

**A CRITICAL ANALYSIS OF THE PSYCHOLEGAL  
ASSESSMENT OF SUSPECTED CRIMINALLY  
INCAPACITATED ACCUSED PERSONS AS REGULATED BY  
THE CRIMINAL PROCEDURE ACT.**

**M SPAMERS**



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by

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## ABSTRACT

This dissertation critically investigates the current framework for psycholegal assessment of accused persons who are suspected or alleged to have lacked criminal incapacity at the time of committing an offence. This system must function as effectively as possible to ensure the interests of justice and the community are best served. Issues that impact how effectively the criminal justice system collaborates with psychologists and psychiatrists, who act as expert forensic mental health assessors, are identified and recommendations are made accordingly.

The study first examines the theoretical base regarding the terminology surrounding criminal capacity, mental illness and automatism, with regard to how the understanding of concepts differ in law and psychology and psychiatry and how this negatively affects the process of assessment. The study then investigates the constitutional rights of accused persons admitted for observation, the effect this has on the patient and legal process, the accuracy and reliability of the diagnosis and the admissibility of expert evidence. Next a comparative study is made utilising English Law as a tool for analysis.

The main findings are that lack of understanding and clarity are the main issues that hinder the collaboration between the legal and mental health care professions and that this may be remedied by a system of registration and education for forensic psycholegal assessors. An alternate and concurrent method of direct referral is also suggested as it may relieve some of the strain on the current system.

**Key words:** Criminal capacity; pathological criminal incapacity; non-pathological criminal incapacity; mental illness, mental defect; psychology and law; psychiatry and law; psycholegal assessment; forensic mental health assessor; English criminal procedure; expert evidence.

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## CHAPTER 1: INTRODUCTION

### 1. Introductory orientation

Psycholegal assessment is the observation of a person by a mental health professional in order to deliver a diagnosis and form an expert opinion that will be of assistance to a legal process. In practice, it is largely here, at the level of assessment, that the mental health and legal professions have crossed paths for decades.<sup>1</sup>

Situations that call for psycholegal assessment are varied, and include cases where the dangerousness of an offender or a person's capacity to enter into a contract must be determined. All psycholegal assessments have in common, however, that a diagnosis must be reached; the functional demands contained in the legal brief - the reason for referral for assessment - must be appreciated and the strength of the causal link between the diagnosis and legal question posed must be determined.<sup>2</sup>

For this process to be effective, a relationship of mutual understanding must exist between the legal and mental health disciplines, but in South Africa there is still considerable difficulty in achieving a workable interface between the two fields and a sizable gap in understanding and successful collaboration, even though the disciplines have a history of interaction.

Issues that, among others, impact on the efficiency of the collaborative relationship between mental health assessment and the legal system include:

- Differentiation between terminology in law and psychology relating to capacity.
- The definition of what a forensic mental health expert is and who qualifies to operate as such.<sup>3</sup>
- Legal principles that are vague or poorly understood by mental health professionals.<sup>4</sup>

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<sup>1</sup> Kaliski in Kaliski *et al* Psycholegal Assessment (2006) 1, 93; Tredoux, Foster, Allan, Cohen, Wassenaar in Tredoux *et al* Psychology and the Law (2008) iv.

<sup>2</sup> Kaliski 3; Burchell Principles of Criminal Law (2007) 373.

<sup>3</sup> Kaliski 2.

- The weight that expert mental health testimony carries in court.<sup>5</sup>
- The weight that different mental health experts attach to the degree to which certain mental disorders effect criminal capacity.<sup>6</sup>
- The risk of malingering by patients admitted for observation.<sup>7</sup>
- The gap in the court's understanding and application of mental health expert testimony to the proceedings.
- The effect of involuntary commitment on the suspected incapacitated accused patient and patient rights.

This is by no means a closed list and certainly demonstrates the challenges faced in reconciling the law with psychology and psychiatry. Even the fact that there is differentiation between the fields of psychology and psychiatry presents problems in psycholegal evaluation.

### **1.1. Psycholegal assessment and capacity.**

Capacity is, in legal terms, a person's ability to perform a specific juristic act. It is a threshold requirement and is needed if a person is to be held accountable for performing certain acts. The present mechanisms to determine criminal capacity are based on the premise that a person is presumed to have the requisite capacity; thus there is a *prima facie* case for the prosecution.<sup>8</sup> This presumption does not apply in cases of children under seven years of age, who are irrebuttably presumed to lack criminal capacity, and cases of children between seven and fourteen years of age, who are rebuttably presumed to lack criminal capacity.<sup>9</sup> A lack of capacity

<sup>4</sup> Kaliski 3.

<sup>5</sup> Foster, Tredoux, Nichols in Tredoux *et al* *:Psychology and the law* (2008) 403.

<sup>6</sup> Kaliski 4; Foster, Tredoux, Nichols 403.

<sup>7</sup> Kaliski 4; Foster, Tredoux, Nichols 403.

<sup>8</sup> Louw in Kaliski *et al* *Psycholegal Assessment* (2006) 39; Kaliski *:My brain made me do it' - how neuroscience may change the insanity defence: editorial* *South African Journal of Psychiatry* 2009 4. Section 78(1A) of the Criminal Procedure Act Act 51 of 1977 states that every person is presumed to not suffer from a mental illness or defect until the contrary is proven on a balance of probabilities. In Eadie 2002 1 SACR 633 SCA the court held that *An* discharging the onus, the State is assisted by the natural inference that in the absence of exceptional circumstances a sane person who engages in conduct which would ordinarily give rise to criminal liability, does so consciously and voluntarily (445C).

<sup>9</sup> Snyman Strafreg (2006) 157, 178; Burchell 366; Louw 39; Van Oosten *:Non-pathological criminal incapacity versus criminal incapacity* 1993 *SACJ* 132, 133; Community Law Centre *:Rebutting the presumption of criminal capacity*. S vs Ngobesi and others 2001 (1) *SACR* 562 *Article 40* 6; Skelton 'Examining the age of criminal

must be alleged and proved before a court. The onus is upon the person alleging lack of capacity to prove this allegation.<sup>10</sup>

A judicial declaration that a person is mentally ill or the person's subjection to the provisions of mental health legislation is not decisive in determination of capacity; a person's capacity (or lack thereof) must be proven before the court in each trial.<sup>11</sup> Judicial declaration or subjection to mental health legislation is however relevant as far as the onus of proof is concerned as it creates a rebuttable presumption of incapacity, shifting the onus of proof to the party who seeks to hold the accused person criminally liable.<sup>12</sup>

Whether a person lacked capacity at a certain point in time is a question of fact to be determined by the circumstances of the specific case. Direct evidence of a person's mental condition at the time when he or she was involved in the commission of a crime is seldom available and whether a person lacked capacity at a specific point in time needs to be proven by expert evidence:<sup>13</sup> Therefore the need for psycholegal assessment.

The mental state of the defendant is usually brought to the attention of the criminal court through the bizarre nature of the crime, a known history of psychiatric treatment, or unusual behaviour by the accused following arrest.<sup>14</sup>

According to Chapter 13 of the Criminal Procedure Act 51 of 1977, in 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 shall in the case of an allegation or appearance of mental illness or mental defect, and may,

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capacity Article 40: *The Dynamics of Youth Justice and the Convention on the Rights of the Child in South Africa* 2006 3.

<sup>10</sup> Section 78(1B) of Act 51 of 1977; Burchell 362; Meyer -Use of the Judicial Section 9 Certification in the Free State<sup>o</sup> *South African Journal of Psychiatry* (2004) 104. In Eadie *supra* it was also held that an accused person who raises such a defence is required to lay a foundation for it, sufficient at least to create a reasonable doubt (445F).

<sup>11</sup> Chetty -Incapacity to determine criminal capacity: mad or bad? A selected case study<sup>o</sup> *Acta Criminologica: CRIMSA Conference: Special Edition* 2008 131.

<sup>12</sup> Snyman 170.

<sup>13</sup> Snyman 169, 170.

<sup>14</sup> Barrett -Profile of mentally ill offenders referred to the Free State Psychiatric Complex<sup>o</sup> *South African Journal of Psychiatry* 2007 56.

in any other case, direct that the matter be enquired into and be reported on in accordance with the provisions of Section 79. (It should be noted that Section 78(2) therefore provides for an enquiry in cases where pathological incapacity must be investigated, as well as non-pathological incapacity, where it may be investigated in terms of Section 79.)<sup>15</sup>

Section 78(2)(a) of the Act provides that 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. Section 79(4)(d) provides that the report shall include a finding as to the extent to which the capacity of the accused to appreciate the wrongfulness of the act in question or to act in accordance with an appreciation of the wrongfulness of that act was, at the time of the commission thereof, affected by mental illness or mental defect or by any other cause.

Chapter 13 of the Criminal Procedure Act thus creates the framework for expert assessment of criminal capacity and the compilation of a report that serves to assist the court in its investigation. This report forms the basis of the forensic mental health expert witness's testimony in court and it is imperative that it be as accurate and of as much value to the court's assessment, the legal process and ultimately the administration of justice, as possible.

## 2. Significance of study

The main purpose of this dissertation is to investigate the involuntary commitment to a mental institution of suspected criminally incapacitated accused persons in terms of Chapter 13 of the Criminal Procedure Act and the impact this has on all elements of the related legal process: Including the impact on the patient, the likelihood of an accurate diagnosis and the true value such findings have for the court in its decision-making.

This will be investigated with reference to the accepted legal and psychological definitions of criminal capacity and the appointment of forensic mental health care experts to observe and report in terms of Section 79.

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<sup>15</sup> Deane -Criminal procedure: from the law reports of *Codicillus* 2006 92.

It is submitted that there is a *lacuna* in the law in this respect and that there is the possibility of grave error. By investigating the position critically and exploring possible alternatives to the current system and possible alterations or suggestions, a better system may be developed that can be more effective and economical, while respecting the rights of all concerned parties and the interest of the community.

### **3. Legal questions**

This dissertation will constitute an attempt to clarify and answer the following legal questions:

- Can there be a workable definition of criminal capacity in terms of both psychology and the law? Is the current definition satisfactory?
- How can the psychological and legal disciplines be reconciled on the point of determining criminal capacity, so that justice will benefit?
- Is the current definition of a forensic mental health care expert for purposes of Section 79 acceptable? If not, how can it be improved?
- What is the effect of involuntary commitment in terms of Section 79 on the patient and accurate diagnosis and how reliable and useful is the report on criminal capacity to the court really?
- Is the legal framework for assessing criminal capacity as a defence acceptable in its current form?

### **4. Methodology**

A multilayered, comparative and critical approach will be followed. Material and formal aspects of criminal law, criminal procedure law, human rights law and the constitution, medical law, clinical information and medical opinion will be taken into account. Relevant legislation, common law, case law, textbooks, journal articles and clinical literature (textbooks, journal articles, DSM IV) will be referenced and analysed

The South African legal position on the topic will be compared critically to English Criminal and Criminal Procedure law and relevant International Law. South African Criminal Procedure Law, as well as aspects of applicable Medical Law, is based on English Law. Modern South African law relating to mental illness and criminal capacity, originated from the English *McNaghten* Rules.<sup>16</sup> It follows logically that a comparison to English Law could be of value and thus the choice of English Law as a useful tool for critical analysis.

The study will exclude incidences in terms of Section 77 of the Criminal Procedure Act, where the accused's ability to stand trial is in question, and will be limited to inquiries under Section 78 where the accused's criminal capacity at the time of commission of the alleged offence must be determined. An inquiry into fitness to stand trial does not have any bearing on the inquiry into an accused's criminal responsibility, as the latter is concerned with whether the accused can be held culpable for his actions and the former with whether the accused can understand and follow court proceedings.<sup>17</sup>

This study will also be limited to instances where criminal incapacity due to pathological or non-pathological reasons is alleged or suspected, thus excluding the other elements of criminal liability that may be affected by mental illness or other reasons that may be reported on in terms of Section 79.

## 5. Structure

- **Chapter 1: Introduction**

In this chapter the title and significance of the study is explained, as well as the background and methodology. The structure will be set out and the legal questions to be answered will be framed.

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<sup>16</sup> Louw 39; Snyman 167.

<sup>17</sup> Africa in Tredoux et al *:Psychology and the law*(2008) 393.

- **Chapter 2: Criminal capacity as legal and medical concept**

In this chapter legal terminology relating to criminal capacity will be investigated and compared to medical terminology. The problems in achieving a workable definition of capacity will be pointed out and addressed. The differences in psychological and psychiatric opinion will be discussed as well as the difference in legal opinion and the opinion of forensic mental health care experts.

- **Chapter 3: The involuntarily committed accused and the court**

In this chapter the effect of involuntary commitment on the accused and the accuracy and reliability of the diagnosis will be discussed with reference to the report in terms of Section 79, patients' rights, the Constitution, the risk of malingering, the weight of expert evidence in court and the problems faced in the interpretation and application of findings by the courts.

- **Chapter 4: Comparison of Chapter 13 with English Law**

English Law will be set out and analysed in this chapter and compared to the position in South Africa.

- **Chapter 5: Critical evaluation of Chapter 13 and suggested reform**

The acceptability of the process surrounding the psycholegal assessment of suspected criminally incapacitated persons will be discussed in this chapter. Means to reconciliation of the legal and psychological disciplines will be suggested and explored and weaknesses and strengths pointed out, also with regard to the discussion of English and International Law.

- **Chapter 6: Conclusion and recommendations**

In this chapter the most important points and findings will be summarised. Suggestions for reform will then be advanced, followed by concluding remarks.

## CHAPTER 2: CRIMINAL CAPACITY AS LEGAL AND MEDICAL CONCEPT

### 1. Introduction

Criminal capacity is a legal term, not a medical one. It has been said that a legally and medically usable definition of criminal capacity that is both sufficiently specific to avoid false positives and broad enough to avoid false negatives is probably impossible. Work done by law reform commissions in other jurisdictions, such as the English and Scottish Law Commissions, reflects the difficulties in attempting to achieve a precise, easily measurable and easily applied legal definition of decisional incapacity.<sup>18</sup>

A main point of contention between the mental health care profession and the legal profession regarding psycholegal assessment lies therein that the law seeks to determine whether a person can be held liable for unlawful conduct and psychiatry seeks to treat, rather than condemn.<sup>19</sup> Capacity in the medical sense relates to a clinical evaluation of an individual's functional ability to make autonomous, authentic decisions about his or her own life; while capacity in the legal sense relates to the judgment of a Court of law about the same issue.<sup>20</sup>

In this chapter this difference and its implicational difficulties regarding legal and mental health care terminology relating to criminal capacity will be investigated. The problems in achieving a workable definition of capacity that satisfies the requirements of both professions, and thereafter the differences in opinion between mental health care professionals in the fields of psychology and psychiatry will be pointed out and addressed.

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<sup>18</sup> English Law Commission -Consultation Paper 119 - Mentally Incapacitated Adults and Decision-Making: An Overview 1991 19.

<sup>19</sup> Kruger & Hiemstra -Criminal Procedure (2008) 13.

<sup>20</sup> English Law Commission 1991 22.

## 2. Criminal capacity in legal terms

### 2.1. Definition

The prosecution in a criminal case must prove, beyond reasonable doubt, that the accused possessed criminal capacity at the time of commission of a crime in order for that person to be held accountable.<sup>21</sup> Criminal capacity is a prerequisite for fault,<sup>22</sup> be it either negligence or intent and without the necessary criminal capacity a person cannot be guilty of an offence.

Criminal capacity can be defined in terms of two legs, which are enquired into after it is determined whether the accused, at the time of the commission of the offence, suffered from any biological condition that could impact on said criminal capacity or if there was any other circumstance that could have had such an effect. The two legs of the test are set out in Section 78(1)(a) and (b) of the Criminal Procedure Act, of which both requirements must be present and proven in order for a person to be held criminally capacitated:<sup>23</sup>

- Firstly the cognitive ability or the ability to understand and appreciate the wrongfulness of the act, and
- Secondly the conative ability or the ability to act in accordance with this understanding.

If either the cognitive or conative leg of the test for capacity is impaired in a significant way or absent in a person, due to either a pathological or non-pathological reason,<sup>24</sup> that person will be considered criminally incapacitated.<sup>25</sup>

This ‘appreciation’ is more than ‘knowledge’ possessed by the accused, but also a capacity to evaluate the act and its effects on the accused himself and others possibly involved. A ‘deliberate judgment’ or ‘perception’ is implied.<sup>26</sup>

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<sup>21</sup> Burchell 358.

<sup>22</sup> Burchell 359; Snyman 157; *S v Adams* 1986 4 SA 882 A at 901; Van Oosten 1993 *SACJ* 129.

<sup>23</sup> Act 51 of 1977; Rumpff Commission Report 94; Burchell 358; Snyman 159, 168.

<sup>24</sup> Van Oosten 1993 *SACJ* 129.

<sup>25</sup> Rumpff Commission Report 95; Burchell 358; Snyman 160; Van Oosten 1993 *SACJ* 129; Le Roux, Mureriwa – Paedophilia and the South African criminal justice system: a psychological perspective 2004 *SACJ* 48.

