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722 Chapter 16 Forensic psychiatry Introduction The word ‘forensic’ derives from the Latin forensis (the forum or court). The scope of forensic psychiatry can be broadly defined as those areas where psychiatry interacts with the law. Although all psychiatrists may be involved, from time to time, in forensic work, forensic psychiatrists in the UK are specifically involved in the assessment and management of mentally disordered offenders and other patients with mental disorders who are, or have been potentially or actually, violent. Provision of forensic services varies across the country, and forensic psychiatrists work in a variety of set tings (e.g. high-security hospitals; medium-secure units; low-secure wards and sometimes open wards; outpatients, day hospitals, and within commu nity teams; prisons). This chapter on forensic psychiatry concentrates on mentally disordered offenders. Mental health legislation, incapacity legislation, and other non-criminal legal matters are covered in E Chapter 20 (see also Table 16.1). The practice of forensic psychiatry is dependent on legislation, the criminal justice system, and local service provision. Hence, although some aspects have fairly wide applicability (e.g. the relationship between mental disorder and offending), many aspects (e.g. legal provisions for mentally disordered offenders) are specific to a particular jurisdiction. We have tried to cover the main legal jurisdictions of the British Isles—England and Wales, Scotland, Northern Ireland (NI), and the Republic of Ireland (RoI)—in some detail. Table 16.1 Abbreviations used to refer to legislation a article p paragraph s section sch schedule MHA 1983 Mental Health Act 1983 MHA 2001 Mental Health Act 2001 MH(NI)O 1986 MCA(NI) 2016 Mental Health (Northern Ireland) Order 1986 Mental Capacity Act (Northern Ireland) 2016 MH(CT)(S)A 2003 Mental Health (Care and Treatment) (Scotland) Act 2003 CP(S)A 1995 Criminal Procedure (Scotland) Act 1995 CJ(NI)A 1966 Criminal Justice (Northern Ireland) Act 1966 CJ(NI)O 1996 Criminal Justice (Northern Ireland) Order 1996 CL(I)A 2006/2010 Criminal Law (Insanity) Act 2006/amended 2010 CP(IUP)A 1991 Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 PoCC(S)A 2000 Powers of Criminal Courts (Sentencing) Act 2000 Other legislation

will be referred to in full, or abbreviations used in tables or boxes will be explained where they arise.

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724 Chapter 16 Forensic psychiatry A brief history of forensic psychiatry Major crimes carried out by those who are mentally unwell are referred to in Greek mythology, ancient drama, and philosophical writings. Heracles (known as Hercules by the Romans) was punished with madness by the jealous Goddess Hera. He misidentified and killed his children, mistaking them as attackers before embarking on his atoning labours. Orestes, driven to despair following his father's death, hears the voice of the Gods com manding him to kill the perpetrator—his mother. His story, depicted in the original courtroom drama by Euripides (c.480–406 BC), sees him acquitted by the casting vote of the head judge as the jury is split 50:50 as to his culpability. Plato (c.428–347 BC), writing a model law for his utopian re public, suggested a reduced punishment for mentally disordered homicide perpetrators. The first identified mentally disordered offender was Aelius Priscus in 180 CE. When asked whether he, a man who killed his mother in a fit of rage, should be held responsible for the crime, the joint Emperors Marcus Aurelius and Commodus replied that if it was determined that Priscus's actions were the result of furor due to alienation of the mind and that he killed his mother under the guise of madness, then punishment need not be considered since he is punished enough by madness itself. Roman jurists believed that, like children, the mad lacked judgement, depriving their ac tions of informed consent. They did not seek punishment for the insane, but they did mandate confinement. In the case of Aelius Priscus, the Emperors ordered him to be kept under restraint to protect his safety and that of his neighbours. The burden of confinement fell to the families in the first instance. That advice was to influence the development of the insanity defence across Europe and was cited in homicide cases in Venice until the Middle Ages. The English jurist Henri de Bracton (c.1210–1268) wrote about crim inal intent, stating that only through examination of the actions and intent of a crime can the commission of a criminal act be established. Richard of Cheddestan (1270) who, while deranged, killed his wife and children before failing to kill himself was simply confined to prison by the Sheriff of Norfolk and thus was subject to a special Royal Inquiry. By the eighteenth century, there were a number of legal writings about the insanity defence and tests for fitness to plead, but there was no dis posal to psychiatric hospital for those acquitted. In 1800, King George III narrowly missed being killed by a bullet, as he entered the Royal Box at Drury Lane Theatre. The assailant was James Hadfield, an ex-military man who, following a head injury, had conversations with God and laboured under various religious delusions. At his trial for high treason, Hadfield's lawyer successfully argued that he was insane at the time of the offence. Until that time, defendants acquitted on the grounds of insanity were gen erally released back to the safekeeping of their families. This case led to the development of the Criminal Lunatics Act of 1800, which allowed for the indefinite detention of insane defendants. Hadfield was admitted to Bethlem Hospital where he spent the remainder of his life.

A brief history of forensic psychiatry Insanity law, as we recognize it today, led from the acquittal on the grounds of insanity of Daniel M'Naghten in 1843. He had attempted to murder Prime Minister Robert Peel but instead shot and killed the Prime Minister's private secretary Edward Drummond. At trial, his defence suc cessfully argued that M'Naghten's delusions of persecution had rendered him no longer a reasonable and responsible being. Due to the controversy of the case, the House of Lords posed questions to a panel of judges, and the answer to one such

question, regarding the legal definition of insanity, became enshrined in law as the M'Naghten Rules (E Legal criteria, p. 779). The evolution of forensic services After the development of the Criminal Lunatics Act of 1800, special wings at Bethlem Hospital were established. The Central Mental Hospital in Dublin was the first secure hospital in Europe and began in 1850 as Central Criminal Lunatic Asylum for Ireland. In England, a secure institution was opened in 1863 at Broadmoor Hospital to house an increasing population of mentally ill offenders at Bethlem. Further high-security or 'special' hos pitals opened later in the twentieth century—Rampton in 1912 as an over flow facility for Broadmoor, and Ashworth in 1988 following a merger of Moss Side Hospital and Park Lane Hospital, itself opened as a Broadmoor overspill unit in 1974. In Scotland, Carstairs was an Army Hospital from 1939 to 1948 before becoming the 'State Institution for Mental Defectives', and following the transfer of criminally insane prisoners from HM Prison Perth, it was renamed the 'State Mental Hospital' in 1957, covering both Scotland and NI. In the 1970s, Graham Young, an ex-patient of Broadmoor Hospital, poi soned a number of his work colleagues, leading to convictions of murder and attempted murder. Subsequent recommendations made in the Butler Report of 1975 led to the creation of medium-secure hospitals to act as intermediate step-down units between high-secure care and the community in the 1980s. Later, in 1992, the Reed Report emphasized the importance of close-to-home care and the least restrictive alternative. This, together with the increasing population of prisoners and community patients requiring secure hospital care, led to the creation of low-security hospitals, offering a bridge between secure care and community living (E Low-security units, p. 751).

726 Chapter 16 Forensic psychiatry The criminal justice system The criminal justice process The following outlines the chain of events that may happen, following the commission of an offence. Offence reported to police l police record offence l police investigate offence l police find suspect l police charge suspect l report to pros ecutor l decision of prosecutor to prosecute l initial court appearance (remanded on bail or in custody) l trial l conviction l sentence (commu nity, prison, fine, discharge, mental health disposal). Most offenders will not go through all these stages (e.g. by pleading guilty, an offender may go from initial court appearance directly to sentencing). At various stages, there may be specific provisions for mentally disordered offenders (E Overview of the pathways of mentally disordered offenders through the criminal justice and health systems, p. 770; E Table 16.3, p. 772). Prosecution • England and Wales—following report by police, the Crown Prosecution Service decides whether the individual should be prosecuted; headed by the Director of Public Prosecutions; service divided into areas and further into branches, each headed by the Chief Crown Prosecutor. Some minor offences prosecuted by the police. • Scotland—the Lord Advocate responsible for prosecuting serious crimes; heads the Crown Office in Edinburgh; most work carried out by 'advocates-depute'. The procurators fiscal prosecute less serious crimes locally. • NI—the Department of the Director of Public Prosecutions for NI. The Director discharges his functions under the superintendence of the Attorney General. • RoI—Director of Public Prosecutions. Criminal courts England and Wales • Magistrates Court All adult defendants appear here first for a decision to remand on bail or in custody; hears all summary (minor) cases and some indictable (serious) cases; maximum sentence 6mths' imprisonment ± £5000 fine; magistrates are mainly lay justices of the peace, with legally qualified stipendiary magistrates in some urban areas. No jury. • Crown Court Deals with more serious indictable offences—cases are committed by the Magistrates Court for trial and/or sentencing; deals with appeals from the Magistrates Court; six regions or 'circuits'; trials heard by a judge and jury (12 adults); sentencing by a judge. • Youth Court Juvenile offenders (10–17yrs); magistrates with special training hear cases; deals with all

offences, except the most serious. • Court of Appeal (criminal division) Usually three judges; hears appeals by the defendant against a conviction or sentence; hears appeals by the Crown against a sentence; can increase or reduce a sentence.

The criminal justice system • Queen's Bench Division of the High Court (Divisional Court) Appeals on points of law and procedure. • UK Supreme Court Established by the Constitutional Reform Act 2005 and assumed the judicial functions of the House of Lords in 2009. Highest appeals court in the UK for civil matters and in England, Wales, and NI for criminal matters. Scotland • District Court Minor cases heard by lay justices of peace (maximum sentence 60 days' imprisonment) or (only in Glasgow) stipendiary magistrates (similar powers to a sheriff). • Sheriff Court Six sheriffdoms, each headed by a Sheriff Principal; summary (sheriff alone) or some solemn (sheriff and jury) cases heard; maximum sentence 12mths' (summary) or 5yrs' (solemn) imprisonment. • High Court of Justiciary (criminal trials) Hears serious cases; judge and jury (15 adults); unlimited sentencing powers; Edinburgh, Glasgow, and on circuit in other towns and cities. • High Court of Justiciary (Court of Criminal Appeal) Highest court of criminal appeal in Scotland. Cases heard by three or more judges; no appeal to UK Supreme Court. Northern Ireland • Essentially as for England and Wales. • Diplock Courts (Judge sitting alone) were used for indictable scheduled (mainly terrorist) cases 1973–2006. Republic of Ireland • District Court Legally qualified justices; summary (up to 6mths' imprisonment) and some indictable (up to 12mths' imprisonment) cases heard. • Circuit Court Cases heard by a judge and jury; indictable cases and appeals from a District Court. • Central Criminal Court (High Court) Cases heard by a High Court judge and a jury; serious indictable cases. • Special Criminal Court Only scheduled offences (mainly terrorist cases); cases heard by three judges. • Court of Criminal Appeal One justice of the Supreme Court and two of the High Court hear appeals from Circuit, Central Criminal, and Special Criminal Courts. • Supreme Court Chief Justice and High Court justices hear appeals from the Court of Criminal Appeal.

728 Chapter 16 Forensic psychiatry Crime A crime is an act to an individual, a community, the society, or the state that is punishable by law. It is a fluid, man-made concept defined by societal rules modified by legislation. What constitutes a crime varies across geog raphy and history. The age of criminal responsibility is 10yrs old in England and Wales and NI, 12yrs in RoI, and 8yrs in Scotland, but the minimal age of prosecution is 12yrs. Crime is broadly divided into crimes against the person (interpersonal violence, assaults, homicide, sexual offences, indecent exposure), crimes of dishonesty (burglary, theft, fraud, forgery), criminal damage (property damage, arson), car crime, drug crime (use, possession, supplying), and other. Crime rates (See Table 16.2.) Only about half of crimes is reported to the police (and officially recorded), of which 13% resulted in a charge/summons (9% for sexual assaults) in England and Wales in 2016. Peak rates 18–20yrs for ♂, 2–3yrs earlier for ♀. Young ♂ aged 10–20yrs account for 50% of crimes. ♀ comprise under 20% of offenders. What are the 'causes' of crime? • Biological The idea of 'born criminals' (Cesare Lombroso) has been discredited in favour of environmental factors. Concordance rates of antisocial behaviour in MZ and DZ twins vary widely. No clear evidence that XYY (so-called 'super-♂' syndrome) causes criminality. • Intelligence Lower intelligence is disproportionally represented in prison populations and in victims of crime. • Upbringing Poor parental supervision, harsh/erratic discipline (high punishment, low praise), marital disharmony, low parental involvement, antisocial families, large family size. • Personality Impulsivity, low threshold for aggression, other traits associated with antisocial personality disorder or psychopathy (callousness, low victim empathy, irresponsibility, egocentricity). • Alcohol and substance misuse Linked to antisocial behaviour,

impulsivity, and poor behavioural control, and directly to criminal acts (e.g. acquisitive acts to fund habit). Indicator of risk in forensic populations. • Childhood disorders ADHD, CD, and ODD are all associated with future offending. • Social theories Rational choice theory: people act in self-interest; they choose to offend after weighing up potential reward against risk (e.g. being caught). Social disorganization theory: delinquency is higher in areas with poor housing, poor health, socio-economic disadvantage, transient populations, and low employment. Strain theory: crime occurs when cultural goals (e.g. wealth, status) are not within an individual's reach through acceptable means (e.g. education, employment). Associated with theories of social deprivation and marginalization. Subculture theory: individuals gain respect and status in communities with pro-offending

Comparisons across jurisdictions should be made cautiously. The number of crimes with the percentage of total for that jurisdiction in parentheses are England and Wales (2017/18)1 Scotland (2016/17)2 NI (2017/18)3 RoI (2017)4 Violence against the person 1,395,688 (25.3) 7164 (3.0) 34,162 (34.8) 16,725 (7.8) Theft 2,009,697 (36.4) 84,867 (35.6) 30,262 (30.8) 69,661 (32.5) Criminal damage and arson 590,299 (10.7) 52,514 (22.0) 18,290 (18.6) 23,253 (10.8) Drug offences 136,089 (2.5) 32,641 (13.7) 6502 (6.6) 16,850 (7.9) Sexual offences 150,732 (2.7) 10,822 (4.5) 3443 (3.5) 2975 (1.4) Robbery 77,103 (1.4) 16,299* (6.8) 577 (0.6) 21,276 (9.9)*** Table 16.2 Crime statistics for the British Isles quoted here. Crime Public order 385,864 (7.0) 18,795 (7.9) 1107 (1.1) 31,231 (14.6) Possession of weapons 38,694 (0.7) 3271 (1.4) 1000 (1.0) 2370 (1.1) Fraud and forgery 638,882 (11.6) 12,039 (5.0) 2958** (3.0) 6124 (2.9) Total 5,515,882 (100) 238,651 (100) 98,301 (100) 214,623 (100.0) 1 M https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmarch2018 3 M https://www.psni.police.uk/inside-psni/Statistics/police-recorded-crime-statistics/ 4 M https://www.cso.ie/multiquicktables/quickTables.aspx?id=cja01 2 M http://www.gov.scot/Publications/2017/09/3075 All sources below accessed 25 July 2018: ** Miscellaneous crimes against society. *** Robbery and burglary.

