Irish Journal of Applied Social Studies
Est 1998. Published by Social Care Ireland

Volume 2 | Issue 2 Article 2

2000-01-01

Editorial: The Future of Dangerous Severe Personality Disorder in Ireland

John S.G. Wells

Recommended Citation
Wells, John S.G. (2000) "Editorial: The Future of Dangerous Severe Personality Disorder in Ireland," *Irish Journal of Applied Social Studies*: Vol. 2: Iss. 2, Article 2.
Available at: http://arrow.dit.ie/ijass/vol2/iss2/2

Editorial: The Future of Dangerous Severe Personality Disorder in Ireland

John S.G. Wells,
Deputy Editor, Irish Journal of Applied Social Studies
e-mail jwells@wit.ie

Introduction

The recent murderous attack on a church congregation by a naked man with a sword in the UK, widely reported in Ireland, once more raises the issue of the way the media shape or reflect the popular perception that the mentally ill are a threat from which the public is at risk. The fact is that is how people view them and this perception appears to be growing. For example, recently there appeared reports in the media that the Gardai trawled psychiatric hospitals in the Dublin area in the belief that the murderer, dubbed a "psychopath" in the media, of Raonaid Murray might be an outpatient (Allen, 1999). Whilst all avenues in a police investigation have to be pursued, the impact of such reports on public views is that it further enhances the sense that mentally ill people are more likely than most to be violent. Thus the recent survey conducted by the Royal College of Psychiatrists on the Irish public's knowledge of mental illness found that 57% strongly believed that people with schizophrenia are violent (Timmins, 1999).

In a number of countries in recent times, there have been one or two murderous incidents which, to the public mind, have seemed so incomprehensible that they have been dubbed "evil" and the word psychopath, which taps into a deep-rooted public anxiety about the mentally ill, has been attached to the murderers by the media. In the United Kingdom there was the murder of a mother and child by Michael Stone (BBC, 1999). In the United States the mass murder by two pupils of their schoolmates in Littleton, Colorado and "copycat" incidents that followed (Wells, 1999). In Australia, the case of David Garry and his actions and threats of violence towards police officers (in this case resulting in the passage of a specific Act of Parliament specifically to contain him alone) (Williams, 1990). Finally, in Ireland we have the case of Brendan O'Donnell and his murder of a priest and mother and child. The professional disagreements as to whether or not such individuals are "mad" or "bad", usually a product of the adversarial legal process and reported in the media without qualification serve to increase the sense of public vulnerability.

A deep seated public fear attached to such terms as "psychopath" has been compounded by the revelation that a number of the perpetrators of these crimes were already known to the authorities and, more particularly had had contact at one time or another with psychiatric services. Such revelations combined with public fear have led to political pressure in a number of countries to introduce pre-emptive measures for the protection of the public.

At the centre of these policy developments is how to manage people suffering from what is variously labelled anti-social, psychopathic, severe or dis-social personality disorder. The behaviour of the minority of persons with severe personality

disorder is often identified by the public as representative of the behaviour of all mentally ill people, and as such reinforces the vulnerability of mentally ill people to prejudice.

What is Severe Personality?

Severe personality disorder has been described as "a persistent disorder or disability of mind that results in abnormally aggressive or seriously irresponsible conduct of the person concerned". Such persons generally have an inability to relate to others and have difficulty learning from previous experience (Department of Health, 1983; Department of Health and Home Office, 1999). They find it difficult to form meaningful relationships, have a low tolerance of frustration, a marked proneness to blame others and a callous disregard for those around them. They often have a criminal history and are also likely to suffer from mental illness.

They generally have a history of childhood difficulties often consisting of an abusive and neglectful family background and poor educational attainment. Many were diagnosed during childhood as having a "conduct disorder". During adolescence they often demonstrate excessively indulgent behaviours involving substance and alcohol abuse, sexual precociousness and thrill seeking behaviours. Consequently they are likely to acquire a criminal record at an early age (Melia et al, 1999).

The average prevalence rate for severe personality disorder in the community found by a number studies stands at between 2-3% (Department of Health and The Home Office, 1999). However, prevalence is considerably higher in the prison population [ibid].

