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Managing dangerous people with severe personality disorder: a survey of forensic psychiatrists' opinions†

AIMS AND METHOD

To canvass the opinions of psychiatrists working in forensic settings on the recent proposals relating to dangerous people with severe personality disorder (DSPD). Psychiatrists from secure settings were invited to a series of meetings. A questionnaire was circulated and the discussions recorded.

RESULTS

Opinion remains divided over diagnosis, treatability and assessment of risk in personality disorders. The medicalisation of DSPD to allow indeterminate detention in unconvicted cases is unacceptable to the majority (75%). There is no consensus on the Government proposals relating to DSPD. Only a minority (20%) of psychiatrists would work in a new specialist service, which has significant implications for service development.

CLINICAL IMPLICATIONS

The involvement of psychiatrists in preventative detention solely for public protection requires greater discussion.

Personality disorder has long been a source of debate, with diagnosis and treatability being particularly controversial (Cope, 1993). The Home Secretary has criticised psychiatrists for not detaining untreatable individuals. The Fallon Inquiry into Ashworth Hospital's personality disorder unit (1999) recommended the creation of reviewable sentences for high-risk individuals. It did not consider unconvicted but dangerous individuals.

In July 1999 a Government consultation paper (Home Office & Department of Health, 1999) introduced proposals for the minority of people with severe personality disorder who, because of their disorder, pose a risk of serious offending. Dangerous severe personality disorder (DSPD) was not defined in the document, but two options were proposed (see Box 1).

Box 1 The recent proposals relating to dangerous people with severe personality disorder (DSPD)

Option A maintains current statutory framework and services, with the following changes:

- greater use of the discretionary life sentence
- powers for remand for specialist assessment of DSPD
- removing treatability requirement from existing civil powers
- establishing specialist services in prisons and hospitals.

Option B proposes new powers and new services, with the following:

- creation of a DSPD disposal available to the courts
- referral of sentenced (including life sentenced) prisoners, through civil proceedings
- DSPD order available from civil proceedings, without a crime
- creation of a new specialist service, separate from prisons and hospitals.

Fallon recommendations:

- creation of reviewable sentences
- creation of a 'Reviewable Sentences Board'
- remove Sections 3, 37, 38 (MHA 1983) for psychopathic disorder
- maintain Section 47 (MHA 1983) for specific hospital treatments
- replace psychopathic disorder with personality disorder, personality disorder will be undefined
- creation of small, specialised units in prisons and hospitals.

Both the options A and B include removing the Court's power to impose a hospital order in cases of psychopathic disorder. Both would enforce supervision and recall following discharge. Continued detention would be based on risk.
MHA, Mental Health Act.

Method

Meetings were held in four centres (Ashworth, Broadmoor and Rampton Hospitals and The Bracton Clinic Medium Secure Unit). Consultants and senior trainees working in forensic settings were invited to attend. Following a presentation of the Government proposals, psychiatrists discussed key issues and completed a questionnaire. The content of discussions was recorded and key themes extracted. Data were analysed using SPSS for Windows (Norussis/SPSS Inc.).

†See editorial, pp. 282–283, this issue.

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Results

Respondents

A total of 153 questionnaires were completed, 60% (*n*=91) from consultants (67.9% of the consultant membership of the Forensic Faculty of the College) and 26.8% (*n*=41) from senior trainees (45.5% of the senior trainee membership). The responses were split between those working in maximum (special hospitals) and medium security, 40.5% (*n*=62) and 51.6% (*n*=79), respectively, and 7.9% (*n*=5) worked in other services.

Definition/assessment issues

Sixty-eight per cent (*n*=104) of psychiatrists felt confident in their ability to diagnose personality disorder, but only 34.6% (*n*=53) felt severe personality disorder was identifiably different. Seventy-one per cent (*n*=109) were not confident in the interrater reliability of personality disorder diagnosis. Of the 109 respondents who attempted to define DSPD, 48 (44%) included ICD–10 (World Health Organization, 1992) or DSM–IV (American Psychiatric Association, 1994) definitions of personality disorder, 21 (19%) felt it was not systematically definable. Severity was defined in a variety of ways, including: risk of offending (*n*=28; 26%); effect on functioning (*n*=23; 21%); number of traits of specific personality disorder diagnoses (*n*=13; 12%); the number of personality disorder diagnoses (*n*=12; 11%); lack of response to treatment (*n*=10; 9%); and level of emotional instability (*n*=6; 6.5%).

The majority (125, 82%) reported that available risk assessment procedures are inadequate to reliably identify potentially dangerous individuals, and 70% (*n*=107) admitted that the Government proposals would make them more cautious about making a diagnosis of personality disorder. Many psychiatrists questioned the validity of the Government's estimate of the numbers involved, given the lack of clarity.

