

Section One

Context

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Chapter One

From 'Anxious and Sad' to 'Risky and Bad': Changing Patterns of Referrals to the Personality Disorder Service

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The Personality Disorder Service (PDS) at Rampton was created in 1997 and is now a 68-bed service comprising an admission and assessment ward, three treatment wards and a rehabilitation/pre-discharge ward. The service provides a specialist service for the treatment of male patients with a diagnosis of personality disorder who present a grave and immediate risk of harm to others (for a description of the treatment pathway, see this volume, Chapter 5) and is the longest established service of its type in the UK.

On the basis of observations and records, it appeared that the nature of patients being admitted to the PDS has changed since its creation. Krishnan (2005) found that levels of emotional dysregulation, self-harm, suicide attempts, hostage-taking, making threats and sexual and physical violence in this population had increased between 1997 and 2004. Patients also were shown to have been admitted with an increasing number of co-morbid mental health diagnoses after 2000, rising from two co-morbid diagnoses to four in 2004.

There has been a significant change since 1997 in mental health services in prison. The majority of referrals to the PDS have come from HM Prison Service. Poor mental health among prisoners is a major issue; for example, HM Chief Inspector of Prisons (2002) reported that 41% of inmates in high secure prisons should ideally be placed in secure hospitals or psychiatric wards due to the severity of their mental health problems. One particular aspect of mental health among prisoners that has caused much public concern was the high rate of suicide and self-harm. The suicide rate in prison more than doubled between 1982 and 1998

(Birmingham, 2003), from 54 to 128 per 100,000 of the average annual prison population. Liebling (1995) identified prisoners with mental problems as a group who were at particular risk of suicide or self-harm. Until the 1990s the prison service had relied on physical methods of suicide prevention, such as the use of 'strip (unfurnished) cells', despite the damaging effect that such approaches were likely to have on the mental health of vulnerable and distressed prisoners (Birmingham, 2003). However, over the last decade there has been greater emphasis on screening and risk assessment, staff awareness training and support through prisoner 'buddy' schemes and via improved mental health in-reach.

Until earlier this decade, responsibility for prisoners' healthcare lay with the Prison Medical Service, which had repeatedly resisted incorporation into the NHS, despite frequent criticism (Smith, 1999). During the 1990s the prison service came under increasing pressure to improve mental health services for prisoners. The new strategy, 'Changing the Outlook' (Department of Health & HM Prison Service, 2001), stated that prisoners should have access to the same range and quality of services as the general population had through the NHS. This strategy led to the introduction of specialist NHS mental health in-reach teams to support prisoners with the most serious mental health problems and to provide an equivalent function to community mental health teams. While the goal of matching standards of healthcare in prison to those in the community has probably not yet been achieved, standards of care for prisoners with mental health problems and those at risk of suicide have improved markedly in recent years.

Another significant change since 1997 has been the introduction of services for individuals with dangerous and severe personality disorders (DSPD). In 2004, the Peaks Unit opened at Rampton. This was one of four new DSPD units (Department of Health & Home Office, HM Prison Service, 2004). The PDS already treated patients who were dangerous and who had severe personality disorder, but the DSPD services had more stringent admission criteria in terms of level of risk, severity of personality disorder and the establishment of a functional link between patients' offending and their personality disorder.

On the basis of the previously reported changes in the characteristics of patients admitted to the PDS and the impact of the creation of a new service designed to accommodate the most dangerous and severely personality disordered patients, it was decided to investigate changes in the nature of patients admitted to the PDS since 1997. It might be expected that the trends reported by Krishnan (2005) of increasing seriousness of psychopathology and histories of violent behaviour among patients in the PDS between 1997 and 2004 would be reversed after 2004 as the patients with the most severe personality disorders, highest levels of psychopathy and greatest degree of risk were diverted into DSPD services. These hypotheses were explored by Marshall (2008), who reviewed changes in the levels of personality psychopathology in this population between 1997 and 2008.

Method

The study examined demographic, forensic and psychometric data on 145 male patients admitted to the PDS between 1997 and 2008. Patients ranged in age

from 19 to 59 years at the time of admission. The majority (83.4%) were detained under the Mental Health Act classification of psychopathic disorder, 13.8% were dually classified as suffering from psychopathic disorder and mental illness, 2.1% were classified as having a mental impairment and psychopathic disorder and 1% classified with mental illness, mental impairment and psychopathic disorder.

