did not know the nature and quality of his conduct [s20 (1a)] or that it was wrong [s20 (1b)].

Initially, the jury in this case could not decide unanimously whether Freeman was guilty of murder or not guilty because of mental impairment. This was because the jury could not resolve the dispute between the expert witnesses (R v Freeman transcript, 2011, p. 1210). The most significant dispute was over the degree of depression from which Freeman was suffering and the consequences of his illness on his actions. The defense psychiatrist gave evidence that Freeman's depression was severe, while the Crown's expert witnesses testified that it was moderate. Because the defense has to prove mental impairment on the balance of probabilities, if the jury cannot decide which expert to believe, the defense would not be successful. Justice Paul Coghlan explained: 'If it's a question of not knowing who of the experts' evidence should be accepted or not . . . then the defence of mental impairment will not have been made out because for that defence to operate, you have to be satisfied on the balance of probabilities' (2011, p. 1227). In other words, the jury could not decide whether Freeman was more likely to be mentally impaired because they did not know which expert evidence to accept or reject, rendering the defense's argument unsuccessful. Accordingly, on 28 March 2011, Freeman was found guilty on one count of murder.

4.2.1. Proof of mental impairment during the Freeman trial

The defense argued that Freeman lacked the required *mens rea*, because of mental illness, thus committing the act unconsciously, involuntarily and unintentionally like an automaton; and that he was mentally impaired as set out in both limbs of section 20 of the CMIA. Either of these two arguments could lead to an acquittal, unless there is a mental illness that requires treatment and detention at a psychiatric facility, as per section 26 (2) (a) of the CMIA. To prove these two arguments, expert psychiatric evidence from Professor Burrows was sought by the defense. The offender's behavior before and after the crime was analyzed to gain insight into his mental state at the time of the offense.

Before interviewing Freeman thirteen months after the incident, Burrows – who is an eminent psychiatrist and expert on dissociative disorders – first examined reports from four other psychiatrists and considered the interviews he had conducted with Freeman's parents to form an opinion about Freeman's mental state at the time of the crime (R v Freeman transcript, 2011, p. 617). Burrows gave evidence that Freeman had a major depressive disorder at the severe end of the depression scale, intermittently for two years prior to the incident (2011, p. 624–626). He explained that people with major depressive disorders tend to dissociate more than those without, and that in Freeman's case he was at the severe end of the scales for both depression and dissociation such that 'he didn't really know what was going on' (2011, p. 628).

The DSM-IV-TR defines dissociation as 'a disruption of the usually integrated functions of consciousness, memory, identity or perception of the environment with intact reality testing' (APA, 2000, p. 519). The

disruption can be sudden, gradual, transient or chronic. In this case, depression was used to argue mental impairment, and dissociation to argue automatism. In the legal context, automatism refers to the state of an individual who commits a crime involuntarily. It can occur even when consciousness and awareness are present, in a state of dissociation, when there is a lack of control of the criminal conduct but a recollection of the events (McLeod, Byrne, & Aitken, 2004; McSherry, 1997, 2005b) as if they were a dream or a movie. It can also occur whether an individual has or does not have a mental illness, known as insane and sane automatism, respectively. When 'insane automatism' is raised, as it was in this case, it falls under the mental impairment defense because it can lead to a finding of 'not guilty because of mental impairment'.

Burrows argued that there is a direct correlation between hypnotizability and dissociation; the more hypnotizable an individual is, the more easily he or she will dissociate. Because Freeman scored the highest score for hypnotizability, the defense argued that he was in a dissociative state directly related to his severe depression at the time of the crime (2011, pp. 630–631). According to Burrows, Freeman's inability to remember the events further strengthened the evidence of his dissociation and lack of voluntary action. Thus, although Freeman was capable of purposive actions such as making and receiving telephone calls or driving, he was 'severely psychiatrically ill and was impaired in his judgments of what he was going to do', such that he did not know what he was doing when he threw his daughter off the bridge (2011, p. 649). The defense also argued that the memory loss Freeman experienced surrounding the killing, otherwise known as amnesia, was an indication of unwilled and unintentional conduct at the time of the offense. Dissociative amnesia is classified by the DSM-IV-TR as an inability to recall important personal information due to trauma or stress, which is too extensive to be explained by mere forgetfulness (APA, 2000, p. 520). According to the defense, Freeman's dissociative amnesia proved that the killing was not a willed, conscious or voluntary act; and that Freeman did not understand the nature of what he had done or that it was wrong, in line with section 20 of the CMIA.

