**Forensic Psychiatry**

**Crime**

Crime is recorded in the UK through the *British Crime Survey* since 1981 and is generally sub-divided as follows:

* Violent 20%
* Non-violent 80%

Official crime figures have problems due to the variation in definition, underreporting, political rationale, changes over time, and due to he recording of notifiable vs. summary offences

(see: http://www.bbc.co.uk/blogs/thereporters/markeaston/2008/07/crime\_lies\_and\_statistics.html)

*Victimization surveys* are another method of recoding but have the problem of omitting crimes without identifiable victims, recall bias.

(for more detail: [http://books.google.co.uk/books?id=CBRJRJxw8RIC&pg=PA77&lpg=PA77&dq=problems+with+victimisation+surveys&source=bl&ots=YPT1SovfNx&sig=DBPXrjNpra7vF7gxSiWweDqTL58&hl=en&sa=X&ei=Xw5HUpfMB8qk4gTK1YCoDQ&ved=0CEYQ6AEwAw#](http://books.google.co.uk/books?id=CBRJRJxw8RIC&pg=PA77&lpg=PA77&dq=problems+with+victimisation+surveys&source=bl&ots=YPT1SovfNx&sig=DBPXrjNpra7vF7gxSiWweDqTL58&hl=en&sa=X&ei=Xw5HUpfMB8qk4gTK1YCoDQ&ved=0CEYQ6AEwAw)v=onepage&q=problems%20with%20victimisation%20surveys&f=false)

**The decision to act..**

The mental faculty of deciding immediate actions is known as *volition.* It is ultimately the intentional striving for a specific purpose.

Various brain areas are relevant in volition:

1. DLPFC, dorsolateralprefrontal cortex (thought)
2. SMA, supplimentary motor area (actions)

These neuroanatomical areas can be affected by the following disorders – Alzheimer’s disease, intoxication, chronic schizophrenia

**Types of violence:**

*Aggression* is the intentionally hurting another without involving physical injury, whereas, *violence* is the use of physical force resulting in harm and involving physical injury.

Types of violence:

* *Instrumental violence*, is violence intended to attain a goal e.g. street robbery
* *Expressive violence* includes the violent expression of affect or support a state of arousal or ‘high’ derived from the act e.g. domestic violence in the context of jealousy
* *Gang violence* is violence between or within peer groups associated with delinquency e.g. group violence

(see: http://www.sagepub.com/upm-data/39356\_978\_1\_84787\_036\_0.pdf)

As a general rule, victims of crime rarely are strangers (<10%); in fact, circa. 90% are known to the perpetrator

Domestic violence is common, occurring within 1 in 4 relationships. Family and its context remain important as homicide occurs mainly within the family.

Social factors (e.g. employment; socioeconomic factors) have a very strong association in crime and delinquency (i.e. criminal behaviour in children)

*Sexual offending* (clearly, a form of violence) is influenced by impulsivity, societal and cultural norms and cognitive distortions

There are several subtypes:

* Fetishistic
* Internet pornography
* Rape
* Pedophillic
* Abuse of children

*Black and Minority Ethnic* BME) groups only represent 15% of the UK population but are overly restrained/imprisoned and sectioned under the Mental Health Act.

The body of a crime (*Corpus Delicti*) must have 2 components:

* An injury
* A criminal cause

*Criminal responsibility* (being responsible for a criminal act) and *criminal Agency* (a crime not caused by accident or act of God) are important concepts in defining criminal behaviour.

(See: http://www.psychiatryjournal.co.uk/article/S1476-1793(09)00202-X/abstract)

**Neuroanatomical basis:**

Antisocial personality disorder has been associated through functional imaging with frontal (psychopathy)+ temporal lobe deficiencies in some cases.

