PERSONALITY DISORDER, THE CRIMINAL JUSTICE SYSTEM AND THE MENTAL HEALTH SYSTEM

David Neal
Commissioner
Law Reform Commission of Victoria

IN 1987, THE VICTORIAN LAW REFORM COMMISSION WAS GIVEN A reference to examine the law relating to insanity and automatism as criminal defence. The reference was not so much a result of the stringent and well-justified criticisms of the current insanity defence and the associated system of Governor's Pleasure, but the result of controversy surrounding the O'Connor decision in the High Court, a finding that gross intoxication could provide the basis for a successful automatism defence.

As it developed, however, the reference was much more concerned with definition of the insanity defence, an empirical study of the Governor's Pleasure system and examination of the rules about unfitness to stand trial.

The Commission issued a discussion paper entitled *Mental Malfunction and Criminal Responsibility* in August of 1988. The issue of what is to count as insanity for the purposes of the insanity defence arose early in the discussion paper. It quotes the judgment of Mr Justice Dixon of the High Court in *Porter* ([1936] 55 CLR 182 pp. 187–8) saying that 'disease of the mind', the term used in the M'Naghten rules, should be understood as:

> A disease, or disorder, or mental disturbance arising from some infirmity, temporary or of long standing.

He contrasted this with:

> The mere excitability of a normal man, passion, even stupidity, obtuseness, lack of self-control and impulsiveness . . .

In a subsequent paper (Dixon 1957, p. 260) he explained that he drew this distinction to exclude conditions like: drunkenness, conditions of intense passion and other transient states attributable either to the fault or to the nature of man. It is clear from the flavour of this passage and from a general reading of Mr Justice Dixon's view on criminal responsibility that moral blameworthiness was at the heart of his concern and that his formulation of disease of the mind had to do with the undermining of freewill, the basis of his system of criminal responsibility.

By contrast, other judicial approaches to the issue of disease of the mind —most notably the approach taken by Lord Denning in *Bratty v. Attorney-General for Northern Ireland* ([1963] AC 386)—focused much more on the dangerousness of the person's condition and the likelihood that it might be repeated. Lord Denning took the view that:

> Any mental disorder which has manifested itself in violence and is prone to recur is a disease of the mind. At any rate, it is the sort of disease for which a person should be detained in hospital rather than be given an unqualified acquittal.

Both definitions draw the boundaries of disease of the mind very widely leaving the issue of what sorts of conditions fall within or without the definition of disease of the mind very vague. Some courts have developed a distinction between internal and external stimuli, leading to decisions that violent behaviour caused by arteriosclerosis and diabetes, for example, should be treated as diseases of the mind. The unsatisfactoriness of this criterion is perhaps illustrated in some of the cases involving diabetes where mistaken overdoses of insulin have been characterised as external stimuli and therefore not diseases of the mind leaving a plea for automatism open—and cases of diabetics who have failed to take their insulin being characterised as internal causes and therefore diseases of the mind, subject to the operation of the insanity defence. The recent High Court case of *R v. Falconer* ([1991] 96 ALR 545) gives us little additional guidance, referring to criteria like the reactions of a healthy mind, the duration of the condition and the likelihood of recurrence.

Some of the confusion here stems from the purposes for which these inquiries are being made. In some cases, the concern is to make available an insanity defence in situations where a defendant was facing a capital conviction for murder. In the automatism cases, on the other hand, Lord Denning, for example, was plainly concerned about the complete acquittal by the automatism defence of persons whom he regarded to be dangerous and wanted to keep under some form of control. In either case, the width of these definitions was logically broad enough to cover the condition of personality disorder, the main focus of this article.

Personality Disorder and the Insanity Defence

It is very hard to find explicit references to personality disorder—in the sense defined in the psychiatric manuals—in the decided case law on the insanity defence. In part that is due to the fairly recent coining of the term, personality

disorder. During the 1940s, 1950s and 1960s, it was far more common to see references to the main form of personality disorder with which we are concerned—antisocial personality disorder—referred to as psychopathy or sociopathy. It was these terms which tended to be used in the debate trailing back into the 19th century over the distinction between the mad and the bad. However, reading the cases, it would appear that the issue of whether someone with a very severe antisocial personality disorder could successfully claim the insanity defence did not arise very often. In the first place, it seems likely that, at a time when psychiatrists did not distinguish sharply between mental illness and intellectual disability, very bizarre behaviour would simply be classified as mental illness and the issue of whether such a person could be said to have a disease of the mind for the purposes of the M'Naghten defence did not arise.