- Only housebreaking.

730 Chapter 16 Forensic psychiatry values through antisocial behaviour, 'gang culture', and committing delinquent acts with others. Social control theory: people conform to social norms due to strong social bonds and break the law when such bonds are weak. Conformity relates to an upbringing with law-abiding principles, commitment to a particular lifestyle (e.g. being employed, a parent), and attachment to law-abiding peers. Labelling theory: the act of labelling someone a criminal makes them a criminal. Gender theory: men commit crime disproportionately. Feminist perspectives suggest that 'being ♂' is a dominant position, and expressions of masculinity may involve engagement in crime.

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732 Chapter 16 Forensic psychiatry Homicide Definition Homicide is the killing of a person by another. Types • Murder—a person of sound mind and discretion (i.e. sane) commits an unlawful killing (i.e. not self-defence or justified) of any reasonable creature (human being), with an intent to kill or cause grievous bodily harm. The verdict results in mandatory life imprisonment. • Manslaughter/culpable homicide—voluntary: killing with intent to murder, but partial defence

applies (e.g. suicide pact, severe provocation); involuntary: (1) conduct was grossly negligent, given the risk of death, and did kill; (2) conduct was an unlawful act involving a danger of harm and resulted in death. A judge can impose any sentence. • Infanticide (not in Scotland)—killing of a child under 1yr old. • Death by dangerous driving. Psychiatric defences • Insanity—based on the absence of mens rea (a guilty mind) (E Criminal responsibility 1, p. 778). • Diminished responsibility (reduces murder to manslaughter)—the perpetrator was suffering from an abnormality of the mind, a broader concept than mental disorder, at the time of killing (E Criminal responsibility 2, p. 780). Homicide rates A total of 571 recorded homicides in England and Wales (2015/2016), 57 in Scotland (2015/2016), 24 in NI (2014/2015), and 62 in RoI (2015). Rates per million population/yr: England and Wales 10, Scotland 10, NI 13, RoI 14, USA 40, and South Africa 320. Victims of homicide Usually ♂ (70%); highest rates per million population are children under 1yr old; 10% of victims are under 16yrs [57% killed by (step)parent]; women more likely killed by partner/ex-partner (44% in women, 6% in men); men more likely killed by friends or acquaintances (32% in men, 8% in women) or strangers (31% in men, 12% in women). A third of victims are under influ ence (alcohol ± illicit substances) at the time of death in England and Wales. Perpetrators of homicide Predominantly ♂; most common methods: (1) sharp implement, (2) kicking/punching (♂ victims), strangulation/asphyxiation (♀ victims); quarrels, revenge, and loss of temper are common circumstances; 2 in 5 suspects under influence (alcohol ± illicit substances) at the time of the offence (especially ♂).

Homicide Mental disorder and homicide A minority of offenders are mentally disordered. Alcohol and drug depend ence most common (1 in 3 suspects are drug users in England and Wales), then personality disorder. Schizophrenia, delusional disorder, and depres sion may be relevant in a few cases. Psychiatric assessment in homicide As with other offences, the mental state needs to be assessed both currently and retrospectively at the time of the offence. It is important to ascertain whether the person was criminally responsible (which involves exploring the circumstances of the murder and what the person was thinking when they committed the offence), whether the person has a mental disorder, what the risks are, what, if any, treatment is recommended, and where this treatment ought to be provided (see Box 16.1). Box 16.1 Legal aspects of homicide in different jurisdictions The definitions of what constitutes murder differs across the individual nations in the UK and RoI. In England, Wales, and NI, the offender must be of sound mind and discretion and had malice aforethought. Intent is assumed if reckless, knowing that death or serious injury was a virtual certainty. The definition is narrower in the RoI which incorporates an in tentional act to kill. In Scotland, murder is committed when the accused acted with the intention to kill or acted with ‘wicked recklessness’. Scotland differs from England, Wales, NI, and the RoI, with the crime of culpable homicide, instead of manslaughter. There is no legal category for suicide pacts. Additionally, there is no crime of infanticide in Scotland.

734 Chapter 16 Forensic psychiatry Violence 1: theoretical background Violence is an act that causes injury or harm, but notions of what consti tutes acceptable and unacceptable behaviour and what constitutes harm are culturally influenced and constantly under review, as values and social norms evolve. For example, use of corporal punishment in schools was once common, but now such punishment would constitute assault. Besides death and physical injury, psychological insults, property damage, and verbal abuse also constitute harm. This section will focus on acts of physical as sault on others. Types of aggression Violence can be classified in terms of determinants, goals, victims, charac teristics of the act, or motivation. Aggressive acts can incorporate both in

strumental and expressive elements, e.g. aggression used to subdue a victim for sexual gratification (instrumental) and as an angry reaction to the victim fighting back (expressive). • Instrumental aggression—occurs as a by-product of trying to attain a goal. The act of violence is not an end, but a means to some other end, e.g. aggression in a mugging is aimed at obtaining money. Predatory aggression is a related term used in animal studies to describe aggression used for hunting food. Sadistic aggression is a form of instrumental violence used to achieve sexual and/or emotional pleasure through control and /or inflicting harm on a victim. • Expressive aggression—(aka hostile or affective aggression) is affect- driven. It is triggered by a strong, sometimes disproportionate, emotional response (usually anger) to a situation. Acts tend to be impulsive, brief, and explosive, but they may be planned. The primary goal is to harm the other person; examples are violence in response to the discovery of infidelity or in response to being threatened. Specific types of expressive aggression which occur primarily in the animal kingdom are intermale, maternal, and territorial aggression. Theories of aggression • Biological Ethological studies of animals suggest that aggression functions to ensure population control by aiding selection of the strongest for reproduction and social organization; low levels of 5-HT activity and cholesterol associated with aggression; modest genetic contribution; limbic and frontal areas important in determining aggression; testosterone may have a role. • Psychodynamic Freud: aggression initially seen as a response to frustration, later as an instinct; hostile character traits may be caused by fixation at/regression to oral or anal stage. Ego psychologists: aggressive instinct needs to be sublimated or displaced. Neo-Freudians: emphasized sociocultural origins of aggression. Attachment theory: emphasizes early relationships and the impact of their disruption on adult interaction. • Learning theory Rewarding/reinforcing contingencies important, leading to the development and maintenance of aggressive responses to certain stimuli or in order to attain a goal (material gain, escape from aversive stimulus). Frustration aggression hypothesis: frustration leads

Violence 1: theoretical background to aggression, depending on the perceived value of the blocked goal and the degree of frustration; punishment may inhibit aggression but may itself be frustrating or provide model for aggression. Observational learning (modelling). • Cognitive Learning theories seen as too simple and cognition important; cognitive distortions about victims may facilitate aggressive behaviour; appraisal of arousal and context important in determining occurrence of aggression; causal attributions and moral evaluations of self and others may facilitate or reduce aggression. • Social Social structure theory: poor socio-economic standing stifles the pursuit of financial and social success, so seeks success through deviant methods. Social process theory: socialization process through contact with institutions and social organizations steers the individual towards violence. Neutralization theory: neutralization of personal beliefs and values, as the person drifts between conventional and offending behaviour. Social control theory: direct (e.g. through punishment) and indirect (e.g. through social affiliation) control prevents violence. Labelling theory: an original deviant act (primary deviance) results in stigmatization and labelling, leading to hostility, alienation, and resentment in the individual and further deviant behaviour (secondary deviance).

736 Chapter 16 Forensic psychiatry Violence 2 Causes of a violent act Violent acts involve a perpetrator, a victim, and contextual factors. There will usually be an interplay between factors related to these three. Many of the background factors associated with offending generally (E Crime, p. 728) are associated with violence, although violent offenders are usu ally young adults,

rather than teenagers. The specific factors of importance in determining the occurrence of aggressive acts are the same as those needing to be considered in assessing risk of violence (E Assessing risk of violence, p. 748). Types of violent offences There are a wide range of recognized violent offences. For example, in England and Wales, ‘violence with injury’ includes attempted murder, in tentional destruction of a viable unborn child, causing death by dangerous driving/careless driving when under the influence of drink or drugs, more serious wounding or other act endangering life (including grievous bodily harm, with and without intent), causing death by aggravated vehicle taking, assault with injury, and assault with intent to cause serious harm and less serious wounding offences. ‘Violence without injury’ refers to threats or conspiracy to murder, harassment, other offences against children, and as sault without injury (formerly common assault where there is no injury). The seriousness of an assault may be determined by chance factors such as the availability of medical care and the physical health of the victim. Other ways of categorizing violent offences are in terms of the victims and cir cumstances: domestic/spousal abuse, child abuse (E Child maltreatment 2: the duty of care, p. 714), and elder abuse. Rates of violence See Table 16.2—the breakdown in figures can be found within weblinks. Psychiatric assessment and management The clinical assessment of a person who has been violent or who appears to be at risk of violence involves a thorough psychiatric history and an MSE and an assessment of risk (E Assessing risk of violence, p. 748). If the person is facing criminal charges, then a report may have to be prepared, consid ering the issues set out in E Court reports and giving evidence 1, p. 764. Management of risk is described in E Factors to consider (based on HCR- 20), Risk management, p. 749. The acute management of violent patients is described in E Severe behavioural disturbance, p. 1048. Domestic violence One in four women and one in six men experience domestic violence during their lifetime. Women are victims of 70% of domestic violence. In over 10% of cases, serious injuries occur (e.g. broken bones, loss of con sciousness). May be a contributory factor in 25% of suicide attempts, and in 75% of cases, children witness the violence. Accounts for 25% of violent crimes in Britain (which will be an underestimate).

Violence 2 Elder abuse A systematic review found a wide variation in prevalence across countries, from 3% to 27%.1 Over 6% of older people reported abuse in the last month; 5% of couples reported abuse in their relationships. A quarter of those dependent on carers reported significant psychological abuse, and a fifth reported neglect. 1 Cooper C (2008) The prevalence of elder abuse and neglect: a systematic review. Age Ageing 37:151–60.

738 Chapter 16 Forensic psychiatry Sexual offences 1 Offences range from indecent exposure to rape.2,3 Other types of offences (e.g. homicide, assault, robbery, theft, and burglary) may have a sexual com ponent. Sex offending, sexual deviation, and inappropriate sexual behaviour (a range of sexual behaviours which cause offence and/or harm to others) are overlapping, but distinct, concepts. A man who commits a sexual offence against a child may or may not be a paedophile, and a man who exposes himself may or may not be an exhibitionist. A 17-yr-old ♂ who has sexual intercourse with his 15-yr-old girlfriend is committing a sexual offence but will probably not have a sexual deviation. Here the focus will be on indecent exposure and contact sexual offences against adults and children. Types There is a wide range of sexual offending, including, but not limited to, rape, sexual assault (with or without penetration), sexual coercion, sexual exposure, voyeurism, administering a substance for sexual purposes, com municating indecently (with a child), trafficking for sexual exploitation, inter course with an animal, and soliciting; special legislation exists to prosecute sex offenders, but legal classification says little about the actual incident.

Whether the behaviour is an offence or abusive depends on whether the victim is able and willing to consent. All sexual behaviour with children is abusive and illegal. Possession of extreme pornography (depicting bestiality, necrophilia, or severely sadistic acts) is illegal in the UK. Rape and sexual assaults on adults Usually men against women. ♀ perpetrators uncommon. Most rapists are young men from poor social and economic backgrounds, who have a his tory of other offending. Sadistic fantasy is common in men, but sadistic sexual offending is rare. Rape and sexual assaults on children ♀ children are most commonly victimized. Intra-familial abuse (incest) is usually perpetrated by fathers or stepfathers against daughters. Family pathology (dysfunctional families with generational blurring) often mixed with pathology in the perpetrator (substance misuse, personality disorder). Extra-familial abuse is less common. Adolescent offending is associated with poor social skills, physical unattractiveness, and isolation from peers. Adult offenders are more likely to have paedophilic sexual fantasies than adoles cent and intra-familial offenders. Can reflect general antisocial attitudes or the expression of repressed paedophilic impulses in susceptible, disinhibited men (by alcohol, stress, psychiatric disorder). Many offenders can become skilled at targeting and grooming victims to gain trust. 2 Darjee R, Russell K (2012) What clinicians need to know before assessing risk in sexual offenders. Adv Psychiat Treat 18:467–78. 3 Russell K, Darjee R (2013) Practical assessment and management of risk in sexual offenders. Adv Psychiat Treat 19:56–66.

