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PERSONALITY DISORDER AND THE LAW: SOME AWKWARD QUESTIONS

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ABSTRACT

This article raises five key problems for the law in its dealings with those with severe personality disorder. These problems are set in the context of a legislative agenda that has embraced the conflicting objectives of rehabilitation and incapacitation, whilst striving to improve treatment for those with severe personality disorder, and minimising the risk that they are thought to pose to themselves or others. The problems are examined from the perspectives of legislators, realists, clinicians and courts, empiricists and, finally, normativists; in short, what should the law be doing in this arena? The article concludes by urging a cautionary adherence to issues of legal principle in preference to the, albeit starkly portrayed, alternatives: namely, the seductive attractions of therapeutic intervention, or the destructive effects of indeterminate containment.

KEY WORDS

Capacity, criminal responsibility, culpability, dangerous and severe personality disorder (DSPD), Mental Health Act 1983, personality disorder, psychopathy, rule of law, treatment

INTRODUCTION

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. (Article 1, Universal Declaration of Human Rights, 1948)

This resounding statement encapsulates a number problematic themes for lawyers with respect to personality disorder, and acutely so for the extremes of personality disorder embraced by designations such as psychopathy or dangerous and severe personality disorder (DSPD). These designations, discussed further below, are in themselves contentious; they do not have commonly agreed definitions either across disciplines or across jurisdictions. Morse (2008), for example, argues in a fascinating account that psychopaths should be absolved from criminal responsibility for crimes that violate the moral rights of others, but that those with anti-social personality disorder should be held responsible. Equally challenging implications arise from the empirical work of the MacArthur group (Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Roth, Grisso and Banks, 2001) which indicates that it is not the affective and interpersonal 'deficits' typical of psychopaths that are linked to violence, but rather the socially deviant and irresponsible dimensions of their personalities.

In one sense, the precise disorder alleged or term employed is not critical here, for what is of interest is, as Vincent

essentially asks (2008:199), how those differences in people's make-up affects their mental capacities to act as responsible moral agents? Moreover, what these assorted terms do have in common is that people with personality disorder are largely judged by the law to have capacity and therefore do not benefit from the special protections offered to those found to be insane. Yet, those very same personality disordered people may not be able to 'act towards one another in a spirit of brotherhood' because their ability to exercise control as others might over their behaviour is impaired, albeit not extinguished.

This article poses five problems arising out of this disjunction, and in so doing questions whether those with personality disorder are treated fairly by the law. The five problems to be addressed are: do those with severe personality disorder have the cognitive capacity to understand wrong; can the graded concept of capacity and the blunter concept of rational responsibility be aligned; is the ability of those with severe personality disorder to control themselves impaired by a lack of a conventional moral conscience and/or the cognitive ability to restrain themselves; does a lay (mis)understanding of personality disorder and the vocal victims' voice impede reform; does difficulty in defining the target group make it impossible to focus reform initiatives? However, it starts with a brief diversion into the 'Rule of Law' in order to provide some context for the problems that follow.

FIVE PROBLEMS FOR THE LAW

Legal egalitarianism, the principle that all, regardless of status, are equally subject to the law of the realm, is one uncontentious aspect of the rule of law (Bingham 2010; Dicey

1915) It would necessarily require that those with personality disorder are treated as equals. The second relevant principle is that no-one can be punished without a breach of law proven in an ordinary court; thus punishment will only be imposed on those who demonstrably have infringed the law. And, as Bingham powerfully observes (2010:9), the 'hallmarks of a regime which flouts the rule of law are, alas, all too familiar'.

Yet the rule of law also stresses the need for certainty and for clarity (Raz 1979). Law should be prospective and not retrospective in nature: if people are to be liable to punishment they should at least have fair warning of that law and the capacity to comply with it. Thus, the capacity for cognitive knowledge of legal wrong would seem the most basic of pre-requisites. Yet complying with that knowledge requires other abilities and, as is argued further below, the law may not yet properly embrace that concept for those with severe forms of personality disorder.

This first problem for the law arises in part because, in England and Wales at least, knowledge of wrong for the purposes of the protections offered to the 'insane' by the M'Naghten Rules has been interpreted in this narrow sense as knowledge of legal wrong. The position elsewhere, and in particular in the United States, is more complex (see Sinnott-Armstrong and Levy 2011). A requirement for knowledge of legal wrong will exclude the vast majority of those with personality disorder from this limb of the M'Naghten defense, for this defense is confined to those who are so mentally ill, from 'disease of the mind', that they are meaningfully unaware of the law's restraints. That those with disease of the mind are exempt from the underlying legal maxim that 'ignorance of the law is no defense', is based on the unfairness that would otherwise arise: thus the law draws a

distinction between those who cannot and those who do not 'know the law'. However, the basis of even this distinction has recently been challenged in a powerful critique by Ashworth (2010). This critique begins to open up a more nuanced approach to how responsibility should be attributed, both amongst those whose 'state of ignorance' is not attributable to disorder and potentially, for the personality disordered.