Frontal and prefrontal brain area malfunctioning are associated– personality change and disinhibition

Estimates of heritability for antisocial behaviour from recent research in quantitative genetics approximate to around 0.50

This remains hotly debated as a point (see <http://www.independent.co.uk/news/uk/do-your-genes-make-you-a-criminal-1572714.html>)

Biochemically, antisocial behaviour has been associated with:

* Deficiencies in MAO-A – associated with aggression
* Neuronal nitric oxide synthase and serotonergic system dysfunction
* ? Excess Testosterone
* Callous-unemotional (CU) traits in childhood – failure to recognize facial emotional expression -? Resulting in a failure to bond
* Also problems with:

- amygdala –which is involved in processing emotional stimuli

- orbitofrontal cortex – associated with adaptive learning

- uncinate fasiculus – note, *Phineas Gage*

Callous Unemotional traits (often viewed as a precursor to psychopathy) are associated with endocrine abnormalities, including:

* Low levels of cortisol; decreased cortisol response to stress- associated with cold, unemotional violence (psychopathic)
* Serotoninergic dysfunction – associated with emotionally explosive violence

(<http://www.medscape.com/viewarticle/704889_3>)

Antisocial behaviour

The commonest perspective on individual differences in trajectories of antisocial behavior is that suggested by Moffitt (1993, 2006), who has noted difference between individuals whose antisocial behaviour is limited to adolescence (*“adolescence-limited offenders”*) and those whose antisocial behavior starts at a younger age and continues into adulthood (*“life-course-persistent offenders”*).

Gottfredson and Hirschi (1990) noted that the principle cause of antisocial behavior is viewed as deficient self-control.

Caufmann and Steinberg (2000) noted three items that develop into adolescence and that if these are underdeveloped, antisocial behaviour is likely to occur, these include:

1. *temperance -* impulse control
2. *perspective* - taking on the perspective of others’
3. *responsibility* - taking on personal responsibility and resist coercion from others

(See: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886970/)

**Risk factors for violent behaviour:**

* *Individual factors* (for example: low IQ, poor problem solving, low empathy, impulsivity, substance misuse)
* *Familial factors* (parental conflict, inconsistent discipline, parental criminality, unemployment and large family size)
* *Peer factors* (delinquent peers, gang membership, influence)
* *School factors* (low educational attainment, truancy, lack of parental involvement)
* *Community factors* (SEC, high crime neighbourhood) + Early age of offending behaviours)
* Also protective factors -> (opposite of the above - for example, stable employment, relationship status, religion, family, social network, prosocial attitudes etc.)

**Mental Disorder (MD) and violence:**

* Mental illness (especially psychosis) more common in remanded population who were violent vs. non violent
* 10% in community with schizophrenia committed violent act in 12/12 previous vs. 2% without a mental disorder.
* Violence RR is 12x alcohol and 16x drug dependence
* Co morbid personality disorder doubled the rate of violence in the UK
* There are much higher rates of arrest in MD
* 70% with psychopathy reoffended within 5 years of release from prison, versus 23% without it.
* The prevalence of schizophrenia in perpetrators of homicides was 5 % in schizophrenia vs. 1% of the general population
* 9% of homicide offenders schizophrenia, 12% other psychotic disorder, 54% 2ry PD diagnoses (Swedish studies)
* Abbreviated summary: (http://www.health.harvard.edu/newsletters/Harvard\_Mental\_Health\_Letter/2011/January/mental-illness-and-violence)

The statistical significance of the association of MD with violence is robust

PD, alcohol and drug misuse are all much higher risk factors for violence than mental illness.

However, individuals with a MD, - much more likely to be victimized, suicide and self-harm.

Factors such as male gender, 15-30 years old, being socioeconomically deprived and past history of violence are much greater risk factors than schizophrenia

**Homicide**

This is defined as the deliberate act of killing another individual unlawfully.

-5% of homicides have a diagnosis of schizophrenia but account for only 1% of the general population

-1980-2004 – number of homicides with MD fell from 120- 20 per year; it also fell as a proportion of all homicides

Notably, 9% of homicide offenders scz, 12% other psychotic disorders, 54% 2ry PD diagnoses (Swedish)

10% of individuals convicted of homicide have some form of abnormal mental state at time of offence – of which 2/3rds’s have psychoses

10% of homicides have had contact with mental health services within the past year

For victims – they are more often acquaintances, than strangers

For women –victims more likely to be family members

There are reasonably stable levels of homicide in UK (NCI 2013 – indicate rates associated with MD are actually lowering). Homicide is comparatively rare occurring in 1.2/100,000 in the UK (UNODC, 2012). It is more common elsewhere.

