Dangerous Severe Personality Disorder: Extension of the Use of Civil Commitment in the United Kingdom

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People who are violent and character disordered pose serious problems for society. Historically, the social response to such people has varied between two extremes. Psychiatry describes these people as mentally disordered individuals who could be committed for psychiatric treatment. The criminal justice system sees these people as criminals for whom incarceration to serve the goals of incapacitation, deterrence, and retribution is the appropriate response. The current Labor Government of the United Kingdom (UK) has mounted a proposal that purports to combine these two approaches for the benefit of the individual and society. Although widely condemned in the UK by many organizations, including the Forensic Faculty of the Royal College of Psychiatrists (a near counterpart to the American Academy of Psychiatry and the Law (AAPL)), the proposal is likely to be implemented in some form in the near future. In this article, we present the proposal itself as well as some analysis and criticism that has occurred since the Government publicly introduced the proposal in July 1999.

Historical Background

In the United Kingdom, governmental response to people with anti-social behavior has been the subject of legislative and parliamentary deliberations since the Royal Commission on the Care and Control of the Feebleminded in 1904.[1] A new category of "moral imbecile" was added to the Mental Deficiency Act 1913 that allowed people, some of whom would today be diagnosed as having anti-social personality disorder, to receive "care, supervision and control for the protection of others" in mental health facilities.[2] Recognizing that "mental defectives" included anti-social individuals of "higher intelligence" as well as persons of "low intelligence," the Percy Commission relating to Mental Illness and Mental Deficiency of 1957 proposed a new classification of mental abnormality.[3] The new classification, "psychopathic patients," included individuals described in behavioral and emotional terms as "aggressive or inadequate personality." The concept of the psychopathic patient was later incorporated into the Mental Health Act of 1959.[4] Also in 1959, the Working Group on Special Hospitals offered recommendations that psychopathic patients should be housed in separate, therapeutic environments where these patients could be studied.[5]

In 1975, the Butler Commission on Mentally Abnormal Offenders suggested that the term "psychopathic disorder" should be replaced for legislative purposes with the phrase "personality disorder" to describe anti-social individuals.[6] Although not implemented until much later, the Butler committee also recommended the use of discretionary life sentences for people convicted of certain serious violent offenses.

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Current Civil and Criminal Commitment Law

A discretionary life sentence is a criminal adjudication that entails a commitment of indeterminate length to a prison. The discretionary sentence can be revoked at any time by a supervisory authority, the Home Office Secretary. In 1991, a new Criminal Justice Act provided for criminal courts to give discretionary life sentences of indeterminate length to offenders who were convicted of statutorily defined violent or sexual offenses[7] and for whom incapacitation was deemed necessary to protect the public. The use of discretionary life sentences was recently upheld upon judicial review.[8]

UK common law requires that three criteria be met before a court may impose a discretionary life sentence. The conviction must be of a serious nature such that the ordinary sentence would be very long. The convicted person must have a "mental instability" that barring confinement would result in reoffense and further danger toward the public. Finally, the period of time for which the person is a potential danger is either a long time or uncertain. Persons convicted of certain violent and sexual offenses can also be placed on extended periods of parole (for up to 10 years) after serving a custodial sentence.

Current civil commitment in the UK is governed by the Mental Health Act 1983. Initial involuntary civil commitment to general psychiatric facilities for evaluation is for a period up to 28 days. Persons may be committed when they are "suffering from a mental disorder of a nature or degree which warrants his detention in hospital for assessment. . . " and when the patient "ought to be so detained in the interests of his health or safety, or with a view to the protection of others."[9] Continued civil commitment for the purpose of treatment must satisfy three conditions. First, the patient must have one or more of the four forms of statutorily defined mental disorder: mental illness, mental impairment, severe mental impairment, or psychopathic disorder. Psychopathic disorder is defined in the statute to constitute "[a] persistent disorder or disability of mind which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned."[10] Second, the patient's mental disorder must be so severe as to require medical treatment in a hospital. In the case of psychopathic or mentally impaired patients, the physician must show that medical treatment is "likely to alleviate or prevent a deterioration in his condition." Finally, the commitment must be necessary to protect the health or safety of the person or to protect others from harm. Initial commitments under this law last six months and can be renewed for additional one-year terms. The law also provides for periodic judicial review by a Mental Health Review Tribunal. For patients referred in relation to active criminal charges, the law provides for a variety of forensic commitments that address both forensic evaluation and treatment. Other sections of the Mental Health Act restrict the discharge of certain forensic patients when the sentencing court finds that commitment of the patient "is necessary for protection of the public from serious harm."[11]