That lack of capacity does justify the exceptional treatment of those 'without reason' is clear; indeed, special provisions exist in many jurisdictions so that those who are 'insane' - in that they do not know, in a conventional sense, what they are doing - cannot be held culpable, and hence liable to punishment for their behaviour, where the identical behaviour in others would constitute a criminal offence. Yet those with personality disorder are largely held to have this kind of understanding or 'reason' - they do know what they are doing - and so are excluded from an otherwise paternalistic regime which treats those who lack capacity broadly in accordance with their best interests. Indeed, in some jurisdictions the law has *explicitly excluded* those whose repeated criminal or anti-social behaviour might otherwise have been considered to constitute a mental disorder from the protections offered by an insanity defense (see generally Sinnott-Armstrong and Levy 2011, on the effect of the Model Penal Code in the US).

However, capacity is itself a problematic concept and this constitutes the second problem area for the law. Psychologists would argue that capacity is a functional concept and that individuals should not be thought of as having or lacking capacity: an individual may have the capacity to make one decision but not another where those decisions vary in complexity. An individual's capacity to

make particular decisions or do specific things will vary in time and in interaction with the support provided. The Mental Capacity Act 2005 in England and Wales recognises this (see for example, s.1(3)) in its core principles with respect to how capacity is assessed and how decisions should be made for those who do not have the capacity to make them.

However, the criminal law is much more abrupt in its approach so those with personality disorder will encounter both the nuanced variety applied above by the civil law and its blunter counterpart in criminal law. There degrees of capacity are barely recognised beyond the limited defense of diminished responsibility to murder. And even that defense does not exculpate but works primarily as a device, following conviction for the lesser offence of manslaughter, to mitigate punishment. Furthermore, the majority of those verdicts of manslaughter (attributed to diminished responsibility) do not result in hospital disposals and rarely apply (although they are applicable) to those with personality disorder.

This second problem, arising out of differing notions of capacity and its applicability in different areas, can be crystallised in the knotty question of whether the concepts of capacity and rational responsibility are analogous. If decisions are made by people with personality disorder that would not seem reasoned to others, will they nonetheless be regarded as decisions made with capacity by those who judge their behaviour according to current legal principles? This is not an easy question to unpack. Under the Mental Capacity Act 2005, capacity and reason are not analogous: indeed, merely making an unwise decision would be an insufficient basis on which to conclude that a person lacked capacity. But would a decision over which one has not exercised 'choice' be regarded as capacitous, by which I mean one made by a person

with sufficient capacity in law to make the decision in question? Charland (2002), for example, asks whether one can be said to have given capacitous consent to taking medically prescribed heroin in a research trial if one is already addicted to heroin. Much of this turns around threshold questions: how much capacity is required to be able to make particular decisions with consequences of varying severity? Pitching the threshold low enables problematic decisions to be made by those who might arguably need to be protected from the consequences of those decisions; pitching it high will deprive individuals of autonomy but protect them from taking culpable decisions for which they might subsequently be punished. The temptation is to equate capacity with what other people might regard as reasonable (or reasoned) decisions, but this fundamentally undermines the notion that we all value things differently, and that these values ought to be protected within a democratic society insofar as is 'reasonably' possible.

Third, stereotypically those with extremes of personality disorder and, in particular, 'psychopathy' have been held not to have a conventional conscience: in clinical and research terms this has been portrayed as such individuals lacking the emotional component that is normally associated with a cognitive appreciation of the meaning of life's experiences (Cleckley 1976). Or put another way, they may experience problems with feeling guilt, empathising with their victims, learning from their experiences, and indeed responding to punishment (Blair, Mitchell and Blair 2005). This can jeopardise both rehabilitative and treatment endeavours. Whether this lack of a moral conscience should also absolve psychopathic offenders from criminal culpability, albeit not state intervention, is another pertinent question (Morse 2008). Indeed, as Morse sets out (2008:209) it is possible that the failure of psychopaths to restrain themselves (see

below) is not due to some irresistible impulse but rather to an inability, due to rational deficits, to identify good reasons for that restraint.

However, it has recently been suggested that the assertion of an emotional deficit, a form of emotional detachment, may not be wholly accurate (see generally Pham, Durco and Luminet 2010). Psychopaths may be able to identify feelings even if they don't respond to them in a conventional sense; in short, they are emotionally intelligent, but are able to use this intelligence to their own advantage because they perceive themselves as being better able to manage and regulate their emotional states. Neutral observers would not necessarily endorse this unique view, but the analysis would be consistent with a view of psychopaths as having the capacity to be both manipulative and charming (Hare 2003). Some have even argued that such individuals can exploit these deemed deficits, leading to the concept of 'callous empathy' coined by Book, Quinsey and Langford (2007). Much has also recently been made of the explanatory force of empathy, or its absence, across a range of personality disorders (Baron-Cohen 2011) leading to questions about the appropriateness of punishing those with empathetic deficits; whether such questions would run contrary to the findings of the MacArthur group referred to earlier, at least insofar as psychopaths were concerned, remains an issue.

Such psychological 'deficits' may, of course, protect those with personality disorder both from the emotional and traumatic consequences of their own crimes and enable them better to survive detention in either prisons or psychiatric hospitals. And, in non-institutional, commercial and professional contexts, these 'deficits', when combined with high levels of conscientiousness, have indeed been known to be advantageous (for the latest illustration see Mullins-

Sweatt Glover, Derefinko, Miller and Widiger 2010). These authors assert that it is differences in conscientiousness that makes the difference between successful and unsuccessful psychopaths. What constitutes psychopathy is thus contentious: although there may be agreement on the core traits, some of these traits may be adaptive in different settings and some independently adaptive traits, for example fearlessness, may not be included in a designation of psychopathy based exclusively on maladaptive traits.

