Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, Vol. 1.

VERNON L. QUINSEY

This report (Fallon et al., 1999) is prefaced by a letter, dated 6 January 1999, to the Secretary of State, the Right Honourable Frank Dobson. Because the letter succinctly summarizes the report’s contents and context, I quote it in its entirety below.

Dear Secretary of State,

We were appointed by your predecessor in February of 1997 to investigate the functioning of the Personality Disorder Unit (PDU) at Ashworth State Hospital, following allegations made by a former patient, Mr. Steven Daggett, about the misuse of drugs and alcohol, financial irregularities, possible paedophile activity and the availability of pornographic material on the Unit. We were also asked to review in the light of our investigations the policies, clinical care and procedures on the Unit; its security arrangements; the management arrangements for assuring effective clinical care and appropriate security for patients; and the arrangements for visiting on the PDU.

We enclose our report, which has been agreed and signed by all four of us. We would call attention to the following points:

• We found Mr. Daggett’s description of the environment on Lawrence Ward to be largely accurate. Pornography was widely
available on the ward; patients were running their own businesses; 
Hospital policies were ignored; and security was grossly inad-
quate.

- The child at the centre of the paedophile allegations was, in our 
view, being groomed for paedophile purposes. She was permitted, 
often unsupervised, to associate with men with appalling criminal 
records. One of them visited the child at her home when on 
escorted leave. That this was allowed to happen is disgraceful in 
what was supposed to be a hospital, and a high security hospital 
at that. Perhaps worst of all, the clinical staff did nothing about it,
and some of them even judged it to be in the interests of the 
patient.

- The PDU was a deeply flawed creation. A number of highly 
serious reports have demonstrated Ashworth Hospital’s failure to 
care for and manage a large group of severely personality dis-
ordered patients.

- The management culture of the Hospital was dysfunctional. Senior 
managers were secretive, out of touch and totally unable to control 
this large institution.

- Four critical internal reports were suppressed. Ministers were 
misled on two occasions about events at Ashworth.

- We have no confidence in the ability of Ashworth Hospital to 
flourish under any management. It should close.

- More positively, we offer our view for how high security services 
could develop within regional forensic networks involving both 
the NHS and the prison service.

- We suggest changes to the law to introduce reviewable sentences 
for severely personality disordered offenders.

- Last, but not least, we believe the current accountability arrange-
ments within the NHS are unclear and unsatisfactory and recom-
 mend changes. We make judgements about the conduct and 
performance of those most directly involved in these events.

We have found conducting this inquiry a challenging, often 
depressing, but also fascinating task. Whilst there is much we have 
found to criticize, both at Ashworth and in the wider context within 
which it operates, we are convinced that now is the time to grasp 
the nettle and replace the system we have found to be so fundamen-
tally flawed with one which will serve patients, staff and the public 
far better.

Yours sincerely,

Peter Fallon QC
Bristol
GENERALITY OF THE SPECIAL HOSPITAL
SYNDROME

I am likely not alone in enjoying a certain ghoulish voyeurism in reading about scandals safely far away from me and my colleagues. The first three quarters of the report can be read as a sort of ‘Ashworthgate’ and, because the inquiry names names and recommends penalties, one can thrill to the sense of justice fulfilled. That said, and as I hope to demonstrate below, Ashworth’s failings are not confined to itself, nor even, as documented in the report, to the English Special Hospitals. Rather, the programmatic aimlessness and the insularity, secrecy and widespread incompetence among administrators and clinicians observed at Ashworth are, in my view, a necessary consequence of particular features of the Special Hospitals.

Because of the 16 years I worked in maximum-security ‘Special’ Hospitals, the descriptions of the events at Ashworth and the personalities involved in them invoked such a strong sense of déjà vu that I feared for my right temporal lobe. People I had worked with over the years appeared before my mind’s eye, acting out their customary roles in an English setting. Consultation with my Ontario Special Hospital colleagues who had read the Ashworth Report reassured me that either my temporal lobe was functioning as usual or we all suffered from the same neurological disorder. Some anecdotes may justify this sense of déjà vu.

