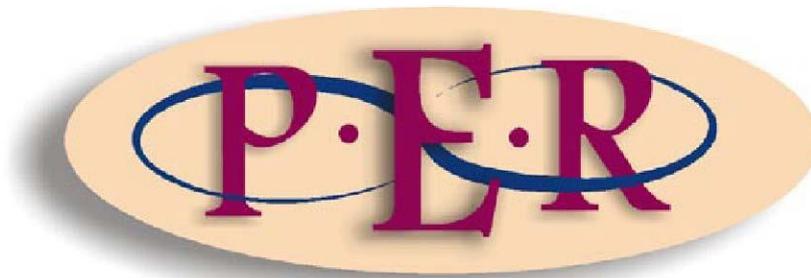


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## LEGAL ASPECTS WITH REGARD TO MENTALLY ILL OFFENDERS IN SOUTH AFRICA

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### 1 Introduction

Burchell<sup>1</sup> explains that mental illness may deprive persons of the capacity to appreciate the unlawfulness of their conduct. It may also deprive them of the capacity to control their conduct. Persons who suffers from a mental illness that has such an effect is said (in legal terms) not to be accountable due to their mental illness. The mentally ill, however, are a distinct subgroup within the penal system.<sup>2</sup> The underlying premise of the defence of mental illness is that persons with mental illness are the victims of an affliction that causes them to behave in an abnormal manner due to their mental illness. They cannot be blamed for their conduct while afflicted by the illness as they lack criminal capacity, or their capacity is diminished. The test for capacity is entirely subjective,<sup>3</sup> relating for example to the capacity of the particular accused person who is alleged to be mentally ill. This note discusses the concept of forensic psychiatry, which is relevant with regard to the defence of mental illness; the concept of mental illness; the defence of mental illness; and how mental illness is interpreted in criminal cases. A conclusion is then drawn to summarise the findings.

### 2 Forensic psychiatry

Forensic psychiatry operates at the interface of two disparate disciplines, namely law and psychiatry. Although most cases in forensic psychiatric practice produce little conflict, functioning at the interface of these two disciplines can lead to confusion and ethical dilemmas.<sup>4</sup> Forensic psychiatry may be defined as follows:<sup>5</sup>

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<sup>1</sup> Burchell *Principles of Criminal Law* 271.

<sup>2</sup> Arrigo *Punishing the Mentally Ill* 105.

<sup>3</sup> See Burchell 2003 *Acta Juridica* 23.

<sup>4</sup> Weinstock, Leong and Silva "Defining Forensic Psychiatry" 7.

<sup>5</sup> This definition of forensic psychiatry was adopted by the American Board of Forensic Psychiatry (ABFP) and the American Academy of Psychiatry and the Law (AAPL). See Weinstock, Leong and Silva "Defining Forensic Psychiatry" 7.

Forensic psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters; forensic psychiatry should be practised in accordance with guidelines and ethical principles enunciated by the profession of psychiatry.<sup>6</sup>

Most forensic psychiatrists do not see themselves as functioning outside of their medical and psychiatric roles. They see themselves (and probably generally are perceived) as utilising their medical and psychiatric skills and techniques.<sup>7</sup> Controversy exists regarding to whom the forensic psychiatrist owes a duty. This problem is in part due to the fact that a standard doctor-patient relationship does not apply. Stone<sup>8</sup> believes that psychiatry enters an ethical morass when it leaves the clinical situation, as in the case of forensic psychiatry. This is discussed further below, when reference is made to the use of diagnostic criteria with reference to forensic settings. In order to fully understand the defence of mental illness it is important to discuss the concept of mental illness in the paragraphs below.

### **3 The concept of mental illness**

Mental illness is a disorder (or a disease) of the mind that is judged by experts to interfere substantially with a person's ability to cope with the demands of life on a daily basis. It can profoundly disrupt a person's thinking, feeling, moods and ability to relate to others. Mental illness is manifested in behaviour that deviates notably from normal conduct.<sup>9</sup> According to Bartol<sup>10</sup> the word "illness" encourages us to look for etiology, symptoms and cures and to rely heavily on the medical profession both to

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<sup>6</sup> Also see Prins "Foreword" xi, who prefers to use the term "forensic mental health", because it reflects shifts in emphasis in a number of dimensions in the field of psychiatry. According to him there is an increasing recognition that work with mentally ill offenders needs to encompass a very wide range of disciplines if the many and varied needs of this group of individuals are to be met. This trend does not diminish the importance of psychiatry, but serves to recognise the many-faceted elements in the challenges that offenders and offender-patients represent. The term "forensic mental health" would therefore then include, for example, law, management, psychiatry, psychology, social work and probation, as well as pharmacy.