As our understanding of the psychological traits that may or may not underpin personality disorder become increasingly sophisticated, the law's response remains, perhaps understandably, relatively static. And quite how the law should respond to those who do not adhere to its underlying precepts creates this third set of problems. Their essence is this: before punishment can be imposed the law requires that culpability be proven on the basis of capacitous law-breaking. But what is to be done about those who retain capacity in a conventional clinical sense, but who nonetheless either lack the ability voluntarily to control their behaviour in the conventional sense, or whose ability is impaired? Thus, whilst lawyers may be happy to draw a bright dividing line between those who don't and those who can't control their behaviour, in the field of personality disorder these distinctions are not so easy. What is to be done about those who may be conventionally culpable in the sense that they knowingly caused injury to another, but who may not merit punishment because they were unable fully to control their behaviour? Or because their own psychological make-up impairs their capacity to respond as others might, or enables them to respond as other's would not or could not? Factors such as a low tolerance for frustration and impulsivity, combined with substance misuse facilitated by impaired moral reasoning, can make for a murky picture: and

yet such maladaptive traits will be placed into a context where, since those with personality disorder remain capable of instrumental reasoning to achieve their goals, the capacity to respond to moral reasoning will remain, at least in part (see Glannon 2008). In short, should those with personality disorder be dealt with differently by the law because their capacity to control themselves is impaired, albeit not extinguished? And is this a matter of mitigation and partial excuse, rather than exculpation?

This is important when one considers what interventions are appropriate for those with personality disorder: in law one needs to be found criminally responsible before punishment can be imposed but just because one is culpable in that legal sense does not mean that punishment should necessarily result - treatment may be aimed at augmenting an 'offender's' ability to control their behaviour and this may be a preferable outcome to mere punishment. This lack of clarity is not assisted in England and Wales, where sentencers are currently required to have regard to a number of purposes including, but not limited to, both punishment and rehabilitation (see Criminal Justice Act 2003 s.142(1)). Yet, if there is a fault in an individual's control mechanisms, then maybe the attribution of culpability should not be a black and white affair. At one level the law recognises these distinctions with its rules on legal and factual causation, but the application of these rules is arguably harsh since, at least insofar as legal causation is concerned, the law will hold blameworthy (in the sense that it regards it as fair to hold them liable) an agent whose contribution to the event is partial. Thus, the law asks were the defendant's actions 'a' cause of the event, albeit not 'the' only cause? Whilst the critical question might be did the individual have sufficient control to be held culpable for this partial contribution to events (a binary decision),

the notion of partial causal responsibility goes only to inculpate not exculpate.

Fourth, and leading on from this, those who offend in the context of severe personality disorder have not acted 'towards one another in a spirit of brotherhood'. This poses further problems for legislators, policy-makers and clinicians since it brings into the equation the interests not only of the personality disordered individual but also an unquantifiable 'other' presence. The existence of a vocal and seriously injured section of the public may in turn combine with a further significant proportion of the wider public who may live in fear, justified or not, of becoming victims. And this fear may be inappropriately fed by a common lay misunderstanding about the nature of personality disorder, and in particular, of the term psychopathy. This can create a momentum for those very legislators and policy-makers to act, and for clinicians to respond.

But what is to be done? And about whom? And this latter question poses a fifth category of problem for lawyers since it is not at all clear that there is agreement about the category of individual for whom special measures might be justified. Are they to be identified on the basis of their offending behaviour (in which case, of what type of offence, of what severity and of what frequency?); or are they to be identified according to the threat of offending they pose (in which case on the basis of what evidence: past offending or of some personal characteristics of the individual, presumably the underlying personality disorder?). And with what degree of certainty are such predictions or judgments to be made in order that they be legally persuasive? Moreover, it should be stressed that these questions are not merely theoretical: the law currently permits the long-term detention of those with personality disorder where

appropriate treatment is available (albeit treatment with no necessary guarantee of effectiveness) even in the absence of proven culpable offending.

And finally, all of these problems need to be addressed in the context of considerable uncertainty amongst the clinical and research community about what the nature of the disorders are, whether they are indeed treatable, remediable or manageable, and how one might know when improvement has come about without taking risks with what may be a population that may have been proven to be capable of the most serious forms of violent or sexual offending. And yet these uncertainties are played out against a legislative and policy agenda which can be as much influenced by inappropriate certainty about what needs to be done and by a public misunderstanding of severe personality disorder, as by any well-informed or balanced approach to personality disorder. In short, the law has yet properly to grapple with what would constitute a fair response to the very real problems those with personality disorder pose: a more graded approach, which would recognise degrees of responsibility appropriate to the range of complex capacities all people have, might be one way forward.

The next sections of this article now shift to examining these problems from the perspectives of a number of players, including both those who work in direct contact with those with personality disorder, and of those who juggle more remotely with what the law is or ought to be. The first section starts by looking in brief at the recent legislative reform initiatives in the unique area of 'dangerous and severe personality disorder' - and unique in the sense that this was a designation unrecognised by either clinicians or legislators.

