**Personality Disorder in Mental Health Law and Criminal Law**

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Abstract

Significant advances have been made in understanding the aetiology and life-course of personality disorder and it is no longer widely considered to be untreatable. Nevertheless, thorny normative issues remain. This chapter explores the evolving psychiatric understandings of personality disorder and the persistent stigma that surrounds the diagnosis despite recent efforts to reduce it. It evaluates concepts of ‘treatability’ in the law of England and Wales and considers recent proposals to reform the Mental Health Act 1983. Finally, it explores how the intersections between mental health law, criminal law and human rights law affect offenders with personality disorders. By drawing these threads together, this chapter highlights how people diagnosed with personality disorders can find themselves excluded both from legal protections accorded to people with mental disorders under criminal law and from legal protections accorded to people with no mental disorder under mental health law. This looks set to continue, as legal reforms in pursuit of person-centred and rights-respecting mental health care continue to be hampered by risk aversion towards offenders diagnosed with mental disorders.

**Introduction**

Over the last two decades, significant advances have been made in understanding the aetiology and life-course of personality disorder, and people given the diagnosis are no longer widely considered untreatable (Pickersgill, 2013). Nevertheless, thorny normative issues remain. Personality disorder has long been criticised as a ‘moral judgement masquerading as a clinical diagnosis’ (Blackburn, 1988, p. 511) and is associated with negative professional attitudes (Bowers *et al.*, 2006). For people with lived experience of the diagnosis, it evokes stigma, shame, hopelessness, and rejection (Lamph *et al.*, 2022). For offenders, a diagnosis can open the door to long-term detention under the Mental Health Act (MHA) 1983. Moreover, the evidence base for treating personality disorders common amongst offending populations continues to be limited. Consequently, offenders with personality disorder detained in hospital to protect the public often have limited prospects of reintegration into the community.

This chapter first explores the evolving psychiatric understandings of personality disorder and the persistent stigma that surrounds the diagnosis despite recent efforts to reduce it. It then evaluates the concept of ‘treatability’ in the former MHA 1983 and its replacement, ‘appropriate medical treatment’, and considers recent reform proposals from the Wessely Review (Department of Health and Social Care, 2018), the White Paper *Reforming the Mental Health Act* (Department of Health and Social Care and Ministry of Justice, 2021), and the Draft Mental Health Bill 2022. Finally, it explores how the intersections between mental health law, criminal law and human rights law affect people with personality disorders.

By drawing these threads together, this chapter highlights key tensions in the law. For many people with personality disorder, their disorders are not sufficient to protect them from conviction and punishment in the criminal law, yet they can be detained and treated against their will under mental health law. In addition, their disorders can be deemed insufficiently treatable to warrant a therapeutic disposal at sentencing, yet they can be detained post-sentence in a psychiatric hospital on the basis that appropriate medical treatment is available for them. Consequently, people diagnosed with personality disorders seem to get a ‘raw deal’ (Pickard, 2015, p. 16). They can find themselves excluded both from legal protections accorded to people with mental disorders under criminal law and from legal protections accorded to people with no mental disorder under mental health law. This looks set to continue, as legal reforms in pursuit of person-centred and rights-respecting mental health care continue to be hampered by risk aversion within government towards offenders diagnosed with mental disorders.

**Defining personality disorder: evolving clinical models**

Personality disorder is a much-debated diagnosis in psychiatry and has undergone significant conceptual shifts over time. Debates in the psychiatric literature focus primarily on whether diagnostic systems should describe personality disorders as a set of categories, separate from each other and distinct from normal personality, or as extremes along a spectrum with normal personality and behaviour (Coolidge and Segal, 1998, p. 592). The fifth edition of the American Psychiatric Association’s (2013) Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and the eleventh edition of the World Health Organisation’s (2022) International Classification of Diseases (ICD-11) have taken rather different directions on this question.[[1]](#footnote-1)

DSM-V contains two models of personality disorder. Section II, intended for clinical use, largely retains the approach of the previous edition (DSM-IV) and describes distinct categories of personality disorder. An alternative model in Section III, intended to inspire research, combines categories with dimensions. Finally, ICD-11 contains an almost entirely dimensional model – a significant departure from previous editions that followed a similar approach to the DSM. Consequently, the two leading manuals for diagnosing mental disorders now take very different approaches to the diagnosis of personality disorder.

Legal practitioners will have to grapple with these changes in psychiatric nosology, as both manuals are often relied upon as authoritative, if imperfect, catalogues of recognised psychiatric disorders for legal purposes (Slovenko 2011; Bartlett 2011; Ahuja 2015). Changing the methods for diagnosing and describing personality disorders has proved controversial, and attempts to address longstanding concerns regarding the validity of the disorder and its moral undertones have only partially succeeded.

To demonstrate how personality disorder is currently defined, it is necessary to briefly explore the differences between these models and the rationales behind them.

Starting with DSM-V, personality disorder is defined in Section II as:

‘an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture…The enduring pattern is inflexible and pervasive across a broad range of personal and social situations…leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning…is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.’ (American Psychiatric Association, 2013, pp. 646–647)

Section II divides personality disorders into categories. In Cluster A are the ‘odd or eccentric’ types: paranoid, schizoid, and schizotypal. In Cluster B are the ‘dramatic, emotional or erratic’ types: antisocial, borderline, histrionic, and narcissistic. In Cluster C are the ‘anxious and fearful’ types: avoidant, dependent, and obsessive-compulsive (American Psychiatric Association, 2013, p. 646). Two further, catch-all categories are described: ‘other specified personality disorder’ and ‘unspecified personality disorder’. Each specified personality disorder comes with its own set of diagnostic criteria. For example, antisocial personality disorder (ASPD) is described as ‘a pattern of disregard for, and violation of, the rights of others’ (American Psychiatric Association, 2013, p. 645). Borderline personality disorder (BPD) is characterised by ‘a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity’ (American Psychiatric Association, 2013, p. 645).