<sup>7</sup> Weinstock, Leong and Silva "Defining Forensic Psychiatry" 9.

<sup>8</sup> Stone 1975 *Am J Psychiatry* 1125.

<sup>9</sup> Bartol *et al Criminal Behaviour* 228-229.

<sup>10</sup> Bartol *et al Criminal Behaviour* 228-229.

diagnose and to treat. The term mental illness need not imply that a person is sick, to be pitied, or even necessarily less responsible than others for his or her actions.<sup>11</sup> According to the American Psychiatric Association<sup>12</sup> no definition adequately specifies precise boundaries for the concept of "mental illness". This concept, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. Mental illnesses have been defined by a variety of terms, such as distress, disadvantage, disability, inflexibility, irrationality, and statistical deviation. Each is a useful indicator for a mental illness, but none is equivalent to the concept, and different situations call for different definitions.

Mental illness in a clinical context is defined as:<sup>13</sup>

... a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (for example a painful symptom) or disability (for example impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (for example, political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual...

Mental illness in a legal context is defined as:<sup>14</sup>

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<sup>11</sup> A term that must be distinguished from mental illness is "mental retardation", which is professionally known as developmental disability. This is a cognitive deficiency measured by IQ tests (specifically, IQ below 70) which cannot be cured. It is a syndrome of delayed or disordered brain development evident before age 18 years. It results in difficulty in learning the information and skills needed to adapt quickly and adequately to environmental changes. See Ainsworth *et al Understanding Mental Retardation* 3.

<sup>12</sup> American Psychiatric Association *Diagnostic and Statistical Manual* xxi.

<sup>13</sup> According to the American Psychiatric Association the term "mental disorder" unfortunately implies a distinction between "mental disorders" and "physical disorders", which is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental disorders" and much "mental" in "physical disorders". However, the problem raised by the term "mental disorder" has been much clearer than its solution, and the term will have to persist until an appropriate substitute is found. See American Psychiatric Association *Diagnostic and Statistical Manual* xxi. Also see the definition of mental disorder according to ICD-10: "a mental disorder is a clinically recognisable collection of symptoms or behaviour associated in most cases with distress or interference with personal functions. A deviant pattern of behaviour, whether political, religious, or sexual, or a conflict between an individual and society, is not a mental disorder unless it is symptomatic of a dysfunction in the individual".

<sup>14</sup> S 1 of the *Mental Health Care Act* 17 of 2002.

... a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health practitioner authorised to make such diagnosis.<sup>15</sup>

From a philosophical perspective, it is reasonably clear that there can be chronic mental malfunction when a person's capacities to respond to the world, to absorb and remember information, to respond with appropriate emotions and to form coherent plans are impaired. What is not so clear is whether the mind can be the self-contained locus of an illness, or whether mental malfunction should always be thought of as the by-product of physical or bodily illness or impairment. If the mind can be the self-contained locus of an illness, then the mind might be cured by mental means, such as conversation with a therapist. If not, the only effective responses would be medical or pharmacological. Therefore the issue of what mental illness is has practical as well as purely philosophical importance.<sup>16</sup>

Contrary to the concept of mental illness, "mental health" again is defined as the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people and the ability to adapt to change and to cope with adversity.<sup>17</sup>

Using the discussion of the concept of mental illness as a background, a discussion of the system of classification of mental illness now follows.

#### **4 System of classification of mental illness**

Diagnoses and classifications in psychiatry have undergone tremendous changes in the last 40 years. Before the 1950s diagnoses were not only unreliable, but the terms in which they were formulated even had meanings that varied considerably across the

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<sup>15</sup> Also see the definition of "severe or profound intellectual disability": "a range of intellectual functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self-care and requiring constant aid and supervision, to severely restricted sensory and motor functioning and requiring nursing care". S 1 of the *Mental Health Care Act 17 of 2002*.

<sup>16</sup> For interesting views of the philosophy of mental illness or health, see Gibson and Huemer *Literary Wittgenstein* 267; and further, Craig *Routledge Encyclopedia of Philosophy* 314-316.

