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Choice, deliberation, violence: Mental capacity and criminal responsibility in personality disorder

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ABSTRACT

Personality disorder is associated with self-harm and suicide, as well as criminal offending and violence towards others. These behaviours overlap when the means chosen to self-harm or attempt suicide put others at risk. In such circumstances, an individual's mental state *at one and the same time* may be deemed to meet the conditions for criminal responsibility, and to warrant involuntary hospital admission. I explore this tension in how people with personality disorder are treated at the hands of the criminal and civil law respectively in England and Wales: they may be deemed sufficiently mentally well to be punished for their crimes, but not deemed sufficiently mentally well to retain the right to make their own decisions about matters of serious importance to their own lives, including whether or not to continue them. The article divides into four sections. After introducing this tension, Section 2 sketches the nature of personality disorder and the psychology underlying self-directed and other-directed violence. Section 3 addresses the questions of whether people with personality disorder who are violent, whether towards self or others, typically meet the conditions for criminal responsibility and mental capacity respectively, considering in particular whether their underlying desires and values, or their emotional distress, affect their mental capacity to make treatment decisions. Section 4 then considers what we might do to address the tension, within the confines of current legislation. Drawing on *The Review of the Mental Health Act 1983*, I argue that we are ethically justified in involuntarily admitting to hospital people with personality disorder who pose a serious risk to themselves only if we simultaneously undertake to offer genuine help for their future, in the form of appropriate treatment, social support, and better life opportunities — a provision which, as things stand in England and Wales, is sorely lacking.

1. Introduction

Consider the following clinical vignette:

P has a long history of involvement with mental health services and is well known to the local police. He has a diagnosis of personality disorder and takes a number of psychiatric medications, including sleeping pills and sedatives. He has had repeated hospital admissions due to overdoses and other forms of severe self-harm, usually in the form of cutting or burning. He drinks regularly, and can become aggressive and threatening, especially when drunk.The police and the community mental health team are currently trying to locate P, who made an emergency appointment with his doctor this morning. P arrived in a dishevelled, agitated, and emotionally distressed state. Upon questioning, he admitted to intending to kill himself, but ended the appointment abruptly when his doctor suggested a voluntary admission to hospital, saying his mind was made up and no one could help.P was found late that evening, after spending the day drinking alone in his car, and then returning home and setting fire to his flat. The smoke and flames alerted a neighbour who called for help. P suffered smoke inhalation and minor burns. No one else in the building was injured. P was charged and subsequently convicted of arson that recklessly endangered lives. Had P been found before setting the fire, he would in all likelihood have been involuntarily admitted to hospital.

P's story is hypothetical, but it will be familiar to many of those who work with personality disorder in mental health and criminal justice services. Personality disorder [PD] is associated with self-harm and suicide, as well as criminal offending and violence towards others. These behaviours overlap only infrequently. Self-harm and suicide has a profound impact on family and friends, but it is rare that the means chosen to self-harm or attempt suicide also put others at direct physical risk. But it does occur. Common examples include attempts to harm or kill oneself by setting fires, like P, or by driving over bridges or overpasses, onto railroad lines, or into oncoming traffic or buildings.

P's story sharply highlights a tension in how people with personality disorder are treated by criminal and civil law respectively in England and Wales. On the one hand, prisons in the UK are populated by people with PD: it is estimated that 64% of male and 50% of female

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offenders have a personality disorder (NOMS, 2011). Offenders with PD are sometimes diverted from the courts or given a hospital disposal. But as these statistics testify, they are routinely judged criminally responsible and correspondingly held to account.[1] On the other hand, people with personality disorder who present to mental health services at risk of self-harm or suicide can be admitted to hospital under a Section of the Mental Health Act [MHA] in England and Wales, which allows involuntary detention and compulsory treatment in the presence of a mental disorder (including PD) in cases of risk and irrespective of mental capacity. [2]

Good clinical practice aims to avoid involuntary detention and compulsory treatment, especially if previously counter-productive. However, if community management is not a viable option and the risk of harm to self is judged to be serious, the MHA may be used to admit people with a mental disorder to hospital against their will.[3] Especially with respect to people with a mental disorder where risk of harm to self is stable and long-standing, this may cause clinical disquiet and ethical unease if grounds are lacking for overriding treatment decisions based on mental incapacity under the Mental Capacity Act (MCA), which is the law in England and Wales protecting people who are unable to make treatment decisions for themselves.[4] Under the MCA, treatment decisions can be made on behalf of patients and in their best interests, when they are unable to do so themselves due to "an impairment of, or disturbance in the functioning of, the mind or brain" which affects their capacity for rational deliberation.[5] Although the MCA states clearly that every person is presumed to have the mental capacity to make their own treatment decisions and, moreover, that the presence of any condition, such as a mental disorder, cannot in itself justify an assumption to the contrary, it is nonetheless the case that the presence of a mental disorder can affect the ability to rationally deliberate. When this is proven to be so, clinicians can both ethically and legally justify involuntary detention and compulsory treatment of people with mental disorder who pose a risk to self based on mental incapacity under the MCA, potentially quelling any sense of disquiet or unease. However, when mental capacity is retained despite the presence of a mental disorder, then use of the MHA is required instead.