In two High Court cases in which antisocial personality disorder did arise—*Willgoss* ([1960] 105 CLR 295) and *Stapleton* ([1952] 86 CLR 358)—the High Court treated antisocial personality as a disorder of the mind but the defendants failed because they could not satisfy the other limb of the M'Naghten defence—they could not prove that they lacked the ability to know that their actions were wrong. In the case of *Jeffrey* ([1980] 7 ACR 55), the Tasmanian Supreme Court ruled that it was up to the jury to decide whether the defendant's severe antisocial personality disorder fell within the *Porter* definition of disease of the mind. The judge indicated his clear view that in the case before him, the defendant did have a disease of the mind. A Western Australian decision—*Hodge* ([1985] 19 ACR 29)—has been interpreted as going the other way. However, in fact the case was decided on an insufficiency of evidence about the defendant's mental condition in that case and the Western Australian court explicitly left the issue open for further consideration.

To summarise, courts considering the insanity defence have not given clear guidance about what constitutes disease of the mind. In some ways this is understandable since the questions the courts were putting were not directed at the essence of mental illness but rather at questions of moral and criminal responsibility in the one line by Mr Justice Dixon and protection of the community from dangerous individuals in the other line by Lord Denning. In some ways this is reasonable given that the insanity defence is plainly not restricted to mental illness and could be invoked by someone who, for example, had an intellectual disability or other disabling condition which deprived them of the ability to reason about right and wrong. Moreover, the courts have made it clear that the concept of disease of the mind was not co-extensive with the characteristics which might be adopted by psychiatrists from time to time. Although psychiatric evidence is obviously central in cases involving an insanity defence, the judges have made it clear that psychiatric opinions about a particular defendant should not be treated as determinative by the jury. The insanity defence is built on legal and moral conceptions about guilt which may be influenced by the medical opinion of psychiatrists but not determined by those opinions.

Personality Disorder and Civil Commitment

The Law Reform Commission of Victoria released its discussion paper on these matters in August of 1988. In the discussion paper, the Commission gave its view that antisocial personality disorder should be regarded as a disease of the mind for the purposes of the insanity defence and the determination of guilt or innocence (Law Reform Commission of Victoria 1988). It distinguished between issues of responsibility and an issue which had been of concern to the mental health authorities, the question of disposition. Under the Commission's recommendations in the discussion paper, people found not guilty by reason of mental impairment would no longer be detained in prisons. However, in deference to the concerns expressed by the Office of Psychiatric Services among others, in the case of someone found not guilty on the ground of mental impairment—where that mental impairment was a severe antisocial personality disorder—the court could order that person to be detained in a prison. Basically, the Commission was prepared to depart from the principle that people found not guilty should not be held in prisons because it was advised that mental hospitals simply did not have the facilities to deal with the people with antisocial personality disorder. That view was criticised in response to the discussion paper by the Office of Corrections and ultimately the Commission decided in its final report that no exception should be made to the principle that people found not guilty should not be held in prison.

In the course of those deliberations, the issue arose on several occasions about release decisions from the criminal justice system especially where those decisions involved people with antisocial personality disorder who had served their full sentence. The Chairman of the Parole Board, Mr Justice Vincent, who was also a member of the Law Reform Commission, had raised this issue on several occasions. He pointed out that the issue was becoming urgent in one case and that there were two or three other cases where the same issue would arise in the near future. These cases involved people who had been denied parole on account of their dangerousness but who would serve their full term and thus be entitled to release in the near future. The people involved had been found guilty and given indeterminate sentences. If they fell within the civil commitment criteria of the *Mental Health Act 1986* (Vic), the dangers posed by their release would not arise.

The Commission decided to issue an interim report on this issue. That report was entitled, *The Concept of Mental Illness in the Mental Health Act 1986* and was published amidst much controversy in April 1990. An early draft of the report, which had been circulated to a limited number of people for comment, was leaked to the press. There were dark mutterings about a conspiracy among the Commission and government ministers, violent attacks on the Commission's report by psychiatrists, and inexcusable and probably defamatory attacks on the then Chief Forensic Psychiatrist, Dr John Grigor. Similar attacks were made on the Commission. The Report of the Social Development Committee (1990, p. 32) described the reasoning as dishonest; and psychiatrist, Dr Neville Parker (1991, p. 372), published an article claiming that the Commission was not averse to misrepresenting the views of psychiatrists.

