

# Incapacitating the Dangerous in England and Wales

## High Expectations - Harsh Reality

### **Herschel Prins<sup>1</sup>**

‘Never predict anything, particularly the future.’

(Attributed to Samuel Goldwyn, Film Producer)

### **Introduction**

This presentation offers some brief comments on the socio-historical concept of ‘dangerousness’, legal and sentencing issues in contemporary context, problems of definition and, finally, some clinical considerations in the light of the foregoing discussion. A number of these issues are discussed more fully in my book ‘Will They Do it Again?’<sup>2</sup>

### **Historical Context**

It has been suggested that the first recorded use of the word ‘danger’ occurred in about 1523 and that its use in the civil and criminal courts increased in the 19th Century.<sup>3</sup> The word certainly has powerful and pejorative connotations. For example, English law - from Elizabeth I onwards (and earlier) - had always catered for the ‘dangerous’ classes, holding that the poor were not only ‘idle’ but likely to be ‘dangerous’. Harsh penalties were therefore imposed upon ‘sturdy beggars’ and ‘vagabonds’. Such legacies remained in various revisions of the Poor Law until the late nineteenth century. From then onwards the law attempted to define categories of persons who were considered to be a threat to the social and economic fabric of society. For example, the Prevention of Crime Act of 1908 introduced the notion of Preventive Detention for persistent offenders (not all of them dangerous); this was carried forward into the Criminal Justice Act of 1948. This latter enactment also introduced Corrective Training and a revised form of Borstal Training. These

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2 Prins, H. (1999) *Will They Do It Again? - Risk Assessment in Criminal Justice and Psychiatry*, Routledge.

3 See Craft, M. (1984) *Predicting Dangerousness and Future Convictions Among the Mentally Abnormal*, in M. Craft and A. Craft, (eds) *Mentally Abnormal Offenders*, Baillière Tindall.

measures were superceded in the Criminal Justice Act of 1961, into which was introduced the provision of the Extended Sentence.<sup>4</sup> It should also be remembered that notions of dangerousness were reflected in early mental health practice. For as Parker states:

The practice of confining some of the insane stretches back more than 600 years in England. The type of detained patient has varied, always including those considered to be dangerous ... The forms of security employed have changed little over the period; perimeter security, internal locks and bars and individual restraint by both physical and chemical means have been in continuous use to a greater or lesser degree in various guises up to the present day.<sup>5</sup>

A socio-cultural perspective has also been provided by commentators such as the French authority Foucault. He suggested that from the 19th century onwards alienists (early psychiatrists) were employed increasingly to manage and understand patients' often unpredictable and disturbed behaviour.<sup>6</sup> Recent concerns are dealt with in the following sections.

## Recent Concerns

### Background

A number of legislatures, notably in some of the states on the continent of North America, have made attempts to define dangerousness for the purposes of incarceration of individuals adjudged to be dangerous, be this incarceration in penal or mental health care institutions. Currently in the UK, there are no statutes that attempt to define dangerous individuals specifically, though the law does recognise for example such offences as reckless (dangerous) driving, endangering the lives of passengers, and being in possession of, or distributing, dangerous drugs. However, as I shall show in the next sub-section, in recent times the notion of dangerousness has been an important consideration in criminal justice and mental health legislation.<sup>7</sup> It is also of interest to note that in the last few years there has been an increase in the use of the 'life' (indeterminate) sentence for cases not involving homicide. This has been justified in various appeal court decisions on the grounds that by such means offenders considered to be dangerous (but not necessarily mentally abnormal within the meaning of the current mental health legislation) can be incarcerated until such time as the authorities (for example, the Home Secretary) consider, on the basis of expert advice, that they may be safely released. However, it should also be noted that decisions based solely on concerns about dangerousness appear to have recently become 'contaminated' by considerations based on political expediency. This would appear to have occurred in Myra Hindley's case and some others<sup>8</sup> So far as those formally judged to be mentally disordered are concerned, current mental health legislation recognises the concept of potential dangerousness.

4 See Norval Morris for a useful account of the genesis of the 'habitual criminal' legislation up to and including the 1948 Act. Morris, N. (1951) *The Habitual Criminal*, Longmans. The earlier history of notions of 'dangerousness' in criminal justice may be found in Rennie, Rennie, Y. (1978) *The Search for Criminal Man*, Lexington.

5 Parker, E. (1985) *The Development of Secure Provision*, in L. Gostin (ed), *A Review of Special Services For the Mentally Ill and Mentally Handicapped in England and Wales*. Tavistock.

It should also be remembered that it was only after Hadfield's case in 1800 that special secure provision was made available.

6 Foucault, M. *About the concept of the "dangerous individual" in 19th Century Legal Psychiatry*. *International Journal of Law and Psychiatry*, 1, 1-18, 1978.

7 See for example, Baker, E. 'Dangerousness' - *The Neglected Gaoler: Disorder and Risk Under the Mental Health Act, 1983*. *Journal of Forensic Psychiatry*, 3, 31-52, 1993. See also Baker, E. *Dangerousness in English Law*. *International Bulletin of Law and Mental Health*, 5, 40-42, 1994.

8 See *The Times*, Law Report, December 19 1997, p.39 (Q.B. Divisional Court) for the judgment in *R. v. Secretary of State For the Home Department, ex parte Hindley*.

