

Editorial

Forensic psychiatry and public protection†

Alec Buchanan and Adrian Grounds

**Summary**

The prominence of risk in UK social and criminal justice policy creates opportunities, challenges and dangers for forensic psychiatry. The future standing of the specialty will depend not only on the practical utility of its responses to those opportunities and

challenges, but also the ethical integrity of those responses.

Declaration of interest

None.

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The UK government's review of the dangerous severe personality disorder (DSPD) programme^{1,2} takes place at a time when UK and US criminal justice policy places increasing emphasis on risk.³ In the USA, high rates of violent crime have become expected, and hence in need of management.^{4,5} In the UK, the DSPD programme is one of a range of initiatives, including indeterminate prison sentences and antisocial behaviour orders, that have been justified by reference to public protection, as well as the rights of victims. The Criminal Justice and Court Services Act 2000 and the Criminal Justice Act 2003 extended responsibility for crime control to 'duty to co-operate' organisations that include housing providers and health trusts.

The DSPD programme coincides also with a wider shift in UK social policy affecting mental health legislation and services. A generation of inquiries into excesses of institutional control in the 1960s and 1970s⁶ gave way in the 1980s and 1990s to examinations of perceived failures of control in the community. The law reform pendulum swung from minimising the scope of compulsory powers in the 1950s⁷ to expanding the scope of compulsion.⁸ The reappraisal of DSPD does not mean that this shift has been reversed: the government's preferred option – which makes little reference to commissioned research – is to increase and diversify the programme's capacity using current resources.¹ The increased prominence of risk in UK social policy creates opportunities, challenges and dangers for forensic psychiatry.

Risk management in psychiatry

Risk is a property of situations, rather than individuals, and psychiatry is practised in many settings where risk is difficult to manage. Out-patient clinics, hospital emergency departments, day units and general psychiatric in-patient wards all demand their own, particular, clinical approaches. Risk is not a symptom or a sign of mental illness, but one of many considerations to be borne in mind in the provision of good psychiatric care. Psychiatric services are organised to meet a range of clinical needs, not just risk, and the limits of prediction mean that any attempt to stratify patients, and provide dedicated services for those assessed as posing the greatest risk, will misclassify many.⁹

†See reappraisal, pp. 431–433, this issue.

Taken together, these considerations explain some aspects of the management of violence risk that are unlikely to change soon. First, most of the significant acts of psychiatric patient violence, including most psychiatric homicides, are carried out by patients of general, not forensic, services.¹⁰ Second, as services are presently configured, staff who work in general psychiatric services often have the greatest experience of the settings where risk is most difficult to manage. Third, their base in medium and high secure in-patient services limits the opportunities of many forensic clinicians to be involved in the treatment of some groups, including 'stalkers' and the perpetrators of domestic violence, where forensic training and experience could be expected to be of particular help.

The clinical imperatives of forensic psychiatry are the same as those of general services, however.¹¹ In addition, the nature of their patients' problems gives forensic clinicians particular experience of the conflicts involved in simultaneously providing care and protecting others, as well as in seeking to ensure that responsibilities to third parties do not compromise ethical practice. The configuration of forensic services means that if this experience is to be brought to bear on the management of risk in community settings, it will largely be through collaboration with, not substitution for, general psychiatric services. Increased collaboration between general and forensic services also benefits the long-term management of forensic patients. For as long as they are discharged to general services, continuity of care will demand that interventions designed to manage risk can be applied by those services.

Treatments in secure settings

The increased focus on risk in criminal justice has not produced a comprehensive approach to the provision of care to mentally disordered prisoners in England and Wales. Prison mental healthcare receives about a third of the resources required to deliver a stated policy objective of equivalence with care elsewhere.¹² The Bradley Report recommendations¹³ and responses^{14,15} are unlikely to remedy this inequity. In circumstances of financial austerity there is a risk that economic, not clinical, concerns will shape prison healthcare. Overstretched prison mental health in-reach teams are not usually resourced for the important, additional function of providing specialist clinical risk assessments for release and community supervision.¹⁶

These constraints contrast with the £200 million invested¹⁷ in the treatment of people with personality disorders through the DSPD programme. Approximately 240 places were created in prison and high secure hospitals. The research suggests that new money did not remove old challenges. Admission to prison DSPD

units was often justified on custodial grounds, making it difficult to provide a consistently therapeutic environment. The costs and benefits of the assessment phase were questioned.^{18–20} Even with a new programme and dedicated funding, less than 10% of time was spent in therapy and 1 in 10 patients had no treatment in 1 year.^{17,21} Unusually, however, a sufficient amount of the funding was allocated to research for some conclusions to be possible.