**Infanticide**

This is defined as the intentional killing of an infant by their mother

It is associated with:

* depressive disorder
* postpartum psychosis and depression
* dissociative responses
* maternal childhood sexual abuse

There are various categorizations – *altruistic, psychotic, accidental, unwanted, spousal revenge.*

(http://www.psychologytoday.com/blog/frontpage-forensics/201302/infanticide-exploring-the-heart-darkness)

**Filicide (any age killing)**

Up to 50% have an association with MD; however there are often multiple relevant factors.

(http://ajp.psychiatryonline.org/data/journals/ajp/3764/1548.pdf)

**Miscellaneous offences to others:**

Murder suicide – depression coexists in 20-60% - more common than homicide but less associated with substance misuse + criminal history

**Non-fatal assaults**

There are 1 million cases a year (E + W)

*Common assault* – intentionally/recklessly causes another person to apprehend the application of immediate unlawful force ([assault](http://en.wikipedia.org/wiki/Assault) which is the apprehension, of such contact.)

*Aggravated assault* – when the individual attempts to cause serious bodily injury to another or causes such injury purposely, knowingly, or recklessly under circumstances manifesting extreme indifference to the value of human life; or attempts to cause or purposely or knowingly causes bodily injury to another with a deadly weapon.

*Battery* – if he intentionally/recklessly applies unlawful force to the body of another person. (A battery is committed when the threatened force actually results in contact to the other and that contact was caused either intentionally or recklessly.)

9% of individuals convicted of non-fatal violence have been found to have schizophrenia.

Most cases are under the influence of alcohol.

The Rate of non fatal assaults equates to – 2033/100,000 (in E+W)

**Fire setting**

1 in 4 of fire setters intentionally started the fire, this offence is known as *arson.*

It is often hard to distinguish Mental Disorder-related arson from non-Mental disorder related arson.

Research is largely limited to case series on individuals admitted to forensic hospitals.

Most offenders are male, although the proportion of female arsonists is increasing.

Arsonists are often unmarried, poorly educated, isolated, and unemployed or unskilled labourers and mental illness is overrepresented as is substance misuse.

There are several sub types:

* pathological fire setting (2 occasions – preoccupation, no motive)
* pyromania (2 occasions relief tension)
* juvenile fire setters >50% of all arrests – 5-10 years old- usually done for curiosity

It is more common in females within secure hospitals

In females – there is often an emotional meaning regarding property and others (communicative act)– revenge/jealousy and hatred (displaced aggression).

There is no direct relationship between MD + arson

See: http://www.stoparsonuk.org

However, fire setting is associated with:

* Personality Disorder
* Psychotic illness
* Learning disability
* Intoxication and substance misuse

There can be several motivations for fire setters:

1. *Goal related* e.g. insurance, earn money, covering up evidence, gang activities, expressive feelings
2. *Object of Interest* e.g. relief of tension (– pyromania like), sexual arousal, depression reduction

Assessment:

* What was the person’s early experience of fire?
* Number/frequency/duration of history/impulsivity of past fire setting/motives for past fire setting/psychosocial circumstances triggering past fires
* Psychiatric assessment – presence of mental illness?
* Personality assessment
* Functional analysis – ABC
* Current understanding of fire setting and risk: ideation, intent, plan
* Access to fire setting materials
* Stressors and circumstances relevant to fire setting
* Compliance with supervision and treatment
* Stressors and coping mechanisms
* Social support network
* Marital status
* Realism of plans/goals
* Parental violence and alcoholism
* History of suicide attempts
* Psychotic/revenge motive
* Social skills
* Psychopathy
* Familial dysfunction

Treatment:

Mental disorder related, fire safety information (e.g. face up course), increasing responsibility for dangerousness for arson, social & coping skills, anger/aggression management, self esteem and relapse prevention

(ref: <http://www.jaapl.org/content/40/3/355.full.pdf>)

According to Rix’s 1994 study 8% had a psychotic illness and 11% had a manic depressive disorder, but the majority had personality disorder and substance misuse.

(ref: <http://www.ncbi.nlm.nih.gov/pubmed/8159068> and http://www.ncbi.nlm.nih.gov/pubmed/17191632)

Prognosis:

Recidivism rates vary c. 4% - 20%, often mental disorder is a poor prognostic feature.