Thus, Sections 2 and 3 of the 1983 Mental Health Act (England and Wales), make provision, *inter alia*, for the compulsory detention of an individual with a view to the ‘protection of other persons’. And Section 25 of the Act uses the words ‘dangerous to other persons’..in dealing with restrictions on discharge by the nearest relative. In addition, Section 41 of the Act makes provision (subject to certain criteria being satisfied) for placing an order restricting discharge upon a person made the subject of a Hospital order to protect the public from ‘serious harm’<sup>9</sup> More specifically, the proclivities of some offender-patients are recognised in the setting up and maintenance of the three High Security Hospitals in England and Wales (Broadmoor, Rampton and Ashworth) for those patients who ‘exhibit dangerous, violent or criminal propensities’<sup>10</sup> During the past two decades the law and practice relating to both mentally abnormal and dangerous offenders have been examined by five different groups - *The Butler Committee, The Scottish Council on Crime, The ‘Floud’ Committee, The Reed Committee* and, most recently, in the joint *Home Office and Department of Health* report on *Managing People with Severe Personality Disorder*.<sup>11</sup>

### **Current Concerns**

Put somewhat crudely, the last ten years or so have witnessed an almost morbid governmental pre-occupation with the need for public protection. This concern has been reflected in a number of legislative ‘themes’. *First*, certain changes in sentencing policy and practice introduced by the Criminal Justice Act, 1991 (as amended by a further enactment in 1993), the Criminal Justice and Public Order Act, 1994, the Crime (Sentences) Act, 1997, (as amended by the Powers of Criminal Courts (Sentencing Act, 2000)), and the Sex Offenders Act, 1997.<sup>12</sup>

In brief, and taken together, the effect of these pieces of legislation has been to concentrate the minds of sentencers, criminal justice and mental health professionals, not only on just deserts, but on *public protection*; the latter a concern much espoused by past and present Home Secretaries. So rapid and numerous have been the various enactments, and so ill thought out as to their possible overall consequences, that it led one distinguished legal academic (who had best remain anonymous) speaking at a conference on severe personality disorder, to state that (and I paraphrase slightly) it seemed to him that legislation appeared to be written down on the back of a post-card between the Home Office and the House of Commons! Such legislation seems to seek an uneasy and perhaps not very workable compromise between punitive and rehabilitative values, with an emphasis on the former. David Faulkner has cogently described this trend in terms of ‘exclusive’ and ‘inclusive’ views of society and human relationships. He states:

The ‘exclusive’ view emphasises personal freedom and individual responsibility, but is inclined to disregard the influence of situations and circumstances. It distinguishes between a deserving majority who are self reliant, law abiding and entitled to benefit themselves without

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9 For a discussion of ‘serious harm’ see Stone, N. A (1995) *Companion Guide to Mentally Disordered Offenders*. Owen Wells, at pp 71-72.

10 Section 4 *National Health Service and Community Care Act 1990*.

Scotland has its own ‘State Hospital’ at Carstairs. Northern Ireland makes occasional use of the English and Scottish facilities. *Dangerous offender-patients in the Republic of Ireland are detained in the Central Hospital, Dundrum*.

11 See Prins, H. (1999) *Will They do It Again?* pp 14-16;

also Padfield, N. (1996) *Bailing and Sentencing the Dangerous*, in Walker, N. *Dangerous People*, Blackstone Press. See also Home Office and Department of Health, (1999), *Managing People With Severe Personality Disorder - Proposals For Policy Development*, and Prins, H. *Dangerous Severe Personality Disorder - An Independent View*, *Prison Service Journal*, 126, 8-10, 2000.

12 For a very helpful discussion of the use of the mandatory life sentence for a second ‘serious’ offence see Plowden, P. *Journal of Mental Health Law*, 5, 101-110, 2001.

interference from others; and an underserving, feckless, welfare dependent and often *dangerous minority* or underclass from whom they need to be protected [emphasis added] ... The contrasting 'inclusive' view recognises the capacity and will of individuals to change - to improve if they are given guidance, help and encouragement; to be damaged if they are abused or humiliated.<sup>13</sup>

Current legislation and practice seem to reflect this polarisation suggested by Faulkner.

Second, current mental health legislation has tended to focus attention and controversy on issues of dangerousness to self and to others.<sup>14</sup> These latter concerns are the subject of legislation for the supervision of a small group of seriously mentally ill persons in the community, thought to be dangerous to self and others, largely on the basis of their non- or sporadic compliance with medication. (Mental Health (Patients in the Community) Act, 1995).

A *third* area has been an increasing preoccupation with the introduction of adequate supervisory procedures, and in particular, the registration of risk. Guidance has emanated from a variety of sources - from central government (NHS Executive) circulars of guidance, from professional bodies (such as the former Association of Chief Officers of Probation, and voluntary bodies such as the Zito Trust, and NACRO). This third force for changes in, and exhortations to improve, practice has been prompted significantly by the publicity given to various *causes célèbres* over the years, for example, the cases of Sharon Cambell, Christopher Clunis, Jason Mitchell, Beverley Allitt and others. Such cases have been the mainspring for the introduction of independent inquiries into homicides committed by those known to the psychiatric services. The need for such inquiries has been the subject of much scrutiny and criticism; it appears that their future control and format will be under the recently established *National Patient Safety Agency* - to be fully operational in 2002.<sup>15</sup>

## Ethical Issues

Before passing on to more clinical matters, it would seem wise to comment briefly upon some important ethical issues. One of the most crucial dilemmas faced by those involved in considering the incapacitation of persons who have exhibited, or are thought likely to continue to exhibit, dangerous behaviour is the requirement for them to balance the need to act in the interests of the community as agents of control and custody on the one hand, and to serve the interests of the individual on the other. Walker has written extensively and informatively on this topic and the brief commentary that follows rests quite heavily upon his work.<sup>16</sup> He alerts us to the fact that, given the current inadequacies of predictive measures (see later), we are likely to detain people in prisons or hospitals on the grounds of their potential dangerousness for far longer than we would on tariff grounds alone. In order to try to limit the need for such detention Walker proposed a set of five 'non-arithmetical rules', as follows:-

13 Faulkner, D. *Building a System on Evidence and Principle: Law Structure and Practice*. Vista, 3, 164-180, 1998.

14 A theme very much emphasised in the recent Government White Paper *Reforming the Mental Health Act, Parts I and II*. Cm 5016-I and II. Department of Health and Home Office, 2000. See also Prins, H. 'Offenders, Deviants or Patients' - Comments on Part Two of the White Paper, *Journal of Mental Health Law*, 5, 21-26, 2001.

15 See Prins, H. (1999) *Will They do It Again? Chapters 4 and 5 for a description of a number of 'homicide inquiries' - their advantages and disadvantages*. The announcement of the new Patient Safety Agency is contained in *NHS Confederation - Briefing - Issue No.49*, May, 2001.