It is unclear whether this ‘wrongfulness’ that needs to be appreciated refers to legal wrongfulness, as opposed to moral wrongfulness.<sup>27</sup> It has been argued that this wrongfulness refers to moral wrongfulness and not knowledge of illegality alone.<sup>28</sup> A person who knows his conduct is illegal, but is under the impression that he is under a divine or moral obligation to commit the offence,<sup>29</sup> or has the mistaken belief that he was acting in self-defence due to hallucinations,<sup>30</sup> illustrates that a strict understanding of legal wrongfulness is insufficient. It has also been argued, however, that an evaluation of moral wrongfulness alone is vague and not always effective, with the example given of a mentally ill person who knowingly commits a crime whilst under the impression that its commission would be for the good of humanity.<sup>31</sup>

It has been submitted that this ‘wrongfulness’ should rather be formulated as whether a person knew the act was wrong according to the ordinary standard adopted by reasonable men.<sup>32</sup> Van Oosten opines that ‘wrongfulness’ includes both the legal and moral wrongfulness of the act, which means that where the accused is capable of appreciating the former but not the latter the reliance on mental illness as defence will be available.<sup>33</sup>

Section 78(1)(b) does not require that the urge be physically irresistible or based on a sudden, unplanned action as opposed to a reflection over a period of time. The formulation of the test as being an ‘irresistible impulse’ is thus inaccurate, as not all mental illnesses manifest in impulsive actions.<sup>34</sup> The normal capacity for self-control needs to be significantly impaired, the accused need not have been subjected to an overpowering force (as the term ‘irresistible’ implies).<sup>35</sup> The court in Kavin held that a gradual disintegration of the mind resulting from a recognised illness or disorder is sufficient to significantly impair the conation leg of capacity and that a person should thus be held incapacitated.<sup>36</sup>

<sup>26</sup> Burchell 381.

<sup>27</sup> Burchell 367; Snyman 171; Louw in Kaliski *et al* *Psycholegal Assessment* (2006) 48.

<sup>28</sup> Snyman 171.

<sup>29</sup> Snyman 171.

<sup>30</sup> Kaliski 103.

<sup>31</sup> Burchell 378-379.

<sup>32</sup> Burchell 379.

<sup>33</sup> Van Oosten 1993 *SACJ* 131.

<sup>34</sup> *S v Campher* 1987 1 SA 940 A at 960.

<sup>35</sup> Burchell 382; Kaliski 104.

<sup>36</sup> 1978 2 SA 731 W at 737.

## 2.2. Pathological and non-pathological criminal incapacity

Pathological criminal incapacity is due to an organic brain disease, either a mental illness or mental defect.<sup>37</sup> It refers to conditions that are inherent to the individual, including such brain diseases as dementia and psychosis.<sup>38</sup> A mental illness or defect is thus a threshold requirement for the defence of pathological criminal incapacity,<sup>39</sup> but the fact that a person suffers from a mental illness also does not automatically establish criminal incapacity.<sup>40</sup>

Non-pathological criminal incapacity is of a temporary nature and is caused by the effects of external factors, such as youthfulness, intoxication, emotional stress or provocation (for example crimes of passion and instances where an abused person snaps and kills their abuser).<sup>41</sup> If it is found that an accused had no criminal capacity at the time of the act due to any reason, he or she must be acquitted.

The distinction between pathological and non-pathological criminal incapacity is critical in the legal system, firstly as expert evidence is required when pathological criminal incapacity is alleged,<sup>42</sup> whereas it is not a strict requirement when non-pathological incapacity is alleged.<sup>43</sup> Secondly, Burchell submits that the burden of proof is affected, as the onus is on the person who raises pathological criminal incapacity to prove on balance of probabilities that the accused was incapacitated and with non-pathological incapacity the onus is still on the State, with the accused having to raise reasonable doubt as to his capacity.<sup>44</sup>

<sup>37</sup> Snyman 169; Louw 38.

<sup>38</sup> Kaliski 97.

<sup>39</sup> Burchell 359; Sec 78(1) of Act 51 of 1977.

<sup>40</sup> Burchell 177.

<sup>41</sup> Burchell 362, Louw 39; Kaliski 97; Snyman 161; Carstens and Le Roux –The defence of non-pathological incapacity with reference to the battered wife who kills her abusive husband– 2000 *SACJ* 13 181.

<sup>42</sup> Van Oosten describes expert evidence in this case as pivotal and that it is borne out by the fact that the legislation requires an enquiry by a panel of experts. Van Oosten 1993 *SACJ* 131.

<sup>43</sup> Deane –Criminal procedure : from the law reports– 2006 *Codicillus* 91-93 92; Louw 39. In the case of Calitz 1990 1 *SACR* 119 A, the court held that the expert evidence was not indispensable, as the court could determine for itself whether the accused was in fact non-pathologically incapacitated on the facts. Van Oosten opines that the matter is not quite settled, as there are cases where it was held expert evidence is a prerequisite, while in other cases the court holds that it is unnecessary, as the court is in a position to rule on the facts alone. Van Oosten 1993 *SACJ* 141. Carstens and Le Roux 2000 *SACJ* 180 submit that expert evidence is essential for this defence to succeed, even though the position is unclear and though certain judgements suggest the courts do not deem it indispensable.

<sup>44</sup> Burchell 390. For a discussion of the possible problems that can result from this reverse onus, see Burchell 392-395 as it falls outside the ambit of this dissertation.

Pathological criminal incapacity is basically a statutory defence that requires a pathological condition and must be proven by the accused, while non-pathological criminal incapacity is a common law defence that does not require a pathological condition and must be disproved by the prosecution.<sup>45</sup>

The procedural difference between pathological and non-pathological criminal incapacity lies therein that a person acquitted because of non-pathological reasons, may go free, whereas a person acquitted because of pathological reasons needs mental health care and the court may ó and probably will ó order for them to be institutionalized.

In the case of *Nursingh*,<sup>46</sup> the accused was acquitted of the murder of family members following an öemotional stormö due to non-pathological criminal incapacity due to provocation, after the expert evidence led indicated that he was predisposed to violent reactions due to his family circumstances and sexual abuse. It was also held that the reason for his non-pathological state of mind was now no longer present and that he would not constitute a danger to the community if acquitted.<sup>47</sup>

### **2.3. Criminal incapacity versus automatism**

It is important to note the difference between criminal capacity and a voluntary human act. These are completely separate elements of criminal liability and have different requirements and defences,<sup>48</sup> though the conation leg of the criminal capacity test in cases where non-pathological criminal incapacity due to provocation is raised as a defence, has been confused with acting in an automatic state in recent years.<sup>49</sup> This lack of clarity is partly a result of the development of the defence of incapacity, particularly cases involving provocation and mental stress and partly as a result of its application in practice.<sup>50</sup>

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<sup>45</sup> Van Oosten 1993 *SACJ* 145.

<sup>46</sup> 1995 2 *SACR* 331 D at 339.

<sup>47</sup> *Supra* at 333.

<sup>48</sup> Snyman 160.

<sup>49</sup> As in the case of Eadie *supra*; Louw *SACJ* 2001 207.

<sup>50</sup> Louw *SACJ* 2001 206.

The inability to act in accordance with an appreciation of wrongfulness must not be confused with the inability to wilfully control the movements of one's body.<sup>51</sup> While criminal capacity is the ability to appreciate the wrongfulness of an act and act in accordance with this appreciation and is thus a psychological element, a voluntary human act is a physical element.<sup>52</sup> Criminal capacity refers to an ability or potential circumstance which the perpetrator possesses that justifies condemnation by the legal system.<sup>53</sup>

The question with voluntariness is whether the conduct was willed and consciously controlled by the individual and thus whether they had physical control of their actions (as opposed to in an automatic state, like an epileptic attack, where the conscious will is overridden).<sup>54</sup> During an automatism, Kaliski<sup>55</sup> states that a person has no control over his behaviour (thus a physical loss of control over his actions), which is usually inappropriate to the circumstances and out of character for the person. If a person lacks the conative ability to act in accordance with an appreciation of wrongfulness, it means that he does have voluntary control over his muscle movements, but that he is unable to resist acting in a way that is contrary to his insight.<sup>56</sup>

Criminal capacity is assessed subjectively, while the voluntariness of conduct is assessed objectively.<sup>57</sup>

A defence of criminal incapacity due to either pathological or non-pathological reasons is raised in cases where a person's capacity to be held accountable is brought into question. Either absolute force or automatism that excludes voluntary conduct is raised as a defence in cases where the question is raised whether an accused had in fact acted.<sup>58</sup> Where automatism due to

<sup>51</sup> Snyman 160.

<sup>52</sup> Snyman 160.

<sup>53</sup> Badenhorst *Vrywillige dronkenskap as verweer teen aanspreeklikheid in die Strafreg ó±n Suiwer regsteoretiese benadering* 1981 *SALJ* 151.

<sup>54</sup> Kaliski 107; Snyman 160. Lambrechts *Die nie-patologiese ontoerekeningsvatbaarheids-verweer van outomatisme in die Suid-Afrikaanse strafreg* 2006 *Interim: Interdisciplinary Journal* 45. This was also reiterated in the case of Chretien 1981 1 SA 1097 A at 1104 where the Appeal Court held that an act for the purpose of the criminal law can only be considered an act if it was controlled by the conscious will and is more than an involuntary muscle movement.

<sup>55</sup> Kaliski 106.

<sup>56</sup> Snyman 164.

<sup>57</sup> Louw 2001 *SACJ* 207.

<sup>58</sup> Snyman 172.

non-pathological reasons is raised, the onus is on the state to prove beyond reasonable doubt that the conduct was voluntary,<sup>59</sup> and where criminal incapacity is raised, the onus differs as discussed above.

This separateness of criminal capacity and automatism has been reiterated by the courts many times, for example in the cases of Ngobese<sup>60</sup> and Pietersen.<sup>61</sup> The court in the Stellmacher case held that the accused was not guilty, either on account of not acting voluntarily or, if he did act, that he was non-pathologically criminally incapacitated.<sup>62</sup> Implicit in this conclusion is that the two represent separate elements and defences.

A state of automatism excludes voluntariness by resulting in circumstances where a person loses intelligent control over their muscle movements. Thus the action is not under the conscious control of the person due to external, non-pathological factors not attributable to mental illness or mental defect.<sup>63</sup> Criminal liability would then be excluded, as a voluntary act is required. Such a loss of voluntariness differs from a simple loss of temper, as illustrated in the cases of Henry<sup>64</sup> and Macdonald.<sup>65</sup> In Henry the court required an identifiable trigger of an extreme nature and in Macdonald the court an identifiable trigger of an extraordinary nature.

It is accepted that for a person to have acted in an automatic state due to non-pathological factors, the person needed to have been subjected to a great deal of stress that resulted in internal tension, building to a climax after the person has endured ongoing humiliation and stress. The automatic state is then triggered by an event unusual in intensity or unpredictable in its occurrence.<sup>66</sup> The cognitive functions are absent and the actions of the person are thus unplanned and the accused is unable to appreciate surrounding events. Acts by the accused may appear purposeful but are typically out of character and after the event the accused would make no attempt to escape and would usually have amnesia regarding the event, but be able to remember

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<sup>59</sup> Snyman 172.

<sup>60</sup> 2002 1 SACR 562 W at 565.

<sup>61</sup> 1983 4 SA 904 OK at 910.

<sup>62</sup> 1983 2 SA 181 SWA at 188.

<sup>63</sup> Kaliski 107.

<sup>64</sup> 1999 1 SACR 13 SCA at 15.

<sup>65</sup> 2000 2 SACR 493 N at 494.

<sup>66</sup> Kaliski 105.

preceding and subsequent events. Conduct is thus automatic, involuntary, reflexive, uncontrolled, unconscious, not goal directed and not motor controlled, where the person is in a dissociative state.<sup>67</sup>

In the case of Arnold it was held that provocation can result in an automatic state where the cumulative effect of the circumstances leads a state where the accused loses voluntary control of his muscle movements.<sup>68</sup>

#### **2.4. Amnesia**

Amnesia of events surrounding a crime is often alleged by accused persons. In the case of Henry the court also held that there is a difference between true or dissociative amnesia and psychogenic amnesia. The difference being that true amnesia implies true involuntariness and is consistent with a state of sane automatism, where psychogenic amnesia is the brain's way of suppressing unpleasant memories and does not indicate involuntariness. Often persons acting in an automatic state have clear and vivid memories of events leading up to the incident as well as afterwards, but cannot recall the offensive act. This is consistent with true amnesia.<sup>69</sup>

The difficulty for mental health professionals and the court in cases where amnesia is alleged lies in determining whether it is true or dissociative amnesia and whether the accused may be malingering.<sup>70</sup> Amnesia must thus only be regarded as supportive evidence and not an excuse in itself, in determining whether an accused was incapacitated or had acted automatically.<sup>71</sup>

#### **2.5. S v Eadie 2002 (1) SACR 633 (SCA)**

In the case of Eadie<sup>72</sup> the use of the defence of non-pathological criminal incapacity due to provocation was seemingly abolished. It was held that there is no difference between non-

<sup>67</sup> Kaliski 105.

<sup>68</sup> 1985 (3) SA 256 at 263.

<sup>69</sup> Henry *supra* at 20. See also the discussion of amnesia in Chapter 3.

<sup>70</sup> See Chapter 3 on discussion of malingering and amnesia. Cima 2004 *International Journal of Law and Psychiatry* 216. Le Roux, Nel & Kritiese perspektief op die rol van amnesie by die vasstelling van strafregtelike aanspreeklikheid 2010 *De Jure* 23.

<sup>71</sup> Kaliski 106, 108; Snymann 58.

<sup>72</sup> In this case the accused beat the deceased to death with a hockey stick in a fit of road rage. The defense relied on the argument that, although Eadie knew his actions were wrong, he could not exercise self-control.

pathological criminal incapacity due to provocation - more specifically the conative leg of the test for capacity or ability to act in accordance with an appreciation of wrongfulness - and the requirement that an act be voluntary.<sup>73</sup> If an accused thus states that he was unable to restrain himself due to provocation, the court held that it is the same as not having voluntary control of his muscle movements and therefore that the defence would be one of automatism.

The court in Eadie, although not wrong in convicting the offender, reached the verdict on flawed reasoning by equating the defence of sane automatism with the second leg concerning conation of the defence of non-pathological criminal incapacity.<sup>74</sup> This was decided, even though the two defences have bearing on separate elements of criminal liability.

It is at this point ó where automatism and the second leg of the test of criminal capacity, namely the conative ability or self-control are separate and different concepts in law ó that law and the mental health care profession seem to part ways.<sup>75</sup> Lack of self-control seems to be a legal construction not readily amenable to psychological analysis.<sup>76</sup> The expert witness in the case of Moses<sup>77</sup> argues that a person can never lose self-control except in a state of automatism. The case of Eadie thus brought the law in line with psychological reasoning,<sup>78</sup> but it cannot hold with accepted legal principles and has created even more problems in the collaborative relationship between the professions by stirring confusion. There has to date not been a case before a court where the issue has been addressed and clarified.

Louw reiterates that even though the courts are the final arbiters in all decisions before them, their decisions must be based on sound foundations.<sup>79</sup> For example, if a sound psychological basis for the concept of óa lack of self-controló is absent, the question as to the basis on which it is justified should be raised.<sup>80</sup>

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<sup>73</sup> Eadie *supra* at 688.

<sup>74</sup> Snyman 164-166.

<sup>75</sup> Louw 50.

<sup>76</sup> Louw 50; Louw 2001 *SACJ* 210.

<sup>77</sup> 1996 1 *SACR* 701 C at 711.

<sup>78</sup> Louw 53.

<sup>79</sup> Louw 2001 *SACJ* 210.

<sup>80</sup> *Ibid.*

## 2.6. Sane versus Insane Automatism

The distinction in terminology that has been made in the past between sane automatism and insane automatism in reported cases and certain legal texts is both inaccurate and confusing,<sup>81</sup> creating difficulties for the courts, legal professionals and mental health experts in distinguishing the separate elements of a crime that are criminal capacity and a voluntary act.

Automatism due to epilepsy has been referred to as insane automatism.<sup>82</sup> This is inaccurate, as people suffering from epilepsy are still sane<sup>83</sup> and would not be certified and institutionalised if a defence of automatism due to epilepsy succeeds.

The terms ‘sanity’ and ‘insanity’ are too close to the term ‘mental illness’ that would result in pathological criminal incapacity. If referring to ‘insane automatism’, one is referring to automatism due to brain pathology.<sup>83</sup> The crux of the defence of automatism is involuntary conduct that is not due to a disturbance of the mind (as opposed to physical brain injury for example).<sup>84</sup> If one uses the term ‘insane automatism’ mental disturbance immediately comes to mind.