The prosecution rejected the claims of mental impairment and of insane automatism. The Crown, based on the evidence put forward by Bell and Skinner, argued that Freeman was guilty of murder. As argued by Mullen in the Fitchett case, psychiatric opinion as evidence is regarded as more reliable and valuable the sooner interviews with the offender are conducted after the committal of the crime. The prosecution argued that because four other psychiatrists saw Freeman thirteen months before Burrows did, and within days or months of the event, their opinion that he was not mentally impaired at the time of the incident was more reliable simply because of the proximity of their interviews to the incident (2011, pp. 666–667). It was these psychiatrists' reports that Burrows used to form his opinion of mental impairment at the time of the crime.

The Crown psychiatrists gave evidence that Freeman's depression could not amount to mental impairment. Further strengthening the argument that psychotic illnesses and symptoms are more readily accepted as leading to mental impairment than are depressive illnesses, Bell argued that in terms of knowing the wrongfulness of an act, for people with depression, unless they are suffering from the severe form with psychotic features, the capacity for moral reasoning and the understanding of right and wrong are intact and 'preserved' (2011, p. 828). Indeed, Bell argued, as people get more depressed (and do not suffer from psychotic symptoms), their 'moral sensibility becomes heightened . . . rather than losing an ability to think about the difference between right and wrong through that self-blaming mindset that the person acquires; there is a sharpened sense of wrongfulness and rightness and their own place in that' (2011, pp. 828–829). Thus, the manner in which Freeman conducted a conversation with his friend in the UK on the morning of the incident 'clearly demonstrates an awareness of his personal circumstances at the time, and memory of what has happened in the previous twenty four hours' (2011, pp. 843–844). Freeman knew that what he was doing was wrong because in that conversation he is 'very clearly indicating a sense that he has been wrongfully treated, badly treated, unfairly treated [and] to think in that way is to think in moral terms about what has happened to him' (2011, p. 844). This did not suggest that he was not aware of the nature or wrongfulness of his act. Bell was thus suggesting that Freeman was suffering from moderate depression, had no psychotic symptoms and was therefore not mentally impaired. Likewise, Skinner testified that there was no evidence to suggest a lack of the required *mens rea* because the offense 'can be explained . . . on the basis of underlying psychological dynamics' (2011, p. 756); that is, the ongoing acrimonious custody disputes that occurred on the day prior to the offense and the unfavorable court decisions that Freeman regarded as unfair. Because 'people in dissociation act in accordance to their will and are conscious of what they're doing' (2011, p. 803), Skinner gave evidence that Freeman was not suffering from 'a mental illness, automatism or other mental condition having the effect that he did not know what he was doing or did not know the conduct was wrong' (2011, p. 757).