A (parochial) legislator's view

In England and Wales, the most recent legislative initiatives have been based seemingly on a view of the severely personality disordered as encapsulating a very needy but inappropriately neglected group. Hence, in 1999 a government document which launched the DSPD programme of reform asserted

Dangerous severely personality disordered people often do not get the help they need to manage the consequences of their disorder. Most have a lifelong history of profound difficulties from an early age - many are the children of violent, abusive or inadequate parents, some may have been removed into care. Many are poorly educated and have a history of difficulty in finding work and housing. In adult life they have difficulty forming meaningful relationships with others, frequently become involved in substance misuse, and suffer from depression or other mental illness. They are more likely than others to die violently by suicide or in accidents. So far no effective strategies have been identified to prevent development of severe personality disorder. (Home Office and DoH 1999:5)

The intentions of this document might be seen as wholly honourable. Indeed, in 2000 the then Secretary of State appealed with seeming irritation, bordering on incredulity, to the conventions of mainstream medical practice by asserting

Quite extraordinarily for a medical profession, the psychiatric profession has said that it will take on only patients whom it regards as treatable. If that philosophy applied anywhere else in medicine, no progress would be made in medicine. It is time that the psychiatric profession seriously examined its own

practices and tried to modernise them in a way that it has so far failed to do.

(Jack Straw: *Hansard* 26 October 2000 column 9)

The notion that the boundaries of successful medical practice have only been extended by clinicians trying to treat difficult cases is intuitively persuasive, but it belies a central truth. Conventional medical practice requires not only clinicians who are willing to offer treatment but also patients who are willing to be treated and who define their own conditions as in need of a remedy. People may not define their disorders as in need of treatment for all sorts of reasons that are understandable because that reasoning is part of the disorder; for example, an individual who believes in the power of herbal remedies or who defines an abnormal condition, perhaps the growth of a tumour, as normal for them may not seek help or may indeed actively resist treatment.

Pearce and Pickard (2010) illustrate well how the obverse of this, treating patients as responsible agents in their own recovery and assisting patients to exercise their own 'willpower' in a non-judgemental manner, can facilitate that recovery rather than impede it. Active patient engagement may be one key to recovery. But people with severe personality disorder may not frequently, or even necessarily, define their disorders as being in need of treatment. And whilst personality disordered patients may well be demanding of a general practitioner's time and skills with respect to their own problematic behaviours, it is not evident that those who go on to commit serious offences were seeking such medical help prior to offending. Notably, of the sample of homicide perpetrators with personality disorder reported to the national confidential inquiry over a five year, 43% of them

had had no previous contact with mental health services (Appleby, Shaw, Kapur, Windfuhr, Ashton, Swinson and While 2006).

Of course treatment within psychiatry does not always require the consent of the patient. This may be either because the patient is unable to give consent due to a lack of capacity (not usually a problem for these with personality disorder, but it may be a relevant factor - see below, in the case of Ian Brady) or because treatment can be imposed on a compulsory basis if the individual falls within the terms of the statute authorising such compulsory treatment for mental disorder. Yet, at least in the UK, this has been perceived in recent times to be a problem in need of a legislative solution.

Whilst it would be a hazardous exercise to determine how health care is rationed across the somatic-psychiatric spectrum (and even the notion of a broad divide, which a spectrum with extremes implies, is itself contested: Matthews 1999) it might be crudely characterised as the use of queuing for those with somatic disorders and an expensive resort to compulsion for those with severe personality disorder. And although there are seemingly insufficient resources to meet the demands of those with various forms of addictive and problematic behaviour who have not offended, or not offended with any great level of seriousness, one might conclude from the extremely generous financial resources put into the DSPD programme (Rutherford 2010) that it is the use of compulsion for a small number of individuals that attracts, and arguably skews, provision for those with personality disorder.

That said, the figures on the use of compulsion under the Mental Health Act 1983 reveal something of a paradox. In its unamended form, which persisted for some 24 years, s.1(2) of

the Mental Health Act 1983 defined 'psychopathic disorder' as those with

a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

Although those with psychopathic disorder clearly could have been compulsorily treated very few were. Indeed, of compulsory admissions during the year 2007-8 there were 9,995 admissions for those with mental illness and only 147 for those with psychopathic disorder. Moreover, of those 147 admissions the bulk (71) emanated from prisoners being transferred to hospital: the courts exercised their powers to send an offender direct to hospital, with or without a restriction order attached, on only 21 occasions. Whether this suggests reluctance on the part of the court to use these orders, reluctance by clinicians to offer beds to the courts for these offenders, or some technical legal impediment, is not entirely clear. But it should be noted that the courts did make hospital orders, with or without restrictions, for 483 offenders suffering from mental illness during that year. And it should also be noted that the legal impediment which the Mental Health Act 2007 was designed in part to address, namely the problematic treatability clause, may have existed as much in the minds of legislators as in reality. This is discussed further below. For if the explanation does lie as much in clinical reluctance to take psychopathically disordered patients into hospital beds, one might question whether any quantity of haranguing of the profession by the relevant Secretary of State is likely to have made any difference.