A total of 22.2% (*n*=34) felt that doctors should be involved in the assessment of personality disorder and 93% (*n*=142) saw a medical role in assessing for intercurrent mental illness. One-hundred (65.4%) reported that psychiatrists should be involved in risk assessments on DSPDs, but five respondents (3.3%) felt psychiatry has no role. Overall, 18.3% (*n*=28) believed psychiatrists should take a lead role in these services, 31% (*n*=47) thought that psychologists should be the team leaders.

Treatability

Eighty-three (54%) considered personality disorder in general as being a treatable condition. Psychiatrists working in the South of England and in Wales were significantly more likely than those in the North to hold this view (66% *v.* 47%, χ^2=4.975, d.f.=1, *P*=0.026). Special hospital psychiatrists were also significantly more likely to consider personality disorder treatable (66% *v.* 46%, χ^2=5.928, d.f.=1, *P*=0.015). Considering those with severe personality disorder, only 28% (*n*=43) reported that this group are treatable. Special hospital psychiatrists were again significantly more likely to view severe personality disorder as treatable (37% *v.* 22%, χ^2=4.172, d.f.=1, *P*=0.041). Many commented on the lack of evidence that there are effective treatments for those at the extreme end of the spectrum.

Nearly two-thirds (62.7%, *n*=96) objected to the removal of the 'treatability criteria' from civil powers to detain DSPDs. Those viewing personality disorder as treatable were significantly more likely to accept this (37% *v.* 13%, χ^2=11.797, d.f.=1, *P*=0.001).

Services for those with DSPD

Most respondents (45.1%, *n*=69) believed that services for those with DSPD should be the joint responsibility of the Home Office and the Department of Health. Half (50.3%, *n*=77) of the sample believed the key emphasis of services should be treatment, but 27.5% (*n*=42) felt public protection should be the main focus. The majority (78.4%, *n*=120) believed that DSPDs should be managed in units that are separate from the units for those with mental illness. Fifty per cent (*n*=77) felt that current facilities are satisfactory if given sufficient resources.

The vast majority (88%, *n*=134) did not concur with the Government's suggestion that the new units could be staffed by the current workforce and only 21% (*n*=32) reported a willingness to work in DSPD units. However, 58.2% (*n*=89) stated that they would undertake assessments of diagnosis and risk in DSPDs. Those who believed personality disorders were treatable were significantly more likely to show a willingness to work in the new services for DSPDs (34% *v.* 6%, χ^2=18.026, d.f.=1, *P*=0.000).

The proposals

Overall, there was no consistent view as to which option is preferable. Eighteen per cent (*n*=28) supported Option A, 21% (*n*=32) Option B and 28% the Fallon recommendations (see Box 1 and Table 1), but 13% expressed a preference for 'no change' in the current position.

There was greatest disagreement over the proposed changes in civil legislation (Table 1). The notion that unconvicted DSPDs could be detained solely on the basis of public protection, rather than individual mental health, caused particular disquiet with some drawing parallels with the role of psychiatrists as agents of social control in the former USSR. Several commentators also suggested that the Government was 'medicalising' DSPD to achieve this.

For DSPDs involved in criminal proceeding, psychiatrists agree with the suggestion that there should be increased use of discretionary life sentences as suggested in Option A. Many commented that the necessary legislation to detain convicted individuals with DSPD already exists in criminal justice legislation, but that judges have been reluctant to utilise it. Furthermore, many pointed out that indeterminate medical detention without effective treatment might be in direct conflict with the General Medical Council (GMC) guidelines (1998) stated in *Duties of a Doctor*.

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Table 1. Elements of the proposals not covered elsewhere

Options	Agree (%)	Disagree (%)	No view (%)
Option A			
Criminal			
Increased use of discretionary life sentences	83.7	6.5	8.5
Powers for remand for DSPD assessment	73.2	16.3	7.2
Compulsory supervision and recall	78.4	9.2	9.2
Creation of special units in prisons	80.4	8.5	8.5
Civil			
Management of DSPDs in health service facilities	29.4	54.2	9.8
Loss of 'gate-keeping' role for doctors	23.5	60.8	10.5
Compulsory supervision and recall	43.8	35.9	13.7
Creation of special units in hospitals	39.9	43.8	12.4
Continued detention based on risk	58.2	27.5	7.8
Option B			
Criminal			
DSPD disposal for courts	49.0	29.4	15.0
DSPD direction for courts	44.4	32.0	15.7
Referral of sentenced prisoners for DSPD assessment	68.0	15.7	11.8
Civil			
DSPD detention order from civil proceedings	17.0	63.4	11.1
Potential for indeterminate sentence without a conviction	9.2	75.2	9.8
Services			
Separate single service for DSPDs	31.4	50.3	11.8
Fallon recommendations			
Creation of a reviewable sentence	63.4	17.6	9.8
Replacing psychopathic disorder with personality disorder	56.9	21.6	16.3
Development of small, specialised units	65.4	17.6	10.5

DSPD, dangerous people with severe personality disorder.