**Stalking:**

F > M as victims

Psychiatrists can be a particular victim group

Mullen 2001 noted several types:

* *Intimacy seekers* – attempt to get a close relationship
* *Rejected* – responding to unwelcome end of relationship
* *Incompetent* – seeking a partner
* *Resentful* – revenge against some previous act/series of actions
* *Predatory* – the motive is to control

The usual mental disorder associations include – functional psychosis + personality disorder

(Ref: <http://apt.rcpsych.org/content/7/5/335.full>)

Clinical management is based on:

* The nature of the contributory mental disorder
* An understanding of what is sustaining the behaviour
* Confronting the almost universal self-deceptions, which deny, minimise or justify the behaviour
* Instilling at least a modicum of empathy for the victim's plight
* Addressing the stalker's rudimentary, or inappropriate, social and interpersonal skills
* Combating substance misuse

(from Mullen, 2001)

Factors associated with stalking:

1. a sexual index offence
2. lack of physical contact with the victim
3. little/no previous acquisitive offending
4. diminished responsibility in those who kill

Prognosis – remains variable

Management –

1. Having the victim avoid confrontation – as this may reinforce the behaviour
2. Transfer the care to another professional
3. Offering counseling to support the victim, making them in touch with professional/legal advice- tell them to inform their employer
4. Treat the underlying MD and address substance misuse issues

[also see above]

**Sexual offending**

Various types of offending come into this group– frottism, fetishism, exhibitionism, paedophilia, sadomasochism, voyeurism amongst others.

Sexual offences equate to 1% of recorded crimes. More often committed by someone known to the victim. Sexual offending is frequently under represented in BCS, due to problems with conviction rates. Only <10% of sex offenders – have a mental illness.

Some functional psychotic disorders can be associated with sexual offending through –

* disinhibition, arousal, irritability – 2ry to psychosis
* direct psychotic drive (command hallucinations)
* cognitive distortions or impairments 2ry to psychosis
* poor social skills related to –ve schizophrenic symptoms

The presence of a mental illness is often only a partial explanation of sexual offending. Similar psychosexual profile between MD and non-MD.

During an assessment – individuals could demonstrate psychotic symptoms but this may be stress related

PD – 30-50%, especially ASPD + psychopathy, Substance misuse, LD, Aspergers syndrome, brain damage.

The usual process is to *allow conviction*, to then do targeted psychological offence work.

**Child sexual offending (CSO)**

Paedophilia –is a MD, known as a paraphilia

Fewer than 2% of offences result in conviction.

There is no causal relationship between MD and child sexual offending

Substance misuse, psychosis, PD are less likely than with rapists

There are often more prominent anxiety and affective traits in CSO vs. rapists

A higher proportion of female sexual offences are against children vs. male perpetrated sexual offences

MD commoner in female sexual offenders? (possibly)

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Internet based offending

Emotional dysregulation and intimacy deficits

Depressive + negative mood states – reduced

No previous convictions – often

More often offenders do not reoffend unless a past hx of offending

Typology:

* emotional satisfaction – normally distressed, seek solace thru internet
* intimacy deficit – socially isolated ppl – satisfy intimacy needs
* hyper sexuality – for hi levels of sexual b

Indecent exposure

1/3 reoffend

No general association w MD

more impulsive + risk taking + decreased satisfaction with life

Inhibited guilty exhibitionist (flaccid penis) vs. angry aggressive exhibitionist (erect) – potentially more risky.

Voyeurism

no association between MD

common 11% m 4% f

Pornography offences + incest +necrophilia

No known link with MD

Bestiality

Some MD(?) association – limited literature available

motivations for sexual offending:

* predispositional and biological vulnerabilities – hormonal or inability to distinguish aggressive/sexual impulses
* childhood experience – phys/sexual abuse -> attachment style effects
* intimacy deficits – inability to establish + maintain intimate relationships
* cognitive distortions – errors of thinking – victim + rationalization

schemas

* i.e. implicit theories -> cognitive processes
* entitlement
* dangerous world
* children as sexual beings
* nature of harm – no harm in sex w children
* uncontrollable world
* women as sex objects
* unknowable women
* uncontrollable male

Various theories of sex offending…

* 4 vulnerabilities – sexual arousal, cognitions justifying sexual offending, affective dyscontrol, ASPD – offending once a critical threshold reached, and a decision is made: counterbalancing other risk factors.
* childhood exp– affect 6 key variables sexual promiscuity and hostile masculinity -? Facilitating sexual aggression for women