All data used in the study were collected as part of patients' initial psychological assessment on first admission to the PDS. Measures of personality psychopathology and risk were chosen that had been consistently used during the period under investigation. Measures of personality psychopathology included clinical subscales measuring anxiety-related disorders, paranoia, borderline and antisocial features, and alcohol and drug problems from the Personality Assessment Inventory (PAI) (Morey, 1991), a self-report measure of Axis I and II mental health conditions, and the Personality Diagnostic Questionnaire-4 (PDQ-4) (Hyler *et al.*, 1994), which provides dimensional and categorical diagnostic measures of personality disorder traits. Standard measures of risk of recidivism changed between 1997 and 2008. Therefore, to allow for comparison of levels of risk of violence, a number of static indicators, which are included in standardized static measures of violence risk – e.g., Violence Risk Scale (VRS) (Wong and Gordon, 2000); Violence Risk Appraisal Guide (VRAG) (Harris, Rice & Quinsey, 1993); HCR-20 (Webster, Douglas, Eaves & Hart, 1997) – and which were available from the demographic and forensic information collected on all new admissions, were used. These static factors were patient's age at the time of admission, age at first violent conviction, number of young offender convictions, number of convictions after the age of 18, age at the time of index offence and level of psychopathy, as measured by the Psychopathy Checklist-Revised (PCL-R) (Hare, 1991).

Results

Of the 145 patients admitted to the PDS between 1997 and 2008, half (50.3%) had been first convicted between the ages of 13 and 16; 77 (53%) had committed an index offence of violence; 36 (25%) a sexual offence; 18 (12%) arson; and 14 (10%) other offences. The mean age at which index offences were committed was 25, with most index offences committed between the ages 18 and 25 (50.3%). Ninety-one (63%) had been sentenced to an indeterminate Hospital Order (section 37/41 of the Mental Health Act 1983), while the rest had originally been sentenced to imprisonment. Of these, 34 (23.5%) had been sentenced to an indeterminate or life sentence and the remaining 20 (14%) had been sentenced to a fixed term, but were now subject to indefinite detention in hospital (Mental Health Act 1983, section 4(5)).

The study used a retrospective between-groups design. Participants were divided into four groups according to their date of admission to Rampton and the PDS. Group 0 consisted of patients admitted to Rampton prior to 1997. While some of these patients had initially been admitted under the classification of psychopathic disorder before a separate PDS had been created, others had initially been admitted under the classifications of Mental Impairment or Mental Illness, and then subsequently reclassified. Group 1 consisted of patients admitted between 1997 and 2000, group 2 consisted of patients admitted between 2000 and 2004, and

Table 1.1 Key findings of differences between patients admitted to the Personality Disorder Service over time

<i>Year of admission</i>	<i>Pre 1997</i>	<i>1997–2000</i>	<i>2000–2004</i>	<i>2004–2008</i>
Antisocial traits measured by PAI (mean scores)	65.3	68.0	68.3	74.8
Drug-related problems measured by PAI (mean scores)	65.0	62.6	67.8	77.7
Aggressive traits measured by PAI (mean scores)	62.0	66.2	63.6	72.1
Number of convictions prior to age 18 (mean scores)	4.8	6.4	9.2	15.6
Total PCL-R Score (mean scores)	22.7	20.2	19.8	20.3

group 3 consisted of patients admitted between 2004 and 2008. The divide between groups 2 and 3 was set at 2004 because this was the point when the DSPD service opened, and it was hypothesized that the patient profile would change at this point.

An analysis of variance (ANOVA) was carried out to investigate differences between the groups (Table 1.1). This showed:

- A significant increase in the degree of antisocial personality traits between 1997 and 2008, as measured by the PAI. However, there was no significant difference in these features in patients admitted between 2004 and 2008.
- A significant increase in drug problems (as measured by the PAI) reported by patients admitted between 1997 and 2008.
- A significant increase in attitudinal and behavioural features associated with aggression (as measured by the PAI) reported by patients admitted in 1997 and 2008.
- A significant increase in the average number of personality disorder diagnostic categories (as measured by the PDQ-4) met by patients between 1997 and 2008; with the highest numbers of diagnostic categories among patients admitted between 2004 and 2008.
- A significant increase in the number of convictions prior to the age of 18 in patients admitted between 1997 and 2008 (from 4.77 to 15.6).
- No significant difference in psychopathy scores (as measured by the PCL-R) of patients admitted over time, including between 2004 and 2008, after the opening of the DSPD service. There were also no significant changes to average factor 1 or factor 2 scores over time.

Based on these results, the following profiles outline the difference between patients admitted to the PDS in 1997 and in 2007.