Only people who have a diagnosis of a mental disorder or for whom there are grounds to suggest the presence of a mental disorder in the absence of a previous diagnosis, and so might benefit from assessment, can be involuntarily detained and compulsorily treated under a Section of the MHA due to risk to self.[6] In England and Wales, people are allowed to self-harm or attempt suicide if there is no diagnosis or grounds suggesting the presence of a mental disorder. Clinical disquiet and ethical unease can result from concern that, in striking contrast to the MCA, the MHA therefore allows discrimination on grounds of mental disorder.[7] Lingering questions – however inchoate or inarticulate these may be – about retention of mental capacity in such circumstances potentially quell this concern by offering the possibility of non-discriminatory grounds for differential treatment, as all people who lack mental capacity to make their own treatment decisions, mentally disordered or not, fall under the MCA. Especially as mental capacity admits of degrees and borderline cases, it is natural to wonder about the extent to which it is retained during periods of serious risk to self, even if, strictly speaking, the conditions specified by the MCA as determining an ability to make one's own decisions likely obtain. Hence part of the tacit acceptance of use of the MHA in such contexts by practicing clinicians may be an underlying uncertainty about the person's mental capacity — a feeling that something about their state of mind warrants interference if and when they fail to act in what appears to be their own best interests.[8]

P's story sharply highlights the tension in how people with personality disorder are treated at the hands of criminal and civil law because his mental state *at one and the same time* is deemed to meet the conditions required for criminal responsibility, and to warrant involuntary hospital admission. For, again, had he been found before setting the fire, he would in all likelihood have been detained under civil law, as opposed to prosecuted under criminal law. Self-harm, suicide, and violence towards others no doubt demand considered and often robust interventions by the state, and the various purposes of, and potential justifications for, criminal and civil law are of course varied and different. There are no doubt many ways we might attempt to reconcile and rationalize P's treatment by criminal and civil law respectively. But it is nonetheless difficult not to feel, at heart, that P gets a raw deal. For, whichever way he turns, he is subjected to the strong arm of the law — deemed sufficiently mentally well to be punished for his crimes, but not deemed sufficiently mentally well to retain the right to make his own decisions about matters of serious importance to his own life, including whether or not to continue it.

The aim of this article is to explore this tension and make some tentative suggestions about how we might better manage the "awkward questions" that personality disorder raises.[9] The structure is as follows. Section 2 sketches the nature of personality disorder and aspects of the psychology underlying self-directed violence on the one hand, and other-directed violence on the other. A natural suggestion for resolving the tension is that (cases like P's notwithstanding) the psychology underlying self-directed and other-directed violence associated with PD is fundamentally distinct, with the state of mind associated with harming oneself expressing pathology, and the state of mind associated with harming others expressing a more rational mentality. I argue that this distinction cannot be sustained in a way that supports the difference in treatment by criminal and civil law. Section 3 addresses the vexed questions of whether people with PD who are violent, whether towards self or others, typically meet the conditions for criminal responsibility and mental capacity respectively; and I consider in particular whether their underlying desires and values, or their emotional distress, affect their mental capacity to make treatment decisions. Although all judgements must be made on a case-by-case basis, I suggest that the conditions for both criminal responsibility and mental capacity may often be met. Section 4 considers what we might do to address the tension, within the confines of current legislation. Drawing on

[1] Personality disorder does not usually fall under The M'Naughten Rules: "to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong" (*Queen v. M'Naghten* (1843) 10 Cl and Fin 20). Nor is a plea of diminished responsibility due to mental abnormality under Section 2(1) of the Homicide Act 1957 necessarily available to reduce a murder conviction to manslaughter.

[2] Statistics documenting use of the MHA in cases of personality disorder are not available, as data pertaining to category of mental disorder has not been collected since 2008.

[3] Cf. *The NICE Guidelines on Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*: "…. although it is not a common occurrence, compulsory treatment [under the MHA] can include medical and surgical treatment for the physical effects of self-harm if the self-harm can be categorised as either the consequence of or a symptom of the patient's mental disorder" (NICE, 2004, p. 92). Note that, although good clinical practice will not use the MHA unless risk to self is judged to be serious, the MHA itself does predicate the power to involuntarily detain and compulsorily treat on a requirement of *serious* risk to self or others, but only on the need for patient "health and safety" or "the protection of other persons" (Sections 2 and 3); there is a severity requirement only with respect to restriction orders imposed due to risk of harm to others (Section 41).

[4] The MCA has very occasionally been deployed to remove the right to refuse treatment for self-inflicted injury with people with personality disorder. For discussion see Peay (2011a, 2011b).

[5] See Sections 1–4 of the MCA. The nature of mental capacity and its connect to rational deliberation are discussed further below.

[6] Or who present to the police in need of removal from a public place to a "place of safety", such as a police station or a hospital, where they can then be kept for 72 h and assessed by an approved mental health professional or clinician. See Section 136 of the MHA.

[7] For discussion see Hope (2004) and Richardson (2013). This feature of the MHA contravenes one of the core guiding principles of *The Review of the Mental Health Act 1983:* "The desire to promote the principle of non-discrimination on grounds of mental ill health has been fundamental to the Committee's approach, and this has led to an emphasis on patient autonomy" (Richardson et al., 1999, p. 3). See too Sections 2.14–2.16.

[8] A further reason may be fear of investigation and litigation if patients with personality disorder commit suicide or seriously harm themselves when in care.

[9] To borrow a phrase from Peay (2011b).