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Mentally Abnormal Killers in the UK Health Care System: Issues Facing the Multidisciplinary Team

REFERENCE: Hambridge, J. A., "**Mentally Abnormal Killers in the UK Health Care System: Issues Facing the Multidisciplinary Team,**" *Journal of Forensic Sciences,* JFSCA, Vol. 40, No. 1, January 1995, pp. 69–73.

ABSTRACT: In the UK, mentally ill offenders can be assessed and given treatment and rehabilitation in a secure health care setting rather than in a correctional facility. Beds in such health care facilities are limited and evidence suggests that only the most serious offenders, such as those who have committed a homicide, are given priority. This paper examines the role of the Regional Secure Unit, a National Health Service provision, in the assessment and treatment of these offenders. A number of issues facing the multidisciplinary team are raised. A case study is presented to illustrate some of these points.

KEYWORDS: psychiatry, mentally ill offenders, health care systems

The philosophy of providing treatment for offenders in a health facility rather than in a correctional facility is documented in the Department of Health/Home Office circular 66/90 [*1*], which advises that no person detainable under the Mental Health Act (1983) should be detained in prison. However, this philosophy is not reflected in practice, with some studies indicating that 2%–9% of prisoners are suffering a psychotic illness [*2,3*]. Reasons for this failure in practice are many, but include the slow development of secure health service facilities [*4*] as well as problems of transfer [*5*]. Evidence suggests that those who have committed the most serious offenses have the greatest chance of receiving psychiatric help [*6*].

There are two main types of health facility for such mentally ill offenders: Special Hospitals and Regional Secure Units (RSUs).

Special Hospitals

Prior to the establishment of the RSUs in the late 1970s and 1980s, the maximum security Special Hospitals traditionally took patients who were difficult or dangerous. These hospitals are geographically isolated, and although staffed by nurses, they are represented by the Prison Officers Association. In the past these hospitals have been severely criticized for their custodial philosophy and practices [*7–10*] and some have suggested their gradual closure [*11*]. The growth in numbers of RSUs, combined with changes in admission policy in Special Hospitals [*12*] has meant that only those individuals who are perceived to pose a "grave and immediate danger" to the public should they abscond are now admitted to the Special Hospitals.

Received for publication 2 Feb. 1994; revised manuscript received 25 May 1994; accepted for publication 8 June 1994.

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Regional Secure Units (RSUs)

This form of secure provision has developed slowly [*4*] following the recommendations of the Butler Report [*13*] and currently provides 597 permanent beds [*14*] spread through most of the 14 Regional Health Authorities in England and Wales [*15*].

The Regional Secure Units (RSUs) aim to provide assessment and treatment of mentally disordered offenders in conditions of "medium security." They are staffed exclusively by health professionals rather than correctional staff. All units are multidisciplinary, usually comprising a consultant psychiatrist, psychiatry registrar, clinical psychologist, occupational therapists, social workers and psychiatric nurses. The units typically hold 20 to 100 patients, usually in a number of wards. There is a fairly high level of physical security, which minimizes the possibility of escape, but the philosophy is one of assessment, treatment, and rehabilitation rather than detention. Within wards there is usually freedom of movement, though many RSUs restrict access to patients' rooms during therapy time. Patients gradually acquire more freedom as part of their rehabilitation program throughout their post-trial period in the unit. Typical stages of increasing freedom might include (depending on the particular unit):

1. escorted by staff in secure grounds
2. allowed in secure grounds without escort
3. escorted by staff in non-secure grounds
4. allowed in non-secure grounds without escort
5. allowed into local community without escort
6. allowed overnight visits away from unit

The Role of the RSU in Homicide Cases

Under English Law (Homicide Act, 1957, section 2 [i]), if a person kills or is party to the killing of another and is found to have been suffering at the material time from "such abnormality of mind. . . . as substantially impaired his mental responsibility for his acts or omissions . . ." then that person will *not* be convicted of murder. In such cases it is common for a person to be found guilty of the lesser charge of manslaughter on the grounds of diminished responsibility.

The RSUs therefore often have an assessment role in homicide cases. Patients are typically admitted from remand prisons a few weeks or months after the offense, when there is some question over their mental state at the material time. They are usually

involuntarily committed under relevant sections of the Mental Health Act (1983). Their assessment usually takes place over a period of months and it is common for the patient to go to trial directly from the RSU. If offenders are found guilty of manslaughter on the grounds of diminished responsibility, are not considered to pose a grave risk to the public, and psychiatric reports suggest there is likely to be a positive response to treatment, then they are likely to be returned to the RSU for treatment under a Section 41 Restriction Order of the Mental Health Act (1983).