16 Walker, N. (1982) *Protecting People* in J. Hinton (ed) *Dangerousness: Problems of Assessment and Management*. Gaskell, pp23-28.

- (1) The exclusion of most property offenders and those cases which he described as causing temporary alarm such as minor threats to decency, for example indecent exposure. (The latter exclusion seems somewhat questionable since the offence of indecent exposure can cause considerable psychological trauma; moreover, a small proportion of indecent exposer go on to commit more serious sexual crimes.)
- (2) He suggests that isolated out-of-character acts should not be included. Previous similar conduct would help to establish whether or not a pattern existed as, for example, declared intentions of future vengeance.
- (3) This rule would operate in an offender's favour if the incentives for his initial offending ceased to exist or, through incapacity, he or she was considered unlikely to repeat his conduct. However, we should note that the first criterion may be less easy to implement than the latter, since it is not unknown for those who have killed to find surrogate victims.
- (4) More frequent use should be made of close supervision and monitoring in the community. In addition, with his customary foresight, Walker suggested barring certain offenders from certain employments (for example with children).
- (5) Finally, Walker suggests that for those who need to be incarcerated for long periods, their detention should be as humane and progressive as possible. Concerns about prison overcrowding and the treatment regimes in certain Special Hospitals and prisons indicate that Walker's laudable suggestion may not be being fully implemented at the present time.

### **The Culture of Risk and Blame**

'Risk is ubiquitous and no human society can be considered risk free.' This short statement from a publication by the Royal Society rightly emphasises the ever-present nature of risk and the foolhardiness of trying to prevent it with absolute certainty. However, we know that humankind abhors ambiguity and uncertainty; humans will engage in dubious and sometimes harmful practices to avoid them. Much recent and current concern about so-called 'dangerous' people has its roots in these phenomena; unless they are properly understood, many of our efforts aimed at dealing with such people will fail. Beck puts an eloquent gloss on the matter - as follows:

Calculating and managing risks which nobody really knows has become one of our main preoccupations. That used to be a specialist job for actuaries, insurers and scientists. Now we all have to engage in it, with whatever rusty tools we can lay our hands on - sometimes the calculator, sometimes the astrology column.<sup>17</sup>

It is crucial to understand the uncertainty of risk prediction (see later). This is particularly important at the present time when blame is so quickly apportioned in a variety of hazardous and tragic circumstances, be they homicides, train or air disasters, flood damage, or BSE. Much concern about risk is media driven; if mental health, criminal justice and legal professionals are forced into making predictions, there may be an assumption on the part of the public that such professionals are capable of getting it right every time. The latter will then assume (perhaps unwittingly), a mantle of infallibility and have to count the cost when they get it wrong, as from time to time they assuredly will. Homicide inquiries are a good example of this problem and one that needs placing

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<sup>17</sup> Beck, U. (1998) *Politics of Risk Society*. In J. Franklin (ed) *The Politics of Risk Society*, Polity Press.

in perspective. Although the number of homicides committed by persons with mental disorders (particularly mental illness) is very small (and has, in fact, contrary to public opinion, actually declined over the past decade) the media seem to have vastly influenced the politicians in their somewhat frenetic search for solutions.<sup>18</sup> It is also worth remembering (as a means of gaining historical perspective) that 'fashions' in criminal justice and mental health come and go. Soothill<sup>19</sup> has demonstrated the manner in which this may occur. He cites as examples our almost ten-year cyclical preoccupations with, for example, homosexuality and prostitution, with rape, with physical child abuse and with so-called 'satanic' child sexual abuse etc. Recent preoccupation has been with so-called 'serial killing' - a much ill-used and abused term which often serves to obfuscate rather than illuminate.<sup>20</sup> Very recently it has been pointed out to me that current 'folk devils'<sup>21</sup> appear to be 'stalkers' and 'errant doctors'. (Dr. Edward Petch, Personal communication, 13.6.01). Reference has recently been made to the hazards of prediction; it is worthwhile commenting on this aspect in a little more detail. The sometime science correspondent of *The Independent* - William Hartston - once expressed our inadequacies very well - as follows:

Such are the risks we all run every day that, if you are an adult between 35 and 54, there is roughly a one-in-400 chance you will be dead within a year. *Homo sapiens* is a bit of a twit about assessing risks. We buy lottery tickets in the hope of scooping the jackpot, with a one-in-14 million chance of winning, when there's a one-in-400 chance that we won't even survive the year ... the evidence suggests that our behaviour is motivated by panic and innumeracy. (*The Independent*, 19 September, 1997, pp 10-11).

There is a vast and ever growing literature on the prediction of risk.<sup>22</sup> If, by prediction, we mean the capacity to get it right every time, the short answer has to be 'no'. If we have more modest goals, and ask if there are measures that could be taken to attempt a possible reduction in dangerous behaviour, then it is possible to give a qualified 'yes'. Pollock and Webster put the matter very succinctly: 'From a scientific perspective [the question] is impossible to answer since it is based upon an unscientific assumption about dangerousness, namely that it is a stable and consistent quality existing within the individual.'<sup>23</sup> They suggest that a translation into more appropriate terms would produce the following question:

What are the psychological, social and biological factors bearing on the defendant's ... behaviour and what are the implications for future [behaviour] and the potential for change?

Despite the fact that considerable actuarial and computer facilitated research has been carried out into the prediction of anti-social behaviour generally, this tends to suggest that although actuarial

18 See for example, Taylor, P. and Gunn, J. *Homicides by People With Mental Illness: Myth and Reality*, *British Journal of Psychiatry*, 174, 9-14, 1999.

19 Soothill, K. *The Serial Killer Industry*, *Journal of Forensic Psychiatry*, 4, 341-354, 1993.

20 Prins, H. *A Proposed Socio-Legal Classification of Serial Killing - With Special Reference to 'Serial Killing'*. *The British Journal of Forensic Practice*, 2, 9-11, 2000.

21 Taken from the title of Stanley Cohen's book *Folk Devils and Moral Panics*, McGibbon and Key, 1972. (A book that could usefully be read and re-read by all politicians).