Sexual offences 1 Online sexual offending against children The Internet has increasingly become a method of distributing obscene/ unlawful sexual images, especially of children. The speed of technological developments and the global reach of the Internet, across legal jurisdictions, have left the police and legal authorities struggling to keep pace, and the law in this area is continually developing. In England and Wales, the Protection of Children Act 1978 and Section 160 of the Criminal Justice Act 1998 made it an offence for anyone to take or allow to be taken, possess, show, distribute, or publish any indecent image of a child. Similar laws exist in Scotland and NI. The Criminal Justice and Immigration Act 2008 outlawed possession of ‘extreme pornographic images’. Rates of offending A total of 2.5% ♀ and 0.4% ♂ reported experiencing a sexual offence in previous 12 months; the vast majority was indecent exposure, sexual threats, and unwanted touching; 0.4% of women were victims of rape (or attempts) in 2012; ♀ aged 16–19yrs at highest risk of victimization, risk decreases with advancing age; victim–offender relationships in most ser ious offences: partner (56%), other person known to victim (30%), stranger (10%), and family member (7%); 15% of offences reported to the police. Aetiology Multiple theories have been proposed; single-factor models include bio logical (e.g. abnormal hormone levels, genetic abnormalities), evolutionary (e.g. sexual coercion as a conditioned response to overcome competitive disadvantage), personality (e.g. poor childhood attachment leads to inef fectual relationships, antisocial attitudes, etc.), cognitive (involves thinking errors of denial, minimization, entitlement, and blaming of victim; distorted interpretation of actions, e.g. confusing a hug with sexual interest), social learning (abused to abuser or influence of extreme pornography resulting in sexual deviance), and feminist (does our culture tolerate masculine violence towards women?). Single-factor theories are flawed and have largely been replaced by multifactor models incorporating personal, psychological, and environmental factors. Typologies Various typologies have been proposed (based on the nature of the act, motivation of the offender, characteristics of the offender, and character istics of the victim) but lack validity and reliability. Examples include com pensatory, sadistic, power/control, and opportunistic typologies for rapists. Sexual offenders are a heterogenous group, and it is not helpful to squeeze them into typology boxes. Rates of sexual re-

offending Ten to 20% of sexual offenders commit further sexual offences over 5– 10yrs; non-sexual recidivism more common than sexual recidivism; higher in extra-familial child molesters, compared to familial molesters; the more diverse the offender (♂ and ♀, adults and children), the higher the risk of re-offending.

740 Chapter 16 Forensic psychiatry Sexual offences 2 Characteristics of sex offenders A heterogenous group; possible relevant factors are deviant sexual fantasy, sexual dysfunction, abnormal personality (impulsivity, lack of empathy, in hibition, social anxiety), relationship difficulties (poor social skills, social iso lation), alcohol or drug misuse, cognitive distortions (regarding sex, women, or children), problems with assertiveness and control of anger, histories of victimization. Mental disorder and sex offending The most common mental disorders found in sex offenders are person ality disorder, paraphilias, and alcohol and substance misuse; severe mental illness is rare. Sex offenders with psychosis share many features of other sex offenders, and offending is rarely due to specific psychotic symptoms. Disinhibitions due to mania or organic disorders may lead to, usually minor, offences. Most sex offences committed by people with ID are associated with lack of sexual knowledge, poor social skills, and inability to express a normal sex drive appropriately. A few more serious and persistent offenders with ID may share characteristics with other sex offenders. Sexual side effects (e.g. anorgasmia, impotence) sometimes cause paradoxical problems such as an increase in masturbation and the devising of more deviant sexual fantasies. Assessment Aim to gather sufficient evidence to determine the risk, and formulate an understanding of the case. Use as many sources of information as pos sible. At interview—full psychiatric history, including psychosexual history (see Box 16.2), personality assessment, and MSE; explore the nature of current and previous offences. Try to establish a rapport before asking about sexual history. Some centres (mainly in North America) use penile plethysmography (measuring the extent of penile erection in response to various stimuli). Viewing time assessments are based on the finding that people spend more time looking at images they find sexually appealing. Box 16.2 Components of a psychosexual history • Acquisition of sexual knowledge, e.g. from peers, family, pornography. • Sexual attitudes, e.g. rape-supportive, towards women/children. • Sexual development, e,g. age of puberty, age started dating, age of first sexual encounter. • Relationship history, e.g. number, duration/quality of relationships, gender/age of partners, fidelity, abuse. • Sexual orientation, e.g. ♂, ♀, children. • Sexual fantasies. • Sex drive, e.g. strength of libido, sexual preoccupation. • Sexual dysfunction, e.g. erectile issues, premature or delayed ejaculation (can also ask about medications and physical health). • Current sexual practices, e.g. nature and frequency of sexual outlets (e.g. intercourse, masturbation), materials used (e.g. pornographic images, videos, thoughts), specific conditions required for arousal.

Sexual offences 2 Risk assessment Risk factors can be divided into historical factors (e.g. previous sexual and non-sexual violence, childhood behavioural problems, employment prob lems, substance misuse, relationship problems), stable dynamic factors— most commonly targeted through treatment (e.g. poor social influences, hostility towards women, pro-offending attitudes, poor problem-solving, sexual deviance, impulsivity, callousness), and acute factors that may indi cate that offending is imminent (e.g. stress, escalation in drug or alcohol use, new access to victims). Interestingly, denial has not been found to be related to recividism and may actually be protective. Poor victim empathy is also not a risk factor. Various sexual violence risk assessment instruments are available, including Static-99, Sexual Violence Risk-20 (SVR-20), and Risk for Sexual Violence Protocol (RSVP). Management Needs to be individualized and based on risk

assessment. Monitoring Techniques include talking to the offender, friends, and family; covert surveillance; CCTV; drug and alcohol testing; and checking use of the media/Internet. Supervision Overly restrictive supervision can be counter-productive, but strategies can involve detention in institutions (prison, secure hospital), mandatory assessment at day centres, notification requirements of where abouts, electronic tags, and curfews. Treatment Psychological programmes are available in prisons and through probation in the community; group CBT is the treatment of choice. SSRIs may be useful in treating intrusive fantasies or urges; anti-libidinals are more appropriate where there is difficult-to-control hypersexual arousal or de viant sexual urges. Medication should be given on a voluntary basis. Victim safety planning Involves restricting access to named victims or a group of potential victims. In the UK, multiple agencies (police, criminal - justice, social work, prisons, health) work together via the multi-agency public protection arrangements (MAPPA) framework to provide risk management. Circles of Support Is a service established in Canada, provided by trained volunteers, which provides social support for high-risk sex offenders no longer under statutory community supervision.

742 Chapter 16 Forensic psychiatry Stalking Stalking[4] encompasses a constellation of behaviours in which an individual inflicts repeated, unwanted intrusions (contact or communications) upon another in a manner that could be expected to cause distress and/or fear in any reasonable person. Behaviours include following, loitering nearby, spying on, approaching victims, or communicating via phone calls, text mes sages, emails, or social media. Motivations are varied; different typologies have been described. Stalking has existed for centuries but only more re cently been construed as a social problem. The first state to criminalize stalking was California in 1990, after a series of high-profile cases. Epidemiology One in five ♀ and one in ten ♂ are stalked at some point in their lifetimes; in the UK, 5 million people are stalked every year; 80–90% of perpetrators are ♂; 80% of victims are ♀. In a large Canadian study, 33% of victims were pursued by an ex-spouse, 14% by an ex-intimate partner, 28% by casual ac quaintances, 8% by a stranger, 5% by a family member, 5% by a workmate, and 2% by a current spouse; 4% of stalkers were unidentified. Stalker typology • Rejected stalkers Pursue victims in order to reverse, correct, or avenge rejection (e.g. divorce, termination of relationship). Previous sexual relationship. They want to keep victim in their lives. • Resentful stalkers Pursue a vendetta because of a sense of grievance against the victim. Motivated by a desire to frighten and distress. Not following a sexual relationship. • Incompetent suitors Despite poor social or courting skills, incompetent suitors have a fixation on, or in some cases a sense of entitlement to, an intimate relationship with those who have attracted their amorous interest. • Predatory stalkers Initially spy on victims as a precursor to a sexual assault. Stalking can be sustained in this group due to the stalker taking pleasure in voyeurism and fantasy about the coming attack. The victim is often a stranger or an acquaintance. • Intimacy seekers Are infatuated with their victims and believe their victims are infatuated with them too. No previous sexual relationship. • Public figure stalkers Comprise three additional groups: help seekers (repeatedly seek help from public figures, as do not know who else to turn to), attention seekers (hungry for notoriety), and chaotic (motivation is intense, but uncertain). Mental disorder Stalking is a behaviour, not a mental disorder, but research suggests that up to 50% of offenders experience some sort of mental disorder, with per sonality disorders, schizophrenia and other psychotic disorders, depres sion, and substance use disorders being the most common. Where mental

4 Mullen PE, Pathé M, Purcell R (2009) Stalkers and Their Victims, 2nd edn. Cambridge: Cambridge University Press.

Stalking disorder does play a role, its contribution varies, depending on the nature of the symptoms experienced. A significant minority of cases occur as a result of erotomanic delusions, in which the stalker believes the victim to be in love with them. These stalkers invest heavily in their fictional relationships and often believe the victim has been secretly communicating with them through seemingly innocuous acts or via the media. Victims of stalking can develop depression, PTSD-like symptoms, anxiety disorders, and substance misuse problems. Stalking of health professionals Health professionals (especially mental health professionals) are at i risk of being stalked, compared to the general public. In a Royal College of Psychiatrists postal survey, 10% of responding psychiatrists reported having been stalked; 30% reported harassment. Most stalkers were patients. Stalking risk assessment5 Risk factors For recurrence/persistence: intimacy seeker or ex-partner, stalker over 30yrs, personality disorder (particularly combined with sub stance misuse), chronic psychosis, sending unsolicited materials; for violence: ex-intimate partner, absence of psychosis, suicidal ideation, revenge motive, poor education, threats of violence, personality disorder; for homicide: ex- intimate partner, appearing at victim's home, shorter duration of stalking; threatening messages in victim's car, last-resort thinking. Screening tools (e.g. S-DASH and SASH) are sometimes used by the po lice to identify high-risk cases and guide prioritization. Structured professional judgement tools (e.g. SAM, SRP) can help with risk formulation and management. What to do if you are being stalked • Inform others (family, friends, neighbours, work, police) what is happening, as stalkers will use embarrassed secrecy on the part of the victim to further their stalking aims. • Protect personal information (e.g. social networking sites, household rubbish). • Use an answering machine (enables recording of the stalker's calls). • Keep a diary, and retain all evidence of stalking. • Contact the police early and whenever further incidents occur. • Obtain a restraining order which, if breached, will result in the incarceration of the stalker (although it will not usually prevent stalking in itself). • Give one clear message that you are not interested in a relationship or that the relationship is over, but do not give repeated messages. 5 Stalking Risk Profile. M http://www.stalkingriskprofile.com [accessed 21 June 2018].

744 Chapter 16 Forensic psychiatry Other offences Arson Fire setting is a behaviour. Arson is a crime. Pyromania is a psychiatric diagnosis. Arson is one of the easiest crimes to commit. It is considered a serious offence due to the potential to threaten life and cause massive de struction. Only a small proportion (<20%) result in prosecution. Motivations Fire setting can be accidental or intentional. Arson is wilful and malicious, therefore not accidental. Primary gain motives include re venge, attention seeking, delusional, excitement, boredom, sexual pleasure, cry for help, and jealousy. Secondary gain motives include insurance claims, rehousing, crime concealment, and political protest. Psychiatric disorder Is over-represented in arsonists. Substance use disorders (particularly alcohol use) and personality disorder (particularly antisocial and emotionally unstable) are the most frequent. Psychosis and learning disability are less common. Pyromania is uncommon. Pyromania is an impulse-control disorder in ICD-10 (E Pathological fire-setting/pyro mania (ICD-10/11; DSM-5), p. 422), involving a persistent preoccupation with fire and burning. Fire setting is associated with feelings of increasing tension before the act and intense excitement immediately afterward. Assessment Full psychiatric assessment, with exploration of motive for fire setting and, in particular, any previous history of fire setting. Management Treatment of any mental illness or substance use disorder; social skills training; psychological therapies (e.g. CBT); restriction of access to fire setting paraphernalia (e.g. matches, lighters) in hospital settings. Outcome Rates of further arson 2–20%; rates of any re-offending 10–30%. Other damage to property Acts of vandalism are common, especially in adolescence. There is little psychiatric literature on criminal

damage, excluding arson. Crimes of dishonesty Burglary, theft, and fraud are common offences which are rarely associated with psychiatric disorder. Shoplifting has attracted some clinical attention. About 5% of shoplifters suffer from significant mental disorder (person ality disorder, substance misuse, depression, schizophrenia, dementia). Pure kleptomania is extremely rare (E Impulse-control disorders 1, p. 422). Drug offences Mental disorder rarely an issue (with the obvious exception of substance misuse/dependence and associated conditions). Car crime Impaired ability to drive may be caused by a number of disorders (E Fitness to drive, p. 972). Occasional rare cases of people disinhibited by mania or impaired by dementia who cause serious injury or death. However, mental disorder is rarely an issue in car crime.