A realist's view: the political agenda

Another way of looking at the DSPD initiative was to see it as part of a general programme of reforms aimed at protecting the public from the threats perceived to be posed by those suffering from severe personality disorder. Consistent with this view would be the initial proposal that some individuals with severe personality disorder who had never offended, and who might be of questionable treatability, might nonetheless be subject to a programme of compulsory treatment. Although this particular proposal was never implemented in this form, it had always been possible under the Mental Health Act 1983 that those suffering from the requisite disorders of personality could be admitted to a psychiatric hospital where they met the criteria for admission including showing 'abnormally aggressive or seriously irresponsible conduct': the latter notably implied offending but did not require it. Yet the figures given above suggest the power was rarely used. So the DSPD initiative might have been aimed at making it easier to admit such patients or to encourage more frequent use of the powers for those who could already have been admitted.

Certainly in recent years there has been a greater embracing of indeterminate powers; first through the introduction of 'Indeterminate Sentences for Public Protection' under the Criminal Justice Act 2003 and also by the assorted amendments to the Mental Health Act 1983. These included broadening the definition of mental disorder, extending hybrid orders to all forms of mental disorder (the hybrid order allows the courts to send an offender first to hospital for treatment and then to prison to complete a sentence for the purposes of punishment), removing the notion of time limited restriction orders so that they all become indefinite orders and, critically, diluting the treatability requirement so that it

becomes not predictive but aspirational. Thus, clinicians will no longer have to assert that treatment 'is likely to alleviate or prevent a deterioration' but rather that appropriate medical treatment is *available*, with the *purpose* of medical treatment being 'to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations' (Mental Health Act 1983 s. 145(4)).

It should also be noted that the document referred to above 'Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development' (Home Office/DoH 1999) as having honourable therapeutic intentions can be assessed against this risk-prevention agenda. As Toby Seddon (2008:307) observes 'the language of risk pervades the official documentary discourse' about DSPD: indeed, as he asserts the word 'risk' is used over 100 times in a 76 page document. However, in Seddon's careful analysis the notion that the DSPD programme was based solely on risk is rejected. Rather, as he argues (2008:311), it involved a multi-faceted response which is

at once *political* (designed to play on those public fears), *instrumental* (promising increased public safety through the use of institutional confinement) and deeply *emotive* (going to the heart of our most troubling anxieties about insecurity).

Yet, as he further notes, the risk discourse embedded in the DSPD programme is instrumental in another way. For, unlike comparator programmes for the civil confinement of sexual violent predators in other jurisdictions, most notably but not exclusively the USA, it does hold out the prospect of therapeutic engagement and was not intended to constitute mere preventive detention (Mercado and Ogloff 2007). Whether, of course, the best of these intentions are capable of being

fulfilled is another matter. Eastman's notion that the personality traits constituting the personality disorder 'are' us, and can only be diagnosed as a disorder by assessing the severity of the symptoms against those of a normal population, rather than against what is normal for that individual, makes people with personality disorder peculiarly difficult in treatment terms (Select Committee on Home Affairs, 2000: para 176). Not only may these disorders be difficult (and contentious) to diagnose but they may also be, unlike conventional illness, highly resistant to change; developmental disorders thus cause particular problems for the law. And the early findings of the assessment of the DSPD programmes have not been encouraging, suggesting a morphing back to what arguably may be more akin to containment and less akin to the high aspirations held by DSPD programme evangelists, albeit that the development of such therapeutic endeavours has been welcomed (Tyrer, Cooper, Rutter, Sievewright, Duggan, Maden, Barrett, Joyce, Rao, Nur, Cicchetti, Crawford and Byford 2009, Tyrer, Duggan, Cooper, Crawford, Sievewright, Rutter, Maden, Byford and Barrett 2010, Ramsay, Saradjian, Murphy and Freestone 2009).

The professionals' view: clinicians and the courts

The law starts from the premise that all individuals have the capacity to make decisions about themselves: this is a presumption that can be rebutted. Similarly, whilst psychiatrists may readily conclude that those with various mental illnesses or learning disabilities may lack decision-making capacity with respect to particular decisions, for example the decision to refuse treatment, there is no such easy resolution with respect to those with personality disorder. Indeed, such disorders, broadly conceived as

enduring patterns of maladaptive traits which may even have their defining terms seen as encapsulating a lack of moral behaviour rather than some cognitive impairment (Charland 2006), have not primarily been thought of as affecting an individual's capacity to make decisions. Yet problematic and other offending behaviour - actions and omissions on the individual's part - are largely conceived as a product of the individual's choosing; intervening to change these behaviours can be perceived not only as inherently unlikely to succeed, but also as ethically problematic where it may additionally entail the admission of criminal conduct which has not previously been admitted.