Despite the acceptance of the existence of the phenomenon of severe personality disorder, opinion is divided as to whether it can be categorised as a mental illness, what precisely constitutes the disorder and whether it is treatable (Ashworth Special Hospital Report of the Committee of Inquiry, 1999). The result of these factors is that psychiatrists in general are reluctant to assume responsibility for such individuals as a result of the apparent futility of intervention and the prospective fear of condemnation should these individuals offend violently.

Proposals for Managing Dangerous Severe Personality Disordered People

A number of governments have or are taking determined steps with regard their treatment in the vacuum left by professional disagreements. These involve some form of preventative detention and an insistence that forensic psychiatrists and other psychiatric professionals proactively engage with this client group in terms of risk assessment, containment and treatment.

The USA, Australia and Canada have a community protection model with an emphasis on public safety. Persons deemed dangerous Anti Social Personality Disordered, a risk to future public safety and who commit a crime may be detained indefinitely even if the index offence does not carry a life sentence. These powers come into operation at the time of sentencing or on completion of a term of imprisonment (Department of Health and The Home Office, 1999). The emphasis here is on detention, which can take place either in prison or psychiatric hospital.

The Netherlands and Sweden have a clinical model, in which the emphasis is on diagnosis, prognosis and treatment. The Dutch system for example, allows indeterminate detention in a specialist clinic if an individual is convicted of a crime, which carries a penalty of 4 years or more, is judged to have impaired mental faculties and poses a serious risk of danger to the public.

In our nearest neighbour, the UK, severe personality disorder is recognised under their Mental Health Act, yet British psychiatrists remain largely reluctant to take responsibility for its management. The case of Michael Stone has prompted the UK government to publish two sets of proposals involving preventative detention in order to manage adults with severe personality disorder. The Government also propose to implement a mass screening programme to identify children at risk of developing future severe personality disorder and thereby facilitate early and corrective cognitive and behavioural interventions (Department of Health and The Home Office, 1999).

Others have called for society to recognise that psychiatry is often unable to treat violent or perverse individuals. Such appeals, it seems to me fly in the face of reality. The truth is that psychiatry is expected to deal with such individuals. To opt out is not a realistic option. Rather the discipline has to focus on what can be done, what needs to be developed and how best to engage the public in understanding the different degree of threat posed by different types of mentally disordered individual. What, therefore, is the significance of these international developments for the position in Ireland?

The Irish Situation

Accurate information on the prevalence of severe personality disorder and associated violence in Ireland is difficult to come by. However, there are a number of sources of information which, placed in the context of the international literature, would indicate that Ireland like other nations does have a problem. Current available data on admissions for personality disorder are comparatively small, standing at 40.6 per 100,000 population (Health Research Board, 1996). This roughly works out as a prevalence rate of 4% in Irish psychiatric hospitals (Cooney et al, 1996). This data is undifferentiated between the different types of personality disorder. However, given this statistic it appears likely that those admitted for antisocial personality disorder will be small. However, there is some evidence that indicates that true nature of its prevalence in Ireland is much larger than such data allows for. For example, a study by Cooney et al (1996) of 78 first-time admissions to two psychiatric hospitals over a four-month period found a prevalence rate of 26%. Of these 78, 1 fell clearly into the category of dissocial personality disorder, though a further 6 were of the paranoid/schizoid type. A study in Northern Ireland found that in 44% of suicides there had a personality disorder, the most common being paranoid (14%). Antisocial Personality Disorder was found in 8% of suicides.

A study of the level of serious assaults carried out on mental health professionals surveyed 178 psychiatrists and trainees within the Irish psychiatric system (O'Sullivan and Meagher, 1996). It found that persons with a personality disorder carried out the highest proportion of assaults on psychiatrists (37%). The authors, O'Sullivan and Meagher (1996), conclude that this high

rate is reflective of the increasing number of people with personality disorder being seen by psychiatrists in Ireland.

What these studies demonstrate is that the more severe types of personality disorder are highly prevalent within the psychiatric population. Why then do the official statistics seem to underestimate them. Part of the reason may lie in the large number of young adults within the criminal justice and penal system, which helps to mask the true extent of the issue.