Sane automatism is due to external factors of a temporary nature. These could include, for example: concussion, black-out, sleepwalking and epilepsy.<sup>85</sup>

The practical importance of this distinction, apart from the onus of proof, is the effect on the situation of the accused. If he is found to have acted automatically, he is acquitted and goes free. If he is found to have lacked criminal capacity due to mental illness, he could be institutionalised after acquittal.<sup>86</sup> Lamprechts submits that the reason for creating the term ‘sane automatism’ was to avoid unjustified functioning of the law where a person would have to be committed to an

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<sup>81</sup> Louw 38.

<sup>82</sup> Kaliski 106.

<sup>83</sup> Snyman 172; Burchell 181.

<sup>84</sup> Snyman 172.

<sup>85</sup> Kaliski 107; Burchell 180; Lambrechts 2006 *Interim: Interdisciplinary Journal* 46.

<sup>86</sup> Snyman 59, Burchell 181; Lamprechts 2006 *Interim: Interdisciplinary Journal* 45.

institution if it was found that he had suffered from an *insane automatism* (like epilepsy) at the time of the offence, but was sane at the time of trial.<sup>87</sup>

The term *sane automatism* is purely a legal construct that does not hold with the mental health profession and has been rendered unnecessary since the courts have a wider discretion to case appropriate sentencing than before.<sup>88</sup> It is recommended that this terminology be avoided and that *insane automatism* rather be referred to as *automatism due to mental pathology* and *sane automatism* as *automatism not due to mental pathology*.<sup>89</sup>

This departure from the terms *sane* and *insane automatism* is bolstered by the inference that can be drawn from the changes brought about by the enactment of the Criminal Procedure Act. After enactment of Chapter 13, a mentally ill accused could no longer be considered incapacitated on the grounds that they acted on the basis of an *irresistible impulse*,<sup>90</sup> as had been possible before.<sup>91</sup> The Rumpff Commission held the *irresistible impulse* requirement to be unsatisfactory,<sup>91</sup> as mentally ill persons did not necessarily act on impulse and that the term suggests an overpowering force that renders the accused's actions involuntary or automatic. The inquiry into criminal capacity is not whether the actions were automatic, but whether the individual had rational power over their actions.<sup>92</sup>

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<sup>87</sup> Lambrechts 2006 *Interim: Interdisciplinary Journal* 45.

<sup>88</sup> Lambrechts 2006 *Interim: Interdisciplinary Journal* 46; Section 78(6) as amended by Section 5 of Act 68 of 1998.

<sup>89</sup> Louw 38.

<sup>90</sup> For a discussion of the development of the defence of criminal incapacity as it was derived from English law, see Chapter 4.

<sup>91</sup> Burchell 371.

<sup>92</sup> Louw 49.

### 3. Criminal capacity in mental health care terms

#### 3.1. Introductory remarks

Mental health care professionals follow a fairly deterministic school of thought, while the law presupposes freedom of will, which is the basis of criminal liability and more indeterministic.<sup>93</sup> The determinists are of the view that criminal behaviour is influenced by circumstances (biological, psychological) and hence miscreants are not entirely to blame for their misdeeds. The indeterminists believe in free will, rational choice and if individuals choose to violate the law, they must be punished accordingly.<sup>94</sup> It is this fundamental difference in the pattern of reasoning that causes the difference in approach that is followed by legal and mental health practitioners in the determination of whether a person possessed criminal capacity.

The essential, and obvious, starting point for a mental health professional during a psycholegal assessment is a thorough clinical assessment with accepted diagnoses, that should precede any consideration of the legal or juridical issues.<sup>95</sup> The mental health professional does therefore not start out his evaluation of an accused with the abovementioned legal principles and definitions in mind. Because there is such a difference in opinion between the legal and mental health professions as to what capacity entails, this starting point in assessment is perhaps a main reason for the frustration felt when it comes down to the point of reconciliation of these concepts into a mutually inclusive form which is of use to the legal process.

While capacity in the legal sense refers to the ability to perform a specific juristic act, with criminal capacity encompassing the cognition to appreciate wrongfulness and the conation to act in accordance with this appreciation, capacity in the medical sense relates to the clinical evaluation of an individual's functional ability to make autonomous, authentic decisions about his or her own life.<sup>96</sup>

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<sup>93</sup> Snyman 148-149, Rumpff Report 2 4; Burchell 179.

<sup>94</sup> Chetty 2008 *Acta Criminologica: CRIMSA Conference: Special Edition* 133; Kaliski 2009 *South African Journal of Psychiatry* 4.

<sup>95</sup> Kaliski 4.

<sup>96</sup> Zabow in Kaliski *et al* *Psycholegal Assessment* (2006) 84.

Practically, capacity in the medical sense has been distilled into two components, namely; a person's capacity to assimilate relevant facts and appreciation of their situation as it relates to the facts.<sup>97</sup> Thus a determination of mental capacity or a diagnosis of mental illness by a mental health professional does not necessarily simultaneously address the question if a person can be held to be legally capacitated.<sup>98</sup>

### 3.2. Psycholegal assessment of pathological criminal incapacity

The presence of a ~~mental illness~~ or ~~mental defect~~ at the time of commission of the offence is the threshold requirement for a defence of pathological criminal incapacity to succeed, according to Section 78(1).<sup>99</sup> Once this is established, the effect on the cognitive and conative ability of the accused must be determined.<sup>100</sup>

In terms of determining pathological criminal incapacity, where a mental health professional is called upon to assess and diagnose possible mental illness, the mental illness referred to is a legal term, used to describe certain states that excuse persons from criminal liability, not a medical term.<sup>101</sup> This must be kept in mind by psychologists and psychiatrists, as what they may diagnose as a mental illness or mental disorder, may not meet the statutory requirements for a ~~mental illness~~ or ~~defect~~ that may affect criminal incapacity and their testimony may not be of great technical value in court.<sup>102</sup>

Kaliski explains quite clearly that from the mental health practitioner's viewpoint, the first step in assessment of an accused would be to determine whether the accused suffers from a mental illness, defect or other important condition. Following this, the practitioner must decide whether the severity of the identified condition was enough to significantly impair the accused's cognitive or conative abilities; and lastly whether these impairments influenced the accused's

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<sup>97</sup> Zabow 85.

<sup>98</sup> Burchell 378; Zabow 85.

<sup>99</sup> Act 51 of 1977.

<sup>100</sup> Snyman 171.

<sup>101</sup> Burchell 373; Louw 46; Chetty 2008 *Acta Criminologica: CRIMSA Conference: Special Edition* 129.

<sup>102</sup> Louw 46.

actions at the time of commission of the offence.<sup>103</sup> This is also formulated by Burchell as the test for insanity.<sup>104</sup>

It is not the task of the mental health professional to establish whether the accused possessed criminal capacity as that is an ultimate issue and solely the court's decision, but rather to determine if a disorder, condition or circumstance existed that negated it,<sup>105</sup> and only to pronounce an opinion on the degree of impact such a particular disorder may have had.<sup>106</sup> It is for the Court to decide the question of the accused's criminal capacity, having regard to the expert evidence and all the facts of the case, including the nature of the accused's actions during the relevant period.<sup>107</sup> Individual behavior and functioning are more important than diagnostic label<sup>108</sup>.

### **3.2.1. ‘Mental illness’ and ‘mental defect’**

The definition of a ‘mental illness’ or ‘mental defect’ is a source of difficulties in the relationship between psychiatry and law and since the concepts are both legal and medical, there is bound to be an overlap in terminology.<sup>109</sup> There is no definition of mental illness or mental defect in the Criminal Procedure Act and even though mental illness is defined in the Mental Health Act as meaning ‘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 a diagnosis,’<sup>110</sup> the definition is not binding in a criminal trial.<sup>111</sup> Van Oosten states that ‘mental illness’ and ‘mental defect’ is not clearly defined by the legislator, as it remains an issue of expert evidence to be adjudicated upon by the courts.<sup>112</sup>

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<sup>103</sup> Kaliski 102.

<sup>104</sup> Burchell 373.

<sup>105</sup> Kaliski 103.

<sup>106</sup> Kaliski 5.

<sup>107</sup> Grant ‘Criminal law’ 2006 *Annual Survey of South African Law* 670; Eadie *supra* 445H.

<sup>108</sup> Swanepoel ‘Law, psychiatry and psychology: A selection of medico-legal and clinical issues’ 2010 *THRHR* 194.

<sup>109</sup> Burchell 383.

<sup>110</sup> Act 19 of 1973.

<sup>111</sup> Louw 46.

<sup>112</sup> Van Oosten 1993 *SACJ* 132. This is also the view of Kaliski in the 2009 *South African Journal of Psychiatry* 4.

‐Mental illness‐ as defined by the DSM-IV-TR is ‐a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (i.e. A painful symptom) or disability (i.e. 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.‐<sup>113</sup>

Kaliski opines that both definitions cannot provide objective criteria for a certain diagnosis and the legal definition defers to the judgement of the mental health expert who is authorised to make such a judgement.<sup>114</sup>

In *S v Stellmacher*<sup>115</sup> it was held that a mental illness should at least meet the criteria that it be 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.<sup>116</sup> This criterion identifies only those disorders that are the result of a disease and of internal origin as ‐mental illnesses‐<sup>117</sup>

In clinical practice, as opposed to in the legal definition, any of the diagnoses described and listed in either the DSM-IV-TR or ICD-10 manuals are regarded as disorders.<sup>118</sup> This includes conditions that do not normally affect criminal capacity, like nicotine addiction. It has thus become convention for ‐mental illness or disorder‐ in forensic and judicial context to mean a major psychiatric disorder that is known to be associated with significant cognitive and conative impairments.<sup>119</sup>

DSM-IV-TR refers to the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and ICD-10 to the International Classification of Diseases and Related Health Problems published by the World Health Organisation. Both contain standardised criteria for the diagnosis of psychiatric disorders and clinicians tend to use either

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<sup>113</sup> Kaliski (2006) 244; DSM-IV-TR xxxi.

<sup>114</sup> Kaliski 245.

<sup>115</sup> *Supra* at 188.

<sup>116</sup> Burchell 375; Snyman 170.

<sup>117</sup> Burchell 375.

<sup>118</sup> Kaliski 95.

<sup>119</sup> Burchell 374; Kaliski 98.

one exclusively, as there are many differences between them.<sup>120</sup> Both classification systems, however, warn against their use if not supplemented by formal courses of instruction and training experience, as the classifications contained in them should only be interpreted by trained medical professionals who are able to make a value-judgement and diagnosis in each individual case.<sup>121</sup>

The clinical and legal definitions of mental illness<sup>122</sup> differ significantly. The DSM-IV-TR acknowledges that the concept lacks a definition that covers all situations.<sup>122</sup>

A pathological mental illness refers to a disease of the mind and it does not matter whether the illness is temporary or permanent, curable or incurable, or likely to recur or not.<sup>123</sup> The cause is also irrelevant, provided it is an internal cause. Physical illness elsewhere in the body than the brain may interfere with the mind as well. Mental malfunctions that occur after a blow to the head or consumption of drugs, for example, are external causes and do not result in mental illness,<sup>124</sup> except in the case of the *delirium tremens*.<sup>125</sup>

There is no closed list of mental illnesses or defects in criminal law, and each presentation of mental illness in each individual will also be different from the next person, even those with similar afflictions may differ in significant ways.<sup>126</sup> An accused's criminal capacity needs to be determined in each case individually and as the test is wholly subjective to the particular individual, the particular degree in which mental illness affects capacity in each case will be different.<sup>127</sup> This is especially true as the defence of pathological criminal is described in terms of the effects that a mental illness or defect has on the cognition or conation of a person, not in terms of a specific affliction or condition.<sup>128</sup>

<sup>120</sup> Kaliski 112.

<sup>121</sup> American Psychiatric Association *DSM-IV-TR*(2000) xxxvii; World Health Organisation *ICD-10*(2004) 1.

<sup>122</sup> Kaliski 244; DSM-IV-TR xxx-xxxi.

<sup>123</sup> Burchell 376; Louw 47; Snyman 169.

<sup>124</sup> Louw 47.

<sup>125</sup> See Substance-related disorders below.

<sup>126</sup> DSM-IV-TR xxxii.

<sup>127</sup> Louw 47; Snyman 169.

<sup>128</sup> Chetty 2008 *CRIMSA Conference: Special Edition* 132.

In considering which mental illnesses satisfy the legal definition of insanity and may result in criminal incapacity, disorders can be classified as follows according to the DSM-IV:

- Organic disorders: These disorders are due to a general medical condition and may be temporary or chronic. Symptoms of such disorders include impairment of orientation, memory, comprehension and self-control. Depending on the severity of the disorder, it may well satisfy the legal definition of insanity and result in criminal incapacity.<sup>129</sup>
- Substance-related disorders: Disorders are divided into substance use disorders and substance induced disorders. Substance use disorders such as alcoholism and addictions to mind-altering drugs is not necessarily pathological, endogenous or permanent and persons suffering from these disorders are not necessarily legally insane.<sup>130</sup> Substance induced disorders may be pathological and include the delirium tremens, a mental disorder representing serious alcohol withdrawal and is brought about by excessive and continuous abuse of alcohol. Persons suffering from a delirium tremens act in a confused state and their behaviour would not be purposeful or goal-oriented and may be aggressive and violent due to a misperception of the environment.<sup>131</sup>
- Psychotic disorders: This category is marked by psychotic or related symptoms. A psychotic illness is a type of organic disorder characterised by gross distortions of reality and perception. These disorders are pathological, endogenous and capable of depriving the sufferer of insight or self-control and may satisfy the legal test for criminal incapacity.<sup>132</sup>
- Mood and anxiety disorders: These disorders are divided into disorders where the predominant feature is disturbance in mood and where the predominant feature is anxiety attacks and phobias. Depressions are capable of depriving the sufferer of criminal

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<sup>129</sup> Burchell 384.

<sup>130</sup> Burchell 384.

<sup>131</sup> Peter in Kaliski *et al* Psycholegal Assessment (2006) 135.

<sup>132</sup> Burchell 385.

capacity.<sup>133</sup> Anxiety disorders may manifest as -anxietyø disorders such as phobias, or -dissociativeø disorders such as amnesia or dual personalities. Anxiety disorders do not affect the perception of reality, but dissociative disorders may deprive the sufferer of insight or self-control and thus criminal capacity.<sup>134</sup>

- Personality disorders: This is a group of disorders characterised by immature or distorted development of the personality, resulting in maladapted ways of perceiving, thinking or relating to others.<sup>135</sup> Personality disorders are defined and included in all classification schemes of psychiatric disorders, such as the DSM IV and the ICD 10, but few psychiatrists regard them as -mental disorders or illnessesø and no psychiatric institution would admit under certification anyone whose only diagnosis was a personality disorder, nor would a court find a person to be incapacitated on that basis alone.<sup>136</sup> Assessment of personality disorders should only be used to enhance the understanding of the accused and not to influence a judicial outcome.<sup>137</sup> Psychopathy can be included under this classification of disorder.

Psychopathy was removed from legislation in 1996 as a mental illness and the DSM IV does not include psychopathy as a diagnosis.<sup>138</sup> Accused persons who are diagnosed as psychopaths are held to be criminally capacitated and processed as -dangerous offenders.<sup>139</sup>

-Mental defectørefers to a condition that has resulted in cognitive deficits and an abnormally low intellectual ability, such as mental handicap and dementia.<sup>140</sup> It is possible that individuals suffering from a mental defect have such low levels of intellectual ability, that they lack normal

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<sup>133</sup> S v Kavin *supra*.

<sup>134</sup> Burchell 386.

<sup>135</sup> Burchell 386.

<sup>136</sup> Kaliski 244. Kendell -The distinction between personality disorder and mental illnessø 2002 *British Journal of Psychiatry* 110-115 states that many, and perhaps most, contemporary British psychiatrists seem not to regard personality disorders as illnesses.

<sup>137</sup> Kaliski 248.

<sup>138</sup> Kaliski 247.

<sup>139</sup> Kaliski 247; Section 286A of the Criminal Procedure Act 51 of 1977.

<sup>140</sup> Louw 41, 48; Kaliski 98; Snyman 169.

cognitive or conative functions and thus criminal capacity. The most important difference between mental illness and mental defect in legal terms is that it is a gradual difference.<sup>141</sup>

### **3.3. Psycholegal assessment of non-pathological criminal incapacity**

Non-pathological criminal incapacity as a defence has no closed list of legally accepted causes and forms of non-pathological incapacity due to youth, intoxication, provocation or emotional stress have been identified.<sup>142</sup> A problem originates when a mental health expert is called upon to assess and opine on said loss of capacity, as it is not a generally accepted psychological or psychiatric concept.<sup>143</sup>

The Rumpff Commission of Inquiry Report into the Responsibility of Mentally Deranged Persons sets out that a person's personality is made up of three things: The cognitive ability, the conative ability and the affective or emotional sphere.<sup>144</sup> Where these three functions are harmonious and integrated, there is "psychological normality" and a person is considered capacitated.<sup>145</sup> It is this harmony and "normality" that the mental health professional is called upon to investigate and report on to assist the court in determining whether an accused had criminal capacity at the time of the offence.