Mental disorder and offending 1: overview Mental disorder and offending 1: overview What is the relationship between mental disorder and offending? Mental disorder is common and offending is common, so it would not be surprising to find an individual with both. But is the relationship more than coincidental? When looking at studies of this relationship, one needs to consider: • The nature of the sample studied (community vs institutional; clinical vs epidemiological; pre-treatment vs post-treatment; offenders vs non-offenders). • The criteria used to define mental disorder (legal vs clinical vs operationalized) and the method used to determine its existence (case notes vs interviews; clinically trained vs lay interviewers). • The criteria used to define offending (types of officially recorded offences included; inclusion of unreported or unprosecuted ‘offences’) and the method used to detect offences (official records vs self-report vs third-party report). Most of the research has focused on violence. The following are the main conclusions to be drawn from current evidence. • People with mental disorder as a broad group are no more or less likely to offend than the general population. • Some specific mental disorders do increase the risk of a person acting violently, particularly alcohol- and drug-related disorders and personality disorders, especially those with predominant cluster B characteristics (E Classifications of personality disorder, p. 523). • Schizophrenia has a modest association with violence, but the overwhelming majority of people with schizophrenia are never violent, being more likely to be victims than perpetrators of violence. • In people with mental disorders, the factors most strongly associated with offending are the same as for non-mentally disordered offenders: ♂ gender, young age, substance misuse, disturbed childhood, and socio-economic deprivation. • When considering an offence perpetrated by a person with mental disorder, one should bear in mind that, as with any offence, there is interplay between the perpetrator, the victim, and the situational circumstances. Although mental disorder may play a part, it is rarely the only factor that leads to an offence.

746 Chapter 16 Forensic psychiatry Mental disorder and offending 2: specific disorders and offending Schizophrenia The lifetime risk of violence in people with schizophrenia is about five times that in the general population. The factors most commonly associ ated with violence in people with schizophrenia are those associated with violence in people without psychosis. Alcohol and drug misuse are particu larly important. Specific symptoms may be important but clearly are not enough in themselves; otherwise virtually every person with schizophrenia would be violent. Threat control-override symptoms (delusions regarding being threatened or being controlled) have been found to be associated with violence, but again, most patients with these symptoms are never vio lent. The role of command auditory hallucinations is unclear. When people with psychosis are violent, the victim is more likely to be known to them (particularly relatives) than when violence is committed by non-psychotic individuals. Delusional disorders Delusional disorders are probably over-represented among patients de tained in secure psychiatric hospitals; however,

research on the association between delusional disorders and violence is difficult to interpret, as the samples are usually selective and uncontrolled, and in many studies, pa tients with delusional disorders are categorized with patients with other psychoses, especially schizophrenia. i risk of violence has been reported to be associated with persecutory delusions, misidentification delusions, delu sions of jealousy, delusions of love, and querulous delusions. Jealousy may be dangerous, whether it is delusionally based or not. In some cases, it is difficult to differentiate between premorbid personality disorder (perhaps with paranoid and/or narcissistic features) and delusional disorder. The relevant beliefs are probably no less risky if they are over-valued ideas than if they are delusional. Affective disorders Affective disorders have a far less strong relationship with offending and violence than schizophrenia. Mania commonly leads to minor offending due to grandiosity and disinhibition but rarely leads to serious violence or sexual assaults. Depression is very rarely associated with violence or offending. Extended suicide (also known as altruistic homicide), in which a depressed parent (usually the father) kills members of their family before attempting, and perhaps succeeding in, killing themselves, is extremely rare and impos sible to predict. In some cases, it occurs in depressive psychosis associated with nihilistic delusions, but more commonly, there is a history of marital breakdown in people who are depressed and suicidal but not psychotic. A historical association between shoplifting and depression has been high lighted but is probably insignificant.

747 MENTAL DISORDER AND OFFENDING 2: SPECIFIC DISORDERS Alcohol- and drug-related disorders Alcohol- and drug-related problems are more strongly linked to offending and violence than any other mental disorders. A number of aspects of al cohol and substance misuse may be relevant—direct effects of intoxica tion or withdrawal; funding the habit; personal and social consequences of dependence; the neuropsychiatric sequel of prolonged misuse; and the social context (peer group, socio-economic deprivation, childhood mis treatment); and personal characteristics (impulsivity and sensation seeking), which may lead to substance misuse, may also be associated with offending. Personality disorders Personality disorder is more strongly related to offending and violence than mental illness. Personality-disordered offenders are heterogenous—only a very small number are psychopathic (E Psychopathy and ‘severe’ per sonality disorder, p. 524). Various aspects of personality disorder may be related to offending: impulsivity, lack of empathy, poor affect regulation, paranoid thinking, poor relationships with others, and problems with anger and assertiveness. Learning disability Offending occurs more often in people with milder forms of learning dis ability than in those with severe learning disability. Offences are broadly similar to those in non-learning-disabled offenders and are associated with family and social disadvantage. Evidence for i rates of sex offending and fire-raising is based on highly selected patient samples in secure hospitals and is therefore questionable. In some learning-disabled offenders, poor social development, poor educational achievement, gullibility, and impaired ability to communicate may be important factors. Profound and severe learning disability may be associated with disturbed behaviour, including aggression, but would rarely come to the attention of the criminal justice system. Organic disorders Aggression is well recognized in dementia and delirium but rarely leads to serious violence. Substance misuse is both a risk factor for TBI and a common psychiatric outcome. Up to 70% of those with TBI experience irritability, and up to a quarter demonstrate aggressive behaviour. It is no longer thought that there is an association between epilepsy and criminal behaviour, and violence resulting from epileptic activity is extremely rare.

748 Chapter 16 Forensic psychiatry Assessing risk of violence Context Risk of violence to others is assessed by psychiatrists in a range of situations6,7,8 (e.g. acute assessments in casualty, allowing patients leave, court reports, determining whether a patient should progress from a secure setting; see Box 16.3). Types of violence risk assessment • Clinical: traditionally carried out in an unstructured manner, perhaps guided by the research literature. Clinical risk assessment criticized due to lack of reliability, validity, and transparency. • Actuarial [e.g. violence risk appraisal guide (VRAG)]: statistical approaches based on multivariate analyses of factors in samples of forensic patients or prisoners to determine which predict further violence. Variables predictive of recidivism, given weightings, and combined to give a score. From this score, a probability of recidivism can be calculated. Criticized as factors identified invariably historical, unchangeable attributes. Considered by some to be inflexible and unable to inform risk management. • Structured clinical [e.g. Historical, Clinical, and Risk 20 (HCR- 20)]: intermediate approach. Combines historical factors of actuarial approach with dynamic factors in structured way. Clinically the consideration of each factor is more important than the actual scores, so act as useful aides- mémoires. The approach here is based on this method. Box 16.3 Risk assessment instruments A number of risk assessment instruments have been developed. Most re quire specific training, and all require familiarity with the tool and the risk being assessed. There is no consensus as to which tools should be used and when, and some argue that they should not be used at all. • Violence: structured clinical—Historical, Clinical, and Risk 20 (HCR- 20); Risk Assessment, Management, and Audit systems (RAMAS); Risk Assessment Guidance Framework (RAGF); Offender Assessment System (OASys). Actuarial—Violence Risk Appraisal Guide (VRAG); Psychopathy Checklist-Revised (PCL-R); Reconviction Prediction Score (RPS); Risk of Reconviction (ROR) score; Offender Group Reconviction Scale (OGRS). • Sex offending: structured clinical—Risk of Sexual Violence Protocol (RSVP). Actuarial—Sexual Offending Risk Appraisal Guide (SORAG); Rapid Risk Assessment of Sex Offender Recidivism (RRASOR); Static 99; Sex Offender Needs Assessment Rating (SONAR); Matrix 2000. • Spousal abuse: Structured Clinical—Spousal Assault Risk Assessment (SARA). 6 Quinsey VL, Harris GT, Rice ME, et al. (1998) Violent Offenders: Appraising and Managing Risk. Washington, DC: American Psychological Association. 7 Douglas KS., Hart SD, Webster CD, Belfrage H (2013) HCR-20 (Version 3): Assessing Risk for Violence. Burnaby, BC: Mental Health, Law, and Policy Institute, Simon Fraser University. 8 Royal College of Psychiatrists (1996) Assessment and management of risk of harm to other people. Council report CR53. London: Royal College of Psychiatrists.

Assessing risk of violence Information Sources of information determined by the nature and context of the assessment, using as many sources of information as possible: re cords (psychiatric, general practice, social work, prison, school, criminal), interviews (patient, relatives, staff), psychometric (e.g. PCL-R). The process of risk assessment should take a multidisciplinary approach. Factors to consider (based on HCR-20) • Historical Previous violence (convicted and non-convicted, nature, motivation, victims, context); previous antisocial behaviour (other than violence); relationships (lack of relationships, unstable relationships); employment (poor employment record, disciplinary problems); substance misuse; mental illness (noting its relationship to previous aggression); personality disorder (dissocial, emotionally unstable, paranoid, psychopathy); childhood problems (behavioural disturbance, mistreatment); previous violent attitudes (entrenched beliefs, values, or thoughts); previous difficulties with supervision (absconding, lack of attendance, lack of compliance). • Current (internal) Symptoms (delusions, hallucinations); threats (towards particular victim or group); fantasies (violence, sexual); attitudes (pro-criminal, minimization, denial);

impulsivity—instability (affective, behavioural, or cognitive); insight (into illness, personality, previous violence, and precursors); response to treatment or supervision (pharmacological and psychosocial); plans (realistic). • Current (external) Weapons; access to victims; support (formal and informal); destabilizers (alcohol, drugs, homelessness, victimization); stress (relationship problems, debt, life events). Formulation 'The act of understanding the underlying mechanism of an individual's harm potential in order to develop sensitive and proportionate hypotheses to facilitate change'.9 Anchored by historical factors, with cur rent factors indicating immediate/short-term risk. Risk of what, to whom, when, under what circumstances? Acknowledge uncertainties and informa tion gaps. Emphasize context(s) in which a person may be at i/d risk. If using actuarial methods: are they applicable to this person/risk? Are nor mative values from an appropriate sample? Communication The assessment must be communicated in an appro priate and understandable way to others, including the patient. It must also be documented. Use of scores, percentages, or terms such as low, medium, or high should be explained. Risk management The factors identified in the risk assessment should indicate areas to be addressed in management. They may point to the need for specific treatments (pharmacological or psychological), supervision, sup port, detention, or victim safety planning. Scenario planning Despite best efforts, subsequent violence still occurs. Risk scenarios make the final bridge to risk management and are a pro jection about what could happen, not a prediction of what will happen. Consider repeat offence scenario, optimistic scenario (less serious act), pessimistic scenario (more serious act), and a 'twist' scenario (nature of violence changes, e.g. different type of victim). 9 Douglas KS., Hart SD, Webster CD, Belfrage H (2013) HCR-20 (Version 3): Assessing Risk for Violence. Burnaby, BC: Mental Health, Law, and Policy Institute, Simon Fraser University.

750 Chapter 16 Forensic psychiatry Secure hospitals and units Within the health service, there are psychiatric hospitals and units that offer varying degrees of security.10 The terms high, medium, and low security are used to categorize these services and give some indication of the level of risk that can be managed within a particular unit. However, there are no clear definitions of these levels of security. Different units at the same security level may operate in very different ways; there is blurring between the different levels, and rather than thinking of patients in terms of the level of security required, it is better to consider a particular patient's risk, how this should be managed, and how a particular unit may or may not be able to manage the risk. The network of secure services for a particular area varies considerably from region to region. Security does not just rely on the physical barriers and monitoring, al though these are important. Knowing patients well (from studying their backgrounds and interacting with them) and developing good relationships with them contribute to 'relational security'. Security is also maintained through the procedures set out to manage the environment (e.g. procedure for accessing different activities). It is important to recognize that security is maintained through these three concepts: relational, procedural, and en vironmental security. Multidisciplinary risk assessment and management are essential to this process. High-security hospitals There are five high-security hospitals in the British Isles: • English special hospitals—Ashworth, Broadmoor, and Rampton: serve England and Wales and are each part of a local NHS Trust. Each has about 500 beds. • State Hospital (Carstairs): serves Scotland and NI. Managed by a special health board. About 140 beds. • Central Mental Hospital (Dundrum): serves the RoI. Managed by the Eastern Health Board. About 80 beds. Patients are admitted from prisons, courts, or less secure hospitals. Patients must be detained under mental health or criminal procedure legislation. The majority of patients have committed offences, but a substantial minority are transferred from other hospitals where they are unmanageable. Patients

should pose a grave immediate danger to the public. Admissions are usually for several years. Medium-security units Medium-security units are not as virtually escape-proof as high-security hos pitals but are more secure than locked wards. Vary in size from 30 to 100 beds. Each region in England and Wales has one or more medium-security unit. There are three in Scotland, and one in NI. Patients are admitted from prisons, courts, and less secure units, and also from high-security hospitals. Admissions are not usually for >2yrs. Patients may move on to low-security units, open wards, or the community, being managed by general or forensic services, de pending on local service provision, patients' backgrounds, and clinical needs. 10 Kennedy HG (2002) Therapeutic uses of security: mapping forensic mental health services by stratifying risk. Adv Psychiat Treat 8:433–43.

Secure hospitals and units Some specialist units have been developed for personality-disordered patients, learning-disabled patients, women, and adolescents. The State Hospital (Carstairs) and the Central Mental Hospital (Dundrum) admit many patients who would have been admitted to medium-security units in England and Wales, due to differences in the development of local secure forensic provision in Scotland, NI, and the RoI. Low-security units Low-security units and wards have locked doors but do not usually have a secure perimeter. Some regional forensic services have a combination of low- and medium-security wards; in areas of Scotland and NI, there are low-security forensic wards without medium-security units. IPCUs are low- security short-stay wards, primarily for the care of acutely disturbed gen eral psychiatry patients. In a few areas, they also take patients from courts, prisons, and more secure units, but they are not well suited to providing longer-term assessment or treatment. Progression through levels of security Patients in secure settings progress through a rehabilitation programme, and their security needs are not static. The level of security should be re viewed regularly, and the patient transferred to a facility providing the ne cessary level of security when this is appropriate. Scottish legislation allows patients to appeal against the level of security if they feel this is excessive. This is not possible in other jurisdictions. Referring a patient to secure forensic services • A comprehensive assessment should be made, and details of this should be sent with the referral. • Particular attention should be given to the risk the person poses (E Assessing risk of violence, p. 748) and why this risk cannot be adequately managed in less secure services. • Patients should meet the criteria for compulsory detention in hospital under the relevant legislation.