However, Szmukler (2009) has questioned whether personality disorder may indeed affect one's capacity to make decisions (and which may accordingly either create a basis to intervene against a patient's seeming wishes or absolve someone from criminal culpability). As he observes, clinicians are not infrequently faced with individuals in states of considerable arousal or distress, sometimes with suicidal intentions, where the clinician may wish to seek to override a decision to refuse treatment. Patients who have self-harmed, but who refuse life saving treatments, pose particular dilemmas for clinicians (see David, Hotopf, Moran, Owen, Szmukler and Richardson 2010), evidenced by a number of cases that have come before the courts. These arise in particular where a patient's treatment refusal may lead to death. Persistent self-harm involving personality disorder, or sometimes even harm to a foetus would be amongst those cases: such individuals occasionally have been held to be appropriately subject to a mental health intervention, where capacity or its absence is not a defining criterion (see for example *B v Croydon Health Authority* [1995] 1 All ER 683). Moreover, the approach of the courts to determining a lack decision-making

capacity, admittedly prior to the introduction of the Mental Capacity Act 2005, has been sufficiently malleable potentially to include those with personality disorder: see, for example, *St George's Healthcare NHS Trust v S* [1998] 3 All ER 673 CA. As noted above, these cases seem to arise most acutely where issues of harm to self or to others are entailed. It is accordingly tempting to ask whether the dire nature of the consequences that would follow from assessing an individual to have capacity, leads to that individual being assessed as not having capacity. Or as Szmukler (2009:649) puts it, having observed the real difficulty in deciding and agreeing upon a threshold for attributing capacity 'It is important to bear in mind a temptation for the clinician to raise the threshold when there is disagreement and when there are significant risks'. Again, the advantages referred to earlier that accrue from employing a sliding scale of capacity - amongst others that its sensitivity can enhance autonomous choices - need to be set against the problems that can arise with the consistent application of any such scale when conflicting objectives are pursued.

The context driven nature of this decision is illustrated by two similar cases which arose in respect of offenders convicted of murder but held in different locations; namely a secure psychiatric hospital and a prison. These are the cases of Brady and W (see Peay 2010:140-143). Both concerned individuals with diagnoses of personality disorder (or under the Mental Health Act 1983, 'psychopathic disorder'), who sought to manipulate the situation in which they were detained by resort to self-harm: threatened in Brady's case by the refusal of food, and in W's case the refusal of needed treatment for self-inflicted injury.

The contrast in outcome could not be more stark. In Brady's case, whilst not strictly determinative since the court held that feeding him by force was a treatment that could be given without his consent under s.63 of the Mental Health Act 1983, the court did go on to consider whether he would have had the capacity to refuse treatment, and determined that he would not have had such capacity. Evidence was given by Brady's Responsible Medical Officer, who observed that Brady's ability to weigh information (part of the test for determining whether someone had capacity with respect to a particular decision),

was impaired by the emotions and perceptions he had at the time... These emotions and perceptions were related to his personality disorder.

Indeed, as he said in evidence

His spectacles are blinkered... Although he weighs facts, his set of scales are not calibrated properly in a whole range of things, especially related to Ashworth.

(*R v Collins and Ashworth Hospital ex parte Brady* at para 59)

Yet in the case of W, who had been transferred from prison to hospital (where his disorder was considered not to be amenable to treatment) and then back to prison, the prisoner's decision to self-harm, by attempting to turn a self-inflicted leg wound septic, was held to be capacitous. As Butler-Sloss, the President of the High Court determined, the right of choice to refuse treatment could include 'manipulative reasons' *Re W (Adult: Refusal of Medical Treatment)* [2002] EWHC 901. In so doing she cited the case of *Re T* where the court had held that 'The patient's right of choice exists whether the reasons for making that choice are

rational, irrational, unknown or even non-existent' *Re T (After refusal of treatment)* [1993] Fam 95. Yet, notably, W's psychopathic disorder was characterised by paranoid thinking and a loss of ability to accept responsibility for his own actions. Such characteristics in another context might arguably have created a basis to maintain that he did not have the capacity to refuse treatment.

There are a series of possible reasons why the two courts reached such contrasting decisions: these could include both the relative seniority of the judges involved, the consequences that would follow from a decision made either way (and the Brady case attracted considerable publicity due to the notoriety of the particular patient), and the luxury that the court in Brady did not need to base its decision on the issue of capacity since the fact that the offender was detained subject to the Mental Health Act 1983 made the imposition of feeding possible by this statutory route. However, questions remain about whether, as Szmukler suggests, the convenience of a sliding threshold for capacity in the case of those with personality disorder is perceived as a potential route out of a treatment difficulty. And if this is so, what consequences might follow were the issue of personality disorder to be more rigorously examined in the context of questions about an individual's capacity to make decisions about a particular issue. Are those with personality disorder not to enjoy the same protections in law as those with or without mental illness; or is it that the same sliding scale of convenience might apply to all of those with mental disorder no matter how labelled?

It is notable that in Szmukler's two case studies both were, given sufficient time in interaction with their clinician, held to have the capacity to make the requisite decision

despite having originally been in states where their decision-making might have been thought to be impaired. Quite what made the difference is unclear, but Szmukler does speculate that the lengthy process of assessing the patient's capacity may in itself have been therapeutic (Szmukler 2010:649). It is fair to stress, of course, that in a number of the contested cases where personality disorder has been held to impair capacitous decision-making, there was some urgency to make the decision. The notion that individuals with personality disorder (or indeed learning disability) can be brought to a state of understanding where they can be held to make capacitous decisions is very much in keeping with the notion that the treatments that are likely to be offered (and indeed, likely to be at all effective) are those that require the patient's voluntary participation; namely various forms of cognitive or behavioural therapy, including group therapy and the therapeutic community approach. And the situation is similar for offenders: treatment success for those with personality disorder has been most impressive at institutions like Grendon Prison, the prototype for therapeutic communities in this field, where prisoners volunteer to be transferred, and are not taken under compulsion (although the coercive pressure that the knowledge of indefinite detention in combination with the experience of conditions within the conventional prison system no doubt has some independent effect; Genders and Player 2010). Whether there may be a negative placebo effect arising out of the use of compulsion is an intriguing possibility that deserves fuller exploration.

