MANAGING DANGEROUS PEOPLE WITH SEVERE PERSONALITY DISORDER

Introduction

The Government proposes additional measures to detain dangerous people suffering from severe personality disorder, who pose a risk to society if at large. The proposals are aimed at three different categories:

(a) those who have committed serious offences and are regarded as a risk, and for whom the use of discretionary life sentences could be expanded;
(b) those who are considered dangerous on completion of determinate sentences, and for whom continued detention may be recommended;
(c) those who have committed no offence but whose behaviour may be dangerous.

These proposals, and particularly the last category, clearly raise concerns, both in terms of human rights standards and safeguards, and in terms of the accuracy with which risk can be assessed.

Human Rights

Article 5 of the European Convention of Human Rights provides for a right to liberty, which may only be interfered with in specified ways and for specified purposes. Relevant sections are set out below:

5.1. Everybody has the right to liberty and security of person. No-one shall be deprived of his liberty save in the following cases and in accordance with the procedure prescribed by law:
(a) The lawful detention of a person after conviction by a competent court…..
(c) The lawful arrest or detention of a person effected for the purpose of bringing him before a competent legal authority on reasonable suspicion of having committed an offence or when reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
(e) The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants……

5.4 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if detention is not so lawful.

The decision of the European Court of Human Rights in *X v UK* (24 October 1981) was an important milestone in defining the circumstances in which mental patients could be detained, and led to the Mental Health Act 1983. The broad effects of *X* were both to ensure that patients with psychopathic disorder (as opposed to mental disorder) could not be detained in hospital unless they could benefit from treatment; and to institute a system of regular judicial review for mental patients subject to hospital and restriction orders. One of the consequences was an increase in the number of people sent to prison, rather than to hospital: discretionary life and determinate prison sentences were imposed where previously hospital orders would have been made under the 1959 Mental Health Act.

The number of discretionary life sentence prisoners, sentenced to indeterminate periods of detention, therefore swelled. The uncertainty of their position, underlined by parole changes made by Leon Brittan, as Home Secretary, in 1983, gave rise to important domestic litigation. This progressed in tandem with cases before the ECtHR. Cases such as *Weeks* (2 March 1987) and *Thynne Gunnell and Wilson v UK* (25 October 1990) were brought by discretionary life prisoners arguing that their detention, particularly following recall to prison,

should be properly reviewed. These cases established that Article 5(4) of the Convention required there should be a fair, regular, and judicial system for reviewing detention, involving disclosure of all material, and access to legal representation. As a result of these rulings, discretionary lifer panels of the Parole Board were set up to determine whether risk had ceased and if so, to direct release. These panels mirror the mental health review tribunals introduced by the 1983 Mental Health Act.

In terms of mental patients, the key case of *Winterwerp v The Netherlands* (24 October 1979) developed criteria for avoiding arbitrariness and thus ensuring the lawfulness of the detention of persons of unsound mind. Lawfulness under Article 5 requires that detention must be necessary and proportionate. The *Winterwerp* ruling declared that for detention to be justified under Article 5.1(e), the mental disorder must be established by objective medical opinion; it must be of the kind or degree that requires compulsory confinement; and continued detention will only be valid if the mental disorder persists. However, the judgment falls short of suggesting that treatment is a necessary feature of the detention of these kind of mental patients.

The question of necessity and proportionality was also raised In the case of *Johnson v UK* (24 October 1997), where it was successfully argued that the applicant should have been moved out of hospital. The ECtHR insisted: "it is of paramount importance that appropriate safeguards are in place so as to ensure that any referral of discharge is consonant with the purpose of Article 5.1 and with the aim of the restriction in sub-paragraph (e) and, in particular, that discharge is not unreasonably delayed."

The related question of conditions is also of significance in human rights terms. *Ashingdane v UK* (28 May 1985) makes it clear that persons of unsound mind should be in appropriate institutions, and not, like Mr Ashingdane, kept in conditions of inappropriately high security. The very recent case of *Aerts v Belgium* (1998 EHRLR 777) underlines the necessity for a therapeutic, rather than a punitive, regime for those detained under 5.1(e): thus reinforcing the connection between the reasons for detention and its conditions.

The ECtHR has also stressed the need for the state to ensure the protection of others, most recently in *Osman v UK (1999).* This needs to be balanced against the right of the individual to liberty. So far, Article 5.1(e) has not been found to have been breached by detention primarily for social protection, so long as appropriate safeguards are in place.