To address the question of automatism, Skinner rejected the proposition that Freeman lacked the required voluntariness to commit the crime and that the crime was an unwilled act because he 'was able to discuss plans with his parents, organize his children to prepare for the journey [to school] . . . spoke to the children on the journey [and] was able to make and receive telephone calls' (2011, p. 706). In contrast to the evidence by Burrows, Skinner argued that the memory loss Freeman experienced was due to 'extreme emotional arousal' (2011, p. 752) as a result of the shock or extreme stress that occurs following a killing, rather than indicating unconscious or involuntary behavior. This argument was strengthened by the fact that Freeman 'told his daughter to move into the front seat of the car . . . carried her to the bridge rail and threw her' (2011, p. 755). Similarly, Bell affirmed that 'the presence of a dissociative amnesia does not of itself establish that at the time of the crime the individual was not conscious of his actions, or capable of engaging in voluntary or willed behaviour' (2011, p. 704). He added that complex behaviors such as driving and picking up a telephone 'are not compatible with being dissociated and in a state of committing an act that is not voluntary or conscious' (2011, p. 848). Indeed, everything Freeman did on the day of the incident 'is a complex and protracted sequence of goal directed behaviours' that are incompatible with involuntary behavior (2011, p. 700). Supporting the Crown's case, Bell rejected the defense's argument that Freeman was able to drive a car while dissociated and acting unconsciously, simply because driving is a habitual and over-learned behavior that can be accomplished without conscious awareness. However, to 'direct his child to the wall of the bridge, to lift his child up off the road and then to throw his child over a ledge of a wall which required him to actually lift his child' is not behavior that is over-learned and habitual, but is a one-off that is only possible when there is awareness of the surrounding environment (2011, p. 851). There is therefore no basis, he argued, 'on which to reasonably conclude that he could not and thus did not form any intention' to kill the deceased (2011, p. 857).

This case illustrates the issues that arise from conflicting psychiatric opinions about whether mental disorders such as depression can reach the threshold for mental impairment, which have a significant influence on whether a jury accepts or rejects an offender's claim of mental impairment. Ultimately, in the Freeman case, the jury accepted the evidence of the two psychiatrists for the Crown refuting legal insanity in the context of depression. Non-psychotic illnesses like depression pose difficulties for offenders who employ the defense because these illnesses are not readily accepted as satisfying the criteria set out in section 20 of the CMIA. In addition, the Freeman case demonstrates the difficulties in employing automatism as a result of dissociation, due to conflicting psychiatric opinions about dissociation and purposive behaviors. As is evident from the various psychiatric views presented at Freeman's trial, it is difficult to prove with certainty whether a traumatic

event caused dissociation or whether dissociation caused the lack of voluntary and conscious behavior. This was particularly difficult in the Freeman case because a diagnosis of dissociation is largely based on the subjective account of the individual concerned, and Freeman was unable to give an account of his mental state at the time of the crime (2011, pp. 638–639, 745–746). It could therefore only be speculated that he was dissociating and acting unconsciously at the time of the offense, rather than making these claims with any certainty. Freeman also claimed he suffered from dissociative amnesia, which is a claim that is 'both very easy to make and very difficult to disprove' (Victorian Law Reform Commission [VLRC], 2004, p. 246). The public, judges and juries are likely to be skeptical of a claim of dissociation leading to automatism, particularly if the offender had made threats prior to the offense (VLRC, 2004, p. 246). Automatism was difficult to accept in this case because, prior to killing his daughter, Freeman had told his former wife to 'say goodbye' to her children as she would 'never see [them] again'. Furthermore, amnesia following a violent crime might not be a result of dissociation but rather a coping mechanism in response to the traumatic experience of killing.

5. Discussion

What constitutes 'mental impairment'? Although the legislation in Victoria does not state or specify precisely what it means to be 'mentally impaired', the findings in this research illustrate that, in practice, non-psychotic mental illnesses do not form the basis for a successful defense of mental impairment thereby mitigating criminal responsibility. To the best knowledge of the author, there is no data available on non-psychotic mental illnesses amounting to the legal test of mental impairment. Furthermore, the latest report by the VLRC (2004, p. 237) points out that the defense is only successful for psychotic illnesses. In seven of the nine cases in which mental impairment succeeded as a defense in a study conducted by the VLRC (2003, p. 177), the offenders were suffering from a psychotic illness characterized by hallucinations or delusions. Since the introduction of the CMIA, all of the cases in which mental impairment has succeeded as a defense have concerned offenders who had been psychotic at the time of the homicide (VLRC, 2003, p. 181).