This leaves hanging the notion that the courts accept that capacitous decision-making can be based on irrational reasons. As Craigie and Coram's excellent analysis of the

problematic relationship between capacity and rationality observes (forthcoming)

The law ... aims to preserve the patient's right to determine their own course of treatment, even in the face of dissenting medical advice

and this is in part because capacitous decisions that reflect the individual's own goals, preferences and values are tied up with the selection of those treatment decisions that will best promote the patient's well being. In short, although one can disagree with a treatment decision, that decision may nonetheless be the best for that individual, given their values and objectives. However, what approach should be adopted where the process of pursuing those objectives is deemed irrational, or the values themselves are distorted by cognitive or emotional impairments? The law's desire to preserve individual autonomy may result in privileging decisions that are capacitous in name, but do not reflect the individual's true preferences. This is a hard line to draw where autonomous decision-making is affected by illness so that it does not run its true path. But where it is affected by personality disorder and there is no clear distinction, other than a moral one judged by others, between the true path and the disordered path because the 'personality disorder' is central to the individual's make-up, then the rational and the irrational, the capacitous and the incapacitous, are almost impossible to disentangle.

In the same way in law that the unreasonableness of a mistake may be used by a jury to question whether the alleged mistake has been honestly made, thereby undermining the purity of the maxim that an honest mistake, no matter how unreasonable, provides a defense, decisions judged to be irrational by an

outside observer may cause the capacity of the individual to be more closely examined. Yet this covert approach to the assessment of capacity runs counter to both the common law and statute (The Mental Capacity Act 2005 s1(4)) where unwise decisions (ie substantive outcomes) are not to be used in isolation to judge capacity since this would undermine the law's very objective of protecting autonomous, albeit highly eccentric, decisions.

A (limited) empiricist's view

Arriving at an empirical view of law and personality disorder is fraught: personality disorder has no agreed definition. Moreover, those definitions that exist are based on shifting sands, and sands that are likely to shift again with the revisions to be embodied in DSMV (Leader 2010, 2011). However, the broadening of definitions of mental disorder, and the inclusion of disorders that have not yet manifested themselves, potentially open up psychiatric defenses based on personality disorder.

The law is not immune to such revisions either. For example, indefinite detention based on the potential for future harm already contributes significantly to the prison population (Rutherford 2010) and the recent changes to the law on diminished responsibility under the Coroners and Justice Act 2009 makes 'a recognised medical condition' the gateway to the defense. The terms thereafter to be satisfied include the substantial impairment of either the ability to understand one's own conduct, or to form a rational judgment or exercise self-control (see generally s.52). And if self-control is the limb to be employed then the abnormality of mental functioning has to have a causal connection with, or

constitute a significant contributory factor to, the defendant's conduct. The interaction of broadened clinical conditions with broadened legal defenses has yet to play itself out in practice; and just how, and whether, disorders of mental functioning will embrace those with personality disorder is not clear. Notionally, they could include the aroused and distressed states discussed by Szmukler (2009) above.

Yet, even within the relatively narrow field of DSPD, where definitions were agreed for admission to the new assessment and treatment units, the research evidence shows that these definitions have not been adhered to consistently (Tyrer, Cooper, Rutter, Sievewright, Duggan, Maden, Barrett, Joyce, Rao, Nur, Cicchetti, Crawford and Byford 2009) making any attempt to assess outcomes fraught. Similarly, within the legal arena, the perceived impediment of the 'treatability clause' for those suffering from psychopathic disorder under the Mental Health Act 1983 proved a chimera, albeit one constituting not only a potential clinical 'get-out' clause but also grist for those intent on its legal abolition (see the saga of the Scottish cases discussed in Peay 2010 which illustrates how the treatability requirement has been so broadly interpreted by the courts as to be almost meaningless: the structured environment which facilitated anger management could itself be deemed 'treatment' *Hutchison Reid v Secretary of State for Scotland and another* (1998) House of Lords, 3 December 1998). The gulf between clinical and legal theory, and their practice, makes any convincing empirical assessment improbable.

However, there are empirical questions that can be asked even if they are unlikely to be answered. Against what treatment or rehabilitative standards respectively are efforts in

hospitals and prisons to be assessed? If the primary objective is amelioration of the disorder in hospital and reduction in risk in prison, how is change to be evaluated and validated? What level of certainty in judgements is to be employed (see for example, Szmukler 2003, and Hart, Michie and Cooke 2007)? What is to be done where successful treatment of the disorder may not be associated with reduction in risk; or where successful reduction in subsequent offending may nonetheless leave the disorder intact? If the objective is greater control by the individual of his or her behaviour, how could this be tested where release mechanisms lie in the hands not of the clinicians/therapeutic agents who provide evidence for the existence of change, but in those of Tribunals and Parole Boards who make decisions against a statutory context embracing the absence of disorder and/or minimal risk-taking?