The Government's Proposal

Starting shortly after the current UK Labor Government took office in 1997, the Home Office and Health Ministers began to investigate through working groups the current state of treatment for psychopathic people, with a view toward changing the current system. Investigators surveyed treatment and custodial facilities in the UK, visited the Netherlands, Germany, and Minnesota and Wisconsin in the United States. The group was particularly impressed with the Dutch *Terbeschikkingstelling* (TBS) system,[12] a program for the systematic evaluation and treatment of dangerous, personality-disordered people. The program provides residential therapeutic communities and closely supervised transitions to the community in a highly structured fashion.[13] The Dutch system has been in use for approximately 70 years.

Dangerous severe personality disorder (DSPD) is defined in the government's proposal as "people who have an identifiable personality disorder to a severe degree, who pose a high risk to other people because of serious anti-social behavior resulting from their disorder."[14] Through a national survey,[15] the working groups identified about 1,400 incarcerated men and 400 hospitalized men who met the DSPD criteria. They estimated that an additional 300 to 600 DSPD persons were living in the community. The group estimated that among persons with DSPD, women constituted a very small minority, roughly two percent of all people with DSPD in the UK.

The Home Office proposal provides for powers of detention for DSPD persons, assessment and treatment programs, training and research programs, and social programs aimed at primary and secondary pre-

vention of DSPD.[16] The proposal articulates two options for action. Option A, the more conservative, generally works within the existing legal and institutional framework for addressing the problems posed by DSPD individuals. Option B directs substantial changes in governmental powers to detain individuals with DSPD for evaluation and treatment and provides for a wholly new system of care separate from current prison and National Health Service (NHS) programs.

Option A

Option A would revise criminal justice legislation to increase the use of discretionary life sentences by extending the range of offenses to which it could attach. This option also gives courts new powers to order special forensic assessments to investigate whether defendants meet DSPD criteria. The proposal argues that through this change, courts would be better informed of defendants' potential for future violence. The intended result would be an increased use of discretionary life sentences. After initial conviction, courts would also be barred from sending DSPD persons to forensic hospitals rather than to prison under both options A and B.

Option A also drops the requirement that DSPD persons must be "likely to benefit from hospital treatment" as a criterion for civil commitment. After release from civil commitment, DSPD persons would be subject to mandatory supervision and recall to the hospital or prison if there were changes in their mental condition. Other changes would include improvement in forensic assessment facilities in both prisons and hospitals and improved collaboration between prison and hospital institutions, perhaps with the establishment of a new bureau to oversee DSPD services.

Option B

This option provides a new legal construct, establishing a DSPD order by a Crown Court (akin to superior courts in the United States). A DSPD order can be attached to any criminal sentence after a forensic assessment provides evidence to a Crown Court that the person has "a severe personality disorder and as a consequence of the disorder presented a serious risk to the public." A DSPD order is subject to appeal and periodic review. A DSPD order could also be attached to any already adjudicated prisoners at any time.

The result of a DSPD order is that the person is detained, on an indeterminate basis, in a facility (hospital, prison, or yet to be created new type of residential facility) until they are thought by their mental health professionals to no longer pose a danger to the public. After release from a facility, the DSPD order continues in force in the community; release into the community is conditioned on mandatory supervision by both parole and mental health providers and subject to recall back to the facility for reassessment at any time.

DSPD orders also could be made against civilly committed persons without current or even previous criminal commitment. DSPD orders made in civil proceedings would occur after mandatory forensic assessment and subject to the legal protections of appeal and periodic review. The result of a civil DSPD order is identical to that of a criminal DSPD order—indeterminate detention and mandatory community supervision with the threat of recall. Option B also creates a new special forensic type of service bureau to provide services to DSPD people, separate from existing prison and National Health Services.

Research and Prevention Measures

Acknowledging that there is a substantial gap between the state of current psychiatric knowledge concerning personality disorders, their diagnosis, etiology, and treatment and the information required to plan and implement DSPD programs, the proposal contains support for research on these topics. The proposal outlines work that the government has done in collaboration with Dutch researchers as well as projects within the United Kingdom.