The Commission held that integration of these three functions may break down, that there can be a disintegration of the personality of an individual.<sup>146</sup> This disintegration may be of a minor nature or there may be a total disintegration of the personality. Where this total disintegration happens, the individual cannot be held to have criminal capacity. Where there is only a partial disintegration, the individual will only be found to have diminished criminal capacity. Lack of criminal capacity is exculpatory, whereas diminished criminal capacity is mitigating and is only taken into account when considering sentence.<sup>147</sup>

<sup>141</sup> Louw 48.

<sup>142</sup> Burchell 362.

<sup>143</sup> Carstens and Le Roux 2000 *SACJ* 182.

<sup>144</sup> Rumpff Commission Report (1967) 88.

<sup>145</sup> S v Van der Merwe 1989 2 PH 133 A at 134.

<sup>146</sup> Rumpff Commission Report (1967) 88. Kaliski 40.

<sup>147</sup> Louw 41.

Disintegration of the personality can affect different aspects of the personality, either the cognitive or conative aspects or the affective functions where the individual is incapable of displaying appropriate emotional control.<sup>148</sup> Seemingly uncontrolled emotional outbursts are not considered to be truly uncontrolled if the individual's conative functions are intact, then the person may still have been able to appreciate the wrongfulness of the act and exercise control over their actions.<sup>149</sup> Therefore a disintegration of the affective functions does not usually result in criminal incapacity.

Psychiatrists are sceptical about the existence of non-pathological criminal incapacity as defence, as it is not caused by a mental illness or defect, but by an altered mental state of temporary nature. In some instances though, psychiatrists are prepared to state that the accused's criminal capacity may have been diminished, resulting in a conviction, but lesser sentence in terms of Section 78(7) of the Criminal Procedure Act 51 of 1977.<sup>150</sup>

In his discussion of non-pathological incapacity,<sup>151</sup> Kaliski criticises the defence, and the decision of the court in Laubscher<sup>152</sup> to acquit the accused, on the grounds that it is based on the unfounded assumption that there will not be a recurrence of the behaviour.<sup>153</sup> He states that courts have relied on experts that use quaint terms such as 'emotional storm' or 'total disintegration of the ego' to describe the mental state of the accused, as opposed to pathological states and psychiatric diagnoses as explanations.<sup>154</sup> These descriptions of mental state are dismissed as being 'unscientific' and merely a way of saying the person was 'very, very angry'.<sup>155</sup> He clearly rejects non-pathological criminal incapacity as a defence and again confuses the element of incapacity with automatism when he states that automatic behaviour supposedly follows a climax of intense distress (a 'trigger') right before an offence is committed in his description of the legal position.<sup>156</sup>

<sup>148</sup> Louw 40-42.

<sup>149</sup> Louw 42.

<sup>150</sup> Carstens and Le Roux *SACJ* 2000 183.

<sup>151</sup> Kaliski 105.

<sup>152</sup> 1988 1 SA 163 A.

<sup>153</sup> Kaliski 105.

<sup>154</sup> Kaliski 105; Kaliski 2009 *South African Journal of Psychiatry* 4.

<sup>155</sup> Kaliski 2009 *South African Journal of Psychiatry* 4.

<sup>156</sup> Kaliski 105.

#### 4. Differentiation between psychiatric and psychological terminology

Psychiatry is a medical speciality and psychiatrists primarily assess and treat mental disorders as described in the DSM-IV or ICD-10 and generally use the same methods of examination as other medical specialists (e.g. brain scans, blood tests) and prefer to use biological elements along with psychotherapy.<sup>157</sup>

Psychologists are more concerned with the emotional and psychological factors that contribute to mental states and Psychology is studied at undergraduate and post-graduate level, not medicine.<sup>158</sup> Psychologists' treatment methods usually follow a form of psychotherapy such as Intellectual assessment, Personality assessment or Neuropsychological tests.<sup>159</sup>

It is common to refer to psychology as a single discipline or a set of closely related disciplines with a central, shared intellectual and scientific core, but this is not so, as the branches of psychology can be radically different and may have different foundations. Both law and psychology share a claimed interest in understanding and predicting human behaviour, but have different grounds of legitimate authority. Psychology is legitimated by means of scientific methodology in which objects appear in empirical reality and law by privileging logical argument and reason.<sup>160</sup> This in turn may lead to major disputes between schools of thought in psychology.<sup>161</sup>

The background and theoretical base of each profession are thus vastly different.

Kaliski is of the opinion that most clinicians base their diagnoses on the criteria listed in the psychiatric volumes, the DSM-IV or ICD-10, and that they should be challenged if they do not. He feels that there are many conditions, such as the 'battered woman syndrome'<sup>162</sup> and 'rape

<sup>157</sup> Swanepoel 2010 *THRHR* 181.

<sup>158</sup> Tredoux and Foster in Tredoux *et al* *Psychology and the law* (2008) 8.

<sup>159</sup> Swanepoel 2010 *THRHR* 185.

<sup>160</sup> Tredoux and Foster 25.

<sup>161</sup> Tredoux and Foster 2.

<sup>162</sup> According to Reddi 'Battered woman syndrome: some reflections on the utility of this 'syndrome' to South African women who kill their abusers' 2005 *South African Journal of Criminal Justice* 260, 264: 'Battered woman syndrome' is not and has never been a legal defence in its own right. The term 'battered woman syndrome' is used

trauma syndromeö that are in use that should be avoided as they are not recognised as clinical diagnoses. These labels should only be used if there is authoritative consensus that they are valid entries. He lists psychopathy as an example of a diagnosis not included in the DSM-IV, but that has been extensively researched and described in the literature and is therefore an accepted valid disorder or personality style.<sup>163</sup>

Kaliski indicates that the rationale behind his approach is that modern day psycholegal opinions that are not based on good evidence, but solely on the mental health professionalö experienceö, cannot be tolerated. As to what encompasses «good evidence» two questions should always be posed: Is the evidence based on scientific enquiry? And does it enjoy widespread acceptance in the mental health community?<sup>164</sup>

The problem with statements like that of Kaliski - that a label such as «battered woman syndromeö (BWS) is invalid, as it is not recognised by psychiatry - is that many such labels are recognised in psychology. Where BWS is concerned, some traumatic effects of violence can be identified by using the DSM-IV criteria, such as for Post Traumatic Stress Syndrome (PTSD) and Carstens and Le Roux suggest that the effects of BWS can be accommodated in the diagnostic category of PTSD, thereby facilitating a psychiatric diagnosis which can support a defence of non-pathological criminal incapacity.<sup>165</sup>

In this instance this difference in professional opinion is relevant, because a psychologist has to deliver an opinion alongside psychiatrists in terms of the Section 79 report, and it may cause confusion for the courts as to what opinion carries more evidential weight if there are conflicting opinions.

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to describe a pattern of psychological and behavioural symptoms found in women living in violent relationships and has been most often utilised and recorded in the United States of America and has been generally characterised in American courts as a category of post-traumatic stress disorder.

<sup>163</sup> Kaliski 4.

<sup>164</sup> Kaliski 4. See Chapter 5 for a discussion on the admissibility of expert evidence.

<sup>165</sup> Carstens and Le Roux 2000 *SACJ* 186.

## 5. Critical examination of the mental health profession's understanding of legal issues regarding criminal capacity

One of the problems regarding successful collaboration between the legal and mental health care professions lies in the understanding and knowledge base a professional has of the other field. In Kaliski's excellent book on the subject of psycholegal assessment, he makes considerable strides towards a better understanding between the two fields. Yet he still makes fundamental errors in his explanation of legal principles, which may indicate there is still a ways to go before synchronicity may be reached.

Errors made by Kaliski that are relevant to this study, include this statement:

“The three elements of criminal liability, namely, criminal capacity, unlawful conduct and fault are distinct from each other, have separate requirements, and should be inquired into separately, yet all are interconnected in order to determine liability. For example, while mental illness in the criminal law is actually an inquiry into the criminal capacity of the accused, mental illness may also affect an individual's capacity to commit an unlawful act or the individual's capacity to form an intention. The first element –unlawful act– hinges on the question of voluntary conduct.”<sup>166</sup>

It is respectfully submitted that this can be criticised on a manner of points. Firstly, the three elements of criminal liability mentioned are in fact incorrect. The three elements of a crime are an act or omission, unlawfulness and fault; whilst the five requirements for criminal liability are legality, act or omission, unlawfulness, criminal capacity and fault.<sup>167</sup>

Secondly, mental illness does not affect capacity to commit an unlawful act. An act and unlawfulness are separate elements in criminal law. One does not need capacity to act or to act unlawfully. A mentally ill person can still act and their conduct can still be unlawful, yet they would escape criminal liability if they were found to lack criminal capacity or fault or if it was

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<sup>166</sup> Louw 37.

<sup>167</sup> Snyman 37.

deemed the mental illness resulted in an automatic state where the alleged offence was perpetrated through involuntary muscle movement.

Thirdly, an individual's capacity to form intention is nothing else than criminal capacity. The capacity element is impacted if it is described in these terms, not the element of fault or intention, which are separate. Criminal capacity underpins intention and as such is an element of the crime that has to be proven.<sup>168</sup> It has been stated above that criminal capacity is a prerequisite for fault. Mental illness only impacts the element of fault where it is found that the accused did not have the required intent, due to their mental illness. The test for intention is subjective and mental illness may affect either the accused's perception of unlawfulness or conscious will.<sup>169</sup> When criminal capacity is enquired into, the question is whether the perpetrator was capable of possessing fault and only after this is answered in the affirmative is there enquired into whether the accused did in fact possess fault.<sup>170</sup>

Another error is to refer to 'mental illness' as a defence.<sup>171</sup> The defence would be pathological criminal incapacity by reason of mental illness. It does not automatically follow that a person is necessarily criminally incapacitated if that person suffers from a mental illness. It is possible for a mentally ill individual to appreciate the wrongfulness of conduct as well as have the ability to act in accordance with such an appreciation, therefore mental illness in itself is not a defence. Additionally, it is submitted that the term 'insanity' should be avoided, as it is firstly inaccurate to refer to a defence of insanity and secondly as there is a stigma attached to the terminology.<sup>172</sup>

The statement that persons plead criminal incapacity on the grounds of sane automatism<sup>173</sup> is also fundamentally flawed. Kaliski bases this on the case of Eadie that held that persons pleading criminal incapacity on grounds of provocation should rather rely on automatism as a defence.<sup>174</sup> Criminal incapacity is not pleaded on grounds of automatism.

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<sup>168</sup> Skelton 2006 *Article 40: The Dynamics of Youth Justice and the Convention on the Rights of the Child in South Africa* 3.

<sup>169</sup> Snyman 188.

<sup>170</sup> Badenhorst 1981 *SALJ* 151.

<sup>171</sup> Louw 39.

<sup>172</sup> Chetty 2008 *Acta Criminologica: CRIMSA Conference Special Edition* 130, 131.

<sup>173</sup> Kaliski 106.

<sup>174</sup> As discussed above.

In Chetty's article, the test for criminal capacity is formulated entirely incorrectly.<sup>175</sup> This serves to compound the problem, creating even more confusion. This can be criticised on the following points:

- The biological part of the test is equated with the enquiry into the cognitive ability of the accused to appreciate the wrongfulness of the act. The biological test is whether there was a mental illness, defect or other reason that may have impaired criminal capacity, in other words a threshold requirement. The cognitive test is also incorrectly equated with the enquiry into intent. The question to be asked is whether the accused had the ability to appreciate the wrongfulness of the act, not whether he in fact did appreciate it.
- The psychological part of the enquiry is also equated with the conative ability to act in accordance with the appreciation of wrongfulness. The psychological test is in fact the enquiry into both the cognitive and conative abilities of the accused.

## 6. Conclusion

While it has been said that "criminal capacity" and "mental illness" are legal terms and not medical terms and although law cannot absolutely rely on another discipline and remain reliable, the terminology becomes a fusion of medical and legal components and medical opinion is needed to add meaning to the legal concept.<sup>176</sup>

It is submitted that, in essence, the main problem faced by professionals in the forensic assessment of criminal capacity boils down to education and mutual understanding. Legal professionals should be better informed of the psychology and psychiatry behind criminal capacity and mental health professionals need to be better acquainted with the legal concept of criminal capacity.

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<sup>175</sup> Chetty 2008 *Acta Criminologica: CRIMSA Conference Special Edition* 131.

<sup>176</sup> Van Oosten 1993 *SACJ* 131.

Legal and clinical literature containing conflicting accounts of the relevant terminology and theory only serve to create confusion and compound the problem regarding successful interaction between professions. The effect of this may be forensic expert evidence that is not as valuable to the court as it can be, resulting in a situation where a miscarriage of justice is possible.

## CHAPTER 3: THE INVOLUNTARILY COMMITTED ACCUSED AND THE COURT

### 1. Introduction

In this chapter the effect of involuntary commitment on the accused and the accuracy and reliability of the diagnosis will be discussed with reference to the report in terms of Section 79, patients' rights, the Constitution, the risk of malingering, the weight of expert evidence in court and the problems faced in the interpretation and application of findings by the courts.

### 2. Compiling a psycholegal report

#### 2.1. Section 79 of the Criminal Procedure Act 51 of 1977

Section 79<sup>177</sup> makes provision for a panel of psychiatrists and psychologists that make forensic psycholegal enquiries during the observation period mandated by the court and the report stemming from the findings.

According to Section 79(1)(b) of Act 51 of 1977, where an accused has committed murder, culpable homicide, rape or compelled rape as contemplated in Sections 3 and 4 of Act 32 of 2007, or an offence involving serious violence or if the court considers it necessary, a panel of two or three psychiatrists will be appointed to report on the accused, one from a state hospital who represents the superintendent of the hospital, one from another from a state hospital who is to deliver another objective opinion, and one from private practice who is usually engaged on behalf of the accused. A clinical psychologist may also be appointed in addition if the court so directs.<sup>178</sup>

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<sup>177</sup> Act 51 of 1977.

<sup>178</sup> Louw 50; Kaliski 95.

Section 79(1)(a)<sup>179</sup> provides that in cases involving other offences, only a state psychiatrist is appointed or the superintendent of the psychiatric hospital or a psychiatrist appointed by the superintendent.<sup>180</sup>

The observation in terms of Section 79 entails that persons are admitted for up to 30 days at a time<sup>181</sup> to a designated mental institution and consists of:<sup>182</sup>

- A full physical and neurological examination, including blood tests and tests for substance abuse;
- Interviews by a mental health professional;
- Social work involvement;
- Psychological assessment and tests;
- Other investigations deemed necessary;
- 24-hour observation by nursing staff.

The prosecutor must provide the panel with the following information in order for them to conduct a thorough investigation:<sup>183</sup>

- Whether the accused is being assessed for criminal capacity or fitness to stand trial.
- Who requested the referral.
- The nature of the charge against the accused.
- The stage in the proceedings when the referral was made.
- Statements made in court by the accused prior to referral that are relevant to the enquiry.
- The relevance of the evidence to the enquiry.
- Any information concerning the accused's background.

<sup>179</sup> Act 51 of 1977.

<sup>180</sup> Louw 50; Kaliski 95.

<sup>181</sup> Section 79(2)(a) of Act 51 of 1977. When the period of committal is extended for the first time, Section 79(2)(b) determines it may be granted in the absence of the accused, unless the accused requests otherwise.

<sup>182</sup> Erlacher and Reid in Kaliski *et al* *Psycholegal Assessment* (2006) 315; Barrett -Profile of mentally ill offenders referred to the Free State Psychiatric Complex 2007 *South African Journal of Psychiatry* 56; Calitz *et al* -Psychiatric evaluation of offenders referred to the Free State Psychiatric Complex according to Sections 77 and/or 78 of the Criminal Procedures Act 2006 *South African Journal of Psychiatry* 48.

<sup>183</sup> Section 79(1A); Kaliski 95.

- Any other relevant information.

## 2.2. Report

Though there is no strict format prescribed, a written report should always actually address the required legal issues with clarity, relevance and ethical content, keeping in mind that ultimate issues are not to be addressed, thus an opinion on the guilt of the accused must be avoided and only the matter of criminal capacity discussed.<sup>184</sup> A good report would be comprehensive, objective, instructional, unbiased and expressive of the level of confidence the expert has in the findings.<sup>185</sup>

The report must include a description of the nature of the enquiry, a diagnosis of the mental condition of the accused and a finding as to the extent to which the capacity of the accused to appreciate the wrongfulness of the act in question or to act in accordance with such an appreciation was, at the time of commission thereof, affected by mental illness, defect or any other cause.<sup>186</sup>

It is unclear whether the members of the panel are required to confer with each other in order to reach consensus. Each member of the multi-disciplinary team conducts an enquiry and at some stage ought to present their findings in a case conference, when hypotheses are discussed and any further assessments planned. Ultimately the resulting report represents the consensus of the team.<sup>187</sup> This can be criticised in that the court requires an objective finding from each expert and the consensual report may negate this objectivity when there are dissenting opinions and different views and issues of seniority in the profession or work environment. The report of each individual expert mandated to report on the accused should ideally be untainted by the opinion of another, to enable the court to make its own decision on the evidence presented.