<sup>17</sup> Thompson *Mental Illness* 4. Also see the definition of "mental health status": "the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis". See s 1 of the *Mental Health Care Act 17 of 2002*.

world. By the end of that decade, "anti-psychiatrists", including Laing,<sup>18</sup> and Szasz<sup>19</sup> had started to suggest that diagnosis and classification in psychiatry should be abandoned, together with the concept of mental illness.<sup>20</sup> In the 1960s the World Health Organisation instigated a world-wide programme aimed at improving the diagnosis and classification of mental disorders, fostering research into the reliability of diagnosis and classification. The mental health section of the *International Classification of Diseases* is currently in its 10<sup>th</sup> edition (ICD-10).<sup>21</sup> The American Psychiatric Association developed its own classificatory system, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM); the current classification, DSM-5-TR,<sup>22</sup> was published in 2013.

An examination of a person with psychiatric or psychological problems begins with the attempt to recognise the individual pattern of symptoms and experiences that leads to the establishment of a specific psychiatric diagnosis. This diagnosis should be expressed in a particular nomenclature according to a recognised classification system. The fundamental purpose of diagnosis and classification in medicine is to define a group of discrete disease entities, each of which is characterised by a distinct

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<sup>18</sup> (1927-1989.) Ronald David Laing was a Scottish psychiatrist who wrote extensively on mental illness – in particular, the experience of psychosis. Laing's views on the causes and treatment of serious mental dysfunction (greatly influenced by existential philosophy) ran counter to the psychiatric orthodoxy of the day by taking the expressed feelings of the individual patient or client as valid descriptions of lived experience rather than simply as symptoms of some separate or underlying disorder. Often associated with the anti-psychiatry movement, he himself rejected the label as such, as did certain others critical of conventional psychiatry at the time. See Miller *RD Laing* 7, 19.

<sup>19</sup> (1920-. ) Thomas Stephen Szasz is a Professor Emeritus of Psychiatry at the State University of New York Health Science Center in Syracuse, New York. He is a prominent figure in the anti-psychiatry movement, a well-known social critic of the moral and scientific foundations of psychiatry, and of the social control aims of medicine in modern society, as well as of scientism. He is well known for his books: *The Myth of Mental Illness* (1960); and *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (1970), which set out some of the arguments with which he is most associated. See Slade *Bibliography of Works* 1.

<sup>20</sup> The term anti-psychiatry usually refers to a movement that emerged in the 1960s, which is hostile to most of the fundamental assumptions and common practices of psychiatry. The term anti-psychiatry was first used by the South African psychiatrist David Cooper in 1967. Two central contentions of the anti-psychiatry movement are that: (1) the specific definitions of, or criteria for, hundreds of current psychiatric diagnoses or disorders are vague and arbitrary, leaving too much room for opinions and interpretations to meet basic scientific standards; and (2) prevailing psychiatric treatments are ultimately far more damaging than helpful to patients. See Baker *Mind Games* 1-9.

<sup>21</sup> The ICD-10 is currently being reworked to ICD-11 but the process has not yet been finalised.

<sup>22</sup> TR stands for "text revision".

pathophysiology and/or aetiology. However, for most psychiatric diseases the approach is based more on phenomenology than on pathophysiology and/or aetiology.<sup>23</sup>

The two main current systems of classification in South Africa are the ICD-10 and the DSM-5.<sup>24</sup> It is important to note that there are textual differences between ICD-10 and DSM-5, but according to treaties between the United States and the World Health Organisation, the diagnostic code numbers must be identical to ensure the uniform reporting of national and international psychiatric statistics.<sup>25</sup> ICD-10 is a uniaxial system which attempts to standardise by using descriptive definitions of the syndromes and operational criteria, as well as by producing directives on differential diagnosis. DSM-5 is a multiaxial system which relies on operational criteria rather than descriptive definitions. It states which symptoms need to be present (often quantifying their number and requiring a specific length of time for the symptoms to be present) as well as exclusion criteria.<sup>26</sup>

A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome.<sup>27</sup> The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psycho-social and environmental problems as well as the level of functioning that might be overlooked if the focus were on assessing a single presenting problem.<sup>28</sup>

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<sup>23</sup> Pretorius "Classification" 7.

<sup>24</sup> Allan 2005 *SAJP* 55.

<sup>25</sup> Sadock and Sadock *Synopsis of Psychiatry* viii.

<sup>26</sup> Katona and Robertson *Psychiatry at a Glance* 11.

<sup>27</sup> American Psychiatric Association *Diagnostic and Statistical Manual* 25.

<sup>28</sup> A multiaxial system further provides a convenient format for organising and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis. In addition, this system promotes the application of the bio-psycho-social model in clinical, educational and research settings. American Psychiatric Association *Diagnostic and Statistical Manual* 25.