Possibly unwisely, the Commission decided not to enter the public debate surrounding its report. In the event, the Government did not accept the Commission's recommendation and decided instead to introduce the *Community Protection Act 1990*, an Act to enable the Supreme Court to imprison Garry David if it found him to be dangerous. The opportunity is taken, however, to reject most strongly any suggestion that the Commissioners—who unanimously supported the recommendation—were doing so for any reason other than their sincerely held conclusion that the approach recommended in the Commission's report was the correct approach. This is despite careful consideration of all the criticisms.

With all due respect to those who have reached the opposite conclusion—a respect which has not been reciprocated by some of the Commission's critics—it is easily understandable that sincere people could take opposing views on such a controversial and difficult topic, involving quite fundamental distinctions between madness and badness, an area dogged with controversy for at least 150 years, if not more. It is simply arrogant to do what some of the Commission's critics have done and assert that people who reach a different conclusion must be actuated by political expediency or some such. Were their own arguments overwhelming or those of the Commission so underwhelming, their claims to insight and certainty might be more convincing. But when one interrogates the psychiatric literature for a convincing definition of mental illness, the cupboard is rather bare. Much of the psychiatric literature will tell you that the concept of mental illness is too gross a category to be useful for psychiatric purposes and then goes on to look at smaller categories such as psychoses and neuroses and their various subcategories. The distinguished philosopher, Anthony Quinton, after an extensive review of the psychiatric literature looking for some satisfactory account of mental illness, concluded that the search was largely in vain. Quinton concluded that this was not a great moment, given that many capable practitioners can perform their art or science effectively without being able to give a fully satisfactory philosophical account of what it is that they are doing (Parker 1991, p. 372).

Indeed, the nature of much scientific practice—and this is true of psychiatry—is empirical and has to do with what works in treating psychiatric disorders rather than writing philosophical accounts of it. In a sense, at the risk of gross oversimplification, psychiatrists can claim to know a mentally ill person when they can see one even though they might not be able to give a precise definition of mental illness. Quinton, as a philosopher, is prepared to take on this task. As set out in the Commission's report, Quinton says madness is a fundamental lack of rationality, the fact that the person has lost his or her reason. The Commission (1990) formulated Quinton's idea in this way:

> A person who is systematically unable to function rationally, who is unable to cope with the ordinary pressures of life, who behaves in utterly bizarre ways, and who is grossly destructive of himself and others, is mentally ill.

The author emphasises that this definition does not equate mental illness with violence and that its central idea is about the fundamental and systematic loss of reason. The term bizarre also seems to have upset some of the

Commission's critics. But the very term is used in the Social Development Committee's report in its definition of psychosis.

Although this definition tended to be skated over in many of the criticisms of the Commission's Report on the concept of mental illness, it remains for the author the most plausible account of what is meant by the concept of madness. Indeed, some of the discussions the Commission had with psychiatrists indicated that our positions were not nearly as far apart as some of the debaters would like to suggest. In discussion, these psychiatrists were prepared to concede that someone with a very severe antisocial personality disorder could at times cross into the area of psychosis even though no particular category of psychosis could be allotted to that person. This was understood to mean that they had a sort of residual category for cases which escaped the usual classification system but which they would recognise as mental illness. It may be that the condition which the Commission was describing as at the extreme end of the personality disorder scale is merely the same condition that these psychiatrists were describing as having crossed out of the personality disorder scale and into the psychotic category, even if briefly.

The Concept of Civil Liberty

The discussion has taken a long time to reach the question where many people will feel we should have started. That is, why go into these ruminations about the nature of mental illness? The questions before the conference are not essentially psychiatric questions nor are psychiatrists the only ones with anything to say in relation to them. They are essentially questions about civil liberty and criminal responsibility and they are questions which must be decided ultimately by the body politic. It is not enough to say, as some have been prepared to in the Victorian debate, that if 90 per cent of psychiatrists say that antisocial personality disorder is not mental illness, then it is not a mental illness. Psychiatrists, like other professionals, certainly including lawyers, exercise a great deal of power on behalf of the community and must be able to justify their stewardship to the wider community. Their decisions affect other people's lives and, particularly in these instances, affect their liberties.