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<sup>184</sup> Kaliski, Allan and Meintjes-van der Walt in *Kaliski et al Psycholegal Assessment* (2006) 329-335. Allan and Meintjes-van der Walt also set out guidelines for practitioners in composing the report in terms of section 79 and guidelines for the expert witness in Chapter 23 of his book, which are helpful to the expert witness and offers advice on the law of evidence. Expert witnesses should always be well versed in these rules, so as to be helpful to the court. Education of forensic expert witnesses is key.

<sup>185</sup> Erlacher and Reid 332.

<sup>186</sup> Section 79(4) of Act 51 of 1977.

<sup>187</sup> Kaliski 97.

According to Section 79(5),<sup>188</sup> if the persons conducting the relevant enquiry are not unanimous in their finding, such fact shall be mentioned in the report and each of such persons shall give his or her finding on the matter in question.

Section 78(3)<sup>189</sup> states that if the finding contained in the report is unanimous and the finding is not disputed by the prosecutor or the accused, the court may determine the matter without hearing further evidence. If the said finding is not unanimous or is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence that the prosecutor or defence presented to that end, including the evidence of any person who enquired into the mental condition of the accused under Section 79.<sup>190</sup>

### **3. Patient rights and the Constitution**

#### **3.1. Introductory remarks**

The Mental Health Care Act makes provision for the rights and treatment of mental health care users who are prisoners, receive care either as voluntary, involuntary or assisted users or as state patients admitted under the Criminal Procedure Act,<sup>191</sup> and Section 6(f) provides that a mental health institution may admit and treat individuals referred by court for psychiatric observation in terms of the Criminal Procedure Act. The rights of persons admitted under such a court mandate differ from the rights of other mental health care users in the sense that some rights (such as the right to privacy, to have the mental health practitioner always act in the best interest of the patient and the need to obtain consent to examinations) must be infringed upon to be able to reach the goal of such an observation, which is the report intended for use by the court.

The rights of mentally ill patients, as provided for in the Mental Health Care Act, may be applied to involuntary committed accused persons committed for observation, as they are patients of the

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<sup>188</sup> Act 51 of 1977.

<sup>189</sup> Act 51 of 1977.

<sup>190</sup> Section 78(4) of Act 51 of 1977. Section 78(5) determines that the party disputing the finding may subpoena and cross-examine any person who enquired into the mental state of the accused under Section 79.

<sup>191</sup> Act 61 of 2003.

institution making the enquiry as well as detainees of the state. These rights include the right to dignified and humane treatment (the issue concerning this right is the administration of treatment), freedom from discrimination, the right to privacy and confidentiality, the right to protection from physical and psychological abuse and the right to adequate information about their clinical status and rights.<sup>192</sup>

### **3.2. Rights of persons detained for observation under Chapter 13**

#### **3.2.1. Equality**

According to Section 9(1) of the Constitution, everyone is equal before the law and has the right to equal protection and benefit of the law.

#### **3.2.2. Privacy and Confidentiality**

Privacy is a right enshrined by Section 14 of the Constitution, including confidentiality, and should a medical practitioner reveal information that is privileged, the right to bodily and psychological integrity and right to dignity may be breached as well, as the disclosure of such information could adversely affect a person's dignity and psychological integrity.

Section 14 of The National Health Act<sup>193</sup> stipulates that all information regarding a patient is confidential, unless the health care user consents to disclosure in writing, non-disclosure represents a serious threat to public health or a court order or any law requires disclosure.<sup>194</sup>

A report compiled by a forensic mental health expert should be unbiased and objective, without regard to the interest of either party concerned, and a fiduciary relationship does not exist between the assessor and the patient, where the treating clinician must always act in the best interests of the patient. With this in mind, the Health Professions Council has declared it

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<sup>192</sup> Zabow 61; Sections 7 to 17 of Act 17 of 2002.

<sup>193</sup> Act 61 of 2003.

<sup>194</sup> Section 17.

unethical for a treating clinician to conduct psycholegal assessments on their patients.<sup>195</sup> In psycholegal evaluations, the relationship is best described as one of *examiner-examinee* and the greater needs of the community or justice may come before those of the examinee, contrary to a usual doctor-patient relationship, so it is possible for the assessor to report in a way that may be harmful to the interests of the accused, and accountability to third parties may be involved.<sup>196</sup> The boundaries in the psycholegal relationship is more formal and rigid than in most other clinical relationships.<sup>197</sup>

In the usual clinical relationship, confidentiality is an implied agreement that the clinician not disclose any privileged information received from the patient to third parties unless legally required to do so.<sup>198</sup> It must be kept in mind by the assessing clinician that the report is not like a clinical file that enjoys confidentiality. Nevertheless, there is still a duty on the assessor not to disclose any information not relevant to the evaluation.<sup>199</sup> This needs to be explained to the patient being assessed and the clinician must take care not to reveal privileged information in the report that is not relevant.<sup>200</sup> The accused must also clearly be informed that he does not enjoy the usual fiduciary relationship with the assessor and all that entails with regard to confidentiality and the limits of confidentiality must be discussed and negotiated before and during the observation.<sup>201</sup>

Section 79(7) determines that statements made to a forensic assessor of mental health by an accused during observation that are relevant to the enquiry into mental health are admissible in court and not subject to confidentiality, but only serve to establish mental state and not to prove any other facts relating to the case at hand.<sup>202</sup> The Promotion of Access to Information Act is not applicable to such statements after criminal or civil proceedings have commenced.<sup>203</sup>

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<sup>195</sup> Kaliski, Allan and Meintjes-van der Walt 339.

<sup>196</sup> Zabow and Kaliski in Kaliski *et al* Psycholegal Assessment (2006) 359-360.

<sup>197</sup> Zabow and Kaliski 361.

<sup>198</sup> Zabow and Kaliski 362.

<sup>199</sup> Zabow and Kaliski 363.

<sup>200</sup> Kaliski, Allan and Meintjes-van der Walt 339-340.

<sup>201</sup> Zabow and Kaliski 361, 363; Cohen and Malcolm in Tredoux *et al* *Psychology and the law* (2008) 73.

<sup>202</sup> Act 51 of 1977.

<sup>203</sup> Section 7 of Act 2 of 2000.

The court in Forbes<sup>204</sup> held that it was undesirable that statements made by the accused during enquiries into the accused's mental state should be allowed to be put before the court in evidence for the purpose of establishing the truth of any facts referred to in such statements, save those having direct bearing on the mental condition of the accused.

In the case of Webb<sup>205</sup> the defence called an expert to testify that the accused was criminally incapacitated during the alleged murder he was charged for and the defence objected to the admissibility of statements made to the forensic assessor during the observation. The court held in this instance that the statements were admissible. The court in the case of Leaner<sup>206</sup> also held that, on proper interpretation of Section 79(7),<sup>207</sup> there was no reason why the expert witness could not be questioned regarding a statement made during an enquiry into the mental state of the accused that was relevant to such an enquiry.

The accused must be informed of his right to remain silent and to presumed innocent until proven guilty<sup>208</sup> and right against self-incrimination, but also that this failure to speak or cooperate during the observation will be noted and may be detrimental to the accused in court.<sup>209</sup> In terms of regulation 6(4) of the Mental Health Act<sup>210</sup> the accused, when referred for observation, must be informed that he is under no obligation to disclose any information.

The referral for observation in terms of Section 79 is for the purpose of determining criminal capacity, not to gain additional information to testify on. Only information regarding the enquiry may be disclosed. Anything else is subject to confidentiality.

The right to privacy enshrined in Section 14 of the Constitution includes the right not to have one's person searched. The physical examination of a person in the health care context is an invasion of privacy and can only be lawfully done if the person waives the right for the purpose

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<sup>204</sup> 1970 2 SA 594 K at 599.

<sup>205</sup> 1971 2 SA 340 T at 341.

<sup>206</sup> 1996 2 SACR 347 C at 358.

<sup>207</sup> Act 51 of 1977.

<sup>208</sup> As set out in Section 35 of the Constitution.

<sup>209</sup> Joubert Strafprosesreg Handboek (2009) 20.

<sup>210</sup> Act 19 of 1973.

of the examination,<sup>211</sup> though it is not an absolute right and may be limited in terms of Section 36 of the Constitution for the purpose of a court mandated psycholegal en medical examination.

Radden submits that, because the psychiatric patient's vulnerability is increased due to being at least temporarily and partially deprived of those traits most useful in combating exploitation, this vulnerability imposes a special burden on the clinician, who must adhere to stricter standards of awareness and good conduct.<sup>212</sup> This also holds true for the forensic mental health assessor who enquires into criminal capacity in terms of Section 78 and 79, even though the relationship between assessor and accused is not conventionally therapeutic.

### **3.2.3. Bodily and psychological integrity**

The right to bodily and psychological integrity as enshrined in Section 12(2)(c) of the Constitution includes the right not to be subjected to medical or scientific experiments without the informed consent of the patient.<sup>213</sup> Section 7(2) of the National Health Act<sup>214</sup> provides that a health care provider must take all reasonable steps to obtain the user's informed consent. In the context of court ordered forensic assessment, assessment can proceed without informed consent although it is advisable to try and obtain it. This may not be possible in most cases, due to the nature of informed consent requiring participation in decision-making, capacity and voluntariness.<sup>215</sup>

### **3.2.4. Dignity**

Section 10 of the Constitution states that everyone has inherent dignity and the right to have their dignity respected and protected. This right has a wide scope of application and is often infringed

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<sup>211</sup> Carstens and Pearmain Foundational Principles of South African Medical Law (2007) 943-944.

<sup>212</sup> Radden 'The nature and scope of psychiatric ethics: review article' 2004 *South African Psychiatry Review* 7.

<sup>213</sup> This is reinforced by Section 7(1)(c) of the National Health Act 61 of 2003.

<sup>214</sup> Act 61 of 2003.

<sup>215</sup> Zabow and Kaliski 370. According to the Guide to the National Health Act, for a patient in a hospital or clinic to give informed consent, he or she must know about and understand what health service is going to be given to him or her. He or she must also know about and understand the risks of that service. This well recognised principle of our law was first set out in Stoffberg v Elliott 1923 CPD 12 and was confirmed by the Supreme Court of Appeal in Louwrens v Oldwage 2006 2 SA 161 SCA.

in conjunction with other rights, such as the right to privacy, bodily integrity and to an environment that is not harmful to health or well-being.

### 3.2.5. Environment

According to Section 24 of the Constitution, everyone has the right to an environment that is not harmful to their health or well-being. As stated above, this may be read with a person's right to have their dignity respected and protected.

In the Volkman case, the accused was charged with murder and raised the defence of non-pathological criminal incapacity. The state applied for him to be admitted to Pollsmoor psychiatric hospital for observation in terms of the Criminal Procedure Act. The defence requested that the observation take place during the day only so that the accused would not have to be locked up in the hospital at night. Evidence placed before the court showed that the conditions in the hospital were inhumane. The state requested that the accused be admitted for observation on a full-time basis. The court agreed to the defence's request.<sup>216</sup>

One of the reasons given for this order, was that the accused had not yet been convicted and had a constitutional right to be detained under conditions that are consistent with human dignity under Section 35(2)(e) of the Constitution.<sup>217</sup> In spite of the fact that Section 36 of the Constitution permits rights to be limited if it is justifiable and reasonable to do so, and in spite of the fact that s 78(2) gives the court a discretion whether to refer the accused for observation or not, the court held that given the ~~extremely~~ unpleasant and degrading conditions~~s~~ that the accused would face, it could not exercise its discretion in the state's favour.<sup>218</sup>

### 3.2.6. The rights of arrested, detained and accused persons

Section 35(1) of the Constitution determines that everyone who is arrested for allegedly committing an offence has the right to remain silent and to be informed promptly of this right and of the consequences of not remaining silent. Also no person may be compelled to make any

<sup>216</sup> 2005 JOL 12914 C Case No SS 18/04 (unreported).

<sup>217</sup> Deane *Criminal procedure: from the law reports* 2006 *Codicillus* 91.

<sup>218</sup> Deane 2006 *Codicillus* 92.

confession or admission that could be used in evidence against that person. This relates specifically to the above discussion of confidentiality.

According to Section 35(2), everyone who is detained, including every sentenced prisoner, has the right to be informed promptly of the reason for being detained, and to be detained in conditions consistent with human dignity.<sup>219</sup>

Very few individuals that are sent for psychiatric observation actually know why they have been referred or understand what the assessment encompasses.<sup>220</sup> Either the accused's own council or an officer of the court should explain the process before an accused is admitted to a facility and before conducting the inquiry, an attempt must be made to explain the forensic procedure, the possible outcomes and that the usual rules of confidentiality do not apply.<sup>221</sup>

### **3.2.7. Limitation of rights**

Once it has been established that certain rights in the Bill of Rights are being infringed upon to some degree, as has been done above, a determination must be made as to whether the rights are subject to limitation.

The rights in the Bill of Rights may be limited, according to Section 36 of the Constitution, only in terms of law of general application, to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. While taking into account all relevant factors, including the nature of the right; the importance of the purpose of the limitation; the nature and extent of the limitation; the relation between the limitation and its purpose; and less restrictive means to achieve the purpose.

After it has thus been established that the purpose of the infringing legal rule is sufficiently serious and that there is a rational connection between the infringement and such a purpose, this must be weighed against the infringement in an enquiry into proportionality. If it is then found

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<sup>219</sup> As discussed above.

<sup>220</sup> Kaliski 94. Defendants are clueless ó the 30 day psychiatric observationó 1997 *South African Medical Journal* 1351-1355.

<sup>221</sup> Kaliski 95.

that there is no other, less restrictive, way of achieving the goal of the law, then the right is subject to limitation.

It is submitted that this finds application especially with regard to the right to privacy (where privacy is breached to an extent for purposes of the observation) and the right to bodily and psychological integrity (where consent is not always required to enable the assessor to reach the goals of observation). These rights may then legally be limited.

The limitations clause does not find application, however, with regard to the right to inherent dignity, the right to an environment that is not harmful to their health or well-being and the rights of detained persons to be informed of the reason for their detainment.

#### **4. Treatment during observation period**

There is a deceptive opinion that no treatment should be administered during the observation period as it may interfere with the assessment of the accused's mental state.<sup>222</sup> Kaliski is of the opinion that if there is a history of psychiatric illness and a record that shows the accused is on treatment, that it should be continued.<sup>223</sup> There is less clarity when there is no history of treatment or when the only issue is competence to stand trial as opposed to criminal capacity at the time of the offence.<sup>224</sup> In the USA, treatment during the observation period is only administered if it is deemed to be medically necessary and not for the sole purpose of returning an accused to competency to stand trial or if the accused refuses treatment.<sup>225</sup> Treatment should not be imposed on an unwilling accused undergoing assessment, unless ethical reasons are compelling.<sup>226</sup> Kaliski also feels that the approach that would serve justice best would be to commence treatment as soon as a definitive diagnosis has been reached.<sup>227</sup>

#### **5. Accuracy and reliability of the diagnosis**

The accuracy and reliability of psychiatric and psychological diagnosis in legal settings are particularly important, because diagnosis often influences court findings, financial judgments,

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<sup>222</sup> Kaliski 101.

<sup>223</sup> *Ibid.*

<sup>224</sup> *Ibid.*

<sup>225</sup> Kaliski 102.

<sup>226</sup> *Ibid.*

<sup>227</sup> Kaliski 102.

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>228</sup>

### **5.1. Risk of malingering**

Malingering is defined in the DSM-IV as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.”<sup>229</sup> Resnick<sup>230</sup> states that “malingering requires a deceitful state of mind. No other syndrome is so easy to define but so difficult to diagnose.”<sup>231</sup>

Malingering should be suspected if any of the following is noted:<sup>231</sup>

- Medico-legal context of presentation (e.g. A referral for observation by a court).
- Marked discrepancy between the person’s claimed stress or disability and the objective findings.
- Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen.
- The presence of anti-social personality disorder.

Somatoform disorders<sup>232</sup> and factitious disorders<sup>233</sup> are set apart from malingering by intention and external incentives. It is important that the disorders are not confused.<sup>234</sup>

In identifying malingering, Kaliski sets out that there are generally three components to any deceit that need to be kept in mind, namely the content that is chosen to be misrepresented, the

<sup>228</sup> Swanepoel 2010 *THRHR* 194.

<sup>229</sup> Resnick “The detection of malingered psychosis” 1999 *The psychiatric clinics of North America* 172.

<sup>230</sup> Resnick 1999 *The psychiatric clinics of North America* 159.

<sup>231</sup> DSM-IV-TR 739.

<sup>232</sup> In these cases symptoms are produced unconsciously.

<sup>233</sup> Symptoms are produced or misrepresented purposefully, with the only goal of assuming the role of patient, thus leading to unnecessary but desired medical intervention.