The DSM-V alternative model defines the essential features of a personality disorder as ‘moderate or greater impairment in personality (self/interpersonal) functioning’ and the presence of one or more ‘pathological personality traits’ (American Psychiatric Association, 2013, p. 761). While Section II uses the terms ‘enduring’, ‘inflexible’ and ‘pervasive’, the Section III alternative model describes impairments and traits as ‘*relatively* inflexible and pervasive across a broad range of personal and social situations’ and ‘*relatively* stable across time’ (American Psychiatric Association, 2013, p. 761). While Section II contains ten categories, Section III describes just six specific personality disorders using trait domains: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal (American Psychiatric Association, 2013, p. 763). A trait domain is conceptualised as a spectrum with two opposing poles within which the trait applies in different degrees (rather than being present or absent) (American Psychiatric Association, 2013, pp. 772–3).

While the alternative DSM-V model retains specific personality disorders, ICD-11 has radically abolished all categories of personality disorder except for ‘borderline pattern’. Under ICD-11, a person is first assessed for the presence of a personality disorder. This is then assigned a severity rating (mild, moderate or severe) and described using a set of six prominent personality traits: negative affectivity, detachment, dissociality, disinhibition, anankastia[[2]](#footnote-2) and ‘borderline pattern’ (Tyrer *et al.*, 2019).

The variations in the diagnostic models reflects the difficulties in reaching a consensus on a new personality disorder model that both reflects advances in research on personality disorder and meets the needs of practitioners. Initially, the DSM-V Personality and Personality Disorders Work Group pursued a fully dimensional approach that would abandon the DSM-IV categories. It failed, however, to reach a consensus on which dimensional model to adopt (Zachar, Krueger and Kendler, 2016). The Section III model was a compromise, but it failed to garner support from the American Psychiatric Association due to a lack of expert consensus and concerns that the model was too complex for clinical practice (Zachar, Krueger and Kendler, 2016). The alternative model was included in DSM-V to allow for further research on its validity and clinical utility (Whooley, 2016; Zachar, Krueger and Kendler, 2016).

While the initial proposals of the ICD-11 working group on personality disorder were met with some criticism, the process was comparatively smooth (Tyrer *et al.*, 2019). While the architects of the ICD-11 model initially intended to abolish all personality disorder categories, ‘borderline pattern’ was retained in response to criticisms that the new model disregarded significant advances in treatments for and research on BPD (Herpertz *et al.*, 2017; Tyrer *et al.*, 2019).

**Implications of the new models**

The DSM and ICD have long emphasised the enduring, inflexible, deeply engrained, and pervasive qualities of personality disorders (Tyrer and Seivewright, 2008). David Pilgrim argues that this sense of immutability, coupled with the socially undesirable traits associated with a diagnosis, makes personality disorder particularly stigmatising. He argues that the diagnosis of an enduring ‘abnormal’ personality is ‘a clear moralistic position involving a long-term lack of confidence in those individuals who recurrently act in ways that others find offensive, disappointing and troublesome’ (Pilgrim 2007, p.84). The validity of the personality disorder diagnosis has also come under fire following epidemiological studies showing high levels of co-morbidity between supposedly distinct personality disorders (First *et al.*, 2002; Grant *et al.*, 2005, 2008; Stinson *et al.*, 2008) and between personality disorders and other disorders (First *et al.*, 2002, p. 150).

The architects of the DSM-V alternative model and those of ICD-11 sought to respond to these critiques. Members of the DSM-V work group argued that a dimensional model would reduce stigma by ‘recogniz[ing] and appreciate[ing] that the person is more than just the personality disorder and that there are aspects to personality that can be adaptive, even commendable, despite the presence of a personality disorder’ (Widiger, Livesley and Clark, 2009, p. 246). The architects of the ICD-11 model suggested that introducing a spectrum of severity would reduce stigma by counteracting the notion that personality disorder is immutable and untreatable and by producing a more nuanced, and accurate, description of the nature of the condition (Tyrer *et al.*, 2011b, pp. 248–9).

Significantly, the DSM-V alternative model and the ICD-11 have both shifted away from the view that personality disorders are lifelong, deep-seated disturbances that are separate from normal personality and from each other. These changes reflect recent clinical research indicating that some personality disorder traits decline with age (Lilienfeld, 2005) and variation and remission in symptoms during the life-course of the disorder (Zanarini *et al.*, 2003; Gutiérrez *et al.*, 2012).

Nevertheless, both models continue to use moral judgments and descriptions of socially undesirable behaviours as diagnostic criteria. The traits of ASPD in the DSM-V alternative model include manipulativeness, callousness, deceitfulness, and irresponsibility. Similar terms are used to describe the personality trait of ‘dissociality’ in ICD-11. In ICD-11, ‘negative affectivity’ includes a tendency to reject others’ suggestions or advice, and ‘anankastia’ is characterised by stubbornness, and a lack of spontaneity (World Health Organisation, 2022, sec. 6D11.0 and 6D11.4). Examples of behaviours associated with ‘borderline pattern’ include ‘risky sexual behaviour, reckless driving, excessive alcohol or substance use’ and ‘binge eating’ (World Health Organisation, 2022, sec. 6D11.5). Thus, the argument that a personality disorder diagnosis is essentially tantamount to a declaration of disapproval or dislike still seems to hold true (Lewis and Appleby, 1988; Bowers *et al.*, 2006).

Both systems continue to use the term ‘personality disorder’, which is stigmatising in itself (Sheehan, Nieweglowski and Corrigan, 2016). People with lived experience describe personality disorder as ‘a dustbin label given to people who seem difficult’ that means ‘abnormal’, ‘untreatable’, or ‘bad and evil’ (Castillo, 2003, pp. 69–70). While there is some evidence that clinical attitudes towards personality disorder have improved over time (Day *et al.*, 2018), other studies show that the label continues to provoke negative attitudes amongst practitioners (Lam *et al.*, 2016; Sheehan, Nieweglowski and Corrigan, 2016). Professionals and people with lived experience associate the label with a sense of blame, shame, defectiveness, exclusion, and permanence (Lamph *et al.*, 2022). While a BPD diagnosis has afforded some people a sense of control and hope, these positive attitudes are expressed only where the diagnosis led to support (Horn, Johnstone and Brooke, 2007; see also Lamph *et al.*, 2022). Without such support, a diagnosis is experienced as ‘the killing of hope’ (Horn, Johnstone and Brooke, 2007, p. 262).