## 5 Types of classification of mental illness

Traditionally, mental illness is differentiated into mental retardation<sup>29</sup> (learning disability, in which features of the disorder have been present from birth or an early age), personality disorder (usually present from childhood or adolescence), mental illness (where there is an identifiable onset of illness preceded by normal functioning), adjustment disorder (less severe than mental illness, occurring in relation to stressful events or changed circumstances), disorders of childhood and other disorders (those which do not fit into any other group, including behavioural disorders and substance misuse). Mental illness has traditionally been differentiated into organic and functional (psychotic<sup>30</sup> and neurotic<sup>31</sup>) types.<sup>32</sup>

For the purposes of this contribution, where the defence of mental illness is discussed, it is important to refer to the use of DSM in forensic settings, because the use of DSM in forensic setting might cause some problems as discussed in the paragraphs below.

## 6 The use of DSM-5 in forensic settings<sup>33</sup>

Misuse or misunderstanding of medical diagnoses should concern all physicians, no matter what the setting. The accuracy and reliability of psychiatric and psychological diagnoses in legal settings are particularly important, because diagnosis often

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<sup>29</sup> "Mental retardation", professionally known as developmental disability. This is a cognitive deficiency measured by IQ tests (specifically, IQ below 70), which cannot be cured. It is a syndrome of delayed or disordered brain development evident before age 18 years. It results in difficulty learning information and skills needed to adapt quickly and adequately to environmental changes. See Ainsworth *et al Understanding Mental Retardation* 3.

<sup>30</sup> Psychosis is defined as a severe mental disorder of organic or functional origin characterised by gross impairment in reality testing. The individual incorrectly evaluates the accuracy of his perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence. Specific symptoms indicative of psychosis are delusions, hallucinations, markedly incoherent speech, disorientation and confusion. Psychotic individuals have little or no insight into their symptoms and are so impaired that they cannot meet the usual demands of life. Goldenson *Longman Dictionary* "psychosis" 607.

<sup>31</sup> Psychoneurosis is a mild or moderately severe emotional disorder. It is sometimes simply called neurosis. The patient is able to lead a fairly normal life, but often suffers from feelings of depression, anxiety or inadequacy. Everyone experiences some symptoms of neurosis, particularly when under a strain. A neurotic person experiences these uncontrollable feelings frequently when there is no apparent cause. Neurosis is defined as an emotional or mental disorder accompanied by obsessional behaviour. Obsessions include excessive anger, anxiety or jealousy, or a phobia (an unreasoned fear of hatred such as agoraphobia), or an excessive fear of open spaces. See Reader's Digest *Family Medical Encyclopaedia* "psychoneurosis" 279; "neurosis" 238.

<sup>32</sup> Katona and Robertson *Psychiatry at a Glance* 11.

<sup>33</sup> This discussion is limited to diagnoses in forensic settings.

influences court findings, financial judgments, the liberty interests of defendants, and even social policy. We therefore need the highest possible confidence level for diagnoses and other contributions in legal settings.<sup>34</sup> The law does not set the threshold for determining clinical illness, but it does determine "what particular forms and degree of psychopathology it will recognise as exculpatory" or otherwise relevant to the court's needs. Individual behaviour and functioning are more important than diagnostic labels, although the psychiatrist or psychologist may have to convince the judge of that fact.<sup>35</sup>

DSM-5 is a classification of mental disorders that was developed for use primarily in clinical, educational and research settings. According to the American Psychiatric Association<sup>36</sup> there are significant risks that diagnostic information will be misused or misunderstood when the DSM-5 categories, criteria and textual descriptions are employed for forensic purposes. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder is not sufficient to establish the existence for legal purposes of a mental disorder, mental disability, mental disease or mental defect. In determining whether or not an individual meets a specified legal standard, (for example, competence, criminal responsibility or disability), additional information is usually required beyond that contained in the DSM-5 diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities and disabilities vary widely within each diagnostic category that the assignment of a particular diagnosis does not imply a specific level of impairment or disability. However, by providing a compendium based on a review of the pertinent clinical and research literature, DSM-5 may facilitate the legal decision maker's understanding of the relevant characteristics of mental disorders.

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<sup>34</sup> Reid, Wise and Sutton 1992 *Psychiatr Clin North Am* 529.

<sup>35</sup> Diamond 1985 *Bull Am Acad Psych & L* 126.

<sup>36</sup> American Psychiatric Association *Diagnostic and Statistical Manual* xxiii-xxiv.