The difficulties of controlling the amount of material in patient rooms that occurred at Ashworth also occurred in the maximum-security Oak Ridge Hospital in Ontario, causing the same difficulties in search procedures. Ashworth patients on the Personality Disorder Unit (PDU) were discovered to have access to pornography. Staff apparently felt powerless to intervene and some argued that such access was clinically beneficial. Exactly the same situation occurred in Ontario where staff believed that they were legally prevented from stopping the influx of pornography. Some clinicians, however, took advantage of this situation by systematically monitoring patients’ use of pornography as a method of ascertaining their deviant interests.

Ashworth patients on the PDU were discovered to be running scams, such as ordering CDs under phoney names so as to avoid payment. The same scams occurred in Ontario, as well as some with considerably more flair. My favourite example involves a patient who took advantage of the Ontario government’s new policy of glasnost. Under the Freedom of Information Act, citizens could request government documents that would be provided free of charge. This particular patient made innumerable requests and even succeeded in obtaining a copy of the blueprints for the maximum security institution in which he was housed. It cost various government agencies a great deal to keep up with this volume of requests; in fact, the provincial staff of the Information Office was largely kept busy by this one patient. As a result
of the cost of complying with the requests, government agencies became interested in hiring a consultant to advise them about how to deal with their large volume most efficiently. Who was better placed to be a consultant than the author of the requests himself?

The problems in obtaining and retaining competent psychiatric staff so extensively documented in the report are also general. I first learned of a new plan to attract more and better psychiatrists into the Ontario mental hospital service with better pay and benefits when I worked as a hospital attendant in 1964. These problems did not go away. At the maximum-security Oak Ridge institution, for example, there was a physician who got himself sufficiently drunk to freeze to death in the back-yard of his house on the hospital grounds, there was a psychiatrist who spent the majority of his time at the maximum-security hospital running his private practice in another city by phone, and... well, one could go on, but at the risk of straining the credulity of readers who have no experience with the Special Hospitals. Not that these problems have been limited to the medical profession; for example, there was the social worker who believed that he secretly ran the maximum-security institution, the shop instructor who ran an illegal business selling patients' wood-working products, and so forth. I do not mean to gainsay that many competent and honest staff exist in these institutions, only to state that the problems of incompetence and dishonesty are very real and chronic.

Tensions between treatment and security are endemic to these institutions wherever they are. Interestingly in retrospect, I visited Ashworth (then Park Lane) very briefly in 1981 while on a cycling trip and was told by an ageing attendant that he preferred the way things were done in Broadmoor, by which he meant placing more emphasis on security and less on treatment. In Ontario, the apogee of strife between security and treatment came in 1978 when the entire treatment staff of the Social Therapy Unit of Oak Ridge (the equivalent of the PDU) were locked out by attendant (security) staff and never allowed to return. New, less controversial clinicians were hired, and the hospital administrator was given a job supervising parking lots in another part of the province.

And then there are the reviews, usually occasioned by some egregious oversight or problem that became public knowledge. In the early 1970s, there was an externally aided escape from Oak Ridge. The Ontario Provincial Police conducted a lengthy investigation and produced a report that was distributed to only a very small group of senior managers. Several reviews and internal reorganizations followed over the next few years. The most ambitious of these, the Hucker et al. Report (1985), was commissioned to investigate the practice of mixing civilly committed patients who had committed no crime with mentally disordered offenders, the roles of members of treatment teams, and whether the rights of patients were respected. The investigators were also asked to outline a process of program evaluation.
The 89 recommendations of the Hucker et al. Report are similar in spirit and content to the 57 recommendations of the Ashworth Report. Compare the final recommendation of the Hucker et al. Report, that 'program descriptions, policy memoranda and related material be assembled as a single administrative manual to be revised regularly', with Recommendation 12 of the Ashworth Report, 'that at all times an up to date book containing all relevant security policies and rules should be easily and readily available to all ward staff, and its location and contents should be known by all ward staff'. Discipline-related recommendations are also made in both reports; for example, Recommendation 80 of the Hucker et al. Report is that 'staff members found to conceal abuses by colleagues against patients be regarded as accessories and dealt with accordingly'. Staff recruitment recommendations also occur in both reports; for example, Recommendation 71 of the Hucker et al. Report states that 'the Ministry of Health [should] consult as soon as possible, with University Departments of Psychiatry in Ontario in order to find means to increase the number of suitably trained specialists in forensic psychiatry'.