Finally, from an empirical point of view the dilemmas for those dealing with those with personality disorder are more acute than for those with other mental disorders. The correlations between severe personality disorder and violent behaviour are stronger than for those with mental illness generally, albeit that these correlations may derive as much from a definitional overlap as any underlying causative mechanism. However, the consequence is that the area of manoeuvrability is much reduced between what is attributable to autonomous choice, or to an ingrained pattern of behaviour attributable to underlying personality traits, or to a life exposed to particular norms and values; or indeed the interaction between them, or all three of them.

A normativist's view

It is inevitable that people with personality disorder will find themselves in conflict with the law and do so in arguably more problematic ways than those with mental illnesses: the routine retention of capacitous decision-making, possibly in the context of behaviour which may not be wholly resistible or controllable, challenges the law's mechanisms for determining who should and who should not be held criminally responsible; and who should and who should not be subject to a paternalistic-based form of state intervention. Such elements of qualified determinism are particularly challenging. The chequered history in the United States of the Model Penal Code's framework for the insanity defense, with its exclusion of those engaging in repeated anti-social conduct, is testament to these difficulties (see, for a detailed analysis, Sinnott-Armstrong and Levy 2011). Yet, the desire of legislators to address the problems of self-harm, and harm to others, make resolving those problems an understandable objective. But what limits should there be on this interventionist agenda? Limits imposed by what is known to be possible, or what might be achieved were more efforts or more innovative strategies to be involved? The innovative route risks intervening in the lives of those where intervention is not justified, and may be counterproductive. Furthermore, the negative effects of stereotyping combined with the potential for undermining whatever benefits intervention might bring through a negative placebo effect - making change less likely in the context of compulsory treatment - should all make legislators wary of too bold an approach.

Restraint in intervention based on principles of fairness and respect for human dignity are, of course, those embodied in the Universal Declaration of Human Rights. Here is not the place for a considered examination of those issues: suffice

it to say that if intervention for people with personality disorder is to depart from agreed norms on the basis that therapeutic endeavour may bring benefits, it should require limits to such intervention based on accepted principles. As matters currently stand, neither the Mental Health Act 1983 nor its combination with the European Convention on Human Rights can do much to prevent preventive detention, although challenges might be mounted on grounds of lack of proven efficacy were treatment endeavours demonstrated to be wholly aspirational. Arguably, if intervention is based on grounds of disorder, then the law ought to regulate length of intervention by reference to the *Winterwerp* criteria (*Winterwerp v the Netherlands* (1979-80) 2 EHRR 387). If detention is based on grounds of offending behaviour, then the length of such intervention should be determined prospectively: parliament should determine the framework in advance so that potential offenders have fair warning, with sentencers taking due account of individual circumstances after the offence has been proven. Arguably, the most defensible approach is based on a form of 'just deserts'; namely, a degree of proportionately between the harm caused or risked and the extent of the intervention. And future detention, if indeterminacy is permitted at all, should be based on demonstrable risk, perhaps using a variant of Bottoms and Brownsword's (1983:21) concept of 'vivid danger'; namely, that protective sentences need to be justified with reference to the *seriousness* of harm arising out of the predicted behaviour, its *temporality* (ie how frequently the behaviour is predicted to occur over what period of time and how immediate is the first predicted act?) and its *certainty*, that is, with what confidence is the prediction made? Moreover, in the unlikely event that it can be proved to the requisite standard that the offending behaviour has been caused by an underlying disorder, then those with personality

disorder ought to be dealt with according to the normal principles of culpability; and if culpability cannot be established then a non-punitive (and possibly therapeutic) disposal should follow.

Of course, the argument of this article has been that those with severe personality disorder do not fit neatly into any of these categories. Perhaps it suffices to conclude that we should be vigilant of this range of principles when dealing with those with personality disorder.

Awkward questions for the law

To reiterate, these awkward questions for the law may be summarised briefly.

First, how can clinical and legal concepts of capacity be reconciled where individuals are diagnosed with severe forms of personality disorder?

Second, how do legal concepts of capacity intersect with concepts employed by the criminal law to absolve potential offenders of culpability based on an absence of reason?

Third, how should the law respond to those with severe forms of personality disorder who exceptionally may not have the capacity to have 'knowledge of wrong' as required under the M'Naghten Rules; exceptionally because, in England and Wales, this has largely been interpreted as knowledge of legal wrong? For those with personality disorder a further aspect of this problem arises; if their capacity to appreciate moral wrong is impaired, albeit that they understand at a cognitive level what the law defines as wrong, should they nonetheless

be included within the framework of protection offered by the insanity defense?

Fourth, how do legal concepts of autonomy, self-control and choice fit where those with severe personality disorder may have their ability to control themselves impaired (or diminished) but not extinguished?

It would, of course, be all too easy to consign those with severe personality disorder either to the honourable ministrations of those with high therapeutic ideals or to resign oneself to the notion that, as this is a group for whom the public may not naturally deem deserving of sympathy, little need be done beyond their safe containment. Examined carefully, neither is a comfortable or justifiable outcome.

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Endnote

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