According to Allan,<sup>37</sup> when asked to give a diagnosis in legal settings practitioners should be mindful of the tentative nature of psychiatric diagnoses and that courts require that such a diagnosis must have scientific credibility. South African courts have not been explicit on how they determine the credibility of scientific evidence.

Vorster<sup>38</sup> argues that Allan appears to overstate the tentative status of psychiatric diagnostic categories by giving little weight to the large body of systematic research on which these diagnostic categories are based. Allan makes the point that the diagnosis must be generally accepted by other experts in the field. His comments, although valuable, are less pertinent to the South African context where the situation is quite different. In South African courts there are usually no experts available other than the one giving the evidence. Allan concedes in his article that the *DSM* contains disorders that are controversial. According to Vorster, the converse can also be stated; for example, that psychiatric disorders that may be pertinent are not included. Peer review and publication should be included. In South African courts these are frequently accepted with the presentation of a single source of reference discouraged. Fortunately case law is vital and the system of precedence is always followed. Allan fails to refer to the importance of this procedure. However, he makes the important point that making a psychiatric diagnosis is only the beginning of the task of a forensic psychiatrist. Vorster further states that if forensic diagnoses and assessments are to be reliable and credible, it is essential that forensic psychiatrists and not interfering relatives or legal representatives be in control of the psychiatric examination.

Stevens refers to Sales and Shuman, who state that whereas diagnosis in clinical settings is an evolving phenomenon that the clinician can modify as therapy proceeds, a forensic assessment in most instances is a snapshot described on the witness stand. Finally, although the questions sought to be answered in clinical settings are defined by the clinician and the patient, the questions raised in the forensic setting are defined by the law without regard to their grounding in constructs that respond to clinical or scientific knowledge.<sup>39</sup>

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<sup>37</sup> Allan 2005 *SAJP* 52.

<sup>38</sup> Vorster 2005 *SAJP* 42.

<sup>39</sup> Stevens *Role of Expert Evidence* 55.

## 7 The defence of mental illness

### 7.1 *Mental illness as a defence*

#### 7.1.1 *Fitness to stand trial*

Since 1977 the defence of insanity in South Africa has been governed by statute.<sup>40</sup> In terms of section 77 of the *Criminal Procedure Act*, an accused who suffers from mental illness or defect may as a result not be fit to stand trial.<sup>41</sup> The enquiry into the capacity of the accused to understand the nature of the trial process is seen as a preliminary issue that has to be finalised before the issue of criminal responsibility for the conduct is examined. Burchell<sup>42</sup> argues that this approach can severely prejudice an accused who has a defence to the charge or where the State has a weak case against him or her. The *Criminal Matters Amendment Act*<sup>43</sup> addresses this problem. Section 3(b) of this Act provides that the court may order that such evidence be placed before the court so as to determine whether or not the accused committed the act. This enquiry can be initiated by the prosecution, the defence, or the court of its own accord. The court usually relies on medical evidence and must be satisfied that there is a reasonable suspicion that the accused lacks the capacity to appreciate the nature of the trial proceedings or to conduct a proper defence.<sup>44</sup> Such a capacity to understand can be challenged at any stage of the proceedings.<sup>45</sup>

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<sup>40</sup> Ss 77-79 of the *Criminal Procedure Act* 51 of 1977. Also the *Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters* (RP 69/1967) (also called the Rumpff Report).

<sup>41</sup> S 77(1) of the *Criminal Procedure Act* 51 of 1977: "(1) If it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of section 79."

<sup>42</sup> Burchell *Principles of Criminal Law* 372.

<sup>43</sup> The *Criminal Matters Amendment Act* 68 of 1998.

<sup>44</sup> The question of fitness to stand trial is determined by a psychiatric examination and report. Persons who are found not be fit to stand trial are detained in a mental hospital or prison until they become fit to be tried. See s 77(6) and s 77(7) of the *Criminal Procedure Act* 51 of 1977. For further reading, see *S v Leeuw* 1987 3 SA 97 (A) 17. In this case two psychiatrists, Prof WH Wessels and Dr PJ Gouse, reported in para [4] as follows: "Hy is weens verstandelike vertraging nie in staat om hofverrigtinge dermate te begryp dat hy sy verdediging na behore kan voer nie. ... Hy was weens verstandelike vertraging ten tyde van die betrokke handeling nie in staat om die ongeoorlooftheid daarvan te besef of om ooreenkomstig 'n besef van die ongeoorlooftheid van die betrokke handeling op te tree nie. Hy is dus nie strafregtelik toerekenbaar nie."