Major reports usually result in reorganizations in the Special Hospital system but such reorganizations are also produced by competition for influence among unions, professional guilds, and other interest groups. In Ontario, there have been so many reorganizations in the forensic hospital 'system' that there appears to be no discernible system left in place. We await a future report to set this situation right.

Of course, many of these problems are not shared only between England and Ontario. Some are of great antiquity and that is why Nigel Walker's (1968) epilogue to his classic Crime and Insanity in England is entitled 'The End of an Old Song'. The endless reorganizations that formed part of the reasons for and recommendations of the Ashworth Report appear to have been foreshadowed.

We trained hard but it seemed that every time we were beginning to form teams we would be reorganised. I was to learn later in life that we tend to meet every situation in life by reorganising, and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation. Attributed to Petronius, first century CE. (G. Porter, President of the Royal Society, Anniversary Address, 1989, quoted in MacKay, 1991: 193)

Indeed, the problem of lax security, which figures so prominently in the Ashworth Report, was addressed in a famous statement of legal principle concerning mentally ill offenders preserved in the Justinian Code that was originally written by Marcus Aurelius in response to a query from a Roman governor about 179 CE (Spruit, 1998: 316):

If you have clearly ascertained that Aelius Priscus is in such a state of insanity that he is permanently out of his mind and so entirely incapable
of reasoning, and no suspicion is left that he was simulating insanity when he killed his mother, you need not concern yourself with the question how he should be punished as his insanity itself is punishment enough. At the same time he should be kept in close custody, and, if you think it advisable, even kept in chains; this need not be done by way of punishment so much as for his own protection and the security of his neighbours.

But since we have learned from you by letter that his position and rank are such that he is in the hands of his friends, even confined to his own house indeed, your proper course will be, in our opinion, to summon the persons who had the charge of him at the time and ascertain how they came to be so remiss, and then pronounce upon the case of each separately, according as you see anything to excuse or aggravate his negligence. The object of providing keepers for lunatics is to keep them not merely from doing harm to themselves, but from bringing destruction upon others; and if this last-mentioned mischief should come to pass, it may well be set down to the negligence of any who were too neglectful in performing of their duties.

**CAUSES OF THE SYNDROME**

Although my evidence is anecdotal, I believe that it suffices to demonstrate the generality of the recurring problems of Special Hospitals that are described in the Ashworth Report. Accordingly, explanations of what I refer to as the Special Hospital syndrome, involving insularity, secrecy, widespread incompetence and programmatic aimlessness, must be fairly general, both temporally and geographically. I suggest some tentative explanations for the syndrome below.

1. **The epistemological problem**

How can policy-makers and administrators decide what sort of programs to run, what sorts of staff to hire, which offenders to admit and discharge, what security policies to have, what staff supervisory and disciplinary policies to endorse, and what administrative organization to implement? In the Special Hospitals, these decisions have been and continue to be made in an empirical vacuum, a vacuum that is filled by legal, professional and bureaucratic opinion.

It seems that in the absence of blindingly obvious fact, people strongly tend to hold opinions and advocate policy positions that are first most favourable to themselves, next most favourable to their relatives and allies, and then most favourable to those who resemble them in terms of such attributes as social
class, profession and ethnicity. Thus, policy advice in an empirical vacuum, although usually presented in the guise of objective observation, is a rough measure of broadly defined self-interest. This is not to say that these opinions are necessarily incorrect, much less that they are not usually honestly held.

The results of a poll of professionals, therefore, will be determined by the degree of inescapability of the relevant facts, which professional groups are represented, the degree to which the questions affect individuals' interests, and so forth. Clearly, there will be a great deal of inertia if the persons questioned have stakes in the status quo. Consensus, therefore, is not necessarily related to validity.

Are there blindingly obvious facts that can serve to inform and discipline a discussion of personality disorder and the Special Hospitals? One such fact is that there has not been a convincing demonstration that any treatment yet tried reduces the recidivism of severely personality disordered men. The implications of this observation are far-reaching. No professional group, such as psychologists, psychiatrists, or social workers, can legitimately claim any expertise in treatments or interventions; no training program can credibly train people to deliver treatments or interventions for this group; and neither the health nor the correctional system has any special knowledge about effective intervention for this group. The only sort of knowledge that one could have from experience or the scientific literature concerns interventions that either have not been subject to convincing evaluation or are already known not to work. Ironically, one of the symptoms of the Special Hospital syndrome is that the Special Hospitals employ no special treatment methods known to be effective in reducing the risk of serious offending.