Breaching legal sanction –

repetitiveness – indicate impulsivity or highly antisocial attitudes ?Aspergers

partners / children – stalking or erotomanic attachment

paranoid/hostile attachments in domestic violence

stalking initially can present as this

Link with MD

*Functional psychosis* -

Paranoid sx’s +

TCO ++

*Delusional d –*

Morbid j, erotomania, induced delusions

60% of victim’s family, <10% stranger

ppl with MI – 4-6 times more likely to commit a violent offence

The link between psychosis has not been well established

<10% of overall violence attributed to severe MI

in any year, 1/3000 of a scz committing homicide

5-10 % homicides committed by ppl with scz

PD – 2x additional

Drug and alcohol, many times more x

Alcohol + drug misuse

Common in MDO's

++ problematic in institutions

>50 % drug and >40% alcohol

General population 4% alcohol 2% drugs

Fx that predispose to violence:

Acute intoxication – disinhibition and disorganization

withdrawal – agitation/paranoia

dependence – through compulsion to obtain the substance

alcohol intoxication:

50% of assaults

66% of murder

Direct withdrawal effects

Neuropsychiatric sequelae of long-term use

Social context – (peer group, socioeconomic deprivation, childhood maltreatment)

Personality characteristics – impulsivity and sensation seeking

Scz + SM = 25X violent offending

Scz = 3.6X

18% of pts with a major MD will commit a v offence in the next year vs. 31% for cm SM and 43% +PD

Other risks:

self neglect

self harm – withdrawal dysphoria

being a victim of violence – 1/3rd of victims

PD

4-44% gen pop, 50% psychiatric pts, 78% remand m, forensic pts 65%

Cluster A (odd –PaSS )- poor reality testing, Cluster C (avoidant, obsessional, dependent)- mood states

Cluster B (BANH – borderline, antisocial, narcissistic, histrionic)++ - mood/impulsivity

Violence –

* Alteration in perception e.g. psychosis/dissociation
* Paranoid cognitions – lowered threat perception threshold
* Dysregulated mood states – esp. anger
* Hyperarousal 2ry to the 3 causes
* Lack of empathy or contempt for distress
* Impulsivity and lack of capacity to reflect on actions

Mostly known victims and h/care professionals and women with PD more likely to offend against children.

Antisocial PD

Attitudes / rule breaking / lack of empathy/ impulsivity

Gen pop 6% Prisoners 64% male remand. 65% forensic population

Risk of violence –

* Drug induced disturbance in reality
* Paranoid attitudes and cognitions
* Hyperarousal
* Lack of empathy / contempt for distress
* Impulsivity and lack of capacity to reflect on others
* Grandiosity – contempt to others

Increase risk of violence 10x – anyone at risk

Borderline PD

Pervasive –ve affect, affect dysregulation, hyperarousal/transient psychotic states, intense attachments (turns to threats if relationship threatened), intense anger, dissociative states, repetitive self harm thoughts,

>anterior insula dysfunction (trust and cooperation)

hyper response HPA axis

6% gen pop

23% male remand, 14% male sentenced, 20% female

forensic pts – 24-60%

Increase risk of violence when:

* altered perception of external reality
* paranoid cognitions / lowered threat perception
* dysregulated mood states
* hyperarousal 2ry to above
* presence of asocial features – empathy, contempt for distress
* impulsivity, lack of capacity to reflect on actions
* severe and repetitive self harm – marker / indicator of risk

+SMI / SM

+ perceived abandonment –increase arousal – threat perception – increased risk of v/ self harm –

(care, abrupt changes in routine/physical/psychological security – e.g. bereavements, new accommodation, change of carer)

dependent on care – changes in care package, rejection/abandonment -> acting out/violence – risk for inpatients in secure care

at risk –

(familial violence, physical abuse to children, healthcare professionals, those in relationships)

Narcissistic PD

Which is characterized by grandiosity, admiration, lack of empathy, sense of importance, fantasies re self-brilliance, feeling special and unique, having a sense of entitlement and often exploiting others etc.