22 For studies of the more general aspects of risk and risk-taking see Adams, J. (1995) *Risk*. University College London Press. Also, the Royal Society (1992) *Risk Analysis, Perception, Management*, London. More specifically, in relation to criminal justice and mental health see: Monahan, J. and Steadman, J.H. (eds) 1994, *Violence and Mental Disorder: Developments in Risk Assessment*. University of Chicago Press.

23 Pollock, N. and Webster, C. (1991) *The Clinical Assessment of Dangerousness*, in R. Bluglass and P. Bowden (eds.) (1991) *Principles and Practice of Forensic Psychiatry*. Churchill Livingstone.

techniques can discriminate between high-risk and low-risk *groups*, there will also be a residual majority in the *middle-risk* groups whose re-offending rates are too near 50-50 to be much use prognostically in *the individual case*.<sup>24</sup>

For some years, workers in the criminal justice and mental health fields have taken comfort from the oft-quoted statement by the American psychologist Kvaraceus that ‘nothing predicts behaviour like behaviour’.<sup>25</sup> However, as recent commentators such as Gunn, have pointed out, such statements may rest upon statistical error and reinforce the fallacious view that risk is a static phenomenon and unaffected by changes in social and other circumstances.<sup>26</sup> At the end of the day:

Predicting and preventing violence is a fundamental part of clinical practice ... forensic psychiatrists, psychologists and clinical criminologists are asked to assess cases to make a prediction of the likelihood of harm to others in the future.<sup>27</sup>

### **What’s in a Name?**

The words ‘danger’, ‘dangerousness’ and ‘risk’ have little real meaning on their own. It is only when placed in context that they become useful, but any interpretation must, to some extent, be subjective. Walker makes a useful point when he suggests that ‘dangerousness is not an objective quality, but an *ascribed* quality like trustworthiness. We feel justified in talking about a person as dangerous if he has indicated by word or deed that he is more likely than most people to do serious harm’. (Emphasis added).<sup>28</sup> The Butler Committee, in examining the notion of dangerousness *in relation to mentally abnormal offenders*, considered it to be ‘a propensity to cause serious physical injury or lasting psychological harm. Physical violence is, we think, what the public are most worried about, but the psychological damage which may be suffered by some victims of other crimes is not to be underrated’.<sup>29</sup> Practising clinicians and others who have day-to-day contact with those deemed to be dangerous, generally agree with the late Doctor Peter Scott’s definition that dangerousness is ‘an unpredictable and untreatable tendency to inflict or risk irreversible injury or destruction, or to induce others to do so’.<sup>30</sup> Some clinicians, for example, Tidmarsh,<sup>31</sup> have suggested that Scott’s inclusion of unpredictability and untreatability can be questioned, since the anticipation and modification of a danger does not necessarily minimise the risk. However, Scott did suggest that a key element in the notion of dangerousness was the risk of repetition in the face of measures to reduce it. He also stressed another very important element, namely that its use as a label might contribute to its own continuance - a point that should be heeded by lawyers,

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24 In an evaluation of two risk and need assessment instruments in use by the probation Service, it was found that although the devices predicted reconviction more successfully than ‘chance levels’ the devices were not ‘appropriate for use as the main method of assessing dangerousness’. Home Office, Findings No.143, 2001, p.2

25 Kvaraceus, W. (1966) *Dangerous Youth*, Columbus, p.6.

26 Gunn, J. (1996) *The Management and Discharge of Violent Patients*. In N. Walker (ed) *Dangerous People*, Blackstone Press.

27 MacCulloch, M., Bailey, J. and Robinson, C. *Mentally Disordered Attackers and Killers: Towards a Taxonomy*. *Journal of Forensic Psychiatry*, 6, 41-61, 1995

28 See note 16 *supra*.

29 *Report of the Committee on Mentally Abnormal Offenders*. (Chairman, Lord Butler of Saffron Walden). Cmnd 6244, 1975, p.59. (However, it should be stressed that not all dangerous offenders are mentally disordered and not all mentally disordered offenders are dangerous).

30 Scott, P.D. *Assessing Dangerousness in Criminals*. *British Journal of Psychiatry*, 131, 127-142, 1977.

31 Tidmarsh, D. (1982) *Implications From Research Studies*, in J. Hamilton and H. Freeman (eds), *Dangerousness: Psychiatric Assessment and Management*. Gaskell Books.

sentencers and criminal justice and mental health professionals. For the purposes of this contribution, it is worth noting Floud's statement that 'risk is in principle, a matter of fact, but danger is a matter of judgement or opinion'.<sup>32</sup> Thus, the notion of dangerousness implies a prediction, a concern with future conduct. Most authorities agree that apart from a very small group of individuals who may be intrinsically dangerous because of some inherent physical or other defect (which may make them particularly explosive), the general concern is with the *situation* in which the combination of the *vulnerable* individual with a *provoking incident* may spark off explosive and dangerous behaviour. As noted by the Butler Committee, 'the individual who spontaneously "looks for a fight" or feels a need to inflict pain or who searches for an unknown sexual victim is fortunately rare, although such people undoubtedly exist. Only this last category can be justifiably called: "unconditionally" dangerous'.<sup>33</sup> For our purposes it would seem sensible to now distinguish between *risk* and *danger*.

Risk may be said to be the *likelihood* of an event occurring, and danger may be said to be the *degree of damage (harm)* that may occur should the event take place. Grounds makes the important additional point that both of these also need to be distinguished from worry.

They are not well correlated and judgements and decisions based on worry may not be well founded. The problem is that feelings of worry are expressed by professionals in the vocabulary of risk. The feeling 'I am very worried about X' is likely to be translated into 'X is a high risk' in written and spoken communications. Worry may, however, be excessive or insufficient in relation to the risk. The test is the same as for risk: how well grounded is it in history?<sup>34</sup>

Dangerousness of course means different things to different people. If I asked readers of this journal to rank the following people in order of their dangerousness, they would probably find themselves in some difficulty. Of the following who, for example, would be considered the more dangerous? The bank robber, the persistent paedophile, the person who peddles dangerous drugs to children, the person who drives when knowingly unfit to do so, the swimmer who has a contagious disease, but continues to use the public baths, the bigoted patriot, national leader or politician who believes they are always right, the computer hacker, the person who is HIV positive or has AIDS who persists in having unprotected sexual intercourse with a variety of partners, the consortium which disposes of toxic waste products without safeguards, the forensic mental health or criminal justice professional who always acts on their own initiative without adequate consultation with colleagues and who believes that their 'personality' will 'get them by' in dangerous situations? All of these persons present hazards of one kind or another depending upon the situation in which they find themselves.