The epistemological problem is an important part of the explanation for the recurring problems of the Special Hospitals. Policy discussions have been informed primarily by interviewing professionals, visiting various programs, and the like. Policy recommendations resulting from this process largely reflect self-interests, never outcome data.

Where then is outcome knowledge, of the concrete and obvious type that is required, to come from? The only known way to acquire such knowledge is through large-scale longitudinal studies of different interventions using random assignment in which the integrity of the intervention is systematically measured.1 This is quite a different enterprise from that of ‘encouraging research’ as recommended by the Ashworth Report, although encouraging research into the etiology of severe personality disorder may yield long-term practical benefits.

There is another relevant aspect of the epistemological problem that deserves comment. This concerns how the secure hospitals are actually run. Because it is unknown, particularly for severe personality disorder, what intervention reduces risk, there is difficulty obtaining consensus about what programs should be mounted (e.g. Quinsey and Maguire, 1983) and, because
there is seldom a link between documented program elements and outcome, treatment program development cannot be guided empirically (Gottfredson, 1984). Eccentric theories, often founded on psychodynamically inspired folk-beliefs and with no plausible hypothesized causal mechanism, proliferate under these circumstances. The lack of an evidence-based organizational system extends to policies concerned with staff training and motivation. Paul and Lentz (1977) have conclusively demonstrated the superiority of behavioural over traditional methods (such as those currently used in Special Hospitals) in motivating and training staff to deliver program elements accurately.

Lastly, it is very difficult for organizations that traditionally are not evidence-based to effect program innovations. Fortunately, at least some of the conditions that determine the successful adoption of program innovations have been identified (Backer, Liberman and Kuchnel, 1986).

2. The selection hypothesis

Some years ago I demonstrated how, under conditions of indeterminate confinement, truly dangerous individuals rapidly come to form a large and ever increasing proportion of long-stay patients, even when release decisions have only very modest predictive validity (Quinsey, 1980). Such selection effects apply to an extraordinarily wide range of phenomena and are often unrecognized or underestimated. For example, many of the apparent effects of training, education and treatment are disguised selection effects.

Consider the staffing of secure hospitals. Few children aspire to work in secure Special Hospitals as adults. Most people end up working there as a result of some career happenstance or failure in another line of work. The unattractiveness of Special Hospital work is partly because ‘the dangers are many and the pleasures are few’ and partly for other reasons to be outlined below.

As a direct consequence of the epistemological problem, it is often unclear how staff should be trained or upon what criteria they should be hired or promoted. Hiring typically involves a cursory examination of putatively relevant credentials, followed by an interview. Promotion is generally contingent upon a mixture of seniority and blind luck (akin to the ‘lottery’ determining prison or Special Hospital dispositions for offenders described in the Ashworth Report), custodial criteria (such as few ‘incidents’ and maintaining an orderly ward), or bureaucratic criteria (‘meeting well with others’, writing effective memoranda, and so forth). None of these criteria is known to be related to program effectiveness or treatment outcome.

Some staff, of course, leave the Special Hospital. Usually this is voluntary, because once staff are hired, civil service regulations and unionization make it difficult to fire them. Some staff leave because (1) they are able to find other
work and (2) derive little satisfaction from actually or potentially futile endeavours (i.e. working with people who may be or are perceived to be untreatable). After all, just as a successful scientist is one who solves scientific problems, a successful clinician is one who cures or ameliorates some condition. Both societal and self-perceived success in these endeavours are not just a matter of trying hard, but of achieving or at least seeming to be achieving results. Other staff who are in a position to find employment elsewhere leave because they suffer bureaucratic burn-out. Differential leaving is the final step in the selection process that slowly but surely builds up a cadre of incompetent and disaffected staff. Once this cadre reaches a critical size, the process becomes faster and more efficient.