In 1998, the government sponsored the establishment of a World Wide Web-based research and collaboration project, the Virtual Institute for Severe Personality Disorder (VISPED).[17] VISPED is an international, multidisciplinary project designed to study personality disorders. VISPED provides grant support to train forensic researchers. The principal products of VISPED to date are literature reviews on topics in forensic psychiatry.

The proposal includes a review of primary and secondary prevention programs to reduce the frequency and severity of violence from DSPD individuals. Initiatives directed at primary prevention include programs designed to improve parenting, expand social services for disadvantaged persons, and improve school health and discipline initiatives. Other collateral efforts include juvenile judicial reforms and tailored juvenile drug and mental health

treatment programs to children and adolescents at risk for developing personality psychopathology. Secondary prevention of personality disorders includes plans to expand and tailor adult mental health services to mentally disordered offenders.

Proposed Research for Implementation of DSPD Initiatives

One potential model for the implementation of screening and intensive assessment of persons though to be at high likelihood for a DSPD diagnosis was presented by Dr. David Thornton of Her Majesty's Prison Service at the February 2000 meeting of the Forensic Faculty of the Royal College of Psychiatrists meeting.[18] This research proposal described a scheme of "siftings" to more accurately identify persons thought to be at highest risk for recidivistic violent or sexual offenses. Starting with initial screening by means of the Violence Risk Appraisal Guide (VRAG), an assessment instrument used in research to study risk of violent behavior, a high score on the VRAG would initiate a further inquiry by means of tabulating both Static-99 and VRAG scores. If the combination of these scores was high, then the person would be referred for further assessment using Historical Clinical Risk Management (HCL 20), a clinical assessment tool used to study determinants of violent behavior, and the Violence Rating Scale, (VRS) a newly developed violence assessment tool. If the results indicate a high score, a special assessor (consultant) then conducts a case review, gathering input from members of the person's treatment team. If the person's risk of recidivistic violent or sexual offense potential was believed to be high, then the person would be transferred to a residential facility for further, intensive multidisciplinary assessment including neuropsychological testing.

Analysis and Criticism of Issues Relating to Forensic Psychiatry

Problems with Assessment

The government's proposal for the implementation of screening procedures and formal, residential assessment have not been finalized. There are multiple impediments to the implementation of this or other screening schemes given the nature of the assessment process and the limitations of the currently available assessment tools.

Critics of the government's proposal note that while the research initiatives articulated in the proposal are welcome, the scientific uncertainty of currently available assessment tools prevents rigorously accurate risk prediction.[19] The proposal mentions the potential use of the Hare PCL, the VRAG, the HCL-20, the Static-99, and VRS assessment tools. While these tools are frequently used in research, they have not been demonstrated as accurately identifying persons who meet the commitment standard for dangerousness under the DSPD proposal.

The inherent limitations of the current assessment tools would introduce significant inaccuracies in identifying the DSPD target population. Reservations concerning the current limits of diagnostic and predictive sensitivity and specificity were presented during the drafting of the government's proposal. A parliamentary committee received testimony estimating that there were 2,000 DSPD people in the UK. A hypothetical assessment scheme that accurately identifies people with DSPD 90 percent of the time and misdiagnoses DSPD 5 percent of the time will have the effect of producing a significant number of false positives and false negatives. Among 2,000 DSPD assessments (of actual DSPD people), there will be 200 false positively identified DSPD people, 40 false negatively identified DSPD people, and 1,760 correctly identified DSPD people.[20]

An effect on the assessment process of the ensuing negative (and often sensational) publicity due to the false negatively identified people may be the introduction of defensive practice. Psychiatrists engaged in the assessment of DSPD people may choose to avoid embarrassing crimes by people with criminal records by greatly expanding the numbers of people identified as DSPD. One estimate of the total number of people who could be committed in this fashion was up to 10 times the government's estimate.[21]

One potential consequence of indeterminate DSPD commitment could include active resistance from patients evaluated for DSPD. Given the potential consequences of a lifetime of confinement, it is reasonable to assume that some people will refuse to participate in these assessments, thus presumably reducing the accuracy of these instruments to predict recidivism.

Problems with Proposed Treatment or Ashworth Revisited?