### Clinical Considerations

Sentencers (both professional and lay) and mental health and criminal justice professionals have to carry out their work of limiting 'mayhem' within the constraints of the complex legislative and administrative frameworks referred to earlier; so complicated has this legislative framework become, that even experienced sentencers find some of the legal requirements difficult to

32 Floud, J. *Dangerousness and Criminal Justice*, *British Journal of Criminology*, 22, 213-223, 1982.

33 See note 29 *supra*.

34 Grounds, A. (1995) *Risk Assessment and Management in Clinical Context*, in J. Crichton, (ed) *Psychiatric Patient Violence: Risk and Response*. Duckworth, pp 54-55.



interpret. It might be worth considering whether a consolidating piece of legislation dealing with serious and high-risk offenders ought to be introduced. Professionals not only have to deal with these legal complications, but also have to carry out their work within the current 'blame culture' and to endeavour to balance offenders' and offender-patients' needs against the need to protect the public. As has already been stated, the current political climate puts a premium on the latter. In the concluding section of this contribution I endeavour to point out some of the pitfalls for professionals and to suggest ways in which practice might be improved. I begin by providing four case examples in order to demonstrate some of the dilemmas involved.

### **Case I**

'Paul' is in the community on conditional discharge from hospital (Sections 37/41 Mental Health Act, 1983). The order had been imposed for killing his wife. He had been detained in hospitals for some ten years before being conditionally discharged by a Mental Health Review Tribunal (MHRT). The facts of his original offence were that, having killed his wife (by manual strangulation) he had secreted her body, and it was some months before it was discovered. At the time of his arrest he had been seeing another woman on a regular basis. A year after being conditionally discharged into the community he informed his supervising probation officer that he had been seeing a woman and hoped to marry her. In this case the probation officer's responsibilities seemed quite clear. In the first instance, the development needs to be reported to the Home Office (Mental Health Unit - who have central government responsibility for mentally disordered offenders). Second, the officer needs to ascertain from 'Paul' more details of this new relationship. In the course of such discussion 'Paul' would need to be advised that he should inform the woman of his past history (given the particular circumstances of his original offence). Should 'Paul' be unwilling to do so, it is likely that his probation officer (having taken advice from his line management, and maybe the Home Office) would need to inform 'Paul' that in the light of his refusal to do so, he would have to inform her himself.

To some, perhaps, this might seem like an intrusion into an offender-patient's personal liberty, but the broader issue of the protection of the public, in this case the woman he is seeing and maybe others, necessitates such action. The issues seem clear cut. In other cases there are grey areas that require careful consideration of who else should be involved - as illustrated in case 2.

### **Case 2<sup>35</sup>**

'Tom' is a 60-year-old offender released on life licence for killing a child during a sexual assault. He had been convicted on a previous occasion of indecent assault and had then been made the subject of a Hospital Order without restrictions (Section 37 Mental Health Act, 1983). He had been living in the community on life licence for about two years, and had so far not given his probation officer any cause for concern. His probation officer has just received a 'phone call stating that 'Tom' has been seen 'loitering' by the bus stop outside a local primary school. What should his probation officer do about this development? There would appear to be several steps that need to be taken. First, further information is required as to the source and reliability of the information received. Did this information come via the school or, for example, from a bystander who knew 'Tom's'

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<sup>35</sup> This case situation arose and was dealt with before the current sex offender registration procedures were in force.

history and was perhaps out to make trouble for him by deliberately misconstruing a quite innocent piece of behaviour? (After all, he *could* have been waiting for a bus quite legitimately). The second step in trying to elucidate the problematic behaviour would be to arrange a very urgent appointment to see 'Tom'. Why, for example, was he at this particular bus stop? His responses would have to be judged in the light of details about his previous offences. It would be very ominous if, for example, the circumstances of the offence for which he received his life sentence were similar to the present behaviour. Third, the probation officer would have to consider the pros and cons of contacting the school and/or the local police to ascertain if any complaints or comments had been received concerning similar conduct by 'Tom'. Whatever steps the probation officer takes, *the offender is entitled to be told of the action proposed and the reasons for it*. Such information will be likely to be received and accepted more easily had 'Tom' been given very clear indications at the start of his life licence (or conditional discharge, if he had been dealt with through the mental health care system) concerning his obligations under their terms. 'Tom' needs to be made aware of his supervisor's responsibilities to report any apparently untoward conduct. Sadly, there have been occasions in the past when mutual expectations and obligations have not been shared openly. In such cases an offender or offender-patient can feel legitimately surprised when speedy and sometimes apparently condign action is taken. Some other aspects of the "need to tell" are illustrated in the next two case examples.

### Case 3

A psychiatrist had been seeing regularly a male patient on an informal out-patient basis over a period of several months. In the past, he had had a number of compulsory admissions to hospital for a paranoid psychosis. (Sections 2 and 3 of the Mental Health Act, 1983). During a recent session with his psychiatrist, he reveals a powerful belief that a former girl friend has been unfaithful to him, that he has been following her, and that he feels like killing her. What should the psychiatrist do? In the first instance he needs to check back over past records to see if similar beliefs have been expressed on other occasions and what the outcomes were. Second, he needs to make a careful appraisal of the quality of the patient's intended actions, discussing the case with other professionals and/or his professional bodies. For example, the circumstances of the self-reported 'stalking' require careful and detailed evaluation, as does the quality of his expressed feelings about killing her. *Feeling* like killing someone is not quite the same as expressed threats to kill (which of course in law constitute a criminal offence). If his past history reveals similar threats and his *current* threats have a delusional intensity, then the psychiatrist would be exercising appropriate professional responsibility if he arranged for the patient's former girl friend to be warned about his feelings.