While clinical advances have contributed to a sense that personality disorder is treatable, some scepticism remains (Pickersgill, 2013). Research evidence for the effectiveness of treatment is of moderate quality at best. The most comprehensively studied, and most commonly diagnosed, personality disorders are ASPD and BPD (Tyrer *et al.*, 2011a, 2019). A recent systematic review of psychological treatments for ASPD concluded that ‘there is insufficient evidence to support or refute the effectiveness of any psychological intervention’ (Gibbon *et al.*, 2020, p. 41). A review of pharmacological therapies drew the same conclusion (Khalifa *et al.*, 2020, p. 32).

The evidence base for treating BPD is better, but it continues to be limited by deficiencies in study quality (Bateman, Gunderson and Mulder, 2015). A recent metanalysis found beneficial effects of psychotherapy compared to treatment as usual, but the evidence was only of moderate quality and all trials had a high risk of bias (Storebø *et al.*, 2020, p. 70). While dialectical behavioural therapy and mentalisation-based treatment were found to be more effective than treatment as usual in improving some symptoms, this finding was based on low-quality evidence. Thus, the true magnitude of treatment effects were uncertain (Storebø *et al.*, 2020, pp. 70–71). A review of pharmacological interventions concluded that ‘there is no evidence from [randomised controlled trials] that any drug reduces overall BPD severity’ but that some did improve symptoms (Stoffers *et al.*, 2010, p. 40). Again, the evidence was not robust. A more recent systematic review drew similar conclusions (Gartlehner *et al.*, 2021).

This is not to say that existing therapies have been shown conclusively *not* to work. Rather, more robust research is needed. In the meantime, the National Institute for Health and Care Excellence (NICE) guideline on the treatment and management of ASPD recommends that clinicians consider group-based cognitive behavioural interventions, which are supported by some evidence (NCCMH *et al.* 2010, paras. 8.4.2.1.-2). It also recommends challenging therapeutic pessimism and negative attitudes towards patients and encouraging staff to develop ‘a stronger belief in the effectiveness of their own personal skills’ (NCCMH *et al.* 2010, para. 4.3.1). The NICE guideline on the treatment and management of BPD is also cautiously optimistic. It recommends that clinicians explore treatment options with patients ‘in an atmosphere of hope and optimism, explaining that recovery is possible and attainable’ (NCCMH *et al.* 2009, para. 10.1.4.1.). The guideline recommends that psychotherapy should be delivered in a structured setting, and that clinicians consider dialectical behavioural therapy for self-harm (NCCMH *et al.* 2009, para. 5.12.1.1-3).

The diverging paths taken by DSM-V and ICD-11 could have significant legal and social implications. Research on treatments for the DSM-V personality disorders are likely to continue as these categories have been retained in the manual. However, research on the ICD-11 models may take a different direction, focused on specific traits or behaviours rather than categories. In addition, while the revised diagnostic systems are an improvement, they have not fully addressed the longstanding stigma attaching to personality disorders and the moral judgments that underlie the diagnosis.

Experts rely on the DSM and ICD as the basis for psychiatric diagnoses, and these have significant consequences across a range of legal contexts, including criminal law, medical law, and family law (Bartlett, 2011). The existence of three diagnostic systems increases the likelihood of experts disagreeing over diagnosis, or using different terminology to describe a similar condition. Disagreements can have a decisive impact in legal contexts that require expert consensus. In mental health law, the MHA 1983 generally requires two doctors to certify that they are satisfied that the criteria for detention are met. A key criterion is that the person must be suffering from a mental disorder. Experts basing their assessments on the DSM-V criteria or the ICD-11 may come to different conclusions on this issue, as the criteria are not identical. An apparent lack of consensus could result, for example, in a prison sentence rather than a hospital disposal at sentencing. In the context of criminal law, a recognised psychiatric condition is required to demonstrate injury (*R. v D*, 2006). Consequently, ‘competing diagnoses or conflict between a diagnosis and non-diagnosis…can scupper a case that would have a realistic prospect of conviction in the absence of such conflict’ (Finch, 2022, p. 371).

Moreover, legal actors who are not experts in psychiatric diagnosis will have to familiarise themselves with three different models. This raises the prospect of misinterpretations of psychiatric evidence that can undermine the authority of legal decisions. Commentary on the trial of Anders Breivik in Norway highlights how diagnostic disagreements between psychiatrists in high profile cases can fuel anti-expert or anti-psychiatric commentary in the media, and lead to questionable legal decisions (Melle, 2013). Faced with contradictory psychiatric evidence, a trial court concluded in 2012 that Breivik was not psychotic, and found him legally accountable for killing 77 people. The decision has been criticised for relying on common sense interpretations of Breivik’s behaviour and for relying on the ICD-10 criteria for schizophrenia, seemingly overlooking DSM-IV criteria that could have led to the conclusion that Breivik was psychotic and therefore not legally accountable (Melle, 2013).

**The problem of ‘dangerous’ people diagnosed with personality disorders**

Concerns for the human rights or civil liberties of individuals who could be subject to long-term hospital detention with little prospect of release have long sat alongside demands for public protection from dangerous individuals. In 1999, the Fallon Inquiry into the personality disorder unit at Ashworth Special Hospital concluded that:

there continues to be a wide diversity of opinion among experts from all the professions about the treatment and management of personality disorder and particularly severe personality disorder. There have always been dedicated enthusiasts convinced that they have the answer within their grasp, but there are also the sceptics, probably the majority, who point to the lack of credible evidence that treatment works (Fallon *et al.*, 1999, para. 6.10.1).