The fundamental characteristics of Article 5 protection, which apply to those with severe personality disorders as they do to prisoners and mental patients, can be drawn out from these judgments as:

- detention must be shown to be necessary and proportionate; this will require some form of independent, objective assessment of risk
- there must be regular review, by a judicial body, of any period of indeterminate detention, to establish whether it is still necessary and proportionate
- the conditions of detention must be appropriate to its purpose.

It is, however, right to point out that the ECtHR has never considered a reasoned and researched argument on the detention of those with personality disorders where this is not based on proven recidivism. Objective medical opinion will normally require a proven pattern of past conduct; and if this does not exist it will make it much more difficult, if not impossible, to reach the threshold test for justifying deprivation of liberty.

Diagnosis and Treatment

A separate set of concerns arises from the difficulty perceived by experts and psychiatrists both in identifying and treating those with severe personality disorders.

There is a wide range of professional views about the efficacy of treatment. The difficulty of treatment was highlighted in the *Fallon Report* (1999) into the Personality Disorder Unit in Ashworth Hospital. It pointed to the failings of the unit at Ashworth, and the difficulties of treatment; and recommended that there should be no more hospital orders for personality disordered offenders. It suggested that there should instead be specialist services within the penal and hospital systems, with easy access between the two. *Fallon* was in favour of reviewable sentences, as suggested by the Butler Committee in 1975; and of prioritising the education, training, and continuing professional development of professionals in understanding and managing personality disorder.

Fallon also highlighted the difficulties in diagnosis caused by the lack of a generally accepted definition of severe personality disorder. Appropriately, the consultation paper discusses the need for assessment tools and research in this problematic area. Annex C of the paper reflects reality in not being able to make clear what may be included in a personality disorder finding, suggesting that it is close to one of psychopathic disorder.

Dr Adrian Grounds (in *Criminal Justice Matters* Autumn 1999) suggests that those with personality disorders have effectively been disowned by psychiatrists. Other psychiatrists have agreed (eg Dr Jeremy Coid at the launch of the consultation paper on 19 July 1999) that in recent years schizophrenia and other mental illnesses have tended to be prioritised; and that difficulties continue to surround the identification of personality disorders. Personality disorder itself has been referred to by psychiatrists as a 'dustbin diagnosis'. The inadequacy of psychiatry in this respect has led to a failure in mental health provisions which in its turn has helped to create the conditions for the current proposals.

Difficult as it is, Grounds argues that we now know something about the aetiology of severe personality disorders; and that evidence of them can usually be traced from adolescence onwards. They do not develop in mid adult life. Genetics, temperament, childhood antecedents – there is a likely history of deprivation, cruelty and rejection in severe cases – and family background all play a part. However, there are also protective factors, such as caring relationships, that may inhibit the development of such disorders. Each case is potentially complicated, and it is essential that a detailed knowledge of the person's history is acquired. This will necessitate co-operation: probably less easy to obtain where the consequence may be coercive, and possibly prolonged, detention.

The fact that the current proposals are being made in advance of research evidence, and that there is still no convincing evidence about effective treatment is an additional hurdle. It raises questions about how, once an order is made, it can be discharged. People detained on grounds of risk, without a requirement that they be treatable, may find it hard to show that they are no longer dangerous.

The proposed abandoning of the treatability criterion enshrined in the 1983 Mental Health Act may have the effect of compounding the pitfalls in diagnosis. It raises the fundamental question of what detention will provide, how it may be assessed, and by what criteria progress may be judged.

Risk Assessment

The assessment of risk, central to the justification for detention, is also fraught with practical difficulties. For example, it is difficult to assess risk within the artificial environment of prison;

and difficult to achieve co-operation and progress if prisoners have reason to believe, as has happened in the past, that what is said in therapy in prison has been used to justify continued detention. These problems are likely to affect the subjective and uncertain process of risk assessment. It may be that ethnic minorities, already over-represented in prison, also suffer disproportionately in this context.

Accurate predictions of risk are notoriously problematic, and even if accuracy can be improved there are likely to remain a considerable percentage of false positives (ie those who do not offend although they are thought likely to do so) and false negatives (the converse). Human behaviour will never be predictable; and therefore the standard (as Grounds points out) must rather be defensible decision making. Psychiatrists may not always be able to foresee imminent catastrophe, but they should be able to show that decisions are carefully made, alternatives considered, and judgements reasoned.

Risk assessment, like diagnosis, must be based on good evidence, which will mainly rely upon a detailed knowledge of the person's history. In the culture of blame that has grown in response to the commission of very serious crimes by mentally ill or personality disordered people, psychiatrists may need to distinguish risk from fear. This may be either excessive or insufficient in relation to the actual risk; and professionals may either over- or under-react. It may be that this same culture of blame militates against possible management and support in the community, instead of detention, because it leads to an over-cautious approach.