### Case 4

My final example concerns a case in which the offender-patient had given clear indication of possible intended harm. This concerned events uncovered during a homicide inquiry which I chaired. The perpetrator of the homicide, who had been known to various health care and other agencies, had given a clear written warning to his supervising social worker of his possible intentions. He wrote a letter from the prison in which he was then being held - as follows:

I think that jail is the Best place for me at the moment because it sort's my head out. If I was on the street I would put peples life at risk, so that's over with [original spelling].

We commented as follows:

Although in retrospect, everyone [now] considered that this letter was important and significant, at the time, its content and import were not communicated [by social services] to the Probation Service ... With hindsight, it would appear that the content of this letter might have prompted a referral for further psychiatric assessment.<sup>36</sup>

It is hoped that the above short case examples illustrate some of the dilemmas faced by professionals and will serve as an introduction to the concluding section of this contribution. It is divided into four parts - as follows:

- (i) Aspects of Communication.
- (ii) Vulnerability.
- (iii) Establishing an Effective Baseline.
- (iv) Improving Practice.

### **(i) Aspects of Communication**

A non mental health and criminal justice professional has wisely stated that 'All tragedy is the failure of communication'.<sup>37</sup> Such a statement embraces four aspects of communication that are relevant to this discussion.

- The need for good interprofessional communication. For example, case conferences frequently fail to work because of the mistaken belief that multi-agency is synonymous with multidisciplinary when, in terms of role perceptions and territorial boundaries, it clearly is not.<sup>38</sup>
- The need for adequate communication between worker and offender-patient and an understanding of the impediments to this. These include ambivalence, hostility, fear and denial, not only on the part of the offender-patient, but also that of the worker. Denial is by no means the sole prerogative of offenders and offender-patients. Maybe both offenders, offender-patients and their professionals should heed Banquo's advice to his fellows:

'And when we have our naked frailties hid,  
That suffer in exposure, let us meet,  
And question this most bloody piece of work  
To know it further.'

*Macbeth*, II:iii

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36 Prins, H., Ashman, M., Steele, G. and Swann, M. (1998) *Report of the Independent Panel of Inquiry into the treatment and care of Sanjay Kumar Patel*. Leicester Health Authority.

37 Wilson, J. (1974) *Language and the Pursuit of Truth*. Cambridge University Press, p.9.

38 For an account of an 'imaginary case conference' see Prins, *Will They do It Again?* pp 127-129.

- How well do professionals 'hear' the concerns of the carers of their charges? In the Andrew Robinson enquiry, it became abundantly clear that Andrew's parents had tried to draw attention repeatedly to their fear of his continued psychotically motivated aggression and violence towards them. Their home had become a place of terror and accounts of their fears appear to have gone unheard. Similar accounts of lack of family involvement may be found in a number of other homicide inquiries.<sup>39</sup>
- The need for professionals to be 'in touch' with the warring and less comfortable parts of themselves. This need may show itself in misperceptions of race and gender needs. For example, in our inquiry into the death of Orville Blackwood in Broadmoor, we considered that perceptions of young African-Caribbeans as always being 'Big, Black and Dangerous' might seriously have handicapped some of the staff's handling of this group of offender-patients.<sup>40</sup>
- There may also be unresolved and professionally limiting personal conflicts about certain specific forms of conduct, notable those involving extreme sexual deviance. Perhaps professionals working in this field should heed the statement by Pericles in Shakespeare's play of that name that 'Few love to hear the sins they love to act'. (Act I:i).

## ii) Vulnerability

The assessment and management of dangerous behaviour and the risk factors involved are concerned, essentially, with the prevention of vulnerability, namely taking care not to place the offender or offender-patient in a situation in which they may be highly likely to re-enact their previous pattern(s) of dangerous behaviour. The recognition of this reduces the vulnerability of both the public to the commission of 'unfinished business' and the vulnerability of the offender/offender-patient.<sup>41</sup>

We would do well to heed the musing of King John in Shakespeare's Play when he says, in thinking about what he has set in train for the young Prince Arthur, 'How oft the sight of means to do ill deeds makes deeds ill done' (IV:ii).

## (iii) Establishing an Effective Base-line

All the research and clinical studies in the area of risk assessment and management in criminal justice and mental health attest to the importance of obtaining the basic facts of the situation. It is this kind of evidence that decision-making bodies, such as Mental Health Review Tribunals, the Parole Board and the Home Office require in order to make the most effective decisions. This necessitates having an accurate and full record of, for example, the index offence, or other incident and, in addition, the person's previous history, especially their previous convictions. A bare legal description tells us nothing about seriousness of intention at the time of the offence, or its prognostic significance. This has become of increasing importance today when 'plea bargaining'

39 Blom-Cooper, L. Q.C., Hally, H., Murphy E. (1993) *The Falling Shadow: One Patient's Mental Health Care, 1978-1993*. Duckworth. For other examples see Prins, 38 above - Chapter 5.

40 Prins, H., Backer Holst, T., Francis, E. and Keitch, I. (1993) *Report of the Committee of Inquiry into the Death in Broadmoor Hospital of Orville Blackwood*

and a Review of the Deaths of Two Other Afro-Caribbean Patients. 'Big, Black and Dangerous?'. Special Hospitals Service Authority.