While psychiatrists must maintain pre-eminence in diagnosis for the purposes of treatment and cure—though even here pre-eminence must not mean dominance free of any external review—in the areas with which we are concerned at this conference, madness bears on questions of criminal responsibility and the civil liberty to live in the community free of restraint. These are essentially moral and political questions. They are not medical questions, though medical science has a great deal to say about them. After listening to the medical evidence about the state of a person's mental functioning, the jury in the case of the insanity defence and the parliament in the case of preventive detention, must be convinced by clear criteria and rational argument why some conditions are to be counted as mental illness while others are not. That is to say, if psychiatrists are to claim that neuroses and psychoses are to be included within the concept of mental illness but

personality disorder is not, then the criteria upon which this conclusion rests must be clear. The arguments advanced by the Royal Australian and New Zealand College of Psychiatry to the Law Reform Commission and subsequently to the Social Development Committee fail that test.

For example, in its submission to the Social Development Committee (Victoria. Parliament 1990, p. 32), the College of Psychiatrists laid a great deal of stress on *treatability* as the criterion of illness. Quite apart from the questionable positivist assumption that mental illness and physical illness are appropriately analogised, a moment's reflection reveals that many illnesses do not respond to treatment—sickle cell anaemia, haemophilia, motor neurone disease, some forms of cancer and so on. This does not make them any the less illnesses. It is commonplace, for example, that certain forms of cancer do not respond to treatment. Does that make these forms of cancer any the less illnesses?

Similarly, it was claimed by some that personality disorders are *permanent* conditions whereas illnesses are temporary. Again, the concept of long-term illness, even lifelong illness, is easy to understand. Some of the conditions just listed fill that criterion. Not only is this true in physical illness, but in psychiatry too, the notion of illness as a short-term phenomenon belies a great deal of the practice in psychiatric hospitals where a sizeable percentage of the patient population is there on a very long-term basis.

A third set of arguments had to do with questions which were not really germane to personality disorder as a form of mental illness but had a great deal to do with protecting resources. These were arguments which said that psychiatry could do little for people with personality disorder and that it would be a more rational use of resources to devote them to people with other conditions which could be helped. This is not really an argument that people with a personality disorder are not mentally ill; it is really an argument that they are less deserving of psychiatric resources than other people. This argument about resources is reasonable but it becomes much less so when the same people who were putting it were also advocating that people with personality disorders who were dangerous should be kept in prisons. These people do not appear to have considered the obverse of their own civil liberty argument, that it is also discriminatory and just as much a breach of a person's civil liberty to exclude them from psychiatric services when they are entitled to them, and to say that if they are dangerous they should be kept in prisons rather than psychiatric institutions. The resources argument raises yet more difficult policy questions about the services provided to mentally ill people and whether there should be a return to some notion of asylum in the best sense of that word for people whose mental condition makes them unable to function in serious respects in the wider community.

Finally, some said that mental illness—or more accurately, the sort of mental illness for which people could only be committed—was related to people who had hallucinations. Again, it is not clear why hallucinations should count as the distinguishing criterion, and nor is it clear where people with hallucinations, delusions and the like part company from ones who have a radically abnormal perception of their place in the world. Is the classic

caricature of a person who believes himself to be Napoleon Bonaparte so far from a person whose self-conception is that he is an avenging angel of death waging war against a community that wronged him?

The author's conclusion about these criteria offered by the College of Psychiatrists and others is that the criteria offered for mental illness by the psychiatrists are unconvincing. On the other hand, Quinton's concept of a systemic inability to function rationally seems much closer to the kernel of the concept. As perhaps the greatest living philosopher, Sir Isaiah Berlin (Laslett & Runciman 1964, p. 27) put it:

> If I find a man for whom it literally makes no difference whether he kicks a pebble or kills his family, since either would be an antidote to ennui or inactivity, I shall not be disposed . . . to attribute to him merely a different code of morality to my own or that of most men, or declare that we disagree on essentials, but shall begin to speak of insanity . . . ; I shall be inclined to consider him mad, as a man who thinks he is Napoleon is mad.

The author's conclusion is that someone whose severe personality disorder satisfies this definition should be classifiable as mentally ill for the purposes of civil commitment. While the concern of psychiatrists to protect limited resources can be understood—a great deal of the vehemence of the psychiatric criticisms in this area may stem from that concern—people already stigmatised by their violence and involvement with the criminal justice system cannot be excluded from psychiatric services simply because they present resource problems and are consigned to the prison system.