In the United Kingdom, therapeutic communities for personality disordered patients within special fo-

rensic hospitals have not been unequivocally successful. In the 1980s and 1990s there were three forensic hospitals in the UK with specialized treatment units for personality disorder patients. Among these hospitals, recurrent, severe problems characterized the high security psychiatric treatment unit at Ashworth Hospital. After a series of high profile incidents, including one in which a seven-year-old girl had unsupervised visits with convicted pedophiles, the government commissioned a report into the problems at this hospital. The Fallon Commission[22] recommended that patients with a sole or primary diagnosis of personality disorder should be managed in separate high security facilities or dispersed among different facilities. They wrote that "there is no rational justification for keeping this very manipulative and troublesome sub-group in expensive therapeutic unit(s) providing management and treatment techniques from which they gain no benefit."

In an "official response," the Home Office[23] "rejected" the report's recommendations concerning the closure of the treatment units for personality disordered patients as well as the general condemnation of the proposed DSPD therapeutic communities. Professional organizations and the Fallon Report have also questioned the feasibility in relation to patient discipline, milieu safety, and staff recruitment of creating wards of concentrated, violent persons adept at subverting order and safety.[24]

The research base to support the government's proposal is weak at best. We are aware of no randomized trials of community forensic treatment that target the population defined by DSPD.[25] From meta-analytic reviews of the available research on forensic treatment communities, overall recidivism is thought to vary with multiple conditions; many of these conditions concern substance use and situational variables outside of the control of the therapeutic community.[25]

Furthermore, staff to implement a potentially large, new residential treatment system are unavailable. The number of forensically trained psychotherapists in the UK is currently miniscule. An estimated 2,000 people eligible for DSPD commitment suggests the need to staff high security services for at least 1,000 people. If these are to be therapeutic milieus, about 20 patients per unit is a reasonable census. Fifty such new units, or even 20 units if each holds 50 patients, all of whom are committed indefinitely, requires forensic professional mental health staff, who are currently in short supply throughout the existing forensic treatment system in the UK.[26] The magnitude and expense of creating an entirely new system of inpatient mental health treatment for approximately 2,000 people for an indeterminate time period has made some critics question whether the government actually intends to commit to the expenditure of the monetary resources necessary to make the proposal viable.[27]

Ethical Problems

Perhaps the most vexing aspect of the DSPD proposal is the ethical questions it poses for professional participants in the DSPD assessment and treatment initiatives. Although some persons to whom DSPD orders may attach would likely be considered treatable, the significant scientific uncertainty concerning efficacy of treatment for severely personality disordered patients presents an ethical dilemma to psychiatrists. If the government succeeds in removing the ability to be treated criterion from the current civil commitment law, psychiatrists claim that their assessments of and efforts to work with a DSPD population will be subverted to an explicitly social control purpose. Critics argue that in co-opting the civil commitment process to criminal justice ends, psychiatrists would be abrogating their fiduciary duty to their patients.

The critics of the proposed DSPD civil commitment proposal note that evaluation and testimony by a psychiatrist for the purposes of obtaining a DSPD order would not further any legitimate clinical goals. Other critics have noted that participation in DSPD Crown Court proceedings would be professional service without a medical purpose to the giving of information.

An official response of the Royal College of Psychiatrists (RCP) "severely question(s) whether it is the medical profession's job, the use of medical health personnel and mental health facilities to take part in those sort of issues" (i.e., forensic evaluations for DSPD commitments).[28] The RCP also argues that elements of the DSPD proposals "compromise individual rights excessively in favor of public order that they do become little more than a public order act."[29] Removing the ability to benefit from treatment would subvert the therapeutic purpose of civil commitment; according to the Royal College of Nursing, "We do not provide custody for people in the Health Service institutions whether or not they are likely to benefit."[30]

Perhaps the least ethically palatable element of the

government's proposal was the extension of DSPD orders and commitments to people who had not been accused or convicted of criminal violence. In the absence of a past history of violence, predictions of future violence are problematic at best. Psychiatrists have expressed concern that applying DSPD assessments for people who are not criminally adjudicated strikes a lopsided balance between a person's liberty interest and public safety.