752 Chapter 16 Forensic psychiatry Police liaison Prevalence of psychiatric disorder Recent NICE guidance states 39% of people held in custody by the police suffer from mental disorder.11 Liaison and diversion • Diversion of people with mental disorders from the criminal justice system to healthcare can operate at any stage of the criminal justice process. The term is often used to refer to early diversion, the transfer of mentally disordered people from police custody or at their first court hearing. • Diversion schemes operate in some areas whereby a specific service is provided to the police and/or courts to help identify and divert mentally disordered individuals. These schemes may also be known as police or court liaison schemes. • Police or court liaison is the process or system by which mental health services provide assessment and/or diversion for people with mental disorder at an early stage of the criminal justice process. In many cases where a person is diverted, the police, prosecutor, or court will discontinue the criminal justice process. This will be particularly appro priate in most cases where individuals with mental disorder will have com mitted relatively minor offences. However, diversion does not necessitate this, and where appropriate, particularly where more serious offences have been committed, a prosecution may be pursued, in

parallel with diversion for care and treatment. Powers allowing the police to take a person to a place of safety • The police have powers under mental health legislation to convey a person whom they believe is suffering from mental disorder to a place of safety. (Specific powers are set out in Box 16.4.) • The purpose of these powers is to allow for a psychiatric assessment. • Use by the police of these powers does not oblige mental health services to admit the person. Arrest and detention in custody Where an offence has been committed, a mentally disordered offender may be arrested and taken into police custody. • Issues to address when assessing a person in custody: • Is there evidence of mental disorder? • Is treatment in hospital required? If so, how urgently? • What is the nature of the alleged offence, and is there any evidence of a serious risk to others? • Is the person fit to remain in police custody? • Is the person fit to be interviewed by the police? Do they require an appropriate adult? • Would they be fit to plead if they were to appear in court (E Fitness to plead 1: assessment, p. 774)? 11 National Institute for Health and Care Excellence (2017) Mental health of adults in contact with the criminal justice system. M https://www.nice.org.uk/guidance/ng66 [accessed 21 June 2018].

Police liaison • Options following assessment if a person appears to be mentally disordered: • Admission to hospital informally or under mental health legislation. • Treatment in the community. • Recommend admission on remand, following first court appearance. • Recommend further assessment on remand in custody or on bail, following first court appearance. • Fitness to remain in police custody: there are no legal criteria to determine whether a person is ‘fit to remain in police custody’. A person may be unfit to remain in police custody due to physical illness or mental disorder. Where a person is mentally disordered, such that there would be a serious immediate risk to their own health if they remained in the police cells, then they would be unfit to remain in police custody and should usually be admitted to hospital. This would normally be discussed with a representative of the prosecutor for the court where the case would be heard.. Box 16.4 Powers allowing the police to take a mentally disordered person to a place of safety England and Wales Section 136 MHA 1983 allows the police to appre hend a person who appears to be mentally disordered in a public place, and to convey them to a place of safety where they may be detained for up to 72hrs. The place of safety should be a mental health setting, but often a police station is used. The purpose of Section 136 is to allow for the person to be assessed by mental health services. Following the assess ment, the person may be diverted to mental health services (informally or under compulsion), arrested and taken into police custody, or released. Scotland Section 297 MH(CT)(S)A 2003 allows similar provisions in Scotland, but detention may be for up to 24hrs only. NI Article 130 MH(NI)O 1986 allows similar provisions in NI, but de tention may be for up to 48hrs only. RoI Under Section 12 MHA 2001, if a garda has reasonable grounds for believing that a person is suffering from a mental disorder and that, because of the disorder, there is a serious likelihood of the person causing harm to himself/herself or another person, the garda may take the person into custody. If necessary, the garda may use force to enter the premises where it is believed that the person is. The garda must then go through the normal application procedure for involuntary detention in an approved centre. If the garda’s application is refused, the person must be released immediately. If the application is granted, the garda must remove the person to the approved centre. Note: in England and Wales, Scotland, and NI, these powers do not allow the police to enter premises if they want to remove a person who appears to be suffering from a mental disorder. Under these circumstances, powers are available under Section 135 MHA 1983, Section 293 MH(CT)(S)A 2003, and article 129 MH(NI)O 1986.

754 Chapter 16 Forensic psychiatry Police interviews: fitness, false confessions, and appropriate adults Mental disorder may affect a police interviewing12,13,14 by: impairing the ability of a person to communicate; leading to the person giving unreli able evidence; or making a person vulnerable to becoming distressed. In some cases, mental disorder may be so severe that a person is unfit to be interviewed. • There is no legal basis for fitness to be interviewed, but the following issues may be relevant: • Does the detainee understand the police caution after it has been fully explained to him or her? • Is the detainee fully orientated in time, place, and person and does he or she recognize the key persons present during the police interview? • Is the detainee likely to give answers which can be seriously misconstrued by the court? • Where a person is mentally disordered and fit to be interviewed, an appropriate adult should be present during the police interview. Appropriate adult schemes operate differently in the different jurisdictions of the British Isles (E Appropriate adults, p. 754). • False confessions have been at the heart of some notorious miscarriages of justice. Three types are recognized: • Voluntary (the person voluntarily presents and confesses to a crime he has not committed). • Coerced compliant (persuasive interrogation leads to a person confessing to an offence they know they have not committed). • Coerced internalized (amnesia or subtle manipulation by the interrogator leads to the person believing they have committed a crime which they have not). Appropriate adults • England and Wales—the Police and Criminal Evidence Act (PACE) 1984 and its Codes of Practice provide a statutory basis for appropriate adults. Appropriate adults should be requested by the police where a detained person is under 16yrs or is deemed to be ‘vulnerable’ (perhaps due to mental disorder). The appropriate adult may be a relative or carer. • Scotland—no statutory basis for appropriate adult schemes. Schemes operate to provide appropriate adults, who should not be a relative or carer and who should be requested by the police when they are interviewing any mentally disordered person. These schemes do not cover children. • NI—similar statutory basis as England and Wales. • RoI—no specific provisions. 12 Gudjonnson GH (1993) The Psychology of Interrogations, Confessions and Testimony. Chichester: Wiley. 13 Birmingham L (2001) Diversion from custody. Adv Psychiat Treat 7:198–207. 14 Pearse J, Gudjonnsen G (1996) How appropriate are appropriate adults? J Forens Psychiatry 7:570–80.

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756 Chapter 16 Forensic psychiatry Court liaison Court liaison broadly covers all aspects of psychiatric assessments for courts, but here it is used narrowly to refer to psychiatric assessment at an early (usually the first) court appearance. The terms ‘liaison’ and ‘diversion’ in relation to the police and courts are described in E Police liaison, p. 752. Preparation of court reports and giving evidence in court are covered in E Court reports and giving evidence 2, p. 766. Some areas have court liaison or diversion schemes, aimed at identifying people with mental disorders at an early stage of the court process and diverting them to appropriate mental health services where necessary. Some screen all detainees, but most rely on referrals from criminal justice staff when mental disorder is suspected. In many schemes, the first assess ment is by a CPN who then refers the person on, if necessary. Backup from psychiatrists is necessary for those cases where admission, particularly under compulsion, may be necessary. Features of successful court liaison schemes • ‘Owned’ by mainstream general or forensic services. • Staffed by senior psychiatrists. • Nurse-led and closely linked to local psychiatric services. • Good working relationships with courts and prosecution. • Good methods for obtaining health, social services, and criminal record information. • Access to suitable interview facilities. • Use of structured

screening assessments. • Direct access to hospital beds. • Ready access to secure beds. • Access to specialized community facilities. • Integrated with police and prison liaison schemes. In many areas, there are no dedicated schemes. Under these circumstances, it is important that it is clear to the police, courts, social services, and health services how an urgent assessment may be obtained, if necessary. Issues to be addressed when assessing a person at an early court appearance • Is there evidence of mental disorder? • Is assessment and/or treatment in hospital required? • If so, how urgently? • What is the nature of the alleged offence and is there any evidence of a serious risk to others? • Is the person fit to plead (E Fitness to plead 1: assessment, p. 774)?

Court liaison Options following assessment if a person appears to be mentally disordered • Admission to hospital informally or under mental health legislation. • Treatment in the community. • Recommend admission on remand (E Overview of the pathways of mentally disorered offenders through the criminal justice and health systems, p. 770). • Recommend further assessment on remand in custody or on bail. In many cases, it will be appropriate for the criminal justice process to be discontinued. However, where serious offences are alleged, it would be usually appropriate, if diversion is necessary, for the person to be remanded in hospital (E Overview of the pathways of mentally disorered offenders through the criminal justice and health systems, p. 770).

758 Chapter 16 Forensic psychiatry Prison psychiatry 1: overview Introduction In 2014, England and Wales had a prison population of 146 prisoners per 100,000 people. This is the eleventh highest rate of incarceration among European jurisdictions, and the highest rate among western European jur isdictions. Scotland had the twelfth highest rate, with 145 prisoners per 100,000, and NI was lower with a rate of 98 prisoners per 100,000 (ranked twenty-second). Prison populations continue to grow.15,16,17 Prisons in the UK are either local prisons (accommodating remand prisoners and pris oners serving sentences of <2yrs) or training prisons (taking prisoners serving sentences of >2yrs). In practice, a number of prisons perform both functions. Security varies, depending on the categories of prisoners held. All prisoners are categorized solely on security considerations—‘A’ (the highest category, requiring maximum security) to ‘D’ (the lowest category, suitable for open conditions). Most ♀ prisoners are kept in separate prisons. The prison remand A person accused of committing an offence may be held on remand in prison, while awaiting trial and/or sentence. Courts should not remand a person in custody, unless there is a good reason not to grant bail. Mentally disordered offenders are more likely to be remanded in custody than other offenders, perhaps because: they are more likely to be homeless; they are considered less likely to comply with bail; they are perceived as more dan gerous because of their mental disorder; there are a number of statutory objections to bail for mentally disordered defendants, even where the of fence is not punishable by imprisonment; and even though remands in cus tody for reports are discouraged, there is a lack of hospital or specialist bail facilities. The prison sentence A prison sentence is imposed on an offender by a judge. He will consider a number of factors, including any mitigating or aggravating circumstances. The sentence may serve one or more of the following functions: punish ment, deterrence, reparation, incapacitation, and rehabilitation. In cer tain circumstances, there may be a mandatory prison sentence (e.g. a life sentence for murder). Most prisoners serving determinate sentences are released before the end of their sentence and subject to a period of super vision and/or recall. The exact nature of this depends on the nature of the offence and the length of the sentence imposed, as well as progress within the prison. Life-sentenced prisoners have a tariff (minimum time to serve as punishment) set by the judge. Following the end of the tariff period, the pa role board may authorize the release of the prisoner

on ‘life licence’. They 15 Allen G (2017) Prison population statistics. House of Commons Library Number SN/SG/04334, 20 April 2017. 16 National Institute for Health and Care Excellence (NICE) (2017) Mental health of adults in contact with the criminal justice system. NICE guideline [NG66]. London: NICE. 17 Fazel S, Hayes AJ, Bartellas K, Clerici M, Trestman R (2016) The mental health of prisoners: a review of prevalence, adverse outcomes and interventions. Lancet Psychiatry 3:871–81.

Prison psychiatry 1: overview are subject to recall to prison, should they breach their parole conditions. Following a legal challenge, the UK Home Secretary has lost the power to set the tariff for prisoners sentenced to life imprisonment, although the Attorney General has the power to petition the Court of Appeal to in crease any prison terms which are seen as unduly lenient. The legality of ‘whole-life orders’ (i.e. where the prisoner is sentenced to die in jail) has previously been challenged in the European Court of Human Rights. These orders were found to be legal, as the Home Secretary in exceptional cir cumstances can review them. In Scotland, an Order of Life-Long Restriction can be added to the sentence of an individual who is felt to pose a signifi cant risk to the general public. In practice, this means that an extensive risk management plan must be developed before a prisoner can receive parole, often resulting in the prisoner spending longer in prison. Mental disorder in prisoners The prevalence of mental disorder in the prison population is high, in com parison with the general population, with some estimates as high as 90% when drug and alcohol problems are included. Estimates for specific dis orders include: psychotic disorders 3.1–4.2%; major depression 8.8–11.7%; alcohol-related disorder 18–30%; drug-related disorder 10–48%; and per sonality disorder (excluding antisocial) 7–10%. It has been estimated that 23–55% of prisoners have psychiatric treatment needs, with 2–5% requiring transfer to a psychiatric hospital. Mental health services in prison Traditionally, the prison health service has been separate from the main stream health service. Between 2008 and 2013, the responsibility for pro viding healthcare in prisons was passed to the NHS in England, Wales, Scotland, and NI. This was in response to findings that healthcare available in prisons was poorer than that available to the general population. Prison psychiatry is now provided by private providers, contracted by the NHS, or NHS psychiatrists working within the prison (normally 1–2 sessions per week). There are normally psychiatric nurses based within the prison, and NHS psychologists also provide input. Access to treatment remains a sig nificant concern. A limited health screen occurs on reception to prison, and prisoners can be identified as having mental health needs. Prisoners can request reviews and can also be referred by prison staff if there are concerns.