1997

Patients admitted to the PDS when it first opened in 1997 had an average of nine juvenile convictions before the age of 18 and a further 14 convictions after the age of 18. On average, the age of their first criminal conviction was 14. Assessments

showed that they tended to be suffering from very high levels of anxiety and presented predominantly borderline personality disorder traits. Their average age at the time of the offence for which they were admitted to hospital was 25. Their offences were predominantly of a non-sexual violent nature. Most were sentenced on conviction to be detained in hospital under the Mental Health Act, rather than being sentenced to imprisonment. As a result, their average age on admission to Rampton was also 25.

2007

Patients admitted to the PDS in 2007 had an average of 32 juvenile convictions before they were 18 and a further 13 convictions after the age of 18. On average the age of their first criminal conviction was 13. Assessments showed them to have predominantly antisocial personality traits, significant drug and alcohol problems and a history of aggression. Their average age at the time of the offence for which they were admitted to hospital was 23 and their offences were mostly of violence. However, patients in this cohort were equally likely to have been sentenced to detention in hospital or life imprisonment, and their average age on admission to Rampton was 35. The large difference between age of offence and age of admission reflected the fact that a significant number of admissions to the service had been in the healthcare system for some time and had either been moved from other high secure hospitals or transferred from medium secure services because they were deemed to be 'unmanageable' in conditions of lower security.

These profiles illustrate some significant changes in the characteristics of patients admitted to the PDS between 1997 and 2008. There has been a significant increase in the number of juvenile convictions, a greater history of antisocial personality traits, aggression and problems associated with alcohol and drug use among patients admitted to the service. Although the average age at which patients committed the offence for which they were currently detained had reduced slightly, from 25 to 23, the average age of patients on admission to the service had increased from 25 to 35 years of age. This reflects the fact that relatively few admissions now are admitted immediately after sentence and that an increasing number spend a significant period moving around the prison service or in less secure mental health facilities before being referred to the PDS as a 'last resort'.

In order to explore reasons for these changes in the types of patients admitted to the PDS, a thematic analysis of referral letters was carried out over the same period to identify why patients had been referred. Referrals were generally made by consultant forensic psychiatrists – either the patient's medium secure unit Responsible Clinician or a visiting psychiatrist from prison. Among referrals prior to 2000 a common theme was the prisoner's self-harm which had become unmanageable, particularly within the prison healthcare system. Referrals after 2000 also make frequent reference to the prisoner's self-injurious behaviour, however, this appeared to be dealt with more effectively within prison healthcare settings following the introduction of more specialist mental health in-reach care in prisons and changes to prison and procedure for managing prisoners at risk of suicide or self-harm. Instead, the primary reason for these more recent referrals was that they were judged to pose too great a risk to others within the institution where they were based. More specifically, there was increasing reference

among referral letters to the subversion of institutional security, continuing use of illegal or prohibited substances and incidents of violence and aggression against patients/prisoners and staff to a level which the institution felt was unmanageable.

Another increasingly common reason for referrals from prison was that the prison service could not meet the individual's treatment requirements. This was particularly the case for prisoners serving life or other indeterminate sentences, for whom release by the parole board would be dependent on their demonstrating a reduction in their level of risk through engagement in accredited offending behaviour programmes. However, a significant number of prisoners with personality disorder traits will either be unable to engage in or complete such a programme because of their extreme emotional lability, behavioural impulsiveness or avoidance, or will be excluded from treatment on the grounds of their high levels of psychopathy or cognitive deficits. Such prisoners find themselves in a 'Catch-22' situation, unable to benefit from necessary treatment because of their personality disorder traits and unable to access treatment for those traits. For them a referral to a specialist personality disorder service is the only way out.

Changes in forensic mental health

There have been a number of changes to the profile of patients admitted to the PDS since it opened.

Reported levels of self-harming behaviour prior to admission remain high. However, self-harm is no longer the primary reason for referrals. Instead, patients tend to be referred because their violent or aggressive behaviour and risk to others are becoming increasingly difficult to manage, or because they present as 'stuck' in treatment and unable to make progress within the prison system. The fact that repeated self-harm and risk of suicide are no longer reasons for referral from the prison service ought to reflect the advances the service has made in the last decade in caring for prisoners at risk of self-harm. The inhumane and counterproductive policy of keeping suicidal prisoners in unfurnished cells has been replaced by a range of more caring and effective policies, which have seen a steady reduction in the number of suicides in prison since 2000. The greater involvement of mental health professionals in prison in-reach as part of this new policy may also have contributed to the prison service being better able to manage those extremely vulnerable prisoners who would previously have been referred to secure hospitals.