THE ASHWORTH RECOMMENDATIONS

The Ashworth Report makes a variety of administrative recommendations, many of them quite specific. Many of the more specific recommendations, as noted above, parallel those contained in similar investigations of Special Hospitals. However, the authors of the Ashworth Report recognize that their specific recommendations will not be sufficient and go on to address broader systemic issues. The question I will address in this concluding section of my review is whether these recommendations are likely to ameliorate the Special Hospital syndrome or simply result in yet one more reorganization, ‘full of sound and fury, signifying nothing’.

The authors of the Ashworth Report appear to have identified one of the principal symptoms of the Special Hospital syndrome. They state:

It is clear that there are very few specialist services dedicated to the treatment and management of personality disorder, a paucity of well-trained staff with an enthusiasm and interest in this group and little or no training in the education of psychiatrists, psychologists or nurses. Indeed there is no consistent body of opinion about what such training should be.

(Fallon et al., 1999: 396–7)

However, having identified the symptom, the report fails to recognize its implications, recommending that severe personality disordered offenders be assessed and managed by a multi-disciplinary team headed by a psychiatrist. Similarly, the report approvingly quotes (Fallon et al., 1999: 392) the sensible argument of Professor West that behaviour modification and attitudinal change are the essential goals, goals that must be pursued in a contingency management system. This advice has staffing and training implications, the most important of which is that behavioural technicians as opposed to nurses appear to have the kind of training in contingency management and
behavioural measurement needed by front-line staff in the type of program envisaged. It must be admitted, however, that at present these program elements are known to apply only to the management of these offenders within institutions, not to a reduction in their future risk.

The report recognizes another symptom of the forensic hospital syndrome. Speaking of severely personality disordered offenders, the report states: ‘We can see no rational justification for keeping this very manipulative and troublesome sub-group in expensive therapeutic units providing management and treatment techniques from which they gain no benefit’ (Fallon et al., 1999: 397). In view of the lack of comparative outcome data, this statement should be amended to read ‘techniques that are of unknown benefit’.

The strategy that the report advocates to keep the apparently untreatable out of the recommended newly constituted specialized treatment service is a flexible transfer system between it and the prison service. This transfer arrangement would be coupled with a new legal device, the reviewable sentence:

The offender is sentenced to a term of imprisonment justified by the usual tariff principles. At the time of his earliest date of release his case would be reviewed by a new judicially-led body, which we have called the Reviewable Sentence Board. . . . Where appropriate the RSB could renew the sentence for up to two years at a time; it could also conditionally discharge the offender for a period up to two years. If satisfied that the offender no longer presents a substantial risk of causing serious harm to others, the Board could discharge him.

(Fallon et al., 1999: 406)

The formulation of the reviewable sentence leads, finally, to the recognition that the Special Hospital emperor is stark naked:

Given that offenders other than personality disordered offenders also present a substantial risk of causing harm to others after release from prison, the Government may wish to consider introducing legislation based on the reviewable sentence principle for other types of offender as well.

(Fallon et al., 1999: 406)

Although the authors of the report do not firmly grasp the nettlesome implications of this statement, the implications are profound and allow for a workable policy that can potentially avoid the Special Hospital syndrome. The real issue that policy must address concerns public safety: the risk that offenders pose that is not appropriately managed by sentences based primarily on the nature of the index offence. Attention to public safety means that the focus in sentencing must be broader than the particular offence, even though this offends some notions of equity. The issue then is
not psychopathy or personality disorder or any diagnostic issue, rather it is
the likelihood than an offender will commit new violent or sexual crimes.
Fortunately, offenders' long-term risk of sexual or violent recidivism can be
accurately forecast by actuarial prediction instruments (whereas it cannot
by clinical judgement).

Of course, psychopathy, antisocial personality disorder and sexual
deviance are related to actuarially determined risk but these merely form
some of the items of actuarial risk instruments. Because there are very many
intercorrelated predictors of violent and sexual recidivism, diagnostic vari-
ables can either be included in the instruments as items or not with no change
in predictive accuracy (Quinsey, Harris et al., 1998; Ward and Dockerill,
1999). This means as well that diagnostic debates over the nature of psy-
chopathy are irrelevant to policies determining offender disposition. In any
case, DSM-IV antisocial personality disorder and psychopathy turn out to be
virtually identical measures when their criteria or items are scored in the same
way (Skilling et al., submitted).