Little in this picture had changed since the 1957 report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the Percy Commission) and the 1975 report of the Committee on Mentally Abnormal Offenders (the Butler Committee). While some progress has been made in respect of BPD, the picture is unlikely to be much different when it comes to ASPD.

Some jurisdictions have taken the step of entirely, or almost entirely, excluding people diagnosed with personality disorder from the scope of compulsory powers. In Ireland, a person cannot be involuntarily admitted to psychiatric hospital unless he or she suffers from mental disorder, defined as ‘mental illness, severe dementia or significant intellectual disability’ (Mental Health Act (Ireland) 2001, s.3). Involuntary admission based on a personality disorder alone is explicitly excluded (Mental Health Act (Ireland) 2001, s.8(2)(b)). Thus, a person diagnosed with a personality disorder can only be involuntarily admitted in Ireland if they have a comorbid condition that meets the mental disorder definition.

In New Zealand and in most Australian jurisdictions (except South Australia), a person must be suffering from ‘mental illness’ and require psychiatric treatment before he or she can be detained under mental health law (Gray *et al.*, 2010; Dawson, 2018). Personality disorder does not fit easily within statutory definitions of mental illness that are tailored to psychosis, thought disorder or mood disorders. Consequently, people with personality disorders in these jurisdictions can only be detained short-term during acute mental health crises (Dawson, 2018).

Under the Australasian approach, the prison service bears responsibility for managing “dangerous” offenders with personality disorders (Dawson, 2018, p. 624). Similarly, the Irish Mental Health Act 2001 implies that ‘it is criminal law, rather than mental health law, that should provide for situations where a person’s decisions possibly place others in jeopardy’ (Reidy and Kelly, 2021, p.3).

Dawson argues that the justification for the Australasian approach is that mental health law should not be used to facilitate the ‘pure preventive detention of people considered “dangerous” but untreatable’ but instead for ‘those most likely to benefit from treatment’ (Dawson, 2018, p. 84). Dawson traces this view back to the influential psychiatrist, Aubrey Lewis (1963, p. 1553), who was wary of the abuse of psychiatry and suggested that:

psychiatrists have no wish to…act…as the agents of organized society in getting ‘deviants’ to conform. If society asks psychiatrists to do this, with ‘psychopathic disorder’ as the thin end of the wedge, it may be predicted that they will refuse.

By contrast, the trend in England and Wales has been towards expanding the scope of mental health law to facilitate the detention of people with personality disorder where they are considered to pose a risk to the public. In the 1990s, the New Labour Government sought to introduce new legislation to detain ‘dangerous people with severe personality disorder’, or DSPD, in psychiatric hospitals (Home Office and Department of Health, 1999). Under the MHA 1983 as originally enacted, a person could only be detained on the grounds of ‘psychopathic disorder’ if treatment in hospital was ‘likely to alleviate or prevent a deterioration of [his or her] condition’ (MHA 1983, former s.3(2)(b)). Psychopathic disorder was a legal rather than a psychiatric concept defined as ‘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.’ The Government presented this ‘treatability’ requirement as a stumbling block to the detention of dangerous individuals in hospital on the grounds that personality disorders were considered untreatable by many psychiatrists (Peay, 2011b, p.176. See further O’Loughlin, 2014).

New Labour’s determination to remove perceived legal impediments to public protection drove the introduction of the MHA 2007 (Daw, 2007). The MHA 2007 amended the MHA 1983, replacing the old categories of mental illness, mental impairment and psychopathic disorder with the single diagnosis of ‘mental disorder’, broadly defined as ‘any disorder or disability of the mind’ (MHA 1983, s.1(2)). It replaced the ‘treatability’ requirement with the new, weaker test of whether ‘appropriate medical treatment’ is ‘available’ to the patient in hospital. The ‘purpose’ of this treatment must be to ‘alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations’ (MHA 1983, s.145(4)). This test applies, *inter alia*, to civil detention for treatment under section 3 and to the transfer of prisoners to psychiatric hospital by the Justice Secretary under section 47 of the MHA 1983.

While awaiting amendments to the MHA 1983, a pilot DSPD Programme was established in both hospital and prison settings to develop treatment and management techniques for the DSPD group. The programme has since been expanded in prisons and in the community under the new title of the Offender Personality Pathway (O’Loughlin, 2019; Skett and Lewis, 2019; Trebilcock *et al.*, 2019). While some commentators point to high profile cases of serious offending by former psychiatric patients such as Michael Stone as the impetus for the plans for the DSPD group (Seddon, 2008; Pickersgill, 2013), others highlight ‘a longstanding frustration within government at the refusal of psychiatrists to address the problem of high risk offenders with personality disorder’ (Maden, 2007, p. 8).

The DSPD group were not only conceived of as presenting a risk to the public, but also as disrupting the work of prisons and secure hospitals and threatening the authority of state institutions to maintain a safe custodial environment (O’Loughlin, 2019, p. 633). While the impact of the DSPD initiative on reoffending rates has yet to be fully evaluated, the reasons for its survival seem to hinge on its effectiveness in managing difficult prisoners at a reduced cost, and on its potential to provide a means for integrating difficult, high-risk offenders into existing systems of offender management and control (O’Loughlin, 2014, 2019; see further Trebilcock *et al.*, 2019).

**From ‘treatability’ to ‘appropriate treatment’ in the MHA 1983**

The DSPD programme and legislative amendments were further designed to address the problem of individuals in special hospitals resisting treatment by refusing to engage with treatment in order to be found ‘untreatable’ and not detainable under the MHA 1983. As the Law Society has highlighted, however, ‘treatability’ was already given a very wide interpretation under the original MHA 1983, and the problems targeted by the DSPD proposals may therefore have been problems of culture rather than of law (The Law Society, 2002).