The methodological approach taken in this study provides contextual and interpretative insight into how and why non-psychotic illnesses like depression do not seem to be readily accepted as fitting the legal test of mental impairment. With legislation that offers no definition of 'mental impairment', it is difficult to decide whether depression can impair one's appreciation of the nature and quality or wrongness of an act and thus mitigate culpability, particularly when there are conflicting psychiatric opinions. Conflicting opinions from mental health experts influence the way members of a jury understand criminal responsibility, as seen in both the Freeman and Fitchett cases. Consensus amongst psychiatrists from both legal parties on the issue of mental impairment results in 'consent mental impairment', where both the prosecution and the defense agree on the matter such that a trial is not needed[2]. However, when this is not the case, it appears that jury members do not readily accept that illnesses such as depression can render individuals legally insane, and tend to 'agree' with the Crown's arguments.

More importantly, the general public's familiarity with the more common mental illnesses like depression may influence the courts' and juries' willingness to exculpate criminal responsibility in the context of offenders who suffer from this type of illness. This may be particularly problematic when considering a criminal act as violent as killing one's own children. Depression is now understood and perceived to be a type of illness that can be experienced by 'anyone' and is psychosocially rather than biologically induced (Angermeyer & Matschinger, 2003; Phelan, Link, Stueve, & Pescosolido, 2000). As such, affected individuals are perceived to be well able to discern right from wrong, and to control their conduct. Jorm, Christensen, and Griffiths (2005) and Jorm, Kitchener, Kanowski, and Kelly (2007) argue that the Australian public does not believe that medical treatment is necessary for conditions like depression, clearly illustrating how the seriousness of depressive illnesses is often underestimated. Depression is seen as a part of life, an aspect of 'the human condition' resulting from adverse life situations (Hogg, 2011, p. 654). These popular perceptions and 'trivializations' of this illness may affect the way members of a jury reach their verdict, such that depressed offenders like Freeman and Fitchett are considered able to control their conduct and are therefore culpable. Contrarily, with 'alien' illnesses such as those of the psychotic type (Phelan et al., 2000) the concept of criminal responsibility is applied differently. Psychotic disorders, characterized by delusions and hallucinations, are understood to be biologically caused illnesses (Angermeyer & Matschinger, 2003; Phelan et al., 2000) that impair perceptions of reality (Douglas, Guy, & Hart, 2009; Link, Monahan, Stueve, & Cullen, 1999) and, therefore, render sufferers unable to control their conduct or appreciate right and wrong. It can be argued that these beliefs significantly contribute to the ready acceptance amongst courts and jurors when psychotic offenders claim mental impairment. Chief Crown Prosecutor Gavin Silbert (21 December 2010) explains why depression may not pass the legal test of mental impairment in practice:

> I'm not sure depression does qualify really because . . . you've got ordinary people sitting on a jury who've either had depression or they've got children who've got depression or they've got relatives. . . and they've got a familiarity with depression. I mean psychosis and schizophrenia are a little bit more difficult to come to terms with unless they've had some involvement with it. You need a major psychosis . . . because as far as the population goes . . . three in four females and two in four males will be depressed at some point in their lives.

In other words, a large proportion of the Australian population suffers from depression or knows of someone who has, and yet they do not commit serious violent offenses. It is therefore unlikely that the courts and jury members will accept that a depressed violent offender can be mentally impaired so as to not know right from wrong at the time of their crime. Lawyer1 (21 December 2010), on the other hand, argues that:

> There are degrees of depression that I suppose when people are very depressed, that too can render them incapable of knowing the nature and quality of their conduct or not understanding that the conduct was wrong.