The most accurate actuarial instruments do not include dynamic or
changeable predictors and serve only to identify long-term risk. The accu-
rcy of these instruments speaks to the inefficiency of current interventions
designed to reduce the risk of serious adult offenders. Because of their static
and historical nature, actuarial instruments can be completed at the time of
the initial trial to inform dispositional decisions. This is very important,
because indeterminate dispositions made at the end of sentence (known as
'back-end' dispositions) as recommended in the Ashworth Report corrode
inmate morale and are widely perceived to involve double jeopardy (Lieb,
Quinsey and Berliner, 1998).

These observations raise the question of community release and the ter-
mination of reviewable sentences. When interventions are developed that
reduce offenders' likelihood of reoffending by known and large amounts,
these decisions will be more straightforward. In the meantime, decisions
regarding community access should be determined in the same way as I
believe they should be determined now, viz. by the quality of the supervision
plan and the control of proximal risk factors in relation to the long-term risk
the offender presents. Over time, the continuing development of community
risk management strategies and surveillance technologies can be expected to
allow the community placement of progressively higher risk offenders.
However, none of this requires biannual reviews conducted by a separate
board as recommended in the report; given current knowledge, the estimate
of an offender's long-term risk will not change from the time of trial. The
important issues therefore involve managing the risk of offenders on what
would be a life sentence in the least restrictive manner compatible with public
safety.

Considerable thought needs to be given to how widely to cast the net of
indeterminate confinement and lifetime parole dispositions. First, there is the standardization of the risk instrument(s) to be employed, the documentation of inter-appraiser agreement that is required to avoid a lottery, and the establishment of a risk threshold or cut-off to determine who will be subject to it. Second, there is the question of to whom the risk appraisals should be applied. In the interests of balancing civil liberties with community safety and of having a relatively manageable number of offenders receiving indeterminate dispositions, the appraisals should be reserved for offenders who have been previously or currently convicted of a serious personal injury offence or hands-on coercive sexual offence and who are highly likely to commit such an offence again.

In summary, my view is that indeterminate sentences with lifetime parole are required only for those few offenders whose risk of violent or sexual reoffending cannot be managed under ordinary sentencing practices. This disposition should be made at the time of the original trial. Risk appraisal does not require formal diagnoses and need not involve mental health professionals, although it does require the use of instruments of known accuracy and appraisers of known reliability. I think that policies concerning interventions designed to reduce the likelihood of violent or sexual crimes among high-risk offenders, including to whom and by whom they should be applied, and in what system they should be offered, should evolve from a process of comparative outcome research and evaluation. This research and development effort will prosper to the extent that the organization that undertakes the effort employs empirically validated methods of running itself. Programs must have a sensible theoretical rationale and be specified well enough for their implementation to be measured.

CONCLUSION

I believe that the Ashworth investigation resulted in a very good report. The specific difficulties of the PDU were addressed clearly, resulting in concrete and feasible recommendations. The investigation also produced some hard thinking about the Special Hospitals more generally and some interesting policy recommendations. However, almost against their will it seemed, the authors of the report were drawn, by the advice they received and their shared perspective, back to the front gate of Ashworth where they began, although they came heart-breakingly close to going free. In my view, the problems of personality disordered offenders and the Special Hospitals require more radical solutions than those envisaged in the Ashworth Report.

Professor Vernon L. Quinsey, PhD, CPych, professor of psychology and psychiatry, forensic/correctional studies, Department of Psychology, Queen’s University, Kingston, Ontario, Canada K7L 3N6
NOTE

1 Sometimes helpful information can be obtained retrospectively if program documentation has been good. For example, the Oak Ridge Social Therapy Unit therapeutic community was an extremely intensive program that attempted to reduce the risk of severely psychopathic (personality disordered) offenders. Ironically, long-term follow-up found that, while the program reduced the recidivism of non-psychopathic offenders, it increased the recidivism of psychopaths (Rice, Harris and Cormier, 1992).

2 A 2-year program has been developed in Ontario community colleges to train behaviour science technicians or BSTs.

REFERENCES


Skilling, T. A., Harris, G. T., Rice, M. E. and Quinsey, V. L. (submitted) ‘Psychopathy and Antisocial Personality Disorder Reflect the Same Underlying Categorical Entity’.