In response, the government notes that "the civil liberties of the person must be carefully balanced against the prerogative to protect the public from known dangerous persons."[31] It does not, however, elaborate how this balance is to be achieved. At the February 2000 meeting of the Forensic Faculty of the RCP,[32] the Right Honorable Secretary of State, Mike Boateng, explained in a teleconference that the government's proposal constituted not psychiatric detention but "preventive detention" for the purpose of protecting the public from known dangerous people. When some members of the audience expressed concerns about the proposal placing too much emphasis on the interest of protecting the public, Mr. Boateng stated that denying individual rights in favor of protecting the public was valid and that psychiatrists who don't agree with his position "don't have to get involved."[33]

In support of the proposal, the government also makes international comparisons to other civil commitment schemes. The governmental proposal describes two models of indeterminate detention currently in use. One model is the medical (or clinical) model, based on the diagnosis and treatment of a psychiatric disorder. After diagnosis and civil adjudication, a person can be detained in a treatment facility, typically a hospital, for treatment of mental illness.[34] Currently, this clinical model of indeterminate detention is used in Sweden and the Netherlands. A second model, the community protection model, places a priority on public safety despite "encroachments" on the detainee's civil rights.[35] Under the community protection model, courts use civil commitment to detain people in prisons or hospitals for indeterminate time periods, provided these people demonstrate a risk to the public. This model has been the basis for recent civil commitment initiatives in Canada (Dangerous Offenders Act 1997) and Australia, as well as for sexually violent predator (SVP) commitments in several U.S. states. Both models of indeterminate civil commitment provide for some type of periodic review by a parole board or a court. These proceedings typically employ civil protections used in criminal proceedings. While the application of SVP commitments has varied among different states, these proceedings have detained about 600 individuals as of the end of 1999.[36] In Canada, about 250 people have been classified as dangerous offenders, and each year about 15 people are classified as dangerous offenders.[37] In the current Dutch TBS system, there are 10 clinics with 100 to 150 individuals.[38]

Legal Challenges

Given that the UK is a full member of the European Union (EU), any DSPD proposal must conform to EU law. Articles 5.1(a), 5.1(e), and 5.4 of the European Convention of Human Rights would also govern the DSPD proposal. These articles establish that everyone has the right to liberty; deprivations of this liberty interest are justified only after a criminal conviction or after a determination that a person is of "unsound mind" and subject to judicial review. With respect to the commitment of psychopathic persons, the law does not define the term "unsound mind." There is no implied right to treatment under EU law.[39] EU case law supports the imposition of discretionary life sentences for criminally convicted people.[40]

The government offered its opinion that the proposal had enough procedural safeguards to satisfy the requirements of EU law.[41] Witnesses gave testimony before parliamentary inquiry that an extremely high standard of proof was desirable to better balance the competing interests between the individual's right to liberty and the government's prerogative of public protection.[42] The government argues that "'beyond a reasonable doubt'. . . cannot be meaningfully applied to diagnosis or prognosis in the way it can to fact." Because it is always possible to doubt a prediction, the government argues that this legal standard is not "a useful test." With respect to the current requirement that a person have a mental disorder that would likely benefit from treatment, the government cites a recent case that broadly expands the definition of "able to be treated" to include nursing care.[43]

Despite considerable critical comment by the RCP, the Labor Government continues its plan to implement the proposal. In February 2000, the government announced a pilot project to implement the residential, multidisciplinary assessment program at a British prison.[44]

Commentary

We share the concerns of our colleagues in the RCP. In our opinion, the DSPD initiative is misguided and pernicious—misguided because there is no extant technology that permits either accurate identification or effective treatment of individuals with DSPD. There is no current evidence that psychiatrists or anyone else can reliably agree on whether people have DSPD or not. While research has examined anti-social personality disorder, no one has yet demonstrated that the concept of DSPD, as defined in the proposal, is either reliable or valid.

The pernicious effects of implementing the DSPD program are that many people who pose no threat to society would be deprived of their liberty, in some cases for a very long time. Second, scarce, specialized forensic professional resources would be diverted from already under-resourced forensic psychiatric services of the NHS. Third, professionals and persons under a DSPD order could be required to engage in therapies that have no scientific support. Finally, and most pernicious of all, the DSPD order when imposed on someone who has never been adjudicated to have engaged in violent behavior, but who is mentally ill and with a treatable disorder, violates a long English common law tradition upholding the rights of the individual to be free from the coercive power of the state.

During parliamentary debate on the DSPD proposal, the government conceded: "We are not aware of any country which detains people who have not committed an offense but are regarded as dangerous and are untreatable."[45] It would be a travesty if the UK should become the first country.

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