?neurobiology – oversensitive temperament at birth, excessive admiration/criticism, severe emotional abuse at childhood, unpredictable care as a child, being valued by parents as a means to regulate own self esteem

Gen pop 1%

8% male remand, 7% sentenced male, 6% female prisoners

forensic pts 26%

Associated with

* violence
* rejected/threatened/criticized
* to protect themselves, react with disdain/rage – violence
* cannot tolerate setbacks/lack of empathy
* fantasies -> perception of notoriety / offending

hi risk paedophiles

+SM/SMI

Defences against self esteem loss -> splitting, self – good, world, bad

2ry devaluation/ idealization, denial

Paranoid PD

Suspiciousness, misperception of others intentions as hostile,

c. 7% of gen pop

29% male remand, 16% female

forensic pts 18%

partners++

?neurobiology – relatives w scz

exposed to parental anger – no way to predict when – learn that this can be expected at any time – PPD thinking patterns

extreme mistrust – need to feel in control + be self sufficient, isolative, hard to accept criticism / collaborate w others

offending – desire to be in control, and control those around them. Critical of others, rigid and tendency to isolate or accept criticism. Difficult to work with others or develop relationships.

Violence – reactive or premeditated

Risks in ‘group’ environment/shared living

Psychopathy

15-30% forensic/prison, 4% pop

PCL R 25-30

Increases risk of violence

**Factor 1 – callous unemotional** – arrogant IP style, grandiose, glib, deceitful, lacking empathy lacks remorse, shallow and labile, deficient affective experience.

**Factor 2 – antisocial** – impulsive, sensation seeking, lack of planning, irresponsible, parasitic lifestyle.

Specific fx increasing risk:

-predatory attitudes

-grandiosity/paranoia

-contempt for others distress

-intelligence and planning capacity

-remorselessness

-impulsivity and lack of reflection on actions

Domestic Violence association, robbery, offences against women & children

Bipolar disorder

1% of population

65% have co morbid MD- often anxiety/ sometimes impulse control (ADHD)

50% have alc disorder or drug dependence (often) or psychopathy

* elation
* hyperarousal
* psychosis
* impaired judgment
* impulsivity
* irritability
* hypersexuality
* intolerance of frustration

?whether associated with violence

if violence associated at a much smaller magnitude than schizophrenia (only 10% of the magnitude)

often offences are minor – c assaults, damage property, offences related to intoxication, theft, failure to pay, sexual indecency.

Serious offences less common: - GBH, arson, rape, death by dangerous driving and homicide. A small number of stalkers suffer from mania.

Other risks

Self neglect – overactivity preventing self care

Reputational/financial – poor judgment

Vulnerability to sexual/financial exploitation – grandiosity/poor judgment

Enter into contracts unwisely – often require capacity assessments

Depression/affective disorders

7-10% of population

75% have cm MD – anxiety, impulse control disorders, SM.

In the context of other risk factors (SM), it is a RF for violence.

RF for domestic killings – triggered off by stimulus resulting in an act otherwise. Depression can act as a disinhibitor. Trigger often provocation.

Psychotic depression -> nihilism and therefore mercy killings.

Clear RF for SM, which can increase risks

Self-neglect or suicide as risks

Frequent consequence of victimization. + punishments as well as form a basis for compensation.

PTSD

Trauma – exceptionally severe/life threatening + distressing or a series of events that cumulatively fulfill the above. Trauma and crime – complex relationship. Victims ++

8% lifetime of pop

psych pop 15-45%

prisoners c.20%

Criteria = REHAB (see Phull, 2012 ICD10 in psychiatry)

Amnesia for the event is not uncommon. Issues re compensation.

Complex PTSD – associated with Borderline PD – prolonged abuse often suffered as children. Higher in forensic pop.

CM SM commonly seen. Psychosis + PTSD -> more +ve symptoms – paranoia/violent thoughts/feelings and behaviour.

No definite causal link between offending and PTSD.

No. of relevant factors:

* hyperarousal
* hypervigilence
* impulsivity / anger
* flashbacks
* dissociation
* nightmares

combat veterans – ++reactive vs. instrumental violence

Index offence often a significant traumatic trigger for inpatients in up to 70% of cases esp. if i/o was unplanned, offender is inhibited, no past forensic hx.

Anxiety disorders e.g. OCD, GAD, phobias, adjustment, and grief

Little evidence of link between this and offending b. severe anxiety can promote dissociation – disinhibition – problem behaviours.

Up to 9% of pop (phobias)

10-25% of prisoners (but some inconsistencies in findings)

Adjustment/grief etc can occur as a compensation claim too as a result of a major incident.