760 Chapter 16 Forensic psychiatry Prison psychiatry 2: the role of the psychiatrist Psychiatrists may be asked to assess prisoners for the following reasons:18 • To provide court reports (E Court reports and giving evidence 1, p. 764). • To provide assessment and treatment, as part of the NHS team providing healthcare. • For statutory purposes (e.g. preparing reports for the parole board). Normally routine appointments will be in the prison healthcare centre (similar to an outpatient department). For other contact (court or parole reports), a specific arrangement will be made. When arranging to see a prisoner, a psychiatrist should make an appointment that will fit in with the prison routine. There will be usually only 2–3hrs in the morning or after noon when there is access to prisoners. The psychiatrist will have to wait to be escorted by prison staff. Assessment of prisoners Prisoners should be seen on their own, unless prison staff or other sources indicate this would be unwise. It may be difficult to get relevant informa tion about the prisoner’s day-to-day functioning and presentation from prison staff, although attempts should be made to do this. Ask

the pris oner for a relative’s telephone number and permission to speak to them. The prison medical file may not contain all the necessary information, and in some cases, other prison records should be examined. History-taking, MSE, and information gathering should proceed as with any other psychi atric assessment. Options in the management of mentally disordered prisoners If a psychiatrist assesses a prisoner and finds that they are mentally dis ordered, he may: • Treat the person in prison. • Arrange for the person to be transferred to mental health services, either by arranging direct transfer from prison (E Overview of the pathways of mentally disorered offenders through the criminal justice and health systems, p. 772) or by recommending a mental health disposal through the courts if the prisoner has not been sentenced yet. No prison, or prison medical centre, is recognized as a hospital under mental health legislation; therefore, compulsory treatment under the MHA cannot be given. All prisoners with severe mental illness should be trans ferred to hospital for treatment. Legal provisions for transferring prisoners to hospital are set out on E Legal provisions for transfer of prisoners to hospital, p. 762. Similar provisions for remand prisoners are discussed in E Overview of the pathways of mentally disorered offenders through the criminal justice and health systems, p. 770 and listed in Table 16.3 for each jurisdiction. 18 Birmingham L (2003) The mental health of prisoners. Adv Psychiat Treat 9:191–201.

Prison psychiatry 2: the role of the psychiatrist Treatment in prison • Medication, monitoring, and modest psychological treatment (supportive psychotherapy perhaps utilizing some cognitive–behavioural or psychodynamic techniques) may be offered to prisoners with mental disorders who do not require treatment in hospital. • Various treatment programmes to address offending behaviour have been developed in prisons. These are run by the prison service and do not involve mental health services. Programmes are available for areas such as sexual offending, anger management, alcohol and substance misuse, and problem-solving. • Some prisons specialize in treating certain mentally disordered prisoners, e.g. HMP Grendon in England offers therapeutic community treatment for personality-disordered prisoners who volunteer to be transferred there; there is a 17-bed psychiatric unit at HMP Maghaberry in NI. Prescribing in prison Prescribing in prison should be similar to prescribing in the community— with some additional considerations. In the prison environment, there can be additional barriers to compliance, with medication being diverted (stolen or sold). Mental health patients can be bullied for medication. Consideration should be given to the ‘street value’ of medication when prescribing. Medication can be ‘supervised’, meaning it is dispensed daily or ‘in possession’, i.e. the prisoner is given a small supply of medication (usu ally weekly or monthly). Supervised medication increases compliance. The form of medication should also be considered—orodispersible or liquid medications increase compliance and reduce the risk of diversion. Suicide in prison Suicide is the most common mode of death in prisons. There are 7600 episodes of self-harm and one suicide per week in prisons in England and Wales. ♂ prisoners have a 3–6 times greater risk of suicide than those in the general population. The most common means is by hanging. Remand prisoners, young offenders, and those with a history of substance misuse and violent offences are at particular risk. Many factors probably contribute to the i rate of suicide in prisons, including: history of psychiatric disorder, previous self-harm, alcohol and substance misuse, and social isolation. Compounded by uncertainty, power lessness, bullying, and isolation. The task of identifying prisoners who are at risk is extremely difficult, as those who kill themselves share the same vulnerabilities and stresses with many other prisoners who do not. A major factor that may reduce suicide rates is improvement in prison conditions. Isolation of prisoners at risk in strip cells still occurs, although it is becoming less frequent and is against official guidance.

762 Chapter 16 Forensic psychiatry Legal provisions for transfer of prisoners to hospital Sentenced prisoners England and Wales Section 47 MHA 1983 (as amended) allows for the transfer of a mentally disordered sentenced prisoner to hospital. There must be reports from two registered medical practitioners addressing what category of mental disorder the person suffers from and whether this is of a nature or degree to warrant hospital detention. The reports are submitted to the Secretary of State who decides whether or not to grant a 'transfer direction'. Section 49 MHA 1983 (as amended) allows the Secretary of State to add a 'restriction direction' to a transfer direction, which has the same effect as a restriction order under Section 41 and may last as long as the sen tence the person was serving. In practice, Section 47 is rarely made without Section 49. Scotland Section 136 MH(CT)(S)A 2003 sets out similar provisions for Scotland. There must be reports from two medical practitioners (one approved) ad dressing whether the prisoner has a mental disorder, that the mental dis order is 'treatable', that the person would be at risk or pose a risk to others, and that the transfer is necessary. The reports are submitted to the Scottish Ministers who decide whether or not to grant a 'transfer for treatment dir ection'. All transferred prisoners are treated as restricted patients for the duration of the prison sentence that they are serving. Northern Ireland Article 53 MH(NI)O 1986 sets out similar provisions for NI. Two medical practitioners (one who is recognized as an approved medical practitioner under the terms of the Commission) must submit reports to the Secretary of State. The issues are similar to England and Wales, except that the mental disorder must be a mental illness or a severe mental impairment. The order is called a 'transfer direction'. Article 55 allows the addition of a restriction direction, as in England and Wales. Republic of Ireland Section 15 Criminal Law (Insanity) Act 2006 (amended 2010) allows for transfer of a prisoner suffering from a mental disorder to a designated centre for the purpose of receiving appropriate care and treatment. Transfer is authorized by the prison governor on the recommendation of one approved medical officer (if the prisoner agrees to the transfer) or of two approved medical officers (if the prisoner is unable or is unwilling to agree to the transfer). Prisoners awaiting trial or sentence England and Wales Section 48 MHA 1983(as amended) is similar to Section 47 but provides for transfer of unsentenced prisoners. Other differences from Section 47

Legal provisions for transfer of prisoners to hospital include: the person must have a mental illness or a severe mental impair ment (cannot be used for a psychopathic disorder or a mental impairment), and there must be an urgent need for treatment. This Section also enables the transfer of civil prisoners and people detained under immigration legislation. Scotland Section 52 CP(S)A 1995 provisions ('assessment orders' and 'treatment orders'), as described in Table 16.3, may be used for prisoners awaiting trial or sentence. The necessary medical recommendations are made to the Scottish Ministers who then apply to a court for the person to be admitted to hospital, in the same way as for a hospital remand made at any court appearance. All transfers under this legislation are treated as restricted pa tients for the duration of the detention. Northern Ireland Article 54 MH(NI)O 1986 sets out similar provisions for NI as Section 48 MHA 1983 for England and Wales. Again, one of the two doctors must be an approved medical practitioner under the terms of the Commission. The prisoner may not be transferred to the State Hospital, as it is in another jurisdiction and the court process has not been completed. All transfers under this legislation are treated as restricted patients for the duration of the detention. Republic of Ireland Sections 4 and 15 Criminal Law (Insanity) Act 2006 (amended 2010) sets out the provisions (E Sentenced prisoners, p. 762) for prisoners awaiting trial or sentence.

764 Chapter 16 Forensic psychiatry Court reports and giving evidence 1 A psychiatrist may be required to provide reports and give evidence in crim inal and civil proceedings. The following deals with reports in criminal pro ceedings. Reports may be requested by the prosecution, the court, or a solicitor. The assessment should be objective and professional and should not be influenced by which ‘side’ has made the request. The clinical issues The clinical issues will involve those that psychiatrists usually assess: diagnosis, treatment needs, prognosis, etc. However, spe cific attention needs to be given to how these clinical issues interact with the legal issues in question. What is the relationship between any psychi atric disorder and past, present, and future offending? How might treat ment or the natural course of the disorder impact on the likelihood of further offending? What impact might the current mental state have on the person’s ability to participate in the court process? The legal issues The request for psychiatric assessment should indicate the legal issues towards which the psychiatrist should direct the assessment. However, in many cases, the instructions are not specific. The main issues to consider are usually: • Fitness to plead (E Fitness to plead 1: assessment, p. 774). • Responsibility (E Criminal responsibility 1, p. 778). • The presence of mental disorder and whether assessment and/or treatment under compulsion (or otherwise) is required (E Mental disorder and offending 1: overview, p. 745). • The risk the person poses (may be relevant in whether a restriction order is imposed, in determining if disposal should be to a secure unit or a special hospital, or perhaps in determining the nature of the sentence imposed; E Assessing risk of violence, p. 748). Before the interview • Comprehensive background information should usually be provided by those requesting the report. Unfortunately, this is often lacking. Ideally, one should have the opportunity to examine: the document specifying the charges, the police summary, witness statements, records of interviews with the accused, records of previous offences, and other reports. Sometimes tape recordings of interviews and photographic or video evidence may be available. • Arrangements should be made to interview the person in prison (if they have been remanded in custody), as an outpatient (if they have been remanded on bail), or in hospital (if they have been admitted to hospital). The psychiatrist should be given reasonable time to complete the assessment and produce a considered report. If there is insufficient time, then this should be stated in the report and any opinion given should be qualified.

Court reports and giving evidence 1 The interview • Check the person’s correct name and details. Introduce yourself and state who has requested the report. • Make it clear that the interview is not confidential and that the information in the report will be seen by others. • It is good practice and advisable to gain written consent from the person to access their health, prison, social work, or educational records. • Clarify that the person has understood this, and seek their consent to prepare the report. • If the person refuses to be interviewed, then this should be respected and reported to the person requesting the report. • Ask the person’s permission to contact a relative and/or their GP for further information. • Follow the usual format for a psychiatric assessment. • Enquiry about the circumstances of the offence, and the person’s understanding of the court process will need to be made in addition. • More than one session may be necessary in some cases. • Physical examination and investigations should be performed, if indicated. After the interview Further information may be gathered from the following sources: • Interviews with relatives or staff (healthcare, prison, or social services). • Health (psychiatric or general practice), prison, social work, or educational records. • In some cases, specific psychometric testing by a psychologist may be necessary (e.g. where a person appears to be learning-disabled). • If insufficient time is available to complete a written report, evidence can be given verbally over the phone and the formal report can follow.

766 Chapter 16 Forensic psychiatry Court reports and giving evidence 2 The report • The various strands of the assessment should be brought together in the report. • The report should be clear, concise, well structured, and jargon-free. • Technical terms (e.g. schizophrenia, personality disorder, delusions, hallucinations, thought disorder) should be explained if they are used. • If a number of sources of information have been used, indicate where the particular factual information in the report has come from, particularly when there are inconsistencies (e.g. 'according to . . . ', 'he stated that . . . '). • The main body of the report should present the information gathered; the opinion should present the conclusions concerning the relevant issues and lead to the recommendations. • The opinion and recommendations should confine themselves to psychiatric issues. Punitive sanctions, such as imprisonment, should never be recommended. • When recommending admission, further assessments, follow-up, or other treatment options such as medication, good practice would be to describe what you have arranged, or intend to arrange, to ensure that this happens. There are different formats for a court report, just as there are different ways of presenting the history and mental state. A suggested structure is given in E Suggested format for criminal court report, p. 768. What will happen to the report? • The report becomes the property of whoever requested it. • Defence reports may or may not be produced in evidence in a particular case; prosecution reports must be revealed to the defence. • Copies of the report should not be sent by the psychiatrist to others (such as the patient's GP, another psychiatrist, or a probation officer) without the consent of both the person examined and the person who commissioned the report. • A psychiatric report may come to be included in various records (health, prison, probation) and may, in the future, be used for reference or in further legal proceedings. Giving evidence In most cases, a psychiatrist will not be required to give oral evidence. However, under some circumstances, this will be the case—a report re quires clarification, the court finds it difficult to accept the opinion, there are conflicting reports, and in specific circumstances where oral evidence is obligatory (e.g. where a restriction order is under consideration). If you are requested to attend court: • Clarify with the court when you should attend. • Prepare in advance by examining the papers and re-reading your report. • Prepare in advance to comment on a conflicting report.

Court reports and giving evidence 2 • Consult references and anticipate questions. You are often asked to read parts or all of your report aloud in court and to clarify any jargon along the way. • Present in a smart, confident, professional manner, and be punctual. • Counsel may request a conference before the court sits. • Have a brief interview with the accused in the court cells if he has not been seen for some time and particularly where fitness to plead may be an issue. When called to give evidence, you will be asked to take the oath, and then you will be questioned by the barrister or solicitor who called you. You will then be cross-examined by the 'other side' before being re-examined. You may take notes with you, but ask the judge before referring to them. Speak clearly and slowly, and explain technical terms. Address the judge. Avoid saying more than is necessary to answer the questions asked. If counsel's questioning is not allowing you to get the appropriate information across, then ask the judge if you may clarify your response. A note on addressing the judge • England and Wales—High Court: 'My Lord' or 'My Lady'; local judge: 'Your Honour'; Magistrate's Court: 'Sir' or 'Madam'. • Scotland—High Court and Sheriff Court: 'My Lord' or 'Sir' and 'My Lady' or 'Ma'am'. • NI—as England and Wales. • RoI—'Your Lordship', 'Judge', or 'Sir'.