Risk assessment is deeply subjective and relies on the scantiest science. There is a particular danger, therefore, in its use in the case of those who have not yet offended, but are thought to be at risk of doing so. It must be questionable therefore whether detention purely on grounds of risk can be said to satisfy the *Winterwerp* criteria, particularly in relation to objective medical evidence.

In addition, the detention of those who may not be treatable raises problems for psychiatrists. While the protection of the public is a legitimate concern, so too is the welfare of the patient. If the action proposed to be taken can have no conceivable benefit to the patient, because treatment is not available, or cannot be undertaken, the ethical dilemma for the psychiatrist in participating in the process will be acute.

The issues that arise in relation to these proposals can be summarised as
- the inexactitude of the diagnosis of severe personality disorder
- questions about the treatability of such persons
- the difficulties of assessing risk, particularly if there is no previous history to rely upon

<u>The current proposals: comments and safeguards</u>

We first make some general points that apply to all forms of preventive detention, and we then go on to examine the three categories for which it is proposed.

Assessing risk

In order to comply with the requirements of Article 5, there must be an objective assessment of risk, both at the point of a decision to detain, and as part of the regular reviews of detention that must then take place.

This will require objective medical expertise. In order to ensure independence and objectivity, it is essential that there should be two opinions, from consultant forensic psychiatrists with relevant expertise, outside the settings in which people are being detained

or assessed for treatment. In the Netherlands (see Annex A) experience has shown that the therapists dealing directly with detained people may lack the objectivity necessary for advising, in this case, on the prolongation of detention; and that high quality, independent opinions are necessary.

Both the standard of proof and the quality of evidence should be high, as once an order is made it will not be easily undone, and lifelong detention, literally, may result .The standard of proof should be the criminal one of beyond reasonable doubt. This is necessary both for human rights and diagnostic reasons: both to satisfy the requirements of proportionality, and also as an essential safeguard in an area where mistakes are likely because of the difficulties surrounding risk assessment and the uncertainty of diagnosis. For an order to be made it should therefore be established beyond reasonable doubt that a serious offence such as rape or murder is likely to be imminently committed. It is notable that this is a course that has been adopted in the USA (see Annex A).

Conditions of detention

Once someone is preventively detained a prison setting will not be appropriate or acceptable, and their conditions and treatment must be of a higher quality and a different order. Management rules would need to reflect this. This will also make it more likely that the cooperation of psychiatrists can be obtained. The resulting effect on people's lives is in our view more important than which Government department is in overall control.

The three categories for preventive detention

Those who have committed serious offences and are regarded as a risk

Statistics show that discretionary life sentences are rarely imposed, though their use has been considerably extended by recent authority dispensing with the need for psychiatric input. We accept that there may be more instances in which such sentences can properly be used in respect of those who have committed serious offences and have severe personality disorders which give rise to a risk of further offending. However, we believe that there should be certain criteria

- the mental condition must relate to the offence for which sentence is being passed, and must have contributed to its commission;
- the offence itself must be a serious one;
- there should be independent psychiatric evidence to support an assessment of serious personality disorder and risk.

Those who are considered dangerous on completion of determinate sentences

These are people who have committed offences for which they have already been sentenced to determinate periods of imprisonment, which are about to come to an end. The legal basis for their detention, under Article 5, ceases once the sentence of the court is completed. In order to acquire the lawful authority to extend detention, there must be the same protections and safeguards as there are for those who have not committed offences. This will involve

- independent expert psychiatric opinion, based upon thorough assessments;
- establishing beyond reasonable doubt, before a judicial body, that a serious offence is likely to be imminently committed on release;
- regular, fair and judicial review of continued detention to establish that it continues to be necessary and proportionate.

There will also be a question, in these cases, about the conditions for detention. It is unfair to detain in prison someone who is disordered, but cannot be admitted to mental hospital. If

detention is to continue it must be in therapeutic, rather than punitive, conditions, and facilities must be considerably enhanced.

Those who have committed no offences but are thought to pose a danger

This last group inevitably prompts the greatest degree of concern. The underlying difficulties of diagnosis, risk assessment, and lack of research and training impact hardest here. The proportionality requirements will be strictest and the risk of arbitrariness most acute. The standard of proof will be hardest to satisfy. In the absence of any evidence that the individual will benefit from treatment, the arguments for social protection will have to be strong in order to strike an acceptable balance between the right of the individual to liberty and the right of the public to protection.