McSherry (2005b) argues that various judges have indicated that conditions falling within the defense of mental impairment include psychotic disorders, cerebral arteriosclerosis, epilepsy and hyperglycemia. This makes the defense narrow, which was confirmed by the interviews with the participants selected for this research. When the research participants were asked about which psychiatric illnesses were successfully raised for the defense in practice, the following were the responses:

> The usual ones would be paranoia, schizophrenia, dissociation.
> [Lawyer2 (21 December 2010)]

> There are particular psychiatric conditions which more readily lead to the conclusion the person is mentally impaired and I suppose the most obvious one is psychosis. Where the evidence is strong in relation to psychosis, that will readily lead to a defense of mental impairment. I think also the condition called paranoid schizophrenia

[2] The Crimes (Homicide) Act 2005 (Act. No.77), 2005 (Act. No. 77) states that if both the prosecution and the defense agree that the defense of mental impairment is established, the trial judge, if satisfied, may direct that a verdict of 'not guilty because of mental impairment' be recorded [s.10 (2)(a)] without empaneling a jury.

> leads to mental impairment. One of the difficult barriers is that of depression. Depression – be it either mild or severe – is not readily perceived as amounting to a mental illness sufficient to lead to a successful defense of mental impairment, although there is no good reason it shouldn't be. But I think . . . the psychotic person who may be quite delusional is an obvious candidate for a mental impairment defense just as the paranoid schizophrenic is also.
>
> [Defense Counsel Patrick Tehan (21 December 2010)]

> A clearly diagnosed psychosis such as schizophrenia would clearly qualify. I mean, we get consent mental impairment in that situation. If you've got the defense psychiatrist saying, 'psychotic, paranoid schizophrenia' and we have them looked at by a psychiatrist on behalf of the prosecution, and they say the same thing, then . . . it goes through as consent mental impairment, there's no dispute about it.
>
> [Chief Crown Prosecutor Gavin Silbert (21 December 2010)]

Thus, although the defense is unclear as to the specific meaning of the term 'mental impairment', in practice it is successful in the case of psychiatric disorders that impair perceptions of reality and therefore knowledge of right and wrong; psychotic-type mental illnesses. Similarly, when the legal representatives were questioned about their understanding of mental illness and the mentally ill, the responses generally referred to psychotic-type mental illnesses, as evident in the following:

> Someone who is just outside the parameters of being normal – now presumably the parameters of being normal are pretty wide – but I guess there are parameters beyond which you go on either side where your behavior just becomes completely bizarre and socially unacceptable and so far outside the norm as to be classified as mentally impaired.
>
> [Chief Crown Prosecutor Gavin Silbert (21 December 2010)]

> As a lawyer, I think mental illness is what's set out in the legislation; as a private person, I think it might go beyond that. Most commonly I think are your cases of schizophrenia, or psychosis, hallucinations.
>
> [Lawyer1 (21 December 2010)]

> The one thing that comes through with a lot of the cases that I've done is . . . the grossly mentally impaired person . . . the sort of classic case of psychosis . . . sometimes accompanied by delusion, sometimes even by hallucinations.
>
> [Defense Counsel Patrick Tehan (21 December 2010)]

> Well, bizarre behavior, delusions. Depressive disorders . . . of course at their most extreme generally lead to suicide, nothing trivial about such depression.
>
> [Lawyer2 (21 December 2010)]

These findings illustrate that, in the legal context, mental illness in its psychotic form is considered severe enough to amount to mental impairment and thereby mitigate culpability in relation to violent crime. Through this defense, psychotic offenders can obtain the required treatment when found 'not guilty because of mental impairment', although the defense can have disadvantages because it can lead to indefinite detention.

Although not representative, this article provides detailed and contextual insight into the operation of the mental impairment defense in Victoria, and its findings are applicable to the international context. The fact that the CMIA is still essentially not very different from the M'Naghten test raises some concerns for mentally ill offenders who suffer from disorders that purportedly fall short of mental impairment under the current defense: those who suffer from psychiatric illnesses other than the psychotic type, particularly depression. This is significant because the defense is almost exclusively raised for homicide cases (due to the possibility of indefinite detention), and the incidence of depression amongst offenders tends to be higher than that of other disorders at the time of committing a homicide (Mullen, 1997). Thus, limiting the defense to psychotic illnesses makes it too narrow and restrictive.