<sup>234</sup> Erlacher and Reid 312.

form the deceit takes on and the process used to convey the deceptive story.<sup>235</sup> This requires that the assessor has a thorough knowledge of disease entities and symptoms complexes, practical implications thereof in the legal context and knowledge of telltale signs of deception such as verbal cues, affective display and motor-phenomena.

Rogers discusses the fact that detection of malingering may be difficult for the assessor, as a clear line between real and malingered symptoms is not always present and that malingering may be partial or total, creating a daunting task to correctly diagnose.

Typical signs of malingered symptom representation such as the following may present:<sup>236</sup>

- Claiming more symptoms than would usually be expected.
- Atypical, improbable and implausible symptoms.
- Incongruence of symptom presentation.
- Symptoms not fitting any known syndromes.
- Discrepancies.
- Attention drawn to symptoms.

In criminal cases, psychosis,<sup>237</sup> cognitive impairment,<sup>238</sup> amnesia<sup>239</sup> and mutism<sup>240</sup> are among the most frequently malingered syndromes.<sup>241</sup> In addition to clinical observations, such as the abovementioned typical signs of malingering, psychological tests can be helpful in detecting deceit. While there is no single valid indication of malingering, a pattern indicative thereof across several tests is strongly diagnostic.<sup>242</sup>

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<sup>235</sup> Erlacher and Reid 315.

<sup>236</sup> Rogers Clinical assessment of malingering and deception (1997) 235.

<sup>237</sup> As discussed in Chapter 2.

<sup>238</sup> As discussed in Chapter 2.

<sup>239</sup> The inability to recall past events, either short term or long term and either intermittently or continuously.

<sup>240</sup> The inability to speak. This can be due to varying causes, including psychiatric and physical reasons. May be malingered as an effective way of withholding information or may be indicative of a mental disorder. To detect malingered mutism, detailed information is required into the past behaviour of the offender before referral, neurological examination and constant close observation, sometimes for longer periods. Erlacher and Reid 320.

<sup>241</sup> Erlacher and Reid 316.

<sup>242</sup> Erlacher and Reid 317.

Where psychosis is malingered, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is a widely used and accepted effective test to detect malingering,<sup>243</sup> along with the Structured Interview of Reported Symptoms (SIRS).<sup>244</sup> These tests use a set of questions the patient must answer and interview items to help indicate a high probability of malingering and negate the risk of an assessor misdiagnosing disorders.<sup>245</sup> If it is suspected that cognitive impairment is malingered, the Rey 15 Item Test,<sup>246</sup> the Forced Choice Test<sup>247</sup> and the Portland Digit Recognition Test<sup>248</sup> are commonly used tests to detect deceit.<sup>249</sup>

## 5.2. Malingering and amnesia

Malingered amnesia is difficult to separate and diagnose from psychogenic amnesia, as there is no symptomatic difference between them, only the reasons behind them differ.<sup>250</sup> Psychogenic amnesia is due to internal reasons that the person is unaware of and malingered amnesia due to external reasons the person is aware of and wants to escape from or avoid. Amnesia is commonly malingered by perpetrators of crimes and is found more often in cases of violent crime than non-violent crime.<sup>251</sup>

The presence of amnesia per se is insufficient as a defence and must only be regarded as supportive evidence and not as an excuse in itself,<sup>252</sup> as it is easy to malinger and is merely a symptom that may indicate a disorder, not a diagnosis in itself.<sup>253</sup> Amnesia is also no proof for criminal incapacity at the time of the defence, and conversely, there is no psychological proof that amnesia is contradictory to a lack of cognitive or conative mental ability.<sup>254</sup>

<sup>243</sup> Pensa -Detection of Malingered Psychosis with the MMPI-2ø 1996 *Psychotherapy in Private Practice* 47-63.

<sup>244</sup> Jelicic -Detection of Feigned Psychosis with the Structured Inventory of Malingered Symptomatology (SIMS): A Study of Coached and Uncoached Simulatorsø 2006 *Journal of Psychopathology and Behavioral Assessment* 19-22.

<sup>245</sup> Erlacher and Reid 316.

<sup>246</sup> A visual memory test using easily remembered items.

<sup>247</sup> A test involving 5-digit numbers presented to the patient to remember, where test scores under the 50% margin of chance may indicate malingering.

<sup>248</sup> A forced choice test with built in sensitivity markers.

<sup>249</sup> Erlacher and Reid 318.

<sup>250</sup> Le Roux, Nel 2010 *De Jure* 24.

<sup>251</sup> Cima 2004 *International Journal of Law and Psychiatry* 215.

<sup>252</sup> Le Roux, Nel 2010 *De Jure* 37.

<sup>253</sup> Kaliski 106, 109.

<sup>254</sup> Carstens and Le Roux 2000 *SACJ* 189.

Alleged amnesia is a perfect tool to avoid describing thoughts, feelings and actions at the time of the defence and is thus often alleged by accused persons who may not be aware that they should well be able to describe preceding events even if amnesia is present.<sup>255</sup> Amnesia claims are more likely from recidivists and in more serious offences.<sup>256</sup>

Four causes of crime-related amnesia have been discussed in forensic literature:<sup>257</sup>

- Dissociation, caused by the stress of the crime. There is increasing forensic opinion that this is an unlikely cause of amnesia and stress and distress is considered to be followed by enhanced memory of events, not loss of memory, though distortions of reality are possible.<sup>258</sup>
- A neuropsychiatric cause related to the circumstances of the offence, such as extreme intoxication leading to blackouts<sup>259</sup> head injury or hypo-glycaemia.
- The accused suffers from an amnestic disorder or a disorder that generally causes amnesia, such as dementia or alcohol induced amnesic disorder.<sup>260</sup>
- Malingering. This should be suspected if there is no clear reason for the amnesia.

Kaliski sets out guidelines for the assessment of amnesia by mental health experts to diminish the risk of malingering that include enquiring into the reason for the alleged amnesia, determining the detailed pattern of amnesia and the fact that a person may still have had criminal capacity, even though an alleged amnesia truly exists.<sup>261</sup> Cases where amnesia is alleged often causes heated debate among experts, as discussed in Chapter 2 where automatisms are accepted to be possible by some experts while others deny it.

The possibility of malingering must always be accounted for, but it should not cloud the judgement of the assessor either and lead to ignoring real symptoms. Malingering can, in the end, only be detected with absolute certainty when the person in question admits to intentional

<sup>255</sup> Kaliski 106, 108.

<sup>256</sup> Kaliski 109; Cima 2004 *International Journal of Law and Psychiatry* 217.

<sup>257</sup> Kaliski 108.

<sup>258</sup> Kaliski 109.

<sup>259</sup> Peter 135.

<sup>260</sup> Peter 136.

<sup>261</sup> Kaliski 109; Peter 136; Erlacher and Reid 319.

deceit.<sup>262</sup> It is important that the accused sent for observation be informed of the outcome of any findings made, for example that a diagnosis of mental illness and criminal incapacity would lead to indefinite detention in a mental institution. This knowledge may undermine the motivation to malinger in cases of lesser crimes.<sup>263</sup>

## 6. Weight of expert evidence in court

The true and practical test of the admissibility of the opinion of a skilled witness, is whether or not the court can receive appreciable help<ø from that witness on the particular issue, which will only be the case where the expert witness is in a better position to offer an informed opinion than the court, not where the court could have come to the same conclusion.<sup>264</sup>

In the case of *S v Van As*<sup>265</sup> the court distinguished between two forms expert evidence may take, namely; situations where the opinion of the expert is based on that of recognised authors or authority in the specific field, or situations where the expert personally conducted experiments, tests or research and then bases his opinion on the results thereof. The court opined that it is easier to align the opinion of the court with that of the expert in the second situation.

In *S v M*<sup>266</sup> it was held that the opinion of an expert witness should not be lightly disregarded when there is no evidence of any error made regarding the facts of the case and where the opinion and reasons for it is delivered in a satisfactory manner.

As discussed in Chapter 2, expert evidence is required in cases where pathological criminal incapacity is alleged, while it is not a strict requirement when non-pathological criminal incapacity is alleged.<sup>267</sup> It is submitted that the necessity of expert evidence should always be

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<sup>262</sup> Erlacher and Reid 327.

<sup>263</sup> Erlacher and Reid 315.

<sup>264</sup> Schwikkard 91. The admissibility of expert evidence is discussed in more detail in Chapter 5.

<sup>265</sup> 1991 2 SACR 91 74 W.

<sup>266</sup> 1991 1 SACR 91 T.

<sup>267</sup> In the cases of Kalogoropoulos 1993 1 SACR 12 A at 21 and Di Blasi 1996 1 SACR 1 A at 7 the court held that a factual basis must always be laid for a defence of non-pathological criminal incapacity and that this is done through expert evidence, although the court may disagree with the opinion of the expert and must ultimately make the decision on incapacity itself. In the case of Loyens 1974 1 SA 330 K at 332, it was held that expert evidence is

determined on a case-by-case basis and that any expert evidence that could assist the court in any way should not lightly be disregarded, especially where there was a court mandated observation period and as the judiciary cannot hold itself to be an expert in the field of psychiatry or psychology.

## 7. Problems faced in the interpretation and application of findings by the courts

Tredoux states that expert evidence by psycholegal assessors may be misinterpreted by the courts.<sup>268</sup> It is therefore essential that lawyers and psychologists are familiar with the underlying principles of forensic mental assessment and the strengths and limitations of what the expert witness can offer the courts.<sup>269</sup> In so doing, the psycholegal assessor will be better able to remain within the realms of their expertise and serve the court ethically and professionally and the lawyer will be able to effectively help direct the court in the knowledge that may be gleaned from the expert to ultimately best serve the best interest of justice.

## 8. The effect of involuntary commitment on the accused

Forcible detention in a hospital can be a distressing, difficult, and an embarrassing process. Patients who are treated involuntarily generally protest and may be difficult to diagnose if they do not cooperate.<sup>270</sup> This impact of coercion may be mitigated if patients feel "respectfully included in a fair decision-making process" and their autonomy is respected as far as possible. Patient advocacy also reduces the antagonism between staff members and patients. It is justified on the grounds of ethics, justice, and rights.<sup>271</sup> The understanding of the regulations and principles governing involuntary treatment is important for physicians wherever they practice. When it is done sensitively, respectfully and conservatively, we can both protect the users' and societies' interests whilst at the same time comply with the principles of the MHCA.<sup>272</sup>

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indispensable, though the court could not determine whether the witness was competent to give expert evidence in this case.

<sup>268</sup> Cohen and Malcolm 66.

<sup>269</sup> Cohen and Malcolm 66.

<sup>270</sup> Moosa, Jeenah -Involuntary treatment of psychiatric patients in South Africa: review 2008 *African Journal of Psychiatry* 111.

<sup>271</sup> *Ibid.*

<sup>272</sup> *Ibid.*

## 9. Conclusion

It is submitted that a balance needs to be reached between the importance of compiling an accurate and helpful report for the court, whilst respecting the rights of the accused person and taking into account all factors that could influence a reliable diagnosis and opinion.

Psycholegal expert evidence is indispensable to the functioning of a fair and effective legal system and its value should not be underestimated by the courts, as there are mechanisms to ensure the credibility of such evidence.

## CHAPTER 4: COMPARISON OF CHAPTER 13 WITH ENGLISH LAW

### 1. Introduction

English Law regarding criminal capacity is analysed in this chapter and compared to the position in South Africa. Section 39(1) of the Constitution determines that, when interpreting the Bill of Rights, a court, tribunal or forum must promote the values that underlie an open and democratic society based on human dignity, equality and freedom, and may consider foreign law.<sup>273</sup>

### 2. Criminal Responsibility, Insanity and Automatism in English Law

#### 2.1. Historical development and relationship to South African Law

The modern defence of criminal incapacity by reason of mental illness is derived from the *McNaghten Rules* in English law created by the House of Lords in 1843.<sup>274</sup> The *McNaghten Rule* states that an individual is not guilty by reason of insanity if he laboured under a mental disease that rendered him incapable knowing the nature and quality of the act he was doing, or if he did know it, that he did not know that the act was wrong.<sup>275</sup>

According to Swanepoel,<sup>276</sup> the *McNaghten Rules* were the first serious attempt to codify and rationalise the attitude of criminal law toward a mentally disordered accused. The medical evidence in this case was in substance that persons of otherwise sound mind, might be affected by morbid delusions and that a person so labouring under a morbid delusion, might have a moral perception of right and wrong, but could be carried away beyond the power of his own control. Such a delusion could leave a person with no such knowledge of right and wrong, or capability

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<sup>273</sup> This may be read together with the decision in Carmichele 2002 (1) SACR 79 (CC) at 81 where it was held that it is the duty of the courts to develop the common law in accordance with the values enshrined in the Constitution. If these values are better expressed in other jurisdictions, it stands to reason that courts should at least seriously consider foreign legal positions.

<sup>274</sup> Louw 39; Snyman 167.

<sup>275</sup> Labuschagne -Violence and mental illnessø2001 *Acta Criminologica* 106.

<sup>276</sup> Swanepoel 2010 *THRHR* 179.

of exercising any control over acts which had a connection with the delusion when it burst forth with irresistible intensity.<sup>277</sup>

The House of Lords instructed a panel of judges, to set down guidance for juries in considering cases where an accused pleads insanity. When the tests set out by the Rules are satisfied, the accused may be adjudged ñot guilty by reason of insanityö and the sentence may be a mandatory or discretionary period of treatment in a secure hospital facility, or otherwise at the discretion of the court instead of a punitive disposal. The MøNaghten rules are sometimes referred to as the ñight and wrong testö.<sup>278</sup>

The MøNaghten Rules did not allow for the case of an accused who realised what he was doing was wrong, but still did so under the compulsion of mental illness.<sup>279</sup> Therefore early tests of insanity for purposes of criminal capacity only included illnesses that affected the cognitive ability and not the conative ability of the accused.<sup>280</sup>

The rules were taken over in South African law, but expanded to include a test based on whether the accused had acted under an irresistible impulse to commit the crime even though the accused understood the wrongfulness thereof.<sup>281</sup> See chapter 2 discussion that impulse need no longer be irresistible after enactment of the CPA.

The ñappreciation of wrongfulnessö in the Criminal Procedure Act is broader than the ñknowledge of wrongfulnessö as set out in the MøNaghten Rules.<sup>282</sup> To appreciate that an act was wrongful, an individual must not only have knowledge of the act but also be able to evaluate the act and the implications thereof for himself and others.<sup>283</sup>

The age of criminal responsibility in England and Wales is 18 years, with children between seven and 18 rebuttably presumed to lack criminal capacity. This differs from South African law where children above 14 years of age are presumed to be criminally responsible unless it is

<sup>277</sup> Swanepoel 2010 *THRHR* 179.

<sup>278</sup> Swanepoel 2010 *THRHR* 179.

<sup>279</sup> Burchell 371.

<sup>280</sup> Burchell 381.

<sup>281</sup> R v Hay 1899 9 CTR 292; R v Smit 1906 TS 783; Louw 39.

<sup>282</sup> Louw 48.

<sup>283</sup> Louw 48. Rumpff Commission Report (1967) 9.14-5.

rebutted, and children between seven and 14 years are presumed to lack criminal capacity unless it is rebutted.<sup>284</sup> In England, children under 10 years of age are irrebuttably presumed to lack criminal responsibility, while this is only true in South Africa for children under the age of seven.<sup>285</sup>

The English law rule that *every person is presumed to be sane and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved* has been adopted by South African law and has been underscored in legislation with Section 5 of the Criminal Matters Amendment Act amending Section 78 of the Criminal Procedure Act, to place the onus on the party who alleges pathological criminal incapacity.<sup>286</sup>

## 2.2. Defences raised on account of mental illness

In most offences it must be proven that the accused's intention was as required for the crime (*mens rea* must thus be present in the form of negligence or intent).<sup>287</sup> The concept of responsibility in law concerns the degree to which the accused is held accountable for the offence committed. Full responsibility goes hand in hand with full rationality and consciousness. Impairment of either alters responsibility.<sup>288</sup>

### 2.2.1. Automatism

Automatism implies the absence of conscious will and therefore guilt.<sup>289</sup> Mental disorder may so impair rationality, that the accused may be found to lack responsibility and not guilty by reason of insanity.

### 2.2.2. Diminished responsibility

The concept of diminished responsibility was introduced by the Homicide Act of 1957 and was intended as a means to avoid the death penalty for people with a lesser degree of mental

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<sup>284</sup> McMurran Forensic Mental Health (Criminal Justice Series) (2009) 4.

<sup>285</sup> McMurran 4.

<sup>286</sup> Burchell 390.

<sup>287</sup> There are a few formally defined or statutory crimes where the act is sufficient for an offence to be committed and it becomes unnecessary to prove *mens rea*, for example with certain traffic violations.

<sup>288</sup> Stone 23-24.