<sup>45</sup> Burchell *Principles of Criminal Law* 372.

### 7.1.2 *The test to determine criminal responsibility*

If the defence of insanity is raised, the test to determine the accused's criminal responsibility must be applied. This test is set out in section 78(1) of the *Criminal Procedure Act*. Section 78(1) reads as follows:

A person who commits an act which constitutes an offence and who at the time of such commission suffers from a mental illness or mental defect which makes him incapable –

(a) of appreciating the wrongfulness of his act; or

(b) of acting in accordance with an appreciation of the wrongfulness of his act, shall not be criminally responsible for such act.

It is clear from the content of section 78(1) that the words "an act which constitutes an offence" do not refer to an offence for which the accused is liable, but only to an act which corresponds to the definitional elements of the relevant crime.

It is important to note that since the decision of the court depends on the facts and the medical evidence of each case, Rumpff JA stated in *S v Mahlinza*<sup>46</sup> that it is impossible and dangerous to attempt to lay down any general symptom by which a mental illness could be recognised as a mental "disease" or "defect". Therefore, for the purposes of the insanity defence in South Africa there is no formal definition of mental illness. However, the court held in *S v Stellmacher*<sup>47</sup> that in order to constitute a mental illness or defect it must at least consist in: "[A] pathological disturbance of the accused's mental capacity and not a mere temporary mental confusion which is not attributable to a mental abnormality but rather to external stimuli such as alcohol, drugs or provocation." In *S v Chretien* the accused, after driving away from a party at

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<sup>46</sup> *S v Mahlinza* 1967 1 SA 408 (A) 417.

<sup>47</sup> *S v Stellmacher* 1983 2 SA 181 (SWA) 187. In this case the accused had been on a strict weight-loss diet for a period of weeks and also performed strenuous physical labour on the day in question. He consumed at least half a bottle of brandy the evening. According to him there was in the bar a strong reflection of the setting of the sun in his eyes which shone through an empty bottle. As a result, he lapsed into an automatistic state, during which he began shooting at people in the bar, killing one person. The question was whether the accused had suffered from a mental illness as contemplated in s 78 of the *Criminal Procedure Act* 51 of 1977. The state did not prove beyond reasonable doubt that the conduct of the accused was indicative of a pathological disorder which is not due to a temporary clouding of the mind not attributable to a mental abnormality. A foundation was laid in the evidence for a reliance on lack of criminal responsibility not caused by mental illness. Bearing in mind the reasonable doubt which exists regarding the cause of his lack of criminal responsibility, the accused had to be given the benefit of the doubt. He was found not guilty and discharged. See Burchell *Cases and Materials on Criminal Law* 356.

which he had been drinking, drove into a crowd of people, killing one and injuring five others. He was acquitted on the basis of his lack of intention due to his level of intoxication. The court, however, accepted that there were degrees of intoxication and depending on the extent to which an individual was intoxicated, his or her intoxication could impair either his or her intention, criminal capacity or the voluntariness of the conduct. Due to tremendous criticism with regard to Chretien's being acquitted due to a lack of intention, the legislature enacted a special offence in the *Criminal Law Amendment Act 1* of 1988 that made it a criminal offence when the level of the accused's intoxication was such that he or she lacked capacity.

Furthermore, every person is presumed not to suffer from a mental illness or mental defect so as not to be criminally responsible in terms of section 78(1) until the contrary is proved on a balance of probabilities.<sup>48</sup> Whenever the criminal responsibility of an accused with reference to the commission of an act or an omission which constitutes an offence is in issue, the burden of proof with reference to the criminal responsibility of the accused shall be on the party who raises the issue.<sup>49</sup>

In terms of section 78(2), if it is alleged at criminal proceedings that the accused is by reason of mental illness or mental defect or for any other reason not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court must in the case of an allegation or appearance of mental illness or mental defect, and may, in any other case, direct that the matter be enquired into and be reported on in accordance with the provisions of section 79.<sup>50</sup>

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<sup>48</sup> S 78(1)(A) of the *Criminal Procedure Act 51* of 1977.

<sup>49</sup> S 78(1)(B) of the *Criminal Procedure Act 51* of 1977.