41 Cox, M. (1979) *Dynamic Psychotherapy With Sex Offenders*, in I. Rosen (ed), *Sexual Deviation*, (Second ed), Oxford University Press.

and advocates' attempts to 'down-grade' offences have become more frequent. An incident that may well have had the ingredients to justify an original charge of attempted murder may eventually end up, by agreement, as one of unlawful wounding. Neither do the bare details of an offence give any real indication of motivation. For example, burglary may take the form of a conventional break-in, or it may have more ominous prognostic implications if, say, the only items stolen were the shoes belonging to the female occupant of the premises. In similar fashion, those males who expose themselves to women in an aggressive fashion associated with erection and masturbatory activity need to be distinguished from those who are more passive and who expose from a distance without erection; the former group are those who are sometimes more likely to go on to commit serious sexually assaultive offences. Scott, in his seminal paper on assessing dangerousness in criminals, stressed the need for a most careful scrutiny of the facts,<sup>42</sup> but sixty years earlier, Freud had also wisely stated 'I learned to follow the unforgotten advice of my master Charcot (the neurologist): to look at the same things again and again, until they themselves began to speak'.<sup>43</sup> And the novelist and polymath Umberto Eco states in his book *Foucault's Pendulum* that 'No piece of information is superior to any other. Power lies in having them on file and then finding the connections'.<sup>44</sup>

Some useful guidance on the basic requirements for risk assessment may be found in the Department of Health's Guidance on the *Discharge of Mentally Disordered People and their Continuing Care in the Community*.<sup>45</sup> The advice emphasises the following points, among others, advocated by the Panel of Inquiry into the case of Kim Kirkman:

past history of the patient; self reporting by the patient at interview; observation of the behaviour and mental state of the patient; *discrepancies between what is reported and what is observed*; statistics derived from studies of related cases and prediction indicators derived from research. (Emphasis added)<sup>46</sup>

Similar points were made by the former Association of Chief Officers of Probation (ACOP) in their *Guidelines on the Management of Risk and Public Protection*. For example, they suggest such questions as:

Who is likely to get hurt? How seriously and in what way? Is it likely to happen right now, next week or when? How often? In what circumstances will it be more rather than less likely to occur? Is the behaviour that led to the offending continuing? What is he/she telling you, not only by words but also by demeanor/actions?<sup>47</sup>

High hopes have been placed upon various procedures for risk *registration*. However, some of the evidence I once gathered from the fields of child care and probation seems to indicate that risk registration does not *necessarily* ensure good practice.<sup>48</sup>

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42 Scott, P.D. *Op Cit*

43 Freud, S. (1914) *On the History of the Psychoanalytic Movement. Vol IV of the Standard Edition of the Works of Sigmund Freud.* (Ed. J. Strachey), Hogarth Press.

44 Eco, U. (1989) *Foucault's Pendulum.* Secker and Warburg.

45 Department of Health (NHS Executive) *Guidance on the Discharge of Mentally Disordered People and Their Care in the Community.* HSG/94/27, 10 May 1994.

46 West Midlands Health Authority (1991) *Report of the Panel of Inquiry Appointed to Investigate the Case of Kim Kirkman.* West Midlands Health Authority.

47 Association of Chief Officers of Probation (1994). *Guidelines on the Management of Risk and Public Protection.*

48 See Prins, H. "I've Got a Little List" (*Koko:Mikado*) *But Is It Any Use? Comments on the Forensic Aspects of Supervision Registers For the Mentally Ill.* *Medicine, Science and the Law*, 35, 218-224, 1995.

#### (iv) Improving Practice

There is no doubt that many professionals carry out very high-quality work in cases requiring risk management. However, there have been instances when the quality of work has shown deficiencies; some of these deficiencies have been highlighted in recent inquiries, such as those into the cases of Andrew Robinson and Jason Mitchell. I now wish to illustrate why this might be and how such deficiencies might be remedied. Basically, it has to do with asking uncomfortable questions. I have tried to group these questions under seven headings in order to describe them as seven possible sins of omission. But before doing so, one or two preliminary general observations may be helpful. Professionals in this difficult and often highly charged area need two types of supervision and support. The first is the support and supervision that holds them accountable to their organisation for what they do. The second, and equally important, is the supervision from line management that enables them to do more effective and empathic work. It is very important for workers to have the chance to share perspectives with their peers. This may assist in the development of knowledge and confidence. The following seven areas of questioning may go some way to providing more effective engagement.

(1) Have past precipitants and stresses in the offender-patient's background been removed? If still present, are they amenable to further work and, more importantly, has the worker the courage to deal with them? A period of long-term work with an offender or offender-patient may induce in the worker a form of 'familiarity', which may blind them to subtle changes in the individual's social and emotional worlds. If we have worked very hard to induce change through the establishment of a 'good' relationship, we may not wish to do anything that may challenge that; we may prefer not to know. Genders and Player, in their study of Grendon Prison, state that they were often reminded of the words of the old song 'I wish I didn't know now what I didn't know then'.<sup>49</sup>

(2) What is the person's current capacity for dealing with provocation? It is useful to remember Scott's advice that aggression may be deflected from a highly provoking source to one that may be scarcely provoking at all. He cited the legendary Medea who, wishing to get back at her unfaithful husband Jason, killed her baby, saying 'that will stab thee to thy heart'.<sup>50</sup> Some of our most perplexing cases are those in which serious violence has been caused to the 'innocent stranger' in the street. Careful scanning of the immediate environment may enable us to sense (and perhaps help the individual to avoid) potentially inflammatory situations. For example, to what extent has the over-flirtatious wife or partner of a jealous husband (partner) courted a potentially dangerous situation by sarcasm, making denigrating remarks about sexual prowess, been otherwise contemptuous, or worn provocative clothing? The same is true with the male in the provocative role, as is the case from time to time, in homosexual relationships. Detailed accounts of previous provoking incidents are therefore vital in order to assess future risk and provide effective continuing management.

(3) How does this offender-patient continue to view him or herself? The need for a 'macho' self image in a highly deviant male sex offender is often based upon unresolved past conflicts with women. This may make him likely to continue to take his revenge by way of serious sexual assaults accompanied by extreme violence and degradation of his victims.

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<sup>49</sup> Genders, E. and Player, E. (1995) *Grendon: A Study of A Therapeutic Prison*. Clarendon Press.      <sup>50</sup> Scott, P.D. *Op. Cit.*

(4) To what extent have we been able to assess changes for the better in this person's capacity to feel empathy for others? Does this individual still treat others as objects rather than as persons upon whom to indulge their deviant desires and practices? The true, as distinct from the pejoratively labelled psychopath, tends to see all those around him (or her) as malevolently disposed.