O'Mahoney's (1997) study points to the remarkable homogeneity of the childhood history of the Mountjoy prison population with regards impoverishment, unstable and abusive family backgrounds, lack of educational qualifications, drug and alcohol abuse, and their inability to form stable relationships. In addition, one in four had attempted suicide and many had had a psychiatric history. All of these, as indicated earlier, feature heavily in the aetiology of severe personality disorder. It must also be borne in mind that the rise in the number of sex offenders in the prison population is also indicative that severe personality disorder is likely to be a feature within the prison population. That is not to say that Mountjoy and other prisons in the state have an exclusive population of people with severe personality disorder, but it may indicate that the disorder does feature as a primary or secondary problem in a number of cases.

This conclusion receives some support from a 1990 analysis of the number of admissions to the Central Mental Hospital, the primary secure forensic facility within the State. This found that prison transfers accounted for 50% of admissions and that 25% of these were of people with a diagnosis of personality disorder (O'Connor et al, 1990). Further support can be gleaned from a

1995 study of 100 admissions to the St Michael's Assessment Centre for juvenile delinquency conducted by Barnes and O'Gorman (1995). They found that 27% of their sample, all under 16 years, fulfilled the diagnostic criteria for conduct disorder, whilst a further 8% fulfilled the criteria for a primary diagnosis of antisocial personality disorder.

The Irish Response to Severe Personality Disorder

Having looked at the possibility of the prevalence of severe personality disorder in Ireland, we need to ask what is the likely environment that psychiatric practitioners in Ireland will need to negotiate? The answer, in my opinion is a little pessimistic, though I must emphasis that my views are contrary to the apparent received opinion within psychiatry in Ireland itself. The focus of my concern is the proposals contained in the White Paper (Department Health, 1995) of on the new Mental Health Act.

For the purposes of the Act it is proposed that mental illness be defined as "a state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he or she requires care or medical treatment in his or her own interests or the interests of other persons" (Department of Health, 1995:21). The proposed criterion for involuntary admission is that a person is suffering from a mental disorder and that there is a likelihood of immediate or imminent harm to self or others. However, personality disorder is specifically excluded from the definition of mental disorder because of the debate on whether or not it is a mental illness. The Irish division of the Royal College of

Psychiatrists (1997) has welcomed this exclusion. This, it seems to me, is regrettable for a number of reasons.

From a legal and civil liberties perspective it is clear that case law under the European Convention for the Protection of Human Rights and Fundamental Freedoms has established that persons categorised as suffering from a severe personality disorder may be detained. Failure to include it within the scope of a new Mental Health Act condemns this group of disturbed individuals to be dealt with within the penal system exclusively. Access to psychiatric expertise is likely to be limited at best as a result. Thus, this apparent denial of the issue will require prison authorities and staff to contain these individuals and deal with their problems as and when they commit and are sentenced for offences.

The White Paper proposals have recently been criticised for their lack of specificity (Law Society's Law Reform Committee, 1999) with regard the definition of mental illness (the Bill has yet to be presented to the Dail at the time of writing). The Law Society cites a proposal by Cooney and O'Neil, (1996) that severe mental illness should be defined in terms of severe impairment of emotional processes and gross behaviour or perceptions, combined with an assessment of dangerousness and treatability. It is perhaps to be regretted that the Law Society did not take this further and draw attention to the fact that under this criteria it would be appropriate to include severe personality disorder within the remit of the proposed Act.

Resistance to include severe personality disorder within the new mental health legislation is based on the view that it would be inappropriate to include it because of the lack of agreement as to

its constitution and treatability and that the balance of psychiatric opinion is that mental illness and psycopathy are quite distinct. However, it seems to me this flies in the face of the reality on the ground as far as practice is concerned.