<sup>50</sup> Also see s 78(3-8) of the *Criminal Procedure Act 51* of 1977: " (3) If the finding contained in the relevant report is the unanimous finding of the persons who under section 79 enquired into the relevant mental condition of the accused, and the finding is not disputed by the prosecutor or the accused, the court may determine the matter on such report without hearing further evidence. (4) If the said finding is not unanimous or, if unanimous, is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence, and the prosecutor and the accused may to that end present evidence to the court, including the evidence of any person who under section 79 enquired into the mental condition of the accused. (5) Where the said finding is disputed, the party disputing the finding may subpoena and cross-examine any person who under section 79 enquired into the mental condition of the accused. (6) If the court finds that the accused committed the act in question and that he or she at the time of such commission was by reason of mental illness or mental defect not criminally responsible for such act - (a) the court shall find

In the case of *S v Kavin*,<sup>51</sup> Kavin was charged on three counts of murder. He took a gun one evening and shot his wife and two children. When his sister asked him what was going on, he replied that it was only a car backfiring. His defence was one of insanity. An inquiry in terms of section 78 of the *Criminal Procedure Act* was held. Kavin suffered from severe reactive depression super-imposed on a type of personality disorder displaying immature and unreflective behaviour. In the opinion of Dr Shubitz and Dr Garb it produced a state of dissociation. Both these psychiatrists as well as Prof Bodemer agreed that Kavin could not act in accordance with an appreciation of the unlawfulness of his act. They based their opinion on the basis of progressive depression. He was therefore not regarded as being criminally responsible for the acts in question. He was thereafter admitted into a psychiatric clinic in terms of section 78(6) of the *Criminal Procedure Act*.

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the accused not guilty; or (b) if the court so finds after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside and find the accused not guilty, by reason of mental illness or mental defect, as the case may be, and direct - (i) in a case where the accused is charged with murder or culpable homicide or rape or another charge involving serious violence, or if the court considers it to be necessary in the public interest that the accused be - (aa) detained in a psychiatric hospital or a prison pending the decision of a judge in chambers in terms of section 29(1)(a) of the Mental Health Act, 1973 (Act No. 18 of 1973); (bb) admitted to, detained and treated in an institution stated in the order in terms of Chapter 3 of the Mental Health Act, 1973 (Act No. 18 of 1973), pending discharge by a hospital board in terms of section 29(4A)(a) of that Act; (cc) treated as an outpatient in terms of section 7 of that Act pending the certification by the superintendent of that institution stating that he or she need no longer be treated as such; (dd) released subject to such conditions as the court considers appropriate; or (ee) released unconditionally; (ii) in any other case than a case contemplated in subparagraph (i), that the accused - (aa) be admitted to, detained and treated in an institution stated in the order in terms of Chapter 3 of the Mental Health Act, 1973 (Act No. 18 of 1973), pending discharge by a hospital board in terms of section 29(4A)(a) of that Act; (bb) be treated as an out-patient in terms of section 7 of that Act pending the certification by the superintendent of that institution stating that he or she need no longer be treated as such; (cc) be released subject to such conditions as the court considers appropriate; or (dd) be released unconditionally. (7) If the court finds that the accused at the time of the commission of the act in question was criminally responsible for the act but that his capacity to appreciate the wrongfulness of the act or to act in accordance with an appreciation of the wrongfulness of the act was diminished by reason of mental illness or mental defect, the court may take the fact of such diminished responsibility into account when sentencing the accused. (8) (a) An accused against whom a finding is made under subsection (6) may appeal against such finding if the finding is not made in consequence of an allegation by the accused under subsection (2). (b) Such an appeal shall be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence. (9) Where an appeal against a finding under subsection (6) is allowed, the court of appeal shall set aside the finding and the direction under that subsection and remit the case to the court which made the finding, hereupon the relevant proceedings shall be continued in the ordinary course."

<sup>51</sup> *S v Kavin* 1978 2 SA 731 (W).

### 7.1.3 Panel for the purposes of enquiry and report under sections 77 and 78

In terms of section 79 of the *Criminal Procedure Act*, the court can refer an accused at any stage of the trial for a psychiatric or psychological assessment of his or her mental state with reference to either section 77 or 78 of the *Criminal Procedure Act*. The Act distinguishes between offences that involve serious violence and those that are non-violent.<sup>52</sup> The accused is usually admitted to a state psychiatric hospital under a warrant for a period of observation of 30 days. Effectively the court must appoint a panel of two or three psychiatrists if the alleged offence involved serious violence. The court has the discretion to appoint a clinical psychologist as well. The court may, for the purposes of the relevant enquiry, commit the accused to a psychiatric hospital or to any other place designated by the court for such periods not exceeding thirty days at a time as the court may from time to time determine, and where an accused is in custody when so committed, he or she shall, while so committed, be deemed to be in the lawful custody of the person or the authority in whose custody he or she was at the time of such committal.<sup>53</sup> When the period of committal is extended for the first time under paragraph (a), such an extension may be granted in the absence of the accused unless the accused or his or her legal representative requests otherwise.<sup>54</sup>