<sup>289</sup> Stone 24.

abnormality than could fall within the *McNachten Rules*, which were the former test for insufficient mental disease.<sup>290</sup> Persons who are insane are entitled to a verdict of guilty. They are then subjected to a detention order issued by the court (similar to South African law where the accused is detained in a psychiatric hospital or prison in terms of Section 78 and 79). If an accused is found to be suffering from recognised levels of mental instability, he or she may receive an indeterminate sentence for the crimes. The accused will be confined to a secure hospital in terms of Section 37 of the Mental Health Act of 1983.<sup>291</sup>

### **2.2.3. Provocation**

The English legal position regarding a defence of provocation differs from South African Law in that it may only be raised against a charge of murder in England, as opposed to the South African position that it may be raised against any crime. The reason for this, is that provocation can be taken into account in sentencing any other crime, but not in the case of murder, as the sentence is determined by legislation.<sup>292</sup>

Before 1957 the crime of murder required a degree of *malice aforethought*, without which the perpetrator could be convicted of manslaughter and spared the death penalty. During the 16<sup>th</sup> century, a *doctrine of implied malice* was designed by which *malice* was deduced from surrounding circumstances, in order to find guilty of murder those who perpetrated unplanned, but brutal, murders. Killing in *heated blood* due to provocation could be excluded from this doctrine and could thus serve as a partial excuse to a murder charge.<sup>293</sup>

The Homicide Act of 1957 redefined the defence of provocation, and Section 3 determines that where on a charge of murder there is evidence on which the jury can find that the person charged was provoked (whether by things done or by things said or by both together) to lose his self-control, the question whether the provocation was enough to make a reasonable man do as he did, shall be left to be determined by the jury; and in determining that question the jury shall

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<sup>290</sup> Shepherd *Simpsons Forensic Medicine* (2003) 25.

<sup>291</sup> Cassim 2004 *Codicillus* 24, 25.

<sup>292</sup> Nel *Toerekeningsvatbaarheid in die Suid-Afrikaanse Reg* (LLM Dissertation 2007 UP) 139.

<sup>293</sup> *Ibid* 141.

take into account everything both done and said to the effect which, in their opinion, it would have on a reasonable man<sup>294</sup>. This changed the common law rule that words alone could never be sufficient provocation to diminish a murder conviction to manslaughter and it is no longer in the trial judge's discretion to remove the defence of provocation from the jury's consideration.<sup>294</sup>

The Homicide Act allows for extenuation for provocation, –whether by things said or things done or by both together<sup>295</sup>– that may cause a person to lose self-control, of which the assessment is a matter for the jury to decide.<sup>295</sup> The two questions before the jury is now whether there is any evidence of provocation and whether there is any evidence that the accused lost control.<sup>296</sup>

In practice, the defendant will usually be examined by a specialist forensic psychiatrist on behalf of the state and may also be examined by a specialist psychiatrist retained by the defence.<sup>297</sup>

Reasonable man is an objective test, though English courts after 1957 frequently added subjective elements to the test by asking whether the person indeed lost control (subjective) and whether the reasonable man would have done so (objective).

The –battered woman syndrome<sup>298</sup>– may be looked at in English law in context of –cumulative provocation<sup>298</sup>–, as it is the loss of control that must be sudden, not the provocation.<sup>299</sup>

#### **2.2.4. Intoxication**

In general English law, the effect of alcohol or drugs is no excuse for criminal behaviour. If a person consumes such a substance voluntarily, any subsequent criminal behaviour is his responsibility, as he should have been aware of the potential effect on his behaviour. Involuntary consumption is a possible defence in such a case. It has also been pleaded in more serious crimes

<sup>294</sup> Nel 145.

<sup>295</sup> Shepherd 25.

<sup>296</sup> *Ibid* 146.

<sup>297</sup> Shepherd 25.

<sup>298</sup> –Cumulative provocation<sup>298</sup>– may be defined as a series of provocations against the accused that, if viewed collectively, would constitute sufficient provocation to form a defence, but if seen in isolation would probably not be sufficient provocation to serve as grounds for a defence. Nel 163.

<sup>299</sup> Nel 166.

that the level of intoxication rendered the accused incapable of forming mens rea. This defence is accepted with great reluctance, along with claims of amnesia.<sup>300</sup>

### **2.3. Insanity, mental disorder and diminished responsibility**

The Homicide Act states that ~~where~~ where a person kills another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested development or any inherent causes or induced by disease or injury) as substantially impaired his acts and omissions in doing or being a party to the killing~~ø~~<sup>301</sup>

The definition of ~~mental illness~~ or ~~mental disorder~~ has undergone many changes throughout the legislative history of the United Kingdom:

- Section 4(1) of the Mental Health Act of 1959 states that ~~In this Act "mental disorder" means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind; and "mentally disordered" shall be construed accordingly.~~<sup>ø</sup>
- Section 1(2) of the Mental Health Act of 1983 states that ~~mental disorder~~ means ~~mental illness, arrested or incomplete development of mind, psychopathic disorder, or any other disorder or disability of mind and mental disorder shall be construed accordingly.~~  
~~Severe mental impairment~~ (same as mental defect in SA law) means ~~a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.~~  
~~Mental impairment~~ means ~~a state of arrested or incomplete development of mind (not amounting to severe impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.~~<sup>ø</sup>

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<sup>300</sup> Shepherd 25.

<sup>301</sup> Shepherd 25.

- The Mental Health Act of 2007 that was implemented in November 2008, amends the Mental Health Act of 1983. The definition of *mental disorder* is amended in Section 1 to mean *any disorder or disability of the mind* so that a single definition applies throughout the 1983 Act and abolishes the references to categories of disorder.<sup>302</sup>

As in South African law, the term *mental illness* is ambiguous and not specifically defined in the Mental Health Act. A memorandum provided by the Department of Health states that *the terms operational definition and usage is a matter for clinical judgement in each case*<sup>303</sup>. It is thus a medical matter to be interpreted by medical practitioners within their medical framework. Medical evidence is admissible as to the question of impairment, but the degree of impairment is up to the jury to decide.<sup>304</sup>

One of the problems Bartlett<sup>305</sup> points out to this approach, is which classification system of mental illness to follow, namely the DSM-IV or ICD-10, as they differ somewhat in diagnostic criteria, though both are accepted clinically by a variety of mental health professionals.

### 3. English Criminal Procedure

In England, the police refer cases to the Crown Prosecution Service (CPS), who decides whether or not a case will be prosecuted based on two tests, namely the evidential test and the public interest test.<sup>306</sup> According to these tests, there thus has to be enough reliable evidence against the accused that could make a conviction possible and that the prosecution is in the public's best interest. Under the Code for Crown Prosecutors there is a general presumption against prosecuting a person who was mentally disordered at the time of the offence, unless overridden by public interest as in serious cases.<sup>307</sup>

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<sup>302</sup> [http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH\\_078743](http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_078743).

<sup>303</sup> Bartlett 47; Shepherd 25.

<sup>304</sup> Bartlett 37.

<sup>305</sup> Bartlett 53.

<sup>306</sup> McMurran 5.

<sup>307</sup> Stone & Faulk's basic forensic psychiatry (2000) 23; McMurran 5-6.

The CPS may contact a mental health professional to prepare a report on an offender, either to rebut a defence report or because a defendant's state of mind is in doubt.<sup>308</sup> An expert opinion may be delivered in such a case on the defendant's fitness to plead or psychiatric defences such as insanity, diminished responsibility and automatism. The CPS may also ask such an expert to deliver an opinion on any view expressed by the defence's expert witness.<sup>309</sup>

In the United Kingdom, mentally disabled or disordered persons are given special rights when they are arrested and detained. The police are obliged to inform a responsible adult of the detention and request that person come to the police station. This adult must be present before the mentally disabled person may be interviewed. Such persons are dealt with by the mental health system rather than the criminal justice system.<sup>310</sup>

Section 35 of the Mental Health Act sets out the procedure that is used for persons awaiting trial for a serious crime and provide courts with an alternative to remanding a mentally disordered person in prison. The order for assessment in terms of Section 35 is done by a court on the oral evidence of a registered medical practitioner if there is reason to suspect the accused is suffering from a mental disorder, though the court will not direct a person to be remanded for assessment if he has already been convicted and the sentence is fixed by law.<sup>311</sup>

A person may be remanded for assessment under this Section for periods of up to 28 days at a time, but not exceeding 12 weeks total, and may be remanded further if it is deemed necessary for the assessment of his mental state. The court may also terminate the remand if it is deemed appropriate.<sup>312</sup> Section 35(8) provides that a person remanded under this Section is entitled to obtain, at his own expense, an independent report on his mental condition from a registered medical practitioner chosen by him and apply to the court on the basis of it for his remand to be terminated under Section 35(7).

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<sup>308</sup> Stone 23; McMurran 5-6.

<sup>309</sup> Stone 23; McMurran 5-6; Cassim -The accused person's competency to stand trial - a comparative perspective- 2004 *Codicillus* 24, 25.

<sup>310</sup> Cassim 2004 *Codicillus* 24, 25.

<sup>311</sup> Section 35(3) of the Mental Health Act of 1983.

<sup>312</sup> Section 35(5) and 35(7) of the Mental Health Act of 1983.

A Mental Health Act assessment can take place anywhere, but commonly occurs in a hospital, at a police station, or in a person's home and treatment, such as medication, can be given against the person's wishes under Section 35 assessment orders, as observation of response to treatment constitutes part of the assessment process.

A court may enact this Section on the medical recommendation of one Section 12 approved doctor, who is a medically qualified doctor recognised under Section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act. They are usually psychiatrists, although some are general practitioners who have a special interest in psychiatry.

In addition to regulating approved doctors, the Mental Health Act also makes provision for Approved Mental Health Professionals. Such a Professional is defined in the Act as a practitioner with extensive knowledge and experience of working with people with mental disorders. Until the 2007 amendments, this role was restricted to social workers, but other professionals such as nurses are now permitted to perform this role. These Professionals receive specialized training in mental disorder and the application of mental health law, particularly the Mental Health Act. Training involves both academic work and apprenticeship and lasts one year. The Approved Mental Health Professional plays a key role in the organization and application of Mental Health Act assessments and provides a valuable non-medical perspective in ensuring accountability.

#### **4. Conclusion**

The definition of 'mental illness' for purposes of determining criminal capacity in English law is much the same as in South Africa, regarding the flexible, indefinite nature of it and the room for interpretation. It is submitted that, although this system has its benefits, justice would certainly benefit from a more definite terminology that would lend an amount of certainty to the practice of psycholegal assessments for both medical professionals and legal professionals alike.

It is submitted that the regulation of approved professionals and their training in forensic settings by the Mental Health Act is something that is desirable for the South African jurisdiction, where it is not regulated.

The criminal procedure regarding observation of suspected mentally ill accused persons seems economical and effective, as it is dealt with not exclusively by the criminal justice system but by the mental health system. It is submitted that such a system of referral could benefit the South African justice system and is also discussed in Chapter 5.

## CHAPTER 5: CRITICAL EVALUATION OF CHAPTER 13 AND SUGGESTED REFORM

### 1. Introduction

The acceptability of the process surrounding the psycholegal assessment of suspected criminally incapacitated persons will be discussed in this chapter. Means to reconciliation of the legal and psychological disciplines will be suggested and explored and weaknesses and strengths pointed out, also with regard to the discussion of English and International Law.

øIn some areas an adversarial relationship has evolved between prosecutors and the psychiatric services. This has mainly been due to poor communication and lack of knowledge concerning the procedure and difficulties experienced by the other party. This state of affairs is extremely counterproductive and could turn a simple request for information into a bureaucratic nightmare. It also adds to the burden of the forensic psychiatric units, as well as the already overburdened judicial system.º<sup>313</sup>

### 2. Mental Health practitioners and the forensic assessment of criminal capacity

The Mental Health Care Act defines a mental health practitioner as a psychiatrist, registered medical practitioner, nurse, clinical psychologist, occupational therapist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services.º<sup>314</sup>

There is no formal training programme or examinations for forensic mental health in South Africa, and a formal postgraduate course is envisaged in future.<sup>315</sup> It is submitted that this is vastly preferable to a system with no medium to ensure forensic experts adhere to a certain standard and reliable level of expertise.

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<sup>313</sup> Meyer -Use of the Judicial Section 9 Certification in the Free Stateº2004 *South African Journal of Psychiatry* 106.

<sup>314</sup> 17 of 2002.

<sup>315</sup> Kaliski 3.

Section 79(8) of the Criminal Procedure Act<sup>316</sup> states that a clinical psychologist and psychiatrist appointed by the courts, other than those appointed for the accused, shall be appointed from a list of clinical psychologists and psychiatrists, compiled in terms of Section 79(9)(a), who are prepared to conduct an enquiry under the Section. Section 79(10) provides that a clinical psychiatrist or psychologist may be appointed to conduct an enquiry under the Section, even though their names do not appear on the list, when said list does not include a sufficient number of experts who may conveniently be appointed.

A psychiatrist or clinical psychologist, as referred to in the Section 79 of the Criminal Procedure Act, means a person registered as such under the Health Professions Act 56 of 1974.<sup>317</sup>

The Health Professions Council of South Africa (HPCSA) is established by the Health Professions Act<sup>318</sup> as the supreme statutory body regulating the medical profession and is as such the guardian of the prestige, status and dignity of the profession and public interests.<sup>319</sup> The HPCSA must ultimately protect the public and guide the medical profession by ensuring professional competence and fostering compliance with standards. The objects of the HPCSA include:<sup>320</sup>

- The co-ordination of professional boards established in terms of the Act (such as the Professional Board for Psychology and the Medical and Dental Professions Board). The HPCSA is the executive body and the boards regulate the professions on a day-to-day basis;
- To promote and regulate interprofessional relations between registered professions in the interest of the public;
- To control and exercise authority in all matters affecting the training of persons diagnosis of physical and mental illness, defects or deficiencies;
- To advise the Minister of health on any matter within the scope of the Act;

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<sup>316</sup> Act 51 of 1977.

<sup>317</sup> Section 79(12) of Act 51 of 1977.

<sup>318</sup> Section 2 of Act 56 of 1974.

<sup>319</sup> Carstens and Pearmain Foundational Principles of South African Medical Law (2007) 251.

<sup>320</sup> Section 3 of the Health Professions Act 56 of 1974.

- To communicate to the Minister of Health information of public importance acquired by the Council in the course of the performance of its functions under the Act.

As no person may practice within South Africa as a medical practitioner or psychologist unless registered under Section 17 of the Act,<sup>321</sup> all such professionals fall under the jurisdiction of the HPCSA. It has become compulsory for all medical practitioners registered in South Africa to undergo continuing education and training for which the HPCSA prescribes rules dictating conditions regarding this continued education in order for professionals to retain registration, the nature of the education and training and the criteria for recognition by the council of continuing education courses and institutions offering them.<sup>322</sup>

Section 4(c) of the Health Professions Act<sup>323</sup> dictates that the HPCSA may consider any matter affecting the professions registrable with the council generally, and make representations or take such action in connection therewith as the council deems advisable. According to Section 15B(d) a professional Board (such as the Professional Board for Psychology and the Medical and Dental Professions Board) may consider any matter affecting any profession falling within the ambit of the professional board and make representations or take such action in connection therewith as the professional board deems advisable. Therefore the HPCSA and its boards are in the position to mandate compulsory training of forensic mental health practitioners that would bridge the gap in understanding and knowledge between psychiatry and the law and result in a more effective system to serve the needs of justice and the community.

HPCSA introduced a system of compulsory Continuing Professional Development (CPD) in terms of Section 26 of the Health Professions Act<sup>324</sup> designed to improve overall patient care, the CPD system requires all professionals registered with HPCSA to earn a prescribed number of Continuing Education Units (CEUs) annually by attending HPCSA-approved education initiatives. Every practitioner is required to accumulate 30 Continuing Education Units (CEUs)

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<sup>321</sup> Section 17 of Act 56 of 1974.

<sup>322</sup> Carstens and Pearmain 256; Section 16 of Act 56 of 1974; Tredoux and Foster 11.

<sup>323</sup> Sections 26 and 34 of Act 56 of 1974.

<sup>324</sup> Act 56 of 1974, in terms of which the HPCSA may from time to time prescribe rules relating to continuing education and the nature and extent thereof.

per twelve-month period and five of the units must be on ethics, human rights and medical law. Mandatory random audits are conducted to ensure compliancy.<sup>325</sup>

Section 50(1) of the National Health Act establishes a forum to be known as the Forum of Statutory Health Professional Councils on which all the statutory health professional councils must be represented.<sup>326</sup> According to Section 50(4)(b), the Forum of Statutory Health Professional Councils must ensure communication and liaison between the statutory health professional councils upon matters affecting more than one of the registered professions, and according to Section 50(4)(i), advise the Minister on the development of coherent policies relating to the education and training and optimal utilisation and distribution of healthcare providers. Section 50(4)(n)(ii) also prescribes that the forum must advise the Minister and the individual statutory health professional councils concerning common educational and training requirements of health care providers.