Dissociative + conversion disorders

Conversion – psychological conflict into physical sx's

Dissociation – from psychological conflict

Up to 33% women/ 25% in gen medicine

Various dissociative disorders – amnesia/possession/identity/convulsions/ sensory/motor etc

Dissociative disorders more common in pts with MD e.g. depression, anxiety, organic brain disorders.

Depersonalization/ derealization in normal individuals at times of stress e.g. Soldiers. Also- for violent offenders at the time of arousal/violence or in response to extreme fear, which may precede violence.

Being ‘out of character’ suggestive of dissociation. Trait dissociation could be associated with future violence.

Dissociate amnesia – known victim/aroused or with alcohol. Very difficult to give evidence on amnesia in court cases.

Chronic fatigue syndrome & somatoform disorders

No known association with violence/offending.

Paraphilias

Individual exhibits inappropriate sexual behaviour, that are longstanding and cause distress to themselves or others.

E.g. exhibitionism, voyeurism, paedophilia

Gen pop 5-8%

M>F but females 10% of M

High CM with other MD e.g. paedophilia – 93% had a mood disorder/ SM

75% have a PD, 20% psychopathy, autistic spectrum and ADHD

some – assault – frotterism, some theft association -> theft – stealing women’s underwear in fetishtic offenders.

Self harm – sadomasochistic b.

Asperger’s syndrome

<1% pop

These individuals often get labeled scz or PD. Frequent overlap with schizoid PD – some studies show autistic spec commit more violent offences and criminal damage than the gen pop.

Features:

- lack of concern for outcome

- social naivety

- lack of awareness of outcome

- lack of empathy

- misinterpretations of others’ behaviour

- social/sexual rejection, bullying, or family conflict

- CM drug/alcohol use

- CM PD

Association with violence

- Theory of mind deficits – including egocentricity – lack of awareness of impact of victims and of what is wrong in social and emotional terms.

- Deficits in social recipricocity – esp. sexual offending – without appreciating the complex reciprocal interactions between the 2 prospective partners in order for consensual sexual activity occurs

- Restricted repertoire of interests – e.g. fire setting, or bizarre persistent crimes. (e.g. where motive is merely repetition)

Other motives – revenge, changes in environment/ routine, + susceptible to exploitation. Often very violent++

ADHD

i.e. Hyperactivity, inattention and impulsivity

* Inattentive
* Overactive subtypes

Often conduct problems. Children with overactive profiles are at high risk of long-term antisocial b problems.

5-10% school age and 2.5% adulthood

30% of young offenders

4 x M vs. F

impulsiveness deficit executive dysfunction, poor control over b and poor ability to consider consequences and concern for immediate gratification.

Impulsiveness – most likely predictor of offending.

Hyperactivity at 11 – 13 – predicts arrests for violence up to age 22. Problems of restlessness and inattention 2x risk of delinquency. Each CM condition further increases the risk of delinquency / offending.

Inattention and restlessness at 5, more than doubles the risk for delinquency at 14. Each CM condition increases the risk of delinquency / offending.

Conduct disorder and oppositional defiant disorder

CD – persistent failure to control b within socially defined rules.

* defiance of authority
* aggressiveness
* antisocial b

LD is an important RF

ODD – tantrums / conduct problems; can cause family and school disruption

? precursor to CD

ODD 10%, CD 7% (M) 3%(F)

1/3 – ½ of referrals to CAMHS

40% of children with CD become young offenders. 90% YO’s have a CD hx.

Aggressive kids -> low prosocial skills -> social isolation -> hard to establish supportive relationships -> more association with deviant peers -> risk of antisocial b

CD – hostile attributional bias – interpret ambiguous stimuli as being threatening, anger, irritability main mood states

Hx of childhood maltreatment – hypervigilence, aggression in response to any fear stimulus / fearful misinterpretation of others- graded – early onset, severity, spread across situations and hyperactivity.

Some CD develop ASPD – ASPD ? genetic + maltreatment

LD

Impairments in *social and adaptive skills*. <70 IQ – represents the relationship between mental age and chronological age.

1.5% gen pop; 10-60% of prison pop

Often hard to discharge due to lack of community resources.

? offending – related to ability to handle abstract concepts, ?ability to recognize consequences, higher risk for CD, deficits on verbal/memory/visuo motor integration, poor problem solving,

+school failure linked