RSUs also accept mentally abnormal killers from Special Hospitals to assess their suitability for discharge into the community. In these cases the homicide has typically occurred many years ago. This paper will not focus on these patients since they pose different problems for the treatment team.

Homicide and Mentally Abnormal Offenders in RSUs

The relationship between mental illness and homicide is a contentious one, with many methodological pitfalls for researchers. Some have suggested that serious mental illness is no more prevalent in homicide offenders than other groups [*16*], but others report much higher prevalence rates. In Denmark all persons accused of homicide are examined by at least one psychiatrist. One retrospective study over a 25 year period found that 20% of men and 44% of women convicted of homicide were diagnosed as psychotic [*17*]. Epidemiological surveys by Coid [*18*] indicate that more than 25% of homicides in England and Wales are committed by mentally abnormal offenders. Although these figures give some idea of the number of mentally abnormal homicide offenders it is difficult to obtain reliable information on the number of cases entering the RSU system since no centralized data system exists. Fraser [*19*] noted that 8.2% (8) and Earp [*15*] reported 2.9% (4) of all admissions to their RSUs in a five year period followed a conviction for homicide. In the North West Regional Health Authority, 12.3% (10) of all admissions in a three year period to just one 22 bedded ward of the RSU were of patients who had committed a homicide.

Although homicide cases constitute relatively small numbers of individuals they can often expect to reside in the RSU for two years. Almost invariably these patients will be subject to a section 41 Restriction Order (Mental Health Act, 1983), which means that any movement outside of the hospital must be approved by the Home Office. In practice, the process of continual monitoring by the Home Office may further extend their stay.

Their length of stay, and the aforementioned changes in Special Hospitals admission policies suggests that mentally abnormal killers may come to form an increasing proportion of the RSU patient population. It is possible that this is reflected in the author's recent experience when 25% (5) of patients on one ward of an RSU had committed a homicide.

Diagnosis of Offenders

In one study [*12*] the diagnoses of those convicted of section 2 manslaughter in the UK were: 20% schizophrenia; 37% depression and 27% psychopathic disorder. The remaining 16% had no formal psychiatric diagnosis. The lack of a centralized database makes generalizations difficult but in the author's experience those admitted to RSUs following homicide most commonly appear to be suffering from schizophrenia or major depressive illnesses. Those diagnosed as suffering from psychopathic disorder are more likely to be referred to Special Hospitals because of their perceived dangerousness and poor prospects for rehabilitation.

Victims

There are no figures readily available for section 2 manslaughter in the UK, but in 1986 the victim and perpetrator were known to each other in 70% of homicide cases [*20*]. Dell [*12*] found that 50% of the manslaughter offenses took place in a home shared by the victim and offender. Manslaughter therefore appears commonly to be a family affair.

In summary, there are a number of patients entering the RSU system for assessment and treatment, usually diagnosed as suffering from schizophrenia or major depression, who have commonly killed a family member/friend. Their length of stay and changes in admission policy mean that they are likely to form an increasing percentage of the population of RSUs.

Issues Facing the Multidisciplinary Treatment Team

Whom to Admit?

As there are often more offenders than places in RSUs, an informal screening process necessarily precedes more formal assessment. In the absence of a comprehensive database it is difficult to determine precise reasons for an RSU's acceptance or rejection of a prisoner. Coid [*5*] retrospectively examined the records of all mentally abnormal men charged with a variety of offenses, and remanded to one prison for psychiatric reports over a five year period. He found that those with mental retardation, organic brain damage or a chronic psychiatric illness rendering them unable to cope independently in the community were the most likely to be rejected by the National Health Service. While these results may not be generalized to all regions in the UK, in the author's experience those with organic brain damage and mental retardation are unlikely to be admitted, even though there may not be any other suitable facilities available outside of the prison system. Those with a long history of psychiatric illness also appear to be given lower priority than those with no previous history. In the absence of highly specific entry criteria, screening for entry for assessment at an RSU is based on signs or suspicions of mental abnormality, bed availability and perceptions of relatively high level of dangerousness and good rehabilitation prospects.