Discussion

The Government proposals on DSPD, which clearly focus on public protection, address some of the problems and limitations within current legislation, but emphasise the role of psychiatrists rather than other agencies. As yet, there has been little commentary apart from Eastman (1999) and Mullen (1999) highlighting legal and ethical concerns.

This survey illustrates the continuing concern over the lack of clarity in the term DSPD. Most psychiatrists are aware of the low level of agreement over personality disorder diagnoses, even using structured interview schedules. Furthermore, they are uncomfortable with the concepts of severity and dangerousness. While the North American literature on violence risk prediction suggests that instruments such as the Psychopathy Checklist–Revised (PCL–R; Hare, 1991) and Historical, Clinical, Risk Management (HCR–20; Webster *et al*, 1995) are useful, they are not fail safe (Douglas *et al*, 1999). Our study shows that psychiatrists advise caution when diagnosing severe personality disorder.

There is the further issue that DSPD is ill-defined, meaning the figures cited in the Government document may be inaccurate. The numbers detained will undoubtedly grow as admissions outpace discharges given the emphasis on public protection.

Many felt that any doctor involved in the detention of these individuals for public protection alone would potentially breach the GMC's guidelines (1998) that state "make the care of your patient your first concern", and that doctors are abusing their professional position if they "give patients, or recommend to them, an investigation or treatment which you know is not in their best interests". Advice from the GMC may be welcome at this time.

The majority of respondents believed that sentencing and detention should fall within the remit of the courts and that psychiatrists should restrict themselves to assessments of suitability for specific interventions. There is clearly and rightly more reservation over the contribution of psychiatry in those with a primary diagnosis of antisocial personality disorder. This is based on extensive literature that suggests that antisocial personality disorder with high PCL–R scores (Hare, 1991) does appear to benefit from current therapeutic strategies (Losel, 1998). Although there is evidence that some individuals with personality disorder can benefit from treatment in therapeutic communities it must be recognised that these programmes generally only take on those who are willing and likely to benefit from the treatments available.

The low numbers of psychiatrists willing to work in DSPD services seems likely to create significant recruitment problems. Furthermore, these units may become isolated and standards could be hard to maintain. The survey findings, however, do suggest that a substantial number are willing to assess individuals for these units. A split between those assessing and those treating personality disorder may cause problems. The concept of

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preventative detention in health care settings of those who had not been convicted and are untreatable is considered unethical practice (Mullen, 1999).

The role of psychiatry in the assessment and treatment of personality disorders has always been controversial (Collins, 1991; Cope, 1993; Moran, 1999) and this is likely to continue in the absence of a sound research base.

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Characteristics and outcomes of patients admitted to a psychiatric intensive care unit in a medium secure unit

AIMS AND METHOD

There have been no reports on psychiatric intensive care units (PICUs) in medium secure psychiatric facilities. Using case files, we retrospectively examined the characteristics and outcomes of 73 patients who were admitted to a PICU in a medium secure unit between 1 July 1994 and 30 April 1998.

RESULTS

The PICU population was predominantly male, suffering from illness and detained under Part III of the Mental Health Act, 1983. Although the mean length of stay was 75 days, the majority were ultimately transferred to less intensive nursing environments and only nine required transfer to maximum security. In 10% of cases PICU admission was owing to lack of appropriate facilities elsewhere.

CLINICAL IMPLICATIONS

Although the PICU was intended as a crisis facility for the management of challenging behaviours, its function was affected by the lack of clear admission and discharge criteria and appropriate facilities for patients with diverse mental, physical and security needs.

Psychiatric intensive care units (PICUs) were designed to create a safe and controlled environment for the management of acutely disturbed psychiatric patients on a short-term basis, with high staffing levels and a limited number of beds. Admission and discharge criteria are usually clearly defined and the majority have locked doors (Michalon & Richman, 1990; Hyde & Harrower-Wilson, 1996). The average length of stay ranges from 2.6 days (Hafner *et al*, 1989) to 30 days (Citrome *et al*, 1994), although Rachlin (1973) reported that 20% of his patients stayed over 2 months.

The majority of PICUs reported in the literature provide care and treatment for non-offender patients with mental illness who cannot be managed in open wards. In the UK, intensive care for mentally disordered offenders is provided by the secure psychiatric services. Problems in the movement of patients through different levels of security, however, has led to the development of PICUs in some medium secure facilities. As far as we are aware this is the first report on the characteristics and outcomes of a cohort admitted to a PICU in a medium secure unit (MSU) in Britain.

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