For example, there have been recent newspaper reports on the lack of secure treatment facilities for a boy in the Southern Health Board Region who has been assessed by psychiatrists as posing a serious threat to women and girls because of his declared intention and detailed plans to sexually abuse and murder them [Irish Times, 1999]. It is clear that this individual is dangerous, it is also clear that this person is deeply disturbed. It is also clear that he requires a secure therapeutic environment and that the most appropriate carers in this case will be psychiatrists and other mental health professionals. The fact that severe personality disorder will not be recognised under the law does not change any of these issues, but rather serves to further complicate the environment in which practitioners have to operate in relation to such individuals in the future.

Practitioners who believe severe personality disordered individuals do require treatment will merely circumvent the lack of legal provision. For example, during a murder trial at the Central Criminal Court last year it was revealed that the accused had a history of severe antisocial personality disorder. His psychiatrist had attempted to secure him admission to the Central Mental Hospital which, she believed, could help him, by describing him as having a mild mental illness (Irish Times, 1998). Thus lack of inclusion will foster a manipulative practice environment. Furthermore, the need to develop proactive interventionist policies will only become more pressing. The weight of evidence from around the world is that some form of

proactive therapeutic intervention is likely to be needed at some point in the future for the difficult small minority.

Conclusion

Deprivation of liberty within criminal law has always been explained in terms of punishment and is dependent upon the concepts of individual responsibility and moral wrongdoing. Punishment must also be proportionate to the offence. The exception to this case is insanity, since the insane have no moral culpability. Persons with severe personality disorder fall between both stools. Prediction of dangerousness is problematic. Most systems rely on the assessment of a pattern of behaviour linked to offending. The problem is, however, how does one differentiate between a violent offender who is "normal" and one who is an anti-social personality disorder. Policy has to strike a balance between the interests of individuals and those of society. The lack of inclusion of severe personality disorder within the proposed mental health legislation serves neither. It leaves us all vulnerable.

References

Allen, L [1999] Raonaid: hunt for known psychopath *Sunday Tribune* 19th September.
Timmins, E [1999] Psychiatrists warn of mental illness stigma *The Irish Times*
BBC, [1999] *BBC World Service News*19th July.

Williams, C [1990] Psychopathy, mental illness and preventive detention: issues arising from the David case *Monash University Law Review* 16:2:161-183.
Department of Health, [1983] *The Mental Health Act London* HMSO.
Department of Health and Home Office, [1999] *Managing Dangerous People with Severe Personality Disorder Proposals for Policy Development* London HMSO.
Melia , P, Moran, T, Mason, T [1999] Triumvirate nursing for personality disordered patients: crossing the boundaries *safely Journal of Psychiatric and Mental Health Nursing* 6:15-20.
Ashworth Special Hospital Inquiry, [1999] *Ashworth Special Hospital Report of the Committee of Inquiry* London HMSO.
Health Research Board Website [1996] *All psychiatric hospitals and units: admissions analysed by martial status, age and sex* http/HRB.ie
Cooney , T; O'Neill, O [1996] *Psychiatric Detention and Civil Commitment in Ireland* Baikonur Delgany.
O'Sullivan, M; Meagher , D[1996], A survey of Irish Psychiatrists and Trainees *Irish Journal of Psychological Medicine* 13:1:50.
O'Mahoney, P [1997] Mountjoy Prisoners: *A Sociological and Criminological Profile* Dublin Stationery Office.
Wells, J [1999] *Murder and Madness in Ireland* – Conference Paper Working with Vulnerable Populations The Millennium Conference of the Isles Waterford Institute of Technology Oct 21-22.
Barnes, J; O'Gorman, N [1995] A descriptive study of juvenile delinquents *Irish Journal of Psychological Medicine* 12:2:53-56.
Department Health, [1995] A New Mental Health Act White Paper Dublin Stationary Office.

Law Society's Law Reform Committee, [1999] *Mental Health: The case for reform* Dublin Law Society of Ireland.
Cooney, J; Farren, K; Clare, A [1996]Personality disorder among first ever admissions to an Irish public and private hospital *Irish Journal of Psychological Medicine* 13:1:6-8.
Irish Times [1999] Lack of special treatment unit for boy criticised *The Irish Times* 27th August.
Irish Times, [1999] Psychiatrist says she gave false diagnosis *The Irish Times* May 27th.