The RSU screening process can also place prison doctors in a difficult position. Should prison doctors optimally treat prisoners with psychotic illness and thereby reduce their chance of admission to a RSU? Equally, should they not treat and risk the prisoner being considered too disturbed for admission?

How Do You Assess the Patient Once Admitted?

The usual range of multidisciplinary assessments help build a profile of the offender, which can assist the judicial process. However, two issues, not uncommon in forensic psychiatry need to be addressed: faking bad and faking good. With some offenders, there is the suspicion that they may be faking their illness to escape a more severe punishment. Alternatively, other offenders have hidden or attempted to hide their illness from others prior to the offense and continue to do so afterwards, for reasons that are unclear. Later they may attempt to hide their symptoms to speed their discharge. Assessment in both cases necessitates systematic, continuous observation in the RSU. The person will not have faced such continuous observation while in a correctional setting from people with a knowledge of psychiatry. Unusual or inconsistent behavior may then be detected. Observations can be sharpened by the use of formal monitoring instruments (for example, Psychotic

In-Patient Profile [21]). Other patients can sometimes also be a valuable source of additional information. There is a growing literature on the detection of simulation and dissimulation, using such instruments as the MMPI [22–24] and the Millon Clinical Multiaxial Inventory [25]. Although these and other tests may assist in detecting malingering, their reliability and validity are low [26,27]. The author has used several neuropsychological tests designed to detect malingering [28]. These are not presented as neuropsychological tests but as part of the general assessment. In addition, the author has found that the performance demands of the Object Relations Test give the opportunity to look for bizarre responses, which may indicate faking. However, neither of these methods have been validated with a forensic population.

In summary, both forms of faking may be detected by building a comprehensive picture of the patient's behavior, from observation, monitoring, discussion with others in the patient's milieu and the use of tests.

How Do You Maintain a Therapeutic Rather Than a Custodial Atmosphere?

To avoid the custodial pitfalls of the Special Hospitals efforts must be made to ensure that the philosophical position of the unit is clearly outlined and all staff are introduced to this in their induction phase, so that they understand that treatment and security values can coexist [29]. Even the physical design and furnishings of the unit can be used to emphasize a treatment philosophy. The RSU should also have the management framework to constructively deal with staff attitudes to the offender. For example, if the patient has killed his mother and a member of staff has recently lost his or her mother, then that staff member may have particular difficulties in dealing with that patient. These difficulties should be acknowledged and worked through. If staff members have preferences for the patients with whom they work, then efforts should be made to accommodate these. Good exchange of information between staff in both the assessment and treatment phases helps to ensure that the focus is on rehabilitation and treatment. Formal debriefing and supervision mechanisms should also be in place to help staff deal with this difficult work.

How Do You Treat Mentally Abnormal Killers?

In another paper [30] the author has lamented the lack of treatment guidelines for these patients and consequent difficulties which face the multidisciplinary treatment team. Treatment guidelines suggested by the author in that article are summarized in Table 1.

A number of these issues facing the multidisciplinary team are illustrated in the following case history.

TABLE 1—*Treatment guidelines.*

Treatment focus	Intervention
Major psychiatric illness underlying offense	Medication—slow, careful titration Psychoeducational programs
Offender's understanding of offense	Comprehensive explanatory model, using depositions and other relevant information
Post Traumatic Stress Disorder (may become obvious once symptoms of major psychiatric disorder have ameliorated)	Medication Educate, reassure Teach coping strategies to deal with symptoms
Suicide prevention	Monitor closely—especially when insight & clarity of thought return
Grief	Grief therapy Using patient's own coping strategies
Guilt over lack of severe punishment for offense	Cognitive restructuring
Re-integration into society	Problem solving; rehearsals; role plays Increasing personal freedom
Family/friends	Psychoeducational programs (include legal aspects) Discharge planning

Case History

Background

Bill was a 35-year-old married man admitted to the RSU from remand prison on a murder charge. Many staff had preconceived ideas about him due to the extensive coverage his case had received in the local press. His offense occurred in the home of his wife's father, where the victim had been hit on the head with an iron bar and stabbed repeatedly in the neck with some gardening shears. Such was the force of the attack that the blades of the shears had broken off in the victim's neck. The victim was found by his open safe and a considerable amount of cash was missing. One week after the offense Bill confessed to his wife that he had committed the homicide. The cash was never recovered. Staff were resistant to admitting him for assessment due to a mixture of perceived dangerousness and some presumption of premeditation related to the missing cash. However, the views of the consultant psychiatrist prevailed and he was admitted for assessment.