Conclusion

Fundamentally we have here a question about civil liberty. And perhaps it is as well to go back to the modern foundation of liberal thought to assess the issue with which we are confronted. John Stuart Mill's (1975) essay 'On Liberty' gave us a guiding principle about when we are entitled to interfere with the liberty of any individual citizen. His dictum was that we are only entitled to interfere with a person's liberty when that person threatens to do harm to others. The state is not entitled to restrain any of its members simply on the basis that it will be for his own good. Interestingly, Mill made an exception to his principle, for lunatics and children. It is on this basis that we can civilly commit some mentally ill people for their own good. However, today's debate is about the other limb of Mill's principle, locking up people to prevent them from harming others.

Traditionally, we have been jealous of liberty and have not been prepared to detain people on the basis that they might do harm. The one important exception here has been in relation to people who are mentally ill. Where Mill's principle might allow us to engage in preventive detention generally—provided our predictive capacity was reasonable—our practice has been to require two conditions to be met prior to preventive detention; namely that a person lacks the ability to make rational choices by virtue of their mental illness, and that lack of rationality poses a danger to others. While the author accepts much of what is said about the difficulty of predicting dangerousness,

where a judgment is made by proper processes, both that the person lacks the ability to make rational decisions because of mental illness and that that condition makes him or her dangerous to other people, the author is prepared to concede that a restriction on that person's liberty is then justified. These are approximately the criteria which are applied under most of the civil commitment provisions in the Mental Health Acts of the various states.

Ultimately, the argument about whether severe personality disorder can count as a mental illness, may, as the Monash philosopher Chin Liew Ten argues, be sterile or at least so charged as to make it senseless. If a person with a severe personality disorder is so unable to make rational decisions as to be the functional equivalent of a mentally ill person and that inability also makes him or her dangerous to others, then such a person satisfies Mill's principle and is detainable on similar criteria to those upon which we base our civil commitment of the mentally ill.

In Victoria at least, it would now appear that the option of dealing with people who have a severe antisocial personality disorder and who are dangerous through the mental health system is closed. The Community Protection Act has been extended and the government has foreshadowed general legislation to deal with people who have a severe personality disorder and are dangerous. In effect, the current legislation is broadly in line with the argument just put—that the question of whether or not severe antisocial personality disorder can constitute a mental illness is put to one side and the general criteria of lack of rationality and dangerousness form the basis for a different mechanism of civil commitment. It is important to note that this is not a system of general preventive detention and that it does require both the incapacity to make reasoned choices and the threat of danger to others.

For the reasons outlined earlier, such an approach is consistent with Mills' principle about the liberty of the individual, indeed it goes further than Mill did by requiring two criteria rather than one. It is also consistent with the criteria laid down in the Mental Health Act for the commitment of people who are accepted as being mentally ill and dangerous. Indeed, the protections for these people are somewhat greater in that the order to detain must be obtained from the Supreme Court rather than going through the processes of admission to a mental hospital and review by the Mental Health Review Board adopted in the case of mentally ill people. In effect, the Community Protection Act closes a gap opened by the interpretation of the Mental Health Act where people with severe personality disorder would now appear to be excluded from the mental health system which had previously dealt with them in some numbers. Although civil commitment is always a difficult and unpalatable option, if it is conceded that it is justifiable to civilly commit mentally ill people who constitute a danger to others, consistency suggests that people who are in a functionally equivalent position because of a severe personality disorder ought to be treated the same way.

References

Dixon, O. 1957, 'The legacy of Hadfield, M'Naghten and Maclean', *Australian Law Journal*, vol. 31, no. 4, pp. 255–65.

Laslett, P. & Runciman, W. 1964, 'Does political theory still exist?', *Philosophy, Politics and Society*, vol. 1.

Law Reform Commission of Victoria 1988, *Mental Malfunction and Criminal Responsibility*, Discussion Paper No. 14, Law Reform Commission of Victoria, Melbourne.

---------- 1990, *The Concept of Mental Illness in the Mental Health Act 1986*, Law Reform Commission of Victoria, Melbourne.

Mill, J.S. 1975, 'On Liberty', in *John Stuart Mill — Three Essays*, Oxford University Press, London.

Parker, N. 1991, 'The Garry David Case', *Australia and New Zealand Journal of Psychiatry*, vol. 25.

Victoria. Parliament. Social Development Committee 1990, *Interim Report upon Inquiry into Mental Disturbance and Community Safety: Strategies to Deal with Persons with Severe Personality Disorder Who Present a Threat to Public Safety*, Parliamentary Paper No. 131, The Committee, Melbourne.