The same principles, of objective assessment, proof beyond reasonable doubt, and regular independent review, must apply in these cases. Although such an order may not automatically be in violation of Article 5, nevertheless there is a clear risk of breach in each individual case, because of the difficulty of reaching an acceptable threshold of objective justification. We accept that the burden of proof beyond reasonable doubt will be hard to satisfy, but believe that any lesser threshold would fail to strike the right balance between the rights and interests of society and those of the individual, who could be faced with detention, literally, for life.

Sex offenders are one of the groups most often cited as necessitating preventive detention without previous conviction. One of the chief reasons for this is because a substantial number of prosecutions for child abuse do not proceed, because of the difficulty of obtaining evidence and persuading victims to testify. These are serious and difficult questions. However, we would argue that they call for better systems for supporting victims, and perhaps different mechanisms for dealing with this particular kind of offence, rather than the abandonment of the criminal standard of proof. In the Netherlands, for example, there is a self-referral system for people with problems in this area. Treatment is provided, and although it cannot possibly attract all those who need it, reports are encouraging.

Annex A

International comparisons

A number of other countries provide for the continued detention of those perceived to be dangerous on completion of their sentences.

USA

In Kansas the 1994 Mentally Disordered Offenders Act established procedures for the civil commitment of those with a mental abnormality or a personality disorder who were likely to engage in “predatory acts of sexual violence”. It applies to those convicted of sexually violent offences (as well as those charged with such offences who are not competent to stand trial; and those found not guilty by reason of insanity, or because of a mental disease or defect).

It is up to the prison to notify the local prosecutor (if appropriate), who decides whether to file a petition in the state court seeking the person’s involuntary commitment. The court would then have to determine whether probable cause existed to support a finding that the person was a “sexually violent predator” and thus eligible for civil commitment. If such a determination is made evaluation in a secure environment follows. A trial is then held to determine beyond reasonable doubt whether such a finding can be sustained. If so, the person is transferred to the custody of Social and Rehabilitative Services; and control, care and treatment in an institution will follow, until the mental abnormality or personality disorder has so changed that it release is safe.

Legal aid and representation are available, and trials are based on criminal procedure. Where detention results the court must review the case annually; the person detained may file a petition for release at any time; and the Secretary (of Social and Rehabilitation Services) can grant it if appropriate. This will depend on the state being able to continue to satisfy the original burden of proof.

In the leading case of *Kansas v Hendricks* (521 US 346) the Supreme Court upheld H’s commitment, finding that “The statute thus requires proof of more than a mere predisposition to violence; rather it requires evidence of past sexually violent behaviour and a present medical condition that creates a likelihood of such conduct in the future if the person is not incapacitated…..A finding of dangerousness standing alone, is ordinarily not a sufficient ground upon which to justify indefinite commitment”.

The Nebraskan case of *State v Little* (199 Neb. 772) challenged the confinement of untreatable sexual sociopaths, under the Sexual Sociopath Act, on the grounds that it was disproportionate to the offence, and constituted cruel and unusual punishment. Again the court upheld the statute, but only if “an annual evaluation by qualified professional personnel…be made of each sexual sociopath housed in the penal complex and an annual review of treatability be made by the District Court from which such an individual was originally committed.” It agreed with the defendant that once it had been decided that he was untreatable, he was effectively “in legal limbo”, and expected “to bear the burden of proving he has somehow recovered in the vacuum situation in which the statute places him”. Without fair procedures such confinement could easily result in a life sentence, which would be “so disproportionate to the offence committed in this case as to constitute cruel and unusual punishment”.

The Netherlands

The Netherlands has operated the TBS system in some form since 1929. It has been reformed on a number of occasions over the years, as experience of it has grown. It allows

for someone who is pronounced irresponsible on grounds of a defective development or an impairment of his mental faculties to be discharged from prosecution, and as a preventative measure, to be placed in a mental institution for a maximum of two years.

It has been argued there[1] that therapists themselves should not have the final responsibility for advising the court, which imposes the detention, on its possible prolongation. This is because experience has shown that they are prone to overreact: sometimes being too protective, and sometimes too aggressive. They are thought to be too close to the patient; and independent, professional opinions are sought. The Dutch have also found that, in balancing concerns for the patients' welfare and privacy with the responsibility to protect the public it has been of the utmost importance to obtain high quality assessments.

JUSTICE
December 1999

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[1] (H Blankstein: Organisational Approaches to Improving Institutional Estimations of Dangerousness in Forensic Psychiatric Hospitals: A Dutch Perspective)