Assessment

Almost immediately on admission there was suspicion among staff that Bill was faking his psychotic symptoms. This suspicion appeared to be related to both the circumstances of his offense and his presentation on the ward. Staff seemed to find it difficult to maintain a therapeutic approach with him. Bill was interviewed extensively and corroborative data sought from his wife, GP, and previous employer. It appeared that Bill had experienced an undiagnosed obsessive-compulsive disorder over a number of years. He meticulously cleaned the inside, outside and engine of his car and would not let anyone drive or ride in it due to his fear of it becoming dirty. Two years prior to the offense he had quit his submarine welding job because he was obsessionally checking his welds and could not complete the work. In addition, he suffered from morbid jealousy over his wife, and would frequently check on her location, search her handbag, check the bed and her underwear for stains, etc.

Six months prior to the offense his wife asked his GP to see him since she was concerned about his social withdrawal and depression. The GP referred him to a psychiatrist. Bill stated that he was experiencing auditory hallucinations at this time, but did not tell the psychiatrist because he thought the psychiatrist was laughing at him. He was diagnosed as suffering from a major depressive episode. He was treated with antidepressants and referred to a psychiatric hospital as a voluntary patient. He discharged himself after one day and later that day took an overdose. In the six month period prior to the offense he took three overdoses, one of which was very carefully planned, and only a chance factor prevented it being fatal. Bill stated that throughout this period

he was experiencing auditory hallucinations, usually third person commentaries on his actions and derisory comments. He could not identify the voice but believed it was very powerful.

Bill's description of the offense was simple. He had visited the victim socially, and the conversation had turned to ways of keeping capital assets without losing government benefits. This was an area of concern for Bill because he had received a large pay-out from his previous employer and worried that this would affect his sickness benefits. While the victim was showing Bill his wall safe, Bill stated that he heard loud command hallucinations telling him to kill the man and take the money. The room housing the safe was a store room, so he just picked up an iron bar and hit him, and then used the shears to stab him. He stated that he later threw the money away in a garbage bin.

Results of these interviews were fed back to staff through the multidisciplinary meetings and some shift in the attitude towards him was discernible.

Neuropsychological tests for malingering were administered, with no evidence of any faking responses. The Object Relations Test was also administered and his responses were similar to others the author has tested with schizophrenia, with extremely concrete responses and poverty of content. Staff also monitored Bill using the Psychotic In-Patient Profile, with results again indicating a psychotic picture. All these results were exchanged through the multidisciplinary meetings.

Treatment

Bill received a manslaughter conviction and returned to the RSU for treatment under a section 41 Restriction Order (Mental Health Act, 1983). After his conviction he became more floridly psychotic and was considered a risk to himself and others. Initial treatment focused on his psychosis and ensuring that he did not harm himself or others. An antipsychotic depot preparation was used with the dose gradually reduced over time with the remission of his positive schizophrenic symptoms. Bill also attended a schizophrenia psychoeducational group conducted on the ward, which was based on the work of Falloon, Boyd, and McGill [*31*], with modifications to suit the setting and index offenses.

A review of the events leading up to the offense and his subsequent treatment gave Bill a model for his offense, which he felt made sense. In individual work we role-played the questions that his young son and other people might ask him. Bill's wife supported him and joined a psychoeducational program for families of offenders. The program provided interactive education about schizophrenia, goal setting, problem solving and communication training as well as information about the relevant sections of the Mental Health Act, 1983, the Regional Secure Unit and the law.

No obsessive compulsive features were noted during Bill's time on the unit. There was also little evidence of morbid jealousy, but some cognitive work was carried out based on the work of Bishay, Petersen, and Tarrier [*32*].

Over a two year treatment period Bill has gradually gained more freedom and is now allowed into the hospital grounds without an escort. He hopes to be discharged in the near future when Home Office approval is given.

Summary

There are a number of patients entering the RSU system for assessment and treatment, usually diagnosed as suffering from schizophrenia or major depression, who have commonly killed a family member/friend. Those with newly diagnosed psychiatric disorders are most likely to be admitted for assessment and treatment. Those with mental retardation, organic brain damage or a chronic psychiatric illness are least likely to be admitted due to the bed shortage. A number of difficulties in assessment and treatment are raised in addition to maintaining a therapeutic milieu. Their length of stay and changes in admission policy mean that they are likely to form an increasing percentage of the patient population of RSUs.

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