First, the heterogeneity of patients labelled with DSPD contributed to a temporal pattern whereby early recruits, frequently with borderline and dependent traits, were grateful for the increased attention, but the later engagement of patients with antisocial traits was more problematic. Second, the slow pace of treatment made treatment more, not less, difficult. Third, the process of treatment was distorted by patient and staff characteristics. Cooperation was interpreted as manipulation, people were rejected on account of the same behaviours the units were designed to treat and labels such as psychopath, not surprisingly, got in the way. Finally, without segregation, the disclosure inherent in therapy posed a significant risk to the most stigmatised offenders.¹⁷

Psychiatry's ability to provide in-patient care to offenders with personality disorders will depend in part on its being able to address difficulties such as these, not least because the annual cost per patient of a medium secure and high secure hospital bed is respectively four and six times higher than that of a prison place.^{22,23} Research on the new units offers an opportunity for forensic in-patient services to show that some of these barriers to effective care can be overcome. What is learned has the potential to inform psychological treatment in secure settings more widely, as well as treatment guidelines for individual conditions.^{24,25}

Psychiatry and medical ethics

The DSPD proposals provoked complaints that a public protection agenda was being pursued in the name of healthcare.²⁶ However, protecting patients and others was an established part of UK psychiatry when the proposals were made, and in-patient services played a significant role. Substantial numbers of people with personality disorders were detained in secure hospitals under a Mental Health Act category of psychopathic disorder. Over 300 patients per year were being admitted to hospital on hospital orders with restrictions on discharge imposed by courts in order to protect the public.²⁷ The stronger ethical case against the DSPD proposals related to their practical consequences²⁸ and the civil liberty implications of creating a newly coercible group that was not being defined using recognised mental health criteria or by an inability to seek treatment voluntarily.²⁹

The pervasive emphasis on public protection in UK criminal justice and social policy nevertheless throws into sharper relief some preexisting ethical challenges. One relates a psychiatrist's obligations to other agencies and to people who might be at risk. Psychiatrists in forensic settings routinely discuss with patients, and record, details of offences which may be unknown to the courts, probation and the police. The statutory duty on health trusts to cooperate with Multi Agency Panels for Public Protection (MAPPPs)³⁰ has fuelled expectations that mental health services will be helpful, even if this means passing on information about their patients. Yet practice guidelines remain unambiguous that information can be released without consent to protect others only in exceptional circumstances.^{31,32}

The exceptional circumstances most commonly referred to are where a failure to disclose could entail risk of death or serious harm. They do not include the routine provision of information

to bodies charged with the protection of the public. Many of the debates concerning the proper boundaries of medical confidentiality took place before the introduction of MAPPPs and the other initiatives described here. Whether those initiatives change the responsibilities of clinician's and services, or the proper response of those services to a request for information, is in urgent need of clarification.

A second ethical challenge for forensic psychiatry is to minimise the extent to which the stigmatising quality of some patients' histories damages the care they receive. Just as clinical placement should seek the 'least restrictive alternative', so forensic mental healthcare should reflect the same principles and standards that are recognised elsewhere in psychiatry and medicine. The institutional cultures surrounding secure prisons and hospitals make this difficult, and addressing these difficulties is an ethical obligation. The law, too, has a role in enabling treatment and addressing stigma. Recent suggestions for 'capacity-based' reform of mental health legislation made a distinction, in terms of their criteria for compulsion, between the generality of clients and forensic patients.³³ Such distinctions are not always necessary.³⁴

Detaining people on grounds of risk

The interest generated by DSPD distracted attention from the numerical contribution of forensic services to detaining people seen as presenting a risk. Medium and high secure psychiatric units in England and Wales house 3700 people.³⁵ Between 1998 and 2008, fewer than 500 restricted cases per year moved into the community and the 2-year re-conviction rates were 7% for all offences and 1% for grave offences.²⁷ In contrast, the UK prison population is 85 000.³⁶ Of 20 000 people who left prison in the first quarter of 2004, 65% were convicted again of any offence and 12% of a violent offence within 2 years.³⁷ In individual cases, forensic psychiatric services have a crucial role in preventing harm to third parties. At the population level, their role is of necessity limited.