Carroll and Forrester (cited in McSherry, 2005a,b) argue that the defense is narrow because its broadening would lead to the inappropriate pathologizing of 'fleeting mental states' which are distinct from mental illnesses that extend over a considerable period of time. Unsatisfactorily, this test 'reflects a poor understanding of mental illnesses' that is inconsistent with medical knowledge (VLRC, 2003, p. 173). As McSherry (2005b, p. 48) asserts, 'it may be that it is better to focus more on the effect of particular mental conditions on the person's ability to reason, rather than on which mental conditions themselves should form the basis for the defense'. But currently, diagnostic labels do matter because it can be argued that since psychotic symptoms are more persuasive to juries, Fitchett's rationalizations that her children would be better off dead rather than in the care of their father or family members, can be viewed or interpreted as psychotic-like or delusional (see Mullen's and Sullivan's arguments in Section 4.1.1 of this article). It appears that Fitchett's diagnostic label of 'depression' significantly influenced the way members of the jury understood her criminal responsibility, over the course of two different trials, despite the psychotic-like manifestations of her reasoning.

Employing the mental impairment defense should accommodate people affected by a variety of mental conditions. In theory, the defense is not confined to offenders suffering from the psychoses. Currently, however, it seems that only these illnesses are favored. Psychiatric disorders that are deemed to fall under the current defense are very few in number because of the medico-legal issue faced in addressing the question of how mental disorders influence criminal behavior. The legal definition in relation to the ability to reason about right and wrong is not relevant to the diagnosis of mental illness or psychiatric behavior in the medical field. Indeed, as Lawyer1 (21 December 2010) elaborates:

> The medical science which the courts and the legislation rely on may not be up-to-date with the various conditions that can cause a person to act in the way they [do]. So, sometimes you will have doctors saying, 'Look, the person is not mentally impaired because we can't really make that diagnosis', but you feel that there must have been something that caused them to behave in such an irrational, uncharacteristic way, and it may just be that people are looking at it too narrowly.

6. Conclusion

Overall, it may be argued that mentally impaired offenders tried in Victoria are at a disadvantage because in cases in which the courts consider non-psychotic illnesses as falling short of mental impairment there is no option to raise the partial defense of diminished responsibility to achieve a determinate and shorter sentence for manslaughter rather than murder. Having this partial defense can be preferable because a verdict of 'guilty' for murder results in either considerations of an offender's mental health at sentencing, with the possibility of indefinite detention at a psychiatric hospital, or the offender facing a maximum life-term in prison.

One of the arguments for retaining the defense as it is in Victoria is that supervision orders are made only for those with severe (psychotic) mental illnesses, without having to make these orders for those who suffer from other psychiatric illnesses, thereby causing strain on mental health services (VLRC, 2003, p. 184). Due to the limited number of beds

for psychiatric patients in Victoria (Victorian Ombudsman, 2012), this approach reduces unnecessary pressure on limited mental health services. Were the defense to be broadened, patients with less serious illnesses would be admitted to mental health facilities that are already under significant strain (VLRC, 2003, p. 184). However, the lack of psychiatric beds is not a sound reason to retain these laws when considering better policies for mentally ill offenders and the treatments they may require, regardless of the severity (mild to severe) and type (psychotic and non-psychotic) of illness or their moral culpability.

A central policy issue related to these questions concerns the difference between the medical and legal conceptualizations of psychiatric disorders. The medical approach emphasizes diagnosis and treatment, while the legal is more concerned with whether or not offenders are criminally responsible with the aim of maintaining social order. The Victorian legislation defines mental impairment by assessing whether a person lacked the ability to know or reason about their conduct at the time of their offense. By contrast, mental health professionals look for 'physiological causation', and whether an individual could understand or reason about their conduct is irrelevant to the diagnosis of mental illnesses (VLRC, 2003, p. 174). These discrepancies pose serious implications in terms of appropriate treatment for those not considered to be suffering from 'serious' mental illnesses in the context of violence and culpability, and thus fall short of the criteria that amount to mental impairment: non-psychotic offenders.

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