(5) To what extent does the behaviour seem person-specific, or as a means of getting back at society in general, as is the case in some arsonists who, like the monster in Mary Shelley's *Frankenstein*, are 'malicious' because (they are) 'miserable'? The person who says with continuing hatred in their voice, 'I know that one day I'm going to kill somebody', has to be taken very seriously. To what extent are thoughts of killing or injury still present? Is there a pleasurable feel to their talk about violent acts? Is there continuing interest in such material as violent pornography, horror videos, the occult, atrocities, torture, etc.? Sometimes the 'evidence' is less tangible and 'hunches' need to be relied upon - but always carefully followed up and checked out. Thus, Commander Dagleish in P.D. James' *Original Sin* described his 'instinct' [as something] which he sometimes distrusted, but had learned not to ignore.<sup>51</sup>

(6) How much continuing regard has been paid to what the offender-patient actually did at the time of the offence? Was it so horrendous that they blotted it out of consciousness? For example, did they wander off in a semi-amnesic state or, upon realising what they had done, summon help immediately? Or did they, having mutilated the body, go off happily to a meal and a good night's sleep? How much are they still claiming it was a sudden and spontaneous crime, when the evidence shows planning and premeditation? What was the significant role of substance abuse of one kind or another? Prisons and, to a lesser extent, secure hospitals are not ideal places for testing out future proclivities in such people. However, escorted periods of leave with close supervision may enable alcohol intake and its effects to be assessed. The persistent paedophile on an escorted group outing to the seaside may alert observant nursing staff to continuing abnormal sexual interest by having eyes only for the semi-naked children playing on the beach. In similar fashion, staff may report patients' interest (and arousal) when in the presence of the children of visitors to the ward, or to pictures of children on the television. How much is known about what 'aids' to sexual fantasy they are storing in their rooms or cells? (For example, newspaper clippings, graphic details from court depositions.) The offender-patient who says he is writing his life history in a series of exercise books could well be asked to show them to us; somewhat surprisingly, they are very often willing to do so. We may find detailed descriptions of continuing violent and/or sadistic fantasies, which are being used as rehearsal for future activity. All these indicators, coupled with psychophysiological measures, may help us to obtain a better, if not conclusive, perception of likely future behaviour.

(7) To what extent can we discern that this individual has begun to come to terms with what they did? It is important for all professionals and decision-makers to regard protestations of guilt and remorse with a degree of caution. As Russel and Russel state:

A person who expresses guilt is to be regarded with vigilance. His next move may be to engineer a situation where he can repeat his activities (about which he expresses guilt), but this time with rationalisation and hence without guilt. He will therefore try to manipulate his victim into giving him a pretext.<sup>52</sup>

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51 James, P.D. (1994) *Original Sin*. Faber.

*Behaviour*. Little Brown.

52 Russel, C. and Russel, W.M.S. (1961) *Human*

Sometimes, an offender or offender-patient may be reluctant to acknowledge the truth of what they have done for fear of causing hurt to relatives and others close to them. The late Doctor Patrick McGrath, sometime medical superintendent at Broadmoor, cited the case of a paedophilic sadistic killer who consistently denied his guilt in order to spare his 'gentle devoted parents who could not believe his guilt'. When they died, within a fairly short while of each other, he willingly admitted his guilt, and in due course was released.<sup>53</sup> Neither should we forget that in relation to confession and guilt, offender-patients may, in fact, not be guilty of any crime, as a number of *causes célèbres* have so sadly demonstrated.

## 7. Concluding Comments

In this contribution I have endeavoured to place notions of dangerousness and risk within past and current contexts. I have tried to provide some helpful examples of ways in which the supervision of dangerous offenders might be made more effective. Although the advent of sophisticated computational techniques has undoubtedly provided a platform for actuarial advances, it is still the worker at the *individual* level who has to make prognostic judgements and undertake the hazards of ongoing supervision. It is comparatively easy and safe to predict what someone will do two weeks or even a month hence; much more hazardous to predict what they might do in a year's time. In recent years, a good deal of time and energy has gone into other advances, such as offender profiling and much has come to be expected of it. However, recent work has tended to show that much more needs to be done in this field. In addition, profiling is not without its critics.

Central to the task of the criminal justice or mental health professional is a commitment to detail and to tracing connections between behaviour patterns. It also involves a great deal of personal soul-searching in order to come to grips with behaviour that is frequently anxiety-making and sometimes horrifying. It also calls for operating with a greater degree of surveillance and close monitoring than is customary in some areas of 'counselling'. It certainly involves a capacity not to attempt to 'go it alone' and in this area of work there is no place for 'prima donna' activities. Despite the difficulties (or maybe because of them), many workers enjoy the challenge presented by those who have shown, or are adjudged likely to show, dangerous behaviour towards others.<sup>54</sup> Sadly, but perhaps understandably, politicians and the general public have very high expectations that mental health and criminal justice professionals can 'get it right' every time. Professionals can only give of their best on the understanding that they are not infallible; and if society has ordained that risks through legislation will be taken, then occasional failures are inevitable. This is the harsh reality in a field where much is still uncertain and as yet unknown.<sup>55</sup>

## Acknowledgement

My thanks, as usual, to Mrs. Janet Kirkwood for bringing order out of the usual chaos of my drafts.

53 McGrath, P. Book Review. *British Journal of Psychiatry*, 154, p. 427, 1989.

54 Such was the view of a small group of consultant forensic psychiatrists when asked for the reasons why they chose to specialise in forensic psychiatry. See Prins, H. *Characteristics of Consultant Forensic Psychiatrists: A Modest Survey*. *Journal of Forensic Psychiatry*, 9, 139-149, 1998.

55 After this contribution had been drafted, I came across a very thought-provoking paper by Rungay and Munro

(2001) in which they provide an innovative perspective on why it is that professionals seem to be found wanting in so many homicide inquiries. Their central thesis is to suggest that apparently what appears to be 'insensitive behaviour stems from the deployment of rationalization for denying care to mentally ill individuals, in situations in which professionals experience powerlessness to intervene effectively'. See Rungay, J and Munro, E. *The Lion's Den: Professional Defences in the Treatment of Dangerous People*. *Journal of Forensic Psychiatry*, 12, 357-378, 2001