There has been a steady increase in the level of risk of violence presented by patients admitted to the PDS between 1997 and 2008, as indicated by the increase in incidents of threatening behaviour, physical and sexual assaults and hostage-taking, and patients' self-reports of aggression. It might have been expected that the creation of DSPD services for the most complex and high-risk cases would have led to a reduction in the degree of psychopathology and risk among patients admitted to the PDS since 2004, when DSPD services were opened. However, this has not been the case.

The Crime (Sentences) Act 1997 introduced automatic life imprisonment for offenders who were convicted for a second time for specific serious violence or

sexual offences. The Criminal Justice Act 2003 replaced these with the Indeterminate Public Protection Sentence (IPP), which significantly lowered the threshold for passing an indeterminate sentence. IPP sentences can be imposed on any adult judged to pose a significant risk to the public who commits an offence warranting a two-year sentence or who has a previous conviction for specified violent or sexual offences. IPP sentences were introduced in 2005. In 2004, 489 indeterminate sentences were passed in England and Wales. In 2006, 1,738 indeterminate sentences were passed. In contrast, the number of indeterminate sentence prisoners released in 2008 was 138 (Ministry of Justice, 2009a). The proportion of the prison population serving indeterminate sentences has now passed 10% (Coyle, 2007), and it has been predicted that there could be as many as 25,000 people serving indeterminate sentences by 2012 (Solomon, 2007). The prison service, therefore, faces a crisis caused by the number of prisoners serving indeterminate sentences, many with very short tariffs. In particular, it seems likely that many individuals with personality disorder traits who would previously have passed through prison on determinate sentences and avoided or been judged unsuitable for treatment are now 'stuck' in prison on IPP sentences. Already overstretched offending behaviour programmes have struggled to cope with these individuals and a growing number of them are now being referred to secure hospitals for treatment.

While the overall prison population and the number of prisoners serving indeterminate sentences have risen sharply in recent years, the number of high secure psychiatric beds has been falling, from 1,115 in 2002 (Home Office, 2003) to 643 in 2007 (Ministry of Justice, 2009b). It is therefore likely that, with more prisoners 'competing' for fewer beds, admission criteria for high secure hospitals will have tightened, and the level of dangerousness and severity of mental disorder among patients admitted now will be greater than it was a decade ago.

Patients being admitted now tend to be older. This appears to reflect the length of time they have spent 'in the system' rather than the age at which they committed the offence that led to their admission. In part, this reflects the fact that, while the number of beds in high secure hospitals fell by 42% between 2002 and 2007, the number of restricted patients in low and medium secure services increased by 74% during the same period, from 1,874 (Home Office, 2003) to 3,263 (Ministry of Justice, 2009b). This has led to greater pressure on high secure services when patients could not be managed in medium secure services and were referred to more secure services. This is particularly ironic since the expansion in medium secure personality disorder services came about in part to reduce the 'log jam' of personality disorder patients waiting to move out of high secure services (Reed, 1997).

Patients now have higher levels of antisocial personality traits. They have more significant histories of violent behaviour and higher levels of substance abuse. Various studies (e.g., Coid, Kahtan, Gault, & Jarman, 1999; Tyrer, 2000) have found a strong association between drug dependence and a diagnosis of personality disorder, particularly antisocial personality disorder. The significant increase in the reporting of drug problems over time may reflect wider social trends in drug use, with increased use, particularly among younger people, and drug use now to be a more normalized part of some youth cultures (Booth, 2004).

Summary and conclusions

The changes outlined in this chapter reflect many of the important developments in the criminal justice and forensic mental health systems over the past decade; the inexorable rise in the prison population, prison healthcare reform and an increasing emphasis on risk management in both criminal justice and mental health. The changes also reflect important developments in the management and treatment of personality disorder. Berry, Duggan and Larkin (1999) reported that 44% of referrals to Rampton high secure hospital in 1994 with a diagnosis of personality disorder were deemed 'untreatable'. With the changes described in this chapter (the increase in risk of violence, antisocial personality traits and substance misuse history) it seems likely that many of the patients referred to high secure personality disorder services today would have been deemed 'untreatable' by the standards of 1994. In fact, the opposite is true; it is now extremely rare for a potential patient with a diagnosis of personality disorder to be turned down on the basis that the service cannot treat him. Advances in the understanding of personality disorder and in treatment technologies, together with the development of specialist personality disorder services, mean that many patients who would previously have been dismissed as 'untreatable' are now able to access treatment. The discredited notion of the 'untreatable' personality disorder has finally been consigned to where it belongs – the history books.

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