According to Kaliski,<sup>55</sup> it is important to note that the critical first stage in any assessment is to determine whether the accused is suffering from a mental illness or whether there are other psychological or psychiatric factors that are associated with the terms of referral. The *Criminal Procedure Act* requires that mental illness or defect must be present before the question of whether the accused is fit to stand trial or

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<sup>52</sup> See s 79(1)(a)(b) of the *Criminal Procedure Act* 51 of 1977: "78 - (1) Where a court issues a direction under section 77 (1) or 78 (2), the relevant enquiry shall be conducted and be reported on - (a) where the accused is charged with an offence other than one referred to in paragraph (b), by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court; or (b) where the accused is charged with murder or culpable homicide or rape or another charge involving serious violence, or if the court considers it to be necessary in the public interest, or where the court in any particular case so directs - (i) by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court; (ii) by a psychiatrist appointed by the court and who is not in the full-time service of the State; (iii) by a psychiatrist appointed for the accused by the court; and (iv) by a clinical psychologist where the court so directs."

<sup>53</sup> S 79(2)(a) of the *Criminal Procedure Act* 51 of 1977.

<sup>54</sup> S 79(2)(b) of the *Criminal Procedure Act* 51 of 1977.

<sup>55</sup> Kaliski "Criminal Defendant" 110-111.

criminally responsible can be examined. However, the courts will demand a variety of deeper insights into the accused and his or her behaviour. Consequently, it is good practice to conduct complete clinical examinations and to learn how to anticipate the court's requirements.

With reference to *S v Van As*,<sup>56</sup> the role of the expert witness is not to take over or replace the function or duties of the court. The court has to debate and decide on every fact.

## **8 Conclusion**

This contribution has sought to provide an overview of some clinical aspects of psychiatry as well as an explanation of its functioning in forensic settings. It has further included discussion with regard to the classification and diagnosis of mental illness in clinical and forensic settings and provided an explanation of the concept of mental illness, which served as a background for the discussion on the defence of mental illness.

It is clear from the discussion above that psychiatrists work to develop a valid and reliable body of scientific knowledge based on research. They apply that knowledge to human behaviour in a variety of contexts. In doing so they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, social interventionist and expert witness. Their goal is to broaden the knowledge of behaviour and, where appropriate, to apply it pragmatically to improve the condition of both the individual and society. They further strive to help mentally ill persons in developing informed judgments and choices about their treatment and behaviour.

Psychiatrists are also important role players in the legal environment. As explained by Allan in view of the tentative nature of psychiatric and psychological disorders, it is imperative that practitioners remind themselves and legal practitioners that diagnostic constructs should be used with caution in legal settings, preferably only if the diagnosis satisfies the legal perception of scientific credibility. This means that at the very least the witness must be able to demonstrate that the disorder is generally accepted as

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<sup>56</sup> *S v Van As* 1991 2 SACR 74 (W).

evidenced by its inclusion in a diagnostic manual and/or published peer reviews. Even then a diagnosis should be given only if the required diagnostic criteria are present. A competent witness should also have data on the other indicators of scientific credibility that may also be relevant, depending on the specific issues contested in the case.

It remains a fact, however, that psychiatrists and psychologists encounter legal and ethical conflicts whenever they enter the courtroom. Their approach must not be simply diagnostic, simply ethical or simply legal. They must be able to translate their findings for the court, but these findings must come from clinical experience, not from some solely legal or ethical perspective. The legal system needs psychiatric and psychological knowledge about the interfaces of mental disorders, function and behaviour. However, after they have provided their opinions, the psychiatrists must leave the legal issues to the legal practitioners, and the final determination in relation to a defence of mental illness must be left to the judge.<sup>57</sup>

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<sup>57</sup> Reid, Wise and Sutton 1992 *Psychiatr Clin North Am* 529.

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### **LIST OF ABBREVIATIONS**

AAPL	American Academy of Psychiatry and the Law
ABFP	American Board of Forensic Psychiatry
Am J Psychiatry	American Journal of Psychiatry
Bull Am Acad Psych & L	Bulletin of the American Academy of Psychiatry and Law
DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification of Diseases

Psychiatr Clin North Am  
SAJP

Psychiatric Clinics North America  
South African Journal of Psychiatry