The case law under the old MHA 1983 raises the question of whether the removal of the treatability test was necessary in the first place. In *Hutchison Reid v. Secretary of State for Scotland* (1999), the House of Lords interpreted the test very broadly. It held that while the patient was not receiving treatment for his personality disorder, ‘his detention in the hospital was preventing a deterioration of his condition because his abnormally aggressive or seriously irresponsible behaviour was being controlled or at least being modified’ (*Hutchison Reid v. Secretary of State for Scotland* (1999), p. 531). As the patient’s anger management showed improvement in the structured and medically supervised hospital environment, this was enough to satisfy the ‘treatability’ test. This approach was confirmed by the ECtHR in *Hutchison Reid v. UK* (2003, para. 52), in which the Court held that compulsory confinement

may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons’.

The new appropriate medical treatment test has been interpreted even more broadly than the old treatability test. ‘Appropriate medical treatment’ is defined tautologically as ‘medical treatment which is appropriate in (the patient’s) case, taking into account the nature and degree of the mental disorder and all other circumstances of his case’ (s.3(4) MHA 1983). ‘Medical treatment’ is defined broadly and includes ‘nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care’ (s.145(1) MHA 1983). The ‘purpose’ of treatment must be ‘to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations’ (s.145(4) MHA 1983). This sets a lower standard than the treatability test, as ‘purpose is not the same as likelihood’ (Department of Health, 2015, para. 23.4). Medical treatment may fulfil this criterion ‘even though it cannot be shown in advance that any particular effect is likely to be achieved’ (Department of Health, 2015, para. 23.4).

There is a very fine line between mere detention, which is impermissible under the MHA 1983, and appropriately ‘therapeutic’ detention, which is permissible. The MHA 1983 Code of Practice states that ‘simply detaining someone, even in a hospital, does not constitute medical treatment’ (Department of Health, 2015, para. 23.18). Nevertheless, ‘appropriate treatment’ for some patients may consist ‘only of nursing and specialist day-to-day care…in a safe and secure therapeutic environment with a structured regime’ (Department of Health, 2015, para. 23.17). For some, ‘management of the undesirable effects of their disorder may be the most that can realistically be hoped for’ (Department of Health, 2015, para. 23.16).

The courts in some cases have come ‘perilously close to finding that detention is, itself, appropriate treatment’ (Bartlett and Sandland 2014, p. 255). In *MD v. Nottinghamshire Healthcare NHS Trust* (2010), the First-Tier Tribunal (Mental Health) held that a patient, who was not psychologically able to engage with therapy, had ‘the potential to benefit from the milieu of the ward both for its short term effects and for the possibility that it would break through the defence mechanisms and allow him later to engage in therapy’ (*MD,* para. 39). Thus, appropriate treatment was held to be available.

Judge Jacobs seemed to take a more cautious approach in *DL-H v. Devon Partnership NHS Trust and Secretary of State for Justice* (2010). He was concerned that ‘medical treatment’ was defined so broadly in the legislation that there was a ‘danger that a patient for whom no appropriate treatment is available may be contained for public safety rather than detained for treatment’ (*DL-H v. Devon Partnership NHS Trust and Secretary of State for Justice*,2010,para. 33). To avoid this, he advised that tribunals ‘must investigate behind assertions, generalisations and standard phrases’ and consider specific questions:

What precisely is the treatment that can be provided? What discernible benefit may it have on this patient? Is that benefit related to the patient’s mental disorder or to some unrelated problem? Is the patient truly resistant to engagement?’ (*Devon Partnership NHS Trust and Secretary of State for Justice*, 2010, para. 33).

The reference to ‘therapeutic benefit’ seemed to set a higher standard than the legislation itself. However, in a subsequent case, Judge Jacobs said that his statements in *DL-H* *v Devon* were merely intended to guide tribunals in their fact-finding mission. He further held that ‘if the tribunal finds that the patient is not prepared to engage and will never be brought to engage, that will not necessarily be decisive. This is because the definition of treatment is so broad that it includes much that does not require the patient’s engagement in formal therapy’ (*DL-H v Partnerships in Care*,2013, para. 42).

In *WH v Llanarth Court Hospital* (2015, para. 56), the Upper Tribunal confirmed the approach in the Code of Practice, holding that:

it may in some circumstances be difficult to distinguish appropriate treatment from mere detention...If the purpose of the treatment the patient receives is to prevent a worsening of the symptoms or manifestations of his mental disorder, it is likely to constitute appropriate treatment even though the outcome of such treatment may have little or no beneficial effect on the patient.

Thus, whilst ‘mere detention’ cannot constitute appropriate treatment, it is sufficient for treatment to have a therapeutic ‘purpose’, even if it is unlikely to have any beneficial effect. This sets a very low standard. Surely treatment cannot have a ‘therapeutic purpose’ if it is known in advance that it is unlikely to any beneficial effect on the patient? In any event, tribunals are often able to find a therapeutic purpose on the facts of the case. As the judge remarked in *WH* (2015, para. 39), ‘there has been no reported case where a tribunal has found that a patient’s treatment in hospital constituted mere containment’.

This liberal approach may not now comply with the ECHR. In *Rooman v. Belgium* (2009, para. 208), the Court, summarising its case law, held that:

‘the administration of suitable therapy has become a requirement in the context of the wider concept of the ‘lawfulness’ of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for their eventual release’.

The ECtHR held that detaining the applicant in a hospital for 14 years without providing him with therapy in a language he could understand violated Articles 3 and 5 of the Convention. This was, at least in part, because he needed to engage with therapy to have any prospect of being discharged. Accordingly, *Rooman* falls in line with the ECtHR’s case law on the prisoner’s ‘right to rehabilitation’ and right to a ‘hope’ of release (Van zyl smit, Weatherby and Creighton, 2014; Vannier, 2016; Meijer, 2017; O’Loughlin, 2021a).

After *Rooman*, placing a person in a structured environment with the purpose of merely preventing a deterioration in his condition, or providing treatment that has little or no chance of having any beneficial effect may not be complaint with the ECHR. Such regimes could not be said to be oriented towards preparing the individual for release.