To be considered a recognised forensic expert, the practitioner should have worked in an academic forensic facility for an appreciable period and be convincingly experienced.<sup>327</sup> The mere fact that a person is a mental health practitioner does not mean that they are experts in every area of mental health and thus need to demonstrate to the court that they are in fact specialists in the relevant field of expertise, demonstrating both theoretical and practical knowledge.<sup>328</sup> In *Mohammed v Shaik*<sup>329</sup> it was held that it is the task of the court to determine whether an expert possesses the necessary qualifications and experience that would enable him to deliver reliable opinions.

The minimum degree requirement for registration as a professional psychologist is currently a Masters level degree, but the Professional Board of Psychology has tabled a proposal that will make a professional doctorate a requirement in the near future.<sup>330</sup> The Professional Board also

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<sup>325</sup> <http://www.hpcsa.co.za/about-council-overview.php>. A number of steps may be taken against the medical practitioner by the HPCSA in case of non-compliance with CPD guidelines, as set out in:  
[http://www.hpcsa.co.za/downloads/rules\\_reg\\_constitution/cpd\\_guidelines\\_april\\_2009.pdf](http://www.hpcsa.co.za/downloads/rules_reg_constitution/cpd_guidelines_april_2009.pdf).

<sup>326</sup> Act 61 of 2003. As of 9 September 2008, section 50 had not yet been proclaimed by the President.

<sup>327</sup> Kaliski 3.

<sup>328</sup> Allan and Meintjes-van der Walt 343-344.

<sup>329</sup> 1978 4 SA 523 N.

<sup>330</sup> Tredoux and Foster 12.

does not recognise specialist categories in the sense that the Medical and Dental Professional Board recognises specifically trained medical doctors as paediatricians, for example. Expertise is recognised implicitly in the field, though a psychologist who refers to himself as a child psychologist, does not do so by dint of specialist registration.<sup>331</sup>

### 3. Admissibility of expert evidence

The court also needs to determine whether the evidence given is scientifically trustworthy.<sup>332</sup> This is tested through enquiring whether the evidence has been empirically tested, subjected to peer review and publication, whether it has reliability and validity data and whether it has gained acceptance in the scientific community.<sup>333</sup> This indicates that a diagnosis not contained in either the DSM-IV or ICD-10 will probably not satisfy the criteria of being generally accepted within the scientific community, though it is debatable whether such evidence should be completely disregarded.

Kaliski<sup>334</sup> submits that South African courts should adhere to the parameters of expert testimony, as set out in the USA case of *Daubert v. Merrell Dow Pharmaceuticals Inc*, in which psychiatric opinions offered during expert testimony essentially have to be held with ‘reasonable medical certainty’ as this will force experts to provide the courts with evidence that the opinions which they offer are supported in the scientific literature, and have been obtained using acceptable methodology. This view is supported by Tredoux,<sup>335</sup> even though the Daubert Rule has never been explicitly tested in South African law.

If the Daubert criteria are to be met, psychologists and psychiatrists need to employ scientifically sound and valid methods and theories of high standards and be prepared to defend the credibility of methods used to form their opinion, as well as recognise that it may not be an exact science

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<sup>331</sup> Tredoux and Foster 12.

<sup>332</sup> Allan and Meintjes-van der Walt 344.

<sup>333</sup> Allan and Meintjes-van der Walt 344.

<sup>334</sup> Kaliski 2009 *South African Journal of Psychiatry* 4.

<sup>335</sup> Cohen and Malcolm 67.

and strive for objectivity and acknowledge the limitations of their profession, though it is not value-free.<sup>336</sup>

A phenomenon that must be noted, is that researchers in psychology and psychiatry do not necessarily keep in mind that their research outputs may have any significant medico-legal consequence.<sup>337</sup> The importance of this can be demonstrated through the example of recent developments in neuroscientific research where it can be proven that humans subconsciously make decisions before becoming consciously aware of having made a decision (in effect acting in an automatic state for a few moments).<sup>338</sup>

Kaliski offers that if neuroscience continues to provide objective and observable evidence of this, it may be feasible to determine whether some people have deficits in these mechanisms, which in turn may lead to a situation where it may become easier to excuse defendants who are not mentally ill but have clearly demonstrable problems in their brain circuitry, than those who are obviously insane but whose pathology cannot be confirmed objectively.<sup>339</sup> This could potentially have an enormous impact on the defence of automatism and criminal incapacity and it is foreseeable that the courts will readily accept neuroimaging and neurophysiological evidence (even though the diagnoses of psychiatric disorders do not generally depend on objective findings, such as brain scans, and the courts have to accept the experts' clinical judgement or decide between competing clinical judgements).<sup>340</sup>

The reason this should be noted is to demonstrate how psychology and psychiatry are constantly evolving fields with new developments that could potentially change the face of the defence of criminal incapacity. Therefore the expert witness will always be an indispensable source of information to the court of knowledge and experience the court could not possibly presume to possess, though it will always be the role of the court to determine the value and weight of said evidence. Education of both legal practitioners and mental health care professionals in this interface between law and psychology and psychiatry is thus important and very necessary.

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<sup>336</sup> Cohen and Malcolm 68.

<sup>337</sup> Kaliski 2009 *South African Journal of Psychiatry* 4.

<sup>338</sup> *Ibid.*

<sup>339</sup> Kaliski 2009 *South African Journal of Psychiatry* 5.

<sup>340</sup> *Ibid.*

#### 4. Reasons for referral for observation by the courts

In an article entitled ‘Psychiatric evaluation of offenders referred to the Free State Psychiatric Complex according to Sections 77 and/or 78 of the Criminal Procedures Act’ by Calitz *et al*<sup>341</sup>, data was analysed from 514 awaiting-trial offenders from the Free State referred to the Psychiatric Complex for 30 days of psychiatric observation, according to Sections 77 and/or 78 of the Criminal Procedures Act, from 1995 to 2001. The reason for their referral was the possibility that they were not triable or accountable.

The majority of the offenders (54,3%) were found to be mentally sound, triable and accountable, and were referred back to the courts. This results in high costs for the Department of Health. To reduce the high rate of unnecessary referrals it is recommended that the courts give clear reasons for the referrals according to each Section.<sup>342</sup>

A significant number of the referred offenders were also first diagnosed as being mentally ill only after the crime was committed. One of the reasons might be the fact that some people with psychiatric disorders are not known to and have not been identified by the mental health system. It is therefore of the utmost importance to implement a comprehensive psychiatric community service.<sup>343</sup>

#### 5. Alternate method of referral<sup>344</sup>

In the 2004 article ‘Use of the Judicial Section 9 Certification in the Free State’ Meyer *et al* enquired into the effectiveness of a direct referral system for persons who perpetrate a crime while suffering from a mental illness that had evolved between the office of the Director of Public Prosecution (DPP) in the Free State, and the Free State Psychiatric Complex (FSPC) during the early 1980s to try to lessen the number of persons admitted for observation.<sup>345</sup>

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<sup>341</sup> Calitz 2006 *South African Journal of Psychiatry* 47-50.

<sup>342</sup> Calitz 2006 *South African Journal of Psychiatry* 48.

<sup>343</sup> Calitz 2006 *South African Journal of Psychiatry* 50.

<sup>344</sup> Meyer 2004 *South African Journal of Psychiatry* 104-108.

<sup>345</sup> *Ibid.*

In terms of this system, a psychiatrist could recommend that a patient (who was charged with a lesser crime and referred for a 30-day observation period) be referred as a state patient and that the charge be withdrawn by the DPP&s office on condition that the accused be admitted for treatment in terms of Section 9 of the Mental Health Act<sup>346</sup> without first being sent for an observation period.

This system is only used in cases of minor crimes and where there is no doubt that the accused is suffering from a mental illness. If there is any doubt, the accused will be referred for the 30-day observation period, or will be evaluated by a psychiatrist during a short court evaluation after which a decision is taken as to which route to follow. In the event of a patient admitted in terms of Section 9, but found not to be suffering from a mental illness the public prosecutor&s office is notified, a report is prepared by the psychiatrist, the charge reinstated and prosecution continued. If a patient was admitted in terms of Section 9 of the Mental Health Act he can be discharged once the multi professional team is convinced that he has been sufficiently treated and rehabilitated.

Regular quality contact between the DPP&s office and the multi-professional forensic psychiatry team is the key to the success of this system that could also benefit other areas of the country that suffer from a shortage of manpower and insufficient funds. If the reduction of time in court, reduced administrative costs, and time spent in custody between observation and court appearances is taken into account, along with the direct savings made in excess of R2 million per year, the total financial impact of this system is truly impressive, not mentioning the time and other resources saved.

The DPP&s office often fulfils the role of mediator between the forensic unit and the court as the DDP has insight into the difficulties and specific needs of both parties. The DDP spends a few hours weekly at the ward round with the multi disciplinary team to ensure that legal processes run smoothly, which in turn means that no patients are discharged too early or kept too long. The DDP is also a valuable source of advice to the doctors concerning liability, rights of patients and

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<sup>346</sup> Act 18 of 1973 that had been repealed in its entirety, except for Chapter 8, by the Mental Health Care Act 17 of 2002.

staff, court decisions, and procedure. The authors of the article submit that the time spent by the DDP at these team rounds make it possible for a parallel system to exist without the danger of ignorance leading to infringement of patient rights. At the same time this system expedites admission of patients who are clearly in need of treatment and prompt treatment normally means earlier remission and reintegration into the community.

The study found that this alternative system is uncomplicated, functions quite effectively with a minimum of inappropriate referrals, and contributes greatly towards decreasing the workload of the judicial as well as the psychiatric system, as well as leading to decreased waiting time for court appearances.

## 6. Conclusion

It is submitted that the HPCSA is in the perfect position to mandate and regulate the training of psychologists and psychiatrists in forensic mental health assessment. Without strict regulation of this area and specific definition of who a forensic health expert is, education and information is the only way to ensure that the gap in understanding between legal and mental health professionals is bridged and to ensure that the interests of justice and the community is best served.

Expert evidence by mental health professionals should be subjected to careful evaluation of its probative value, especially as it is not strictly regulated which persons are qualified to conduct psycholegal observations. The value of such evidence should not be overlooked, the court must just be sure of the credibility of the witness itself and may make use of criteria such as the Daubert Rule to assist in the determination thereof.

It is submitted that the alternate method of referral is closely related to the English system where an arrested person is observed before the Crown Prosecution Service decides to prosecute. This system was shown in the study to be effective and economical, while saving time and resources. It is worthy of further investigation and may offer a solution and even a viable parallel system to the current one in operation.

## CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

The chapters of this dissertation are briefly summarised here, followed by recommendations made and concluding remarks.

### 1.1. Chapter 1

In Chapter 1 the concept of psycholegal assessment was contextualised with regard to criminal capacity as threshold requirement for criminal liability as well as with regard to its place in the criminal justice system. The current framework in terms of the Criminal Procedure Act 51 of 1977, that determines in what instances and how the observation of a suspected criminally incapacitated accused person takes place, was explained. Problems faced in the interactive relationship between the legal profession and mental health care professions were pointed out and it was established that despite the strain caused by this, the interaction is necessary for the effective administration of justice.

The methodology; the significance and limitations of study; and the structure were also set out in this chapter and legal questions to be answered were raised. These legal questions are discussed with regard to the recommendations made below.

### 1.2. Chapter 2

Chapter 2 discussed the concept of criminal capacity and related terminology as the source of many a debate and much confusion between the legal and mental health care professions.

The terminology and theory behind the concept of criminal capacity according to legal principle differs rather dramatically from the concept of capacity in terms of the mental health care professions of psychology and psychiatry. In this chapter it was attempted to find a definition of criminal capacity that was suitable to use in the context of psycholegal assessments. The difference between pathological criminal incapacity and non-pathological criminal incapacity in legal terms was explained and these concepts were juxtaposed with the concept of automatism,

mental illness and mental defect and with the theory base of the mental health profession. The difference between psychology and psychiatry was also explored as it relates to psycholegal assessment.

### **1.3. Chapter 3**

In Chapter 3 the report required of psycholegal assessors in terms of Section 79 of the Criminal Procedure Act was discussed. As this report forms the basis of an expert witness<sup>ø</sup> testimony in court, it is imperative that it be as accurate and complete as possible and that it contains what the court needs in its decision-making.

The Constitutional rights of the involuntarily committed accused person were discussed with regard to the limitation clause and the Mental Health Care Act 61 of 2003. The accuracy and reliability of a diagnosis by a forensic mental health assessor was also examined and the question was investigated whether courts place much weight on the testimony given by the expert witness and problems encountered in this process.

### **1.4. Chapter 4**

Chapter 4 provided an overview of comparable English law and the reasons for its use as a tool for comparative analysis. The historical development and relationship to South African law regarding criminal responsibility and mental illness was discussed. The current legal and legislative position regarding possible defences based on *insanity*<sup>ø</sup> or criminal responsibility, and the procedure relating to assessment of offenders by a forensic mental health expert was compared to the situation in South African law.

### **1.5. Chapter 5**

In this chapter the regulatory framework for psycholegal assessments with regard to the persons that qualify as forensic mental health assessors for purposes of the Criminal Procedure Act and the HPCSA and its Boards is discussed. How admissibility of expert evidence should be

determined is investigated and the possibility of an alternate system of referral is explored, compared to English Law.

## 2. Recommendations

It is submitted that the question as to whether there can be a workable definition of criminal capacity in terms of the law and the mental health care profession, can be answered mostly in the affirmative, with a few provisions. It must be understood that criminal capacity is a legal construct that is given meaning by the expert evidence from forensic psycholegal assessors. Also, although neither the law of mental health professions are exact sciences in the sense that an empirically proven answer is always possible, it is in the interest of justice that whatever can be concrete and sure about the process of determining blameworthiness should be thus. If this is not achieved the possibility of rights violations and a miscarriage of justice exists. For authorities in the legal system, forensic assessors of criminal capacity and accused persons suspected of lacking criminal capacity to lack clarity on what exactly the defence of criminal capacity entails, threatens the accused's right to a fair trial.

It is submitted that the current definition of criminal capacity, as set out in Section 78(1)(a) and (b) of the Criminal Procedure Act, is satisfactory for the effective functioning of the criminal justice system. It is, however, imperative that psycholegal assessors are educated as to what this definition entails and what is required of them when giving evidence, namely only to testify whether there was a pathological or non-pathological disturbance of the mind and to what extent this affected the offenders ability to appreciate the wrongfulness of the act they are committing and their ability to act in accordance with this appreciation. It is submitted that education of both legal and mental health professionals regarding what mental illnesses and defects may affect criminal capacity is needed, to ensure clarity reigns supreme.

Education regarding the difference between automatism and criminal capacity in the legal context and the fact that mental disturbances that are either pathological or non-pathological can affect criminal liability as multiple defences, is also necessary.

This education must be implemented in the form of requisite Continued Education on the matter by the HPCSA and its relevant Boards, as well as in the determination of a formal post-graduate training course on the matter for those psychologists and psychiatrists wishing to act as forensic mental health assessors.

It is submitted that the lack of definition, lack of required qualifications and lack of registration process for forensic mental health assessors is an unacceptable circumstance in the legal system of South Africa and this should be remedied. It is submitted that if a system of registration and training existed, with required qualifications and approved course content, many, if not most of the problems experienced in the relationship between law and mental health practitioners would be addressed and all parties concerned would benefit as a result thereof.

It is submitted that the psycholegal observation of an accused person and the report and expert evidence that is procured as a result of that assessment is of great value in assisting the court in reaching a conclusion where a lack of criminal capacity on the part of the accused is in question. The reliability and accuracy of the report can reasonably be accepted by a court in its discretion, if all factors are taken into account, namely that there are tests to ensure malingering is detected and mechanisms to ensure that an incorrect diagnosis is an anomaly that seldom happens. It is also submitted that a court will more readily let itself be guided by expert evidence in the matter if there were a system of training and registration for forensic assessors and more concrete and strict rules of admissibility of such evidence.

It is submitted that any adverse effects of involuntary commitment for observation on the accused and a diagnosis may be circumvented and prevented if the necessary tests are administered and the assessor is sufficiently trained in sensitivity and other matters. Any possible human rights violations resulting from court mandated observation may also either be minimised or prevented through proper training and implementation of the current system, or if unavoidable and necessary after that, be justified in terms of the limitations clause contained in the Bill of Rights.

It is submitted that the current framework for psycholegal assessment in its current form is in need of refinement to ensure the criminal justice system functions as fairly and effectively as possible, while utilising all the resources available to it in achieving this goal.

An alternate and concurrent system of direct referral is worth further investigation if it will lighten the strain on the current system and benefit all parties concerned.

### **3. Concluding remarks**

It is submitted that further study is justified in the exploration and proposal of a system of registration for forensic psycholegal assessors, a system of training and education for psychologists and psychiatrists wishing to act as such and, following that, continuing education mandated by the HPCSA. The theory and terminology contained in such proposed courses need to be established to ensure certainty on the matters addressed and post-graduate research on these issues must be encouraged in students of law, psychology and psychiatry to assist in furthering the interests of all concerned parties.

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