768 Chapter 16 Forensic psychiatry Suggested format for criminal court report • The following sets out a comprehensive list of the matters that may be set out in a report. • Not all of the issues will be relevant in every case. For example: • Where there is little information available and the recommendation is for further assessment, then the report may be relatively brief, focusing on the issues of relevance to the making of any relevant order. • Where the person has been convicted, consideration of fitness to plead, insanity at the time of the offence, and diminished responsibility (in murder cases) are irrelevant. • Where a report is updating a previous report prepared in the same case relating to the same offence (or alleged offence) or is recommending the extension of an order, then the report may be relatively brief, as long as it addresses whether the person fulfils the criteria for that order and why an extension is necessary. Preliminary information • At whose request the assessment was undertaken, the circumstances of assessment (place, time, any constraints on assessment such as inadequate time to complete assessment due to prison routine). • Sources of information used (interview with the person, interviews with others, documents examined). • The person's capacity to take part, or refuse to take part, and understanding of the limits of confidentiality. • If any important sources of information could not be used, there should be a statement as to why this was the case. Background history Family history; personal history; medical history; psychiatric history; drug and alcohol history; recent social circumstances; personality; forensic history. Circumstances of the offence or alleged offence Give the person's account of events. Include information about the mood and mental state around the time of the alleged offence, any drug or alcohol use on the day of the alleged offence, and how they feel about the alleged offence now. Progress since the offence or alleged offence Particularly where there has been a considerable period of time since the (alleged) offence.

Suggested format for criminal court report Current mental state Opinion • Fitness to plead. • Presence of a mental disorder currently and whether the criteria for the relevant order are met. • Presence of a mental disorder at the time of the offence: • The relationship between any mental disorder and the offence (this is still relevant, even if the person has been convicted, as it may affect the choice of disposal). • Whether the person was insane at the time of the offence. • In murder cases, whether there are grounds for diminished responsibility. • Assessment of risk: • The risk that the person might pose of re-offending. • The relationship between this risk and any mental disorder present. • Does the person require to be managed in a secure setting (medium- security unit, high-security hospital)? • What assessment or treatment does the person require? • Does the person need further assessment? (Where? Does the person need a period of inpatient assessment, and at what level of security? Why? What issues remain to be clarified?) • Does the person require treatment? (What treatment do they need and where?) • State any matters that are currently uncertain and the reasons they remain uncertain. Recommendation • Should the court consider using any particular order? (And if so, what arrangements have been made for the person to be received in hospital or elsewhere under this order?) • Under whose care will the person be? Consider whether an alternative order may be appropriate if circumstances change, so that the order recommended here cannot be acted on, e.g. • If the person is or is not found to be insane. • If the person is or is not convicted. Medical practitioner's details Name; current post; current employer and name of supervisor; qualifi cations; whether fully registered with the GMC; approved under relevant mental health legislation; a statement that the report is given on soul and conscience (in Scotland); statements as to whether the medical practitioner is related to the person and has any pecuniary interest in the person's ad mission to hospital or placement on any community-based order (if mental health disposal is being recommended). The medical practitioner

should sign the report.

770 Chapter 16 Forensic psychiatry Overview of the pathways of mentally disordered offenders through the criminal justice and health systems The following gives an overview of the criminal justice process and how, at each stage, mental disorder may lead to certain courses of action being taken. Different procedures are available in the four main jurisdictions of the British Isles (see Table 16.3 for a summary of the legal provisions for each jurisdiction). The numbers appearing in superscript in the following bullet points give an indication as to which procedures are not applicable in all four jurisdictions—1: England and Wales and Scotland only; 2: not in RoI; and 3: Scotland only. Arrest and police custody After being apprehended, an individual may be diverted to mental health services informally or under civil procedures. Police may also have specific powers allowing them to take mentally disordered individuals for assess ment by psychiatric services. Pre-trial • At a pre-trial court appearance, a mentally disordered individual may be remanded to hospital for assessment and/or treatment.2 With more minor offences, criminal proceedings may be taken no further and an individual may receive care from mental health services either informally or using compulsory measures under mental health legislation. • If an individual is remanded in prison but appears to be mentally disordered, procedures may allow for the transfer of that person to hospital. • If an individual is remanded on bail, conditions may be attached, so that they are required to be assessed and/or treated by psychiatric services. Trial • If a person’s mental state is such that they cannot participate in the court process, then they may be found unfit to plead and would subsequently only be liable to receive a mental health disposal. • Mental disorder may affect a person’s legal responsibility for their actions: • Automatic behaviour (automatism) may lead to complete acquittal or acquittal on the grounds of insanity. • A severe mental disorder may be such that a person is held not to be legally responsible for their actions and they are acquitted on the grounds of insanity (also known as not guilty by reason of insanity or lacking criminal responsibility by reason of mental disorder). Following such a finding, they would only be liable to receive a mental health disposal. • In murder cases, mental disorder may lead to diminished responsibility, reducing the offence to manslaughter (culpable homicide in Scotland), thus avoiding the mandatory life sentence and allowing flexibility in disposal (which may be a penal or mental health disposal).

771 OVERVIEW OF THE PATHWAYS OF MD OFFENDERS • Despite the presence of mental disorder at the time of trial and/or at the time of the offence, a mentally disordered offender may plead or be found guilty. Mental disorder may then be taken into account when sentence is passed. Post-conviction/pre-sentence • Procedures may allow a mentally disordered offender to be assessed in hospital after conviction, but prior to sentencing.2 • Individuals remanded in prison awaiting sentencing may be transferred to hospital if they appear mentally disordered, as at the pre-trial stage.2 Sentencing Following conviction, a mentally disordered offender may receive a mental health disposal:2 • A compulsory order to hospital. • A compulsory order to hospital, with special restrictions in more serious cases. • A compulsory order to hospital, with a prison sentence running in parallel.1 • A compulsory order in the community.3 • Other community disposals. Alternatively, they may, despite the presence of mental disorder, receive a penal disposal either in prison or in the community. During a prison sen tence, if a person appears to be mentally disordered, they may be trans ferred to hospital.

Remand to hospital for assessment s36 MHA 1983 s52K-S CP(S)A 1995 a43 MH(NI)O 1986 s4CL(I)A 2006/2010 England and Wales Scotland Northern Ireland Republic of Ireland public place s136 MHA 1983 s297 MH(CT)(S)A 2003 a130 MH(NI)O 1986 s12 MHA 2001 private premises s135 MHA 1983 s293 MH(CT)(S)A 2003 a129 MH(NI)O 1986 s12 MHA 2001 Transfer of untried prisoner to hospital s48 MHA 1983 s52B-J CP(S)A 1995 or s52K- Table 16.3 Legal provisions for procedures relating to mentally disordered offenders Detention of mentally disordered person in Detention of mentally disordered person in See Table 16.1 for abbreviations. Pre-trial Police S CP(S)A 1995 a54 MH(NI)O 1986 s4CL(I)A 2006/2010 Criteria for fitness to plead R v Prichard HMA v Wilson Stewart v HMA R v Prichard s4CL(I)A 2006/2010 O 1986 s4CL(I)A 2006/2010 Criteria for insanity at the time of the offence M'Naghten Rules HMA v Kidd CJ(NI)A 1966 s5CL(I)A 2006/2010 O 1996 s5CL(I)A 2006/2010 A 1991 s54–57 CP(S)A 1995 a49 and 50A MH(NI) CP(IUP)A 1991 s54 and s57 CP(S)A 1995 a50 and a50A CJ(NI) plead s2–3 and sch 1–2 CP(IUP) time of the offence s1 and s3 and sch 1–2 Procedure relating to a finding of insanity at the Procedure relating to a finding of unfitness to Trial

or CP(S)A 1995 a54 MH(NI)O 1986 s15CL(I)A 2006/2010 CP(S)A 1995 a42 MH(NI)O 1986 s4CL(I)A 2006/2010 Remand to hospital for treatment s36 MHA 1983 s52K-S CP(S)A 1995 a43 MH(NI)O 1986 s4CL(I)A 2006/2010 Interim hospital/compulsion order s38 MHA 1983 s53 CP(S)A 1995 – – Compulsory treatment in hospital s37 MHA 1983 s57A CP(S)A 1995 a44 MH(NI)O 1986 – Restriction order s41 MHA 1983 s59 CP(S)A 1995 a47 MH(NI)O 1986 – Transfer of untried prisoner to hospital s48 MHA 1983 s52B-J CP(S)A 1995 s52K- S Remand to hospital for assessment s35 MHA 1983 s52B-J CP(S)A 1995 s200 Hybrid order (hospital disposal with prison Post-conviction but pre-sentence Sentence treatment s47 MHA 1983 s136 MH(CT)(S)A 2003 a53 MH(NI)O 1986 s15CL(I)A 2006/2010 sentence) s45A-B MHA 1983 s59A CP(S)A 1995 – – Compulsory treatment in community – s57A CP(S)A 1995 – – Guardianship s37 MHA 1983 s58(1A)CP(S)A 1995 a44 MH(NI)O 1986 – Intervention order for incapable adult – s60B CP(S)A 1995 – – Psychiatric probation order sch2 (p5) PoCC(S)A 2000 s230 CP(S)A 1995 sch1(p4) CJ(NI)O 1996 – Restriction direction for transferred prisoner s49 MHA 1983 * a55 MH(NI)O 1986 – Notes: –, no procedure in this jurisdiction; *, all s136 MH(CT)(S)A 2003 transfer directions in Scotland are restricted. Transfer of sentenced prisoners to hospital for Post-sentence

774 Chapter 16 Forensic psychiatry Fitness to plead 1: assessment Essence If a person's mental disorder is such that they cannot participate adequately in the court process, then it has long been held that it is unfair for the person to be tried. If this is the case, the court finds the person unfit to plead and the trial does not proceed. Legal criteria The details of these vary in different jurisdictions but broadly cover the same issues (see Box 16.5). Clinical assessment of fitness to plead The assessment of fitness to plead is concerned with the current mental state and ability of an accused. The issue can be raised by the defence, the prosecution, or the judge. In England and Wales, at least two medical reports are required, and if raised by the prosecution, it must be proved Box 16.5 Fitness to plead—legal criteria for finding England and Wales: R v Prichard (1836) 7 C&P 303 'Whether he can plead to the indictment . . . [and] . . . whether he is of sufficient intellect to comprehend the course of proceedings on trial, so as to make a proper defence—to know that he might challenge any of you [the jury] to whom he might object—and to comprehend the details of evidence . . . ' Scotland: Criminal Justice and Licensing (Scotland) Act 2010 This Act replaced the common law understanding of unfitness to stand trial with a new statutory definition under Section 170: '(1) A person is unfit for trial if it is established on the balance of probabilities that the person is incapable, by reason of a mental or physical condition, of participating effectively

in a trial. (2) In determining whether a person is unfit for trial the court is to have regard to: (a) the ability of the person to: (i) understand the nature of the charge, (ii) understand the require ment to tender a plea to the charge and the effect of such a plea, (iii) understand the purpose of, and follow the course of, the trial, (iv) under stand the evidence that may be given against the person, (v) instruct and otherwise communicate with the person's legal representative, and (b) any other factor which the court considers relevant.' NI As for England and Wales. RoI Statutory definition under Section 4(2) Criminal Law (Insanity) Act 2006: 'An accused person shall be deemed unfit to be tried if he or she is unable by reason of mental disorder to understand the nature or course of the proceedings so as to: (a) plead to the charge, (b) instruct a legal representative, (c) make a choice, where available, on trial by jury or by summary, (d) make a proper defence, (e) in the case of a trial by jury, challenge a juror to whom he or she might wish to object, or (f) under stand the evidence.'

Fitness to plead 1: assessment beyond reasonable doubt or, if by the defence, on the balance of probabilities. In Scotland, it is referred to as unfitness for trial and was previously 'insanity in bar of trial'. Medical evidence is no longer required; however, the case may be adjourned for assessment to occur. In NI, it is referred to as fitness to be tried and at least two medical practitioners are required to give evi dence, one of which must be oral. In RoI, fitness to plead is based on the evidence of an approved medical officer.19 This involves: • Making a diagnosis of mental disorder. • Determining the impact of this disorder on the abilities covered in the legal criteria. Clinicians should be aware that the mental state of an individual may change, and therefore, if some time has elapsed between a clinical exam ination and the accused's appearance in court, then a brief re-examination may be necessary. Diagnoses that may be relevant Dementia and other chronic organic conditions, delirium, schizophrenia and related psychoses, severe affective disorders (mania and depression), ID. Features of an individual's mental state due to their disorder to be taken into consideration • Ability to communicate (schizophrenic thought disorder, manic flight of ideas, depressive poverty of speech, dysphasia of dementia). • Beliefs (e.g. the individual may have delusions that they have a divine mission and that the court process is irrelevant to them). • Comprehension (may be impaired in dementia, acute confusion, or learning disability). • Attention and concentration (may be impaired in any of the conditions listed here). • Memory (as noted, amnesia for the alleged offence is irrelevant, but short-term memory failure due to organic impairment may be such as to make following proceedings in court impossible). In some cases, suggestions may be made as to how the communication and understanding of the accused may be facilitated. However, such suggestions must be practicable in court. In most cases, psychiatric evidence is unani mous and followed unquestioningly in court. A recommendation that an individual is unfit to plead should be reserved for cases where this is beyond doubt. In borderline cases, certain measures (such as a hospital remand) may allow further assessment and treatment to clarify the issue. Where the index offence is relatively minor, it may be appropriate for charges to be dropped and for civil detention to be initiated. In such cases, prosecutors are usually keen to take this course. 19 Eastman N, Adshead G, Fox S, Latham R, Whyte S (2012) Fitness to give evidence. In: Eastman N, Adshead G, Fox S, Latham R, Whyte S. Forensic Psychiatry, pp. 477–8. Oxford: Oxford University Press.