Figures for bed provision and re-offending tell only part of the story, however. Psychiatry faces important challenges in relation to the detention of people on grounds of risk that are not well described by statistics. About half of prisoners whose detention is indeterminate are now serving the new Imprisonment for Public Protection (IPP) sentences, and these are predicted to comprise 11% of the total prison population by 2014.³⁸ It is not known what proportion of IPP prisoners have mental disorders, but 18% have received psychiatric treatment in the past and 21% are currently in treatment.³⁸ Although there are early indications of fewer IPP sentences as a result of the Criminal Justice and Immigration Act 2008,³⁹ the demand for psychiatric evidence in the sentencing of dangerous offenders is set to continue.⁴⁰

The difficulties attaching to the conduct of psychiatric evaluations intended to inform the passing of these sentences are only starting to be explored in the UK literature. On one hand it is inappropriate to comment on a defendant's risk unless psychiatric intervention is proposed or other benefit will result.⁴¹ On the other hand, a psychiatrist should proceed to assess risk only where mental disorder is present.⁴² This raises the question of how, prior to conducting an evaluation, a psychiatrist would know. In either case, the recommended criterion is not always easy to measure. Is treatment in prison a psychiatric intervention, or alcohol misuse a mental disorder, justifying a psychiatric conclusion on risk?

UK and US guidelines state only that it is not improper for a psychiatrist to conduct an evaluation that may contribute to a longer sentence provided that the defendant understands the

nature and purpose of the evaluation.^{43,44} Guidelines have a role in ensuring minimum standards but cannot guarantee best practice. In the context of indeterminate sentencing, best practice should take into account the relevance of the psychiatrist's skills to the questions posed, the coercive circumstances in which a defendant is being asked to participate and the unintended adverse consequences of some psychiatric conclusions, such as a diagnosis of antisocial personality or a poor prognosis. Forensic psychiatry is uniquely located to develop recommendations and guidelines, to advise as to how best practice can become more widespread and to undertake the research and training necessary to ensure that this happens.

Conclusions

The ethical principles of medicine have always informed the participation of forensic psychiatry in public protection and crime risk management strategies. Consistent with the primacy of principles of autonomy, beneficence and non-maleficence, General Medical Council guidance on good medical practice begins with the injunction that doctors make the care of the patient their first concern.⁴⁵ Broadly speaking, the use of powers of compulsion and breaches of confidentiality in order to protect third parties are departures from normative practice that have to be seen as exceptional; such departures require justification and must not go beyond what is proportionate and necessary.

Because the ways in which forensic psychiatrists contribute to the public expectations and to the statutory duties of health organisations are constrained by ethical principles, the objectives of a forensic psychiatry service need to be consistent with those principles. Although it can contribute significantly to the protection of the public in individual cases, crime prevention cannot be its primary purpose. In a social climate that places increasing emphasis on the management of risk, the pressure to do so is substantial. The future standing of forensic psychiatry will depend not only on the practical utility of its responses to the opportunities and challenges presented by recent political developments, but also by the ethical integrity of those responses. It seems an important moment in the history of the subspecialty.

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Transitional object

Jeremy Holmes

The majority of young children have a favoured 'object' to which they turn when stressed or sleepy. The psychoanalyst Winnicott's genius was to theorise this everyday phenomenon. The transitional object is 'transitional' in that it bridges the borderland between 'me' and 'not-me', safely containing children's desires and projections. With its nostalgic maternal resonance, the transitional object comforts and distracts when the parent is absent, helping the child to forge an independent sense of self. For Winnicott transitional objects are the prototype for culture and creative living. Psychotherapy is 'learning to play': re-establishing transitional space in a traumatising and unresponsive world.

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