**From appropriate treatment to therapeutic benefit?**

The debate surrounding appropriate treatment has returned following the publication of *Modernising the Mental Health Act* (Department of Health and Social Care, 2018), the final report of the Independent Review of the Mental Health Act 1983 chaired by Professor Sir Simon Wessely. A Draft Mental Health Bill 2022 based on the proposals contained in a White Paper entitled *Reforming the Mental Health Act* (Department of Health and Social Care and Ministry of Justice, 2021) is currently undergoing scrutiny by a Joint Committee of members of the House of Commons and House of Lords.

The Wessely Review was conducted in a much calmer political climate than that facing its predecessor, the Expert Committee chaired by Professor Genevra Richardson commissioned in 1998 to review the MHA 1983 (Department of Health, 1999). In the Foreword to the Review, Professor Sir Wessely wryly comments that his Review’s terms of reference included ‘the problems of the rising rate of coercion, seen as something undesirable, as opposed to the aim of public policy’ (Department of Health and Social Care, 2018, p. 8).

The Wessely Review proposed that the following purposes be enshrined on the face of the Mental Health Act: ‘to confer and authorise the powers (including coercive powers) necessary for the treatment of mental disorder and to safeguard the dignity and rights of those who are made subject to the exercise of such powers and for related purposes’ (Department of Health and Social Care, 2018, p. 67).

It further recommended four key principles to govern the use of compulsory powers:

1. Choice and autonomy

2. Least restriction

3. Therapeutic benefit

4. The person as an individual (Department of Health and Social Care, 2018, p. 67).

Most relevant to personality disorder, the Review recommended strengthening the detention criteria under the Act by adding two new requirements. First, that ‘treatment is available which would benefit the patient, and not just serve public protection, which cannot be delivered without detention’. Second, that ‘there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person without treatment’ (Department of Health and Social Care, 2018, p. 113).

Whilst proposing that ‘treatment’ be broadly defined, the Review sought to guard against the idea that detention in itself could be sufficient. It proposed that ‘in situations of crisis, it may be reasonable for the main, but not the only, element of treatment to be to provide a safe therapeutic environment for a brief period of time’ (Department of Health and Social Care, 2018, p. 113). Keeping a person ‘off the streets’ would not be enough, nor would long periods of detention be justified on the basis of ‘general nursing input and self-care planning’ or the ‘assertion that the ‘ward routine’ provides a therapeutic benefit’ (Department of Health and Social Care, 2018, p. 113).

Thus, the Wessely Review recommended a move away from the minimalist requirements in the case law and Code of Practice and towards a requirement for more active therapeutic input. The proposed ‘substantial risk of serious harm’ test would also set a higher bar for detention than the current legislation, and would presumably set a lower bar for discharge.

The Review’s recommendations were not restricted to a particular part of the Act, and it appears that the Review envisaged they would apply to people detained under civil (Part II) and criminal (Part III) powers. There was, however, little detailed consideration of the implications of proposed reforms for Part III patients.

While the current criteria for discharging unrestricted Part III patients are the same as for section 3 patients (MHA 1983, s.72(1)(b)), the criteria for making hospital orders (s.37, MHA 1983) and transfer directions (s.48, MHA 1983) without restrictions make no reference to risk.[[3]](#footnote-3) Currently, an unrestricted patient detained under Part III of the MHA 1983 must be discharged by a Tribunal if the criteria under s.72(1)(b) of the Act are no longer met. If these criteria were strengthened along the lines recommended by the Wessely Review, it is likely that more hospital order patients would be discharged at their first review. But a patient serving a prison sentence[[4]](#footnote-4) could continue to be detained in hospital, so long as their detention continued to be justified under Article 5(1)(a) (detention after conviction). This is also the case under the current MHA 1983.

In *Reforming the Mental Health Act* (Department of Health and Social Care and Ministry of Justice, 2021), the Government published plans to insert the Wessely Review’s ‘substantial likelihood of significant harm’ requirement into sections 2 and 3 of the MHA 1983 Act and the community treatment order (CTO). The consultation paper also proposed to introduce a therapeutic benefit test for section 3 patients and CTO patients. It, however, took the questionable step of proposing to restrict these reforms to Part II patients. This was on the grounds that ‘patients in the criminal justice system have a unique risk profile’ and that changing the detention criteria would ‘compromise [the Government’s] ability to adequately protect the public from risk of harm from sometimes serious or violent offenders’ (Department of Health and Social Care and Ministry of Justice, 2021, p. 27). The paper also suggested that the four Wessely Review principles may not be applicable to Part III patients due to public safety concerns (Department of Health and Social Care and Ministry of Justice, 2021, p. 21).

The assumption that Part III patients are inherently dangerous is not based in evidence. Indeed, a study of 84 patients discharged from medium or low secure hospital wards identified that civil patients in secure settings were more frequently involved in incidents of aggression, sex offending and fire-setting than forensic patients (Galappathie, Khan and Hussain, 2017).

The Draft Mental Health Bill 2022 has since departed from this assumption of dangerous by extending its proposed reforms to the detention criteria under the MHA 1983 to people detained under Part II and Part III. It does not, however, propose to enshrine the Wessely Review principles on the face of the Act.

The Bill proposes to replace s.72(1)(b) with a new s.20(4) that would require the Tribunal to discharge a patient who is liable to be detained under the Act[[5]](#footnote-5) where it is *not* satisfied that:

(a) the patient is suffering from psychiatric disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital; and

(b) serious harm may be caused to the health or safety of the patient or of another person unless the patient receives medical treatment,

(c) it is necessary, given the nature, degree and likelihood of the harm, and how soon it would occur, for the patient to receive medical treatment,

(d) the necessary treatment cannot be provided unless the patient continues to be liable to be detained, and

(e) appropriate medical treatment is available for the patient (proposed new section 20(4), Clause 3 and 4 of the Draft Bill)

These criteria are more stringent than the current s.72(1)(b) as they would require Tribunals to be satisfied that treatment is necessary to avoid 'serious harm’ to the patient or to others, whereas the current criteria merely require treatment to be ‘necessary for the health or safety of the patient or for the protection of other persons’. The wording of the Draft Bill is opaque, however, as it does not specify how likely the harm should be before detention for treatment is necessary. Should it be almost certain to occur, or more likely than not? Furthermore, as is the case under the current Act, the proposals give no further guidance on how the broad terms of ‘nature’, ‘degree’, ‘health’ and ‘safety’ are to be interpreted.