776 Chapter 16 Forensic psychiatry Fitness to plead 2: procedures What happens after a person is found unfit to plead? A person who is unfit to plead may not be subject to penal sanctions. Traditionally, the person would be detained indefinitely in a secure hospital, with special

restrictions on discharge, until they recovered to the extent that they could be tried (although the person would rarely go back for trial, even if they recovered!). This unsatisfactory arrangement is still the case in the RoI. In England and Wales, Scotland, and NI, following a finding of unfitness to plead, there is a trial of facts where the court determines if the person did the act charged. If the facts are found, the person may be subject to one of a range of mental health disposals, depending on their mental state, their needs, and the risk they might pose. Proceedings following a finding England and Wales • Proceedings set out in the Criminal Procedure (Insanity and Unfitness to Plead) Act 1964 (amended 1991, 2004). • Following a finding of unfitness to plead, there is a trial of facts held to determine whether, on the balance of probability, it is likely that the person committed the offence. • If this is not found to be the case, the defendant is discharged; if it is found to be the case, the person may be subject to one of the following disposals: • Hospital order (almost identical to Section 37 MHA 1983). • Hospital order with a restriction order (almost identical to Section 37 and Section 41 MHA 1983). • Guardian order (almost identical to Section 37 MHA 1983). • Supervision and treatment order (similar to a psychiatric probation order). • No order. • If the person has been charged with murder, then there is a mandatory hospital order with an unlimited restriction order. Scotland • Proceedings set out under Section 54 to 57 CP(S)A 1995, as amended by Criminal Justice and Licensing (Scotland) Act 2010. • Following a finding of unfitness for trial, there is an 'examination of facts'. • While awaiting this, the person may be placed in prison, on bail, or in hospital under a temporary compulsion order. • At the 'examination of facts', a determination is made as to whether, on the balance of probability, it is likely that the person committed the offence. • If this is not found to be the case, the defendant is discharged (but may merit civil detention if remains mentally unwell); if this is found to be the case, the person may be subject to one of the following disposals: • Compulsion order (almost identical to Section 57A CP(S)A 1995) in hospital or the community. • Compulsion order in hospital with a restriction order (almost identical to Section 57A and Section 59 CP(S)A 1995).

Fitness to plead 2: procedures • Interim compulsion order (almost identical to Section 53 CP(S) A 1995). • Guardianship order or intervention order (identical to such orders under the Adults with Incapacity (Scotland) Act 2000). • Supervision and treatment order (similar to a psychiatric probation order). • No order. • In Scotland, there is no longer a mandatory restriction order in murder cases. The interim compulsion order is to be used in all cases where the person appears to pose a considerable risk to others; following assessment, if the person is determined to pose a high risk, according to the criteria set out under Section 210E CP(S)A 1995, then the mandatory disposal is a compulsion order to hospital with a restriction order. Northern Ireland • Articles 49 and 50A MH(NI)O 1986 set out almost identical procedures as for England and Wales. Republic of Ireland Under the Criminal Law (Insanity) Act 2006: • If a person is found unfit to be tried, and the court is satisfied that there is reasonable doubt that he committed the alleged act, it will acquit him and no further action under criminal proceedings will be taken. • If that is not the case, then following a finding of unfitness to be tried, the person must be examined by a doctor to determine if they meet the criteria for detention under the MHA 2001; this may occur via a 28-day period of assessment in a designated centre. • If the person does meet such criteria, then they are detained in a designated centre until they are fit to be tried or they no longer require detention in hospital. The designated centre may be a prison or a hospital. Fitness to stand trial Fitness to stand trial is a separate issue from fitness to plead. It concerns whether a person is so unwell (either mentally or physically) that they are unable to appear in court or appearing in court would be detrimental to their health. If you have concerns about a person's fitness to stand trial, you can respectfully

recommend they do not attend court; however, ultim ately, the court will make a decision regarding this. In most circumstances, an individual who was unfit to stand trial due to mental disorder would be unfit to plead.

778 Chapter 16 Forensic psychiatry Criminal responsibility 1 If a person was mentally disordered at the time of an offence, this may af fect their legal responsibility for their actions. The relevant legal issues are: • Insanity at the time of the offence. • Automatism. • Diminished responsibility (E Criminal responsibility 2, p. 780). • Infanticide (E Criminal responsibility 2, p. 780). Insanity at the time of the offence In some cases, the court may find that a person's mental condition was such that they cannot be held responsible for their actions; they are then acquitted on the grounds of insanity [also known as insanity at the time of the offence, not guilty by reason of insanity, or guilty but insane (the present term in the RoI)]. For legal criteria, see Box 16.6. Automatism • If an individual commits an offence when their body is not under the control of their mind (e.g. when asleep), they are not guilty of the offence. • Legally, this is called an automatism. (Note: this is different from the clinical concept of automatism occurring during a complex partial seizure.) • In England and Wales, two legal types of automatism are recognized: insane and sane (automatism simpliciter). The distinction is based on whether the behaviour is likely to recur: • Insane automatism—due to an intrinsic cause (e.g. sleepwalking, brain tumours, epilepsy), results in acquittal on the grounds of insanity. • Sane automatism—due to an extrinsic cause (e.g. confusional states, concussion, reflex actions after bee stings, dissociative states, night terrors, and hypoglycaemia), results in complete acquittal. Note: the distinction is less important now that there is a flexible range of disposals available for those found insane. • In Scotland (until recently), sane automatism was not recognized—it is now recognized only in cases where an external factor is shown to have caused the accused's dissociated state of mind. What happens after a person is acquitted on the grounds of insanity? • Disposal after acquittal on the grounds of insanity is identical to that following a finding of unfitness to plead with the facts found in England and Wales, Scotland, and NI; and that following a finding of unfitness to plead in the RoI (see Box 16.6).

Criminal responsibility 1 Box 16.6 Insanity at the time of the offence—legal criteria England and Wales: M'Naghten Rules of 1843 (West and Walk 1977) 'Every man is presumed to be sane, until the contrary be proved and that to establish a defence on the grounds of insanity it must be clearly proved that at the time of committing the act the accused party was labouring under such a deficit of reason from disease of the mind to not know the nature and quality of the act; or that if he did know it, that he did not know that what he was doing was wrong.' Scotland: Criminal Justice and Licensing (Scotland) Act 2010 As for the issue of unfitness to stand trial, this Act replaced the common law understanding of insanity at the time of the offence with a new statu tory definition under Section 168: '(1) A person is not criminally respon sible for conduct constituting an offence, and is to be acquitted of the offence, if the person was at the time of the conduct unable by reason of mental disorder to appreciate the nature or wrongfulness of the conduct. (2) But a person does not lack criminal responsibility for such conduct if the mental disorder in question consists only of a personality disorder which is characterised solely or principally by abnormally aggressive or seriously irresponsible conduct.' NI: Criminal Justice (NI) Act 1966 A defendant who is found to have been 'an insane person' at the time of the alleged offence shall not be convicted. 'Insane person' means 'a person who suffers from mental abnormality which prevents him— • from appreciating what he is doing; or • from appreciating that what he is doing is either wrong or contrary to law; or • from controlling his own conduct.' Mental abnormality is defined as 'an abnormality of mind

which arises from a condition of arrested or retarded development of mind or any inherent causes or is induced by disease or injury'. RoI: Section 5 Criminal Law (Insanity) Act 2006 'Where an accused person is tried for an offence and, in the case of the District Court or Special Criminal Court, the court or, in any other case, the jury finds that the accused person committed the act alleged against him or her and, having heard evidence relating to the mental condition of the accused given by a consultant psychiatrist, finds that—(a) the ac cused person was suffering at the time from a mental disorder, and (b) the mental disorder was such that the accused person ought not to be held responsible for the act alleged by reason of the fact that he or she—(i) did not know the nature and quality of the act, or (ii) did not know that what he or she was doing was wrong, or (iii) was unable to refrain from committing the act, the court or the jury, as the case may be, shall return a special verdict to the effect that the accused person is not guilty by reason of insanity.'

780 Chapter 16 Forensic psychiatry Criminal responsibility 2 Diminished responsibility • In murder cases, a person's mental condition may be such that although they cannot be fully absolved of responsibility, they are found to be of diminished responsibility (known as impaired mental responsibility in NI). • A finding of diminished responsibility does not result in acquittal, but in conviction for the lesser offence of manslaughter (or culpable homicide in Scotland). • For legal criteria, see Box 16.7. Infanticide • In cases involving the killing of a child aged under 12mths by the mother, she may be convicted of infanticide, instead of murder, if the court is satisfied that the balance of her mind was disturbed by reason of her not fully having recovered from the effect of giving birth to the child, or by reason of lactation consequent upon the birth (Infanticide Act 1938 for England and Wales, Infanticide Act (NI) 1939, Infanticide Act 1949 for the RoI). • These criteria set a lower threshold than those for diminished responsibility. • Disposal in such cases is flexible, as with manslaughter. • This defence is not available in Scotland where diminished responsibility would be used instead in such cases. What happens following a finding of diminished responsibility? • A person is convicted of manslaughter (or culpable homicide in Scotland), instead of murder. • There is therefore no mandatory sentence of life imprisonment, and the court may pass any sentence it sees fit—penal sanctions in the community or prison, or any of the mental health disposals available following conviction (E Overview of the pathways of mentally disordered offenders through the criminal justice and health systems, p. 770).

Criminal responsibility 2 Box 16.7 Diminished responsibility—legal criteria England and Wales: Section 2 Homicide Act 1957 (as amended by The Coroners and Justice Act 2009) 'When a person is party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing.' In R v Byrne (1960) 44 Cr App R 246, 'abnormality of mind' was inter preted widely as: 'A state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal . . . wide enough to cover the mind's activities in all its aspects, not only the perception of physical acts and matters and the ability to form a rational judgement whether an act is right or wrong, but also the ability to exercise will-power to control physical acts in accordance with that rational judgement.' Scotland These were recently set out in Galbraith v HMA Advocate 2001 SCCR 551. The conclusions of the court were: 'In essence, the judge must de cide whether there is evidence that, at the relevant time, the accused was suffering from an abnormality of mind which substantially impaired the ability of the accused, as compared with a normal person, to determine

or control his acts.’ ‘Psychopathic personality disorder’ and voluntary intoxication are ex cluded. The effect of a finding of diminished responsibility is that the ac cused is found guilty of culpable homicide, rather than murder. NI: Criminal Justice Act (NI) 1966 (as amended by Section 53 Coroner and Justice Act 2009) ‘A person who kills or is a party to the killing of another is not to be convicted of murder if they are suffering from an abnormality of mental functioning which . . . (a) arose from a recognised mental condition (b) substantially impaired their ability to (i) understand the nature of their conduct, (ii) to form a rational judgement or (iii) to exercise self-control or (c) provides an explanation for their acts and omissions in doing or being a party to the killing.’ ‘Proof shall be sufficient to reduce, under this section, a verdict of murder to one of manslaughter if it satisfies the jury that, on the balance of probabilities, the accused was suffering from ab normality of mental functioning.’ RoI: Section 6 Criminal Law (Insanity) Act 2006 ‘Where a person is tried for murder and the jury or, as the case may be, the Special Criminal Court finds that the person—(a) committed the act alleged, (b) was at the time suffering from a mental disorder, and (c) the mental disorder was not such as to justify finding him or her not guilty by reason of insanity, but was such as to diminish substantially his or her re sponsibility for the act, the jury or court, as the case may be, shall find the person not guilty of that offence but guilty of manslaughter on the ground of diminished responsibility.’

782 Chapter 16 Forensic psychiatry Assessing ‘mental state at the time of the offence’ Clinical examination • Necessitates the reconstruction of the circumstances of the offence and, in particular, the mental state of the accused at that time. • Along with interviewing the accused, it is extremely helpful to peruse witness statements, police reports, and transcripts of police interviews (or, if possible, to view videotaped interviews). • Other important sources to help with ‘retrospective’ assessment include: • Relatives or other persons who knew the defendant at the time. • Any psychiatric assessment carried out soon after the offence (if the police or court were sufficiently concerned about their mental state). • Any records of contact with psychiatric services at the time and the views of relevant staff who were involved in these contacts. Putting the legal criteria into clinical terms For insanity at the time of the offence • The accused should have been suffering from a severe mental disorder which was the overwhelming factor in determining the occurrence of the offence. • There should be a clear relationship between the offence and the symptoms of the mental disorder. The accused may well have been suffering from a mental disorder at the time of the offence; however, this does not automatically mean they are automatically considered insane at the time of the offence. • It should be noted that the criteria for insanity at the time of the offence in Scotland, NI, and the RoI are broader than not knowing what one is doing or that it is wrong, and encompass an inability to control one’s actions due to mental disorder (see criteria in Box 16.6). • Diagnoses that may be relevant include: dementia and other chronic organic disorders (including those secondary to alcohol or drug misuse); delirium (including DT); schizophrenia and related psychoses; severe affective disorders with psychotic symptoms; and severe ID. Note: in most successful cases, the diagnosis is a psychotic disorder, and de lusions or hallucinations are directly relevant to the behaviour constituting the offence. For diminished responsibility • The accused should have evidently been suffering from an ‘abnormality of the mind’ (i.e. a mental disorder not severe enough to deem them ‘insane’, but of sufficient degree to substantially impair their ability to determine or control their actions; see criteria in E Criminal responsibility 2, p. 780).

Assessing ‘mental state at the time of the offence’ • Diagnoses that may be relevant include: any of the diagnoses listed here for insanity, as well as: non-psychotic affective disorders; acute stress

reactions, adjustment disorders, and PTSD; personality disorders (not primary dissocial personality disorder in Scotland); sexual deviation (not in Scotland); and mild to moderate ID and pervasive developmental disorders (including ASD). • Other conditions that have been successful in gaining a diminished responsibility verdict are PMS and ‘battered spouse syndrome’.