The proposed changes to the ‘appropriate medical treatment’ test in the Draft Bill are light touch. The definition of ‘appropriate medical treatment’ in the Bill is almost identical to the current definition in the Act. The only difference is that ‘reasonable prospect’ has replaced ‘purpose’. This means that a person detained under Part III of the MHA 1983 would have to be discharged (conditionally or absolutely) if the Tribunal was *not* satisfied that appropriate medical treatment was available and that this would have ‘a reasonable prospect of alleviating, or preventing the worsening of, the disorder or one or more of its symptoms or manifestations’.

While ‘purpose’ in the current Act does not seem to require much more than hope that the treatment will have the desired effect, ‘reasonable prospect’ would seem to require an evaluation of the likelihood of treatment having such an effect. This, however, falls short of the requirement for a ‘therapeutic benefit’ proposed by the Wessely Review, where ‘benefit’ ‘would include contributing to the patient’s discharge, and not solely to public safety’ (Department of Health and Social Care, 2018, p. 113). The Wessely Review’s interpretation of ‘treatment benefit’ would fit better with the ECtHR’s insistence on measures to prepare detainees for discharge in *Rooman*. The Government may, however, be reluctant to re-ignite the concerns that resulted in the watering down of the old ‘treatability’ test. Given the limited evidence for the effectiveness of treatments for ASPD, a more robust therapeutic benefit test could run the risk of limiting public protection powers.

**Personality disorder and criminal law**

The mental state of a person with personality disorder whose behaviour poses a risk to him or herself or to others can ‘at one and the same time [be] deemed to meet the conditions required for criminal responsibility, and to warrant involuntary hospital admission’ (Pickard, 2015, p. 16). As Hannah Pickard (2015, p. 16) argues, it is difficult to avoid the feeling that a person in this position

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

In addition, while individuals with personality disorder often do not benefit from the protections offered by the law to those who are deemed insane, they can nevertheless be detained in hospital under the MHA 1983 on the grounds that they have a mental disorder and pose a risk to others (Peay, 2011a, p. 232). The reasons behind and the implications of these seeming paradoxes are examined below.

As Pickard (2015) acknowledges, the purposes and rationales of civil and criminal law are distinct. The MHA 1983 is highly paternalistic, and aims to prevent people with mental disorder from harming themselves or others. Treatment choices are at the discretion of the treating clinician, and treatment for mental disorder can be imposed on a detained person without their consent under section 63 of the MHA 1983, even if they have capacity to refuse treatment under the Mental Capacity Act (MCA) 2005.[[6]](#footnote-6)

Treatment for personality disorder is construed in a broad sense. It includes force-feeding where this is concurrent with or a necessary pre-requisite to treatment for mental disorder (*B v. Croydon Health Authority*, 1995), or where a hunger strike is a symptom or manifestation of personality disorder (*R v. Collins, ex p Brady*, 2001). More recently, kidney dialysis was held to be treatment ‘for’ a personality disorder as the person’s physical condition and his non-compliance with treatment were both held to be ‘manifestations’ of his personality disorder (*A Healthcare v*. *CC*, 2020).

The MCA 2005, by contrast, seeks to *maximise* a person’s ability to make their own decisions about medical treatment (Department for Constitutional Affairs, 2007, pp. 19–20). The threshold for someone to lack capacity under the MCA 2005 is therefore relatively high. People diagnosed with personality disorder tend to befound to have capacity under the MCA 2005. Indeed, 94% of patients and prisoners on the DSPD programme were found to have capacity to consent to treatment (Burns *et al.* 2011, p. 93).

Conversely, the criminal law has been shaped by a judicial desire to *minimise* findings of non-responsibility and to resist challenges to the criminal law’s authority to punish (Eigen, 1995; Wiener, 2003; Loughnan and Ward, 2014). While a personality disorder may constitute a ‘disease of the mind’ under the rules in *R. v. M'Naghten* (1843), only those who did not know the nature and quality of their act and/or that it was legally wrong can be found not guilty by reason of insanity (*R. v. Codère*, 1917; *R. v.* *Windle*, 1952). A defendant with a personality disorder who does not respond to moral reasons or who has problems exercising self-control is unlikely to be found insane (see Morse 2008; Peay 2011a). Indeed, between 1975 and 1988 there were just three findings of NGRI where the primary diagnosis was personality disorder, and in later research there were no successful pleas with this diagnosis (Law Commission 2012, para. 3.38).

Diminished responsibility is more responsive to personality disorder, as it considers, *inter alia*, a person’s capacity to form a rational judgment or to exercise self-control (Homicide Act 1957, s.2). When accepted, the plea avoids the mandatory life sentence for murder and leaves the choice of sentence to the judge’s discretion. The proportion of successful pleas on the grounds of personality disorder are, however, relatively low. In 2005, 10% of successful pleas were based on personality disorder while 28% of successful pleas were based on paranoid schizophrenia (Ministry of Justice 2009, p. 15). In a later study, 73% of defendants with personality disorder who raised diminished responsibility were convicted of murder compared to just 12% of those diagnosed with schizophrenia (Mackay and Mitchell, 2017, Table 8).[[7]](#footnote-7) Defendants with personality disorder who successfully raised diminished responsibility were also more likely to be regarded as deserving punishment, as all such defendants in the study received a prison sentence (Mackay and Mitchell, 2017, Table 8).

An individual with personality disorder may therefore expect to only have the effects of his or her mental disorder taken into account at sentencing, if at all. The Court of Appeal in the leading case of *R. v.* *Vowles* (2015, para. 54(iii)) advised judges that a hospital order with restrictions (MHA 1983, ss.37 and 41) would be warranted at sentencing where:

(1) the mental disorder is treatable; (2) once treated there is no evidence [the offender] would be in any way dangerous; and (3) the offending is entirely due to that mental disorder.

Thus, the Court in *Vowles* created an additional risk-based treatability requirement in sentencing law that is narrower than the appropriate treatment requirement in the MHA 1983. The Court advised that offenders with personality disorder should be given prison sentences rather than hospital disposals. This was on the grounds that it is ‘more difficult to attribute a reduction in culpability to a personality disorder’; that ‘individuals with severe personality disorders are less likely to benefit from hospitalisation’; and that treatment was available in specialist prisons (*Vowles*, 2015, para. 50(iii)-(v)).

After *Vowles*, offenders with personality disorder seemed more likely to receive a prison sentence than a hospital order. However, subsequent cases adopted a more flexible approach (O’Loughlin, 2021b). In *R. v.* *Turner* (2015) and *R. v.* *Hoppe* (2016), two appellants diagnosed with emotionally unstable personality disorder successfully appealed against indeterminate prison sentences. In both cases, the Court of Appeal chose to substitute hospital orders with restrictions based on psychiatric evidence that the appellants’ disorders were treatable and that their offending was related to their mental disorders (O’Loughlin, 2021b). The psychiatric evidence in these cases may have reflected the stronger evidence base for the treatment of BPD, and it is unclear whether the same approach will be adopted for ASPD.

After *Vowles*, a person with a personality disorder may therefore be excluded from a hospital disposal at sentencing on the grounds that treatment is not expected to reduce risk to the public. Yet, the same person may later be detained under the MHA 1983 on the grounds, *inter alia*, that ‘appropriate medical treatment’ is ‘available’ in hospital. This is because the MHA 1983 can be used for the purposes of preventive detention after a prison sentence expires: a possibility that sits uncomfortably with the principle of proportionate punishment.

No routinely published data is available on how frequently sentenced prisoners are transferred to hospital by the Justice Secretary for the purposes of preventive detention under section 47 of the MHA 1983. But, according to data from one study, the majority (65%) of patients admitted to hospital units on the DSPD programme were serving determinate sentences (Trebilcock and Weaver 2012). Most were admitted close to their expected release date, and 20% had been transferred to hospital less than two weeks before they expected to be released from prison (Trebilcock and Weaver 2012).[[8]](#footnote-8) These patients were often angry and some refused to engage with treatment, and this had a negative impact on the work of hospital DSPD units (Burns *et al.*, 2011, p.219 and p.225). While the OPD Pathway aims to identify eligible prisoners early in their sentences (NOMS and NHS England, 2015, p.17) and late transfers have been criticised by the Court of Appeal, transfers late in sentence are still possible where the requirements of the MHA 1983 are ‘scrupulously satisfied’ (*R(TF) v SS for Justice*, 2008).

**Conclusions**

Personality disorder is a controversial and contested diagnosis associated with negative moral judgments towards people whose behaviour is deemed disturbing, demanding, difficult, dangerous, or merely eccentric. While advances in understanding and treating personality disorders are beginning to counteract the notion that they are permanent, the diagnosis continues to be associated with shame and exclusion. For BPD, the picture is more hopeful as the evidence to support treatment techniques continues slowly to improve. For ASPD or dissocial personality disorder, however, there is still little evidence of treatment effectiveness.

Attempts to confine the use of the MHA 1983 to people who need treatment have repeatedly encountered the problem of serious offenders whom the authorities are reluctant to discharge. The Wessley Review’s attempt to counteract a culture of containment has met resistance from government, yet again on public protection grounds. Thus, the risk aversion that saw the introduction of the MHA 2007 and the DSPD Programme continues to impede progressive reforms to mental health law.

Meanwhile, people with personality disorder are largely found to have capacity to refuse treatment under the MCA 2005, yet they can have treatment imposed upon them under the MHA 1983. They are frequently found criminally responsible and deserving of a prison sentence by criminal courts, yet can be detained under the MHA 1983 post-sentence. Offenders with personality disorder in England and Wales are therefore at the intersection between two overlapping coercive systems: the criminal justice system and the mental health system. In a context of risk aversion and flexible legal criteria for detention, compulsion may seem inevitable for offenders who are perceived to be dangerous by criminal justice and mental health authorities. The Draft Mental Health Bill 2022 is a step in the right direction, but more work is needed to move towards a system that is oriented towards discharge, rather than containment, and a greater tolerance for positive risk-taking.

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1. DSM-V is the standard diagnostic manual in the USA, while the ICD is the standard in the UK. WHO member states agreed to adopt ICD-11on 25 May 2019. ICD-11 came into effect in February 2022, replacing ICD-10 (World Health Organisation, 2022). [↑](#footnote-ref-1)
2. This is similar to obsessive-compulsive personality disorder in DSM-V. [↑](#footnote-ref-2)
3. See, for example, the criteria for making a hospital order under s.37 of the Act: ‘(1) Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law,…or is convicted by a magistrates’ court of an offence punishable on summary conviction with imprisonment, and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order… (2) The conditions referred to in subsection (1) above are that — (a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder and that…(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him;…and (b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section.’ A court can make a hospital order subject to restrictions on discharge under section 41 of the MHA 1983, and the Justice Secretary can make a transfer direction subject to restrictions under section 49. [↑](#footnote-ref-3)
4. Under the MHA 1983, there are two main routes into hospital for people serving a prison sentence: the section 45A hospital and limitation direction under section (attached by a sentencing court to a prison sentence) or the section 47 transfer direction (an order to transfer a sentenced prisoner to hospital made by the Secretary of State). [↑](#footnote-ref-4)
5. Apart from patients detained for assessment under section 2 of the Act. [↑](#footnote-ref-5)
6. This power is subject to safeguards for certain treatments under sections 57 – 58A. Treatment must not breach Article 3 of the ECHR. See further (Bartlett, 2011b). [↑](#footnote-ref-6)
7. Figures calculated by the author from data in Mackay and Mitchell (2017). [↑](#footnote-ref-7)
8. This figure has been calculated by the author from the data reported in Trebilcock and Weaver (2012). The data is based on 69 admissions to DSPD units in high secure hospitals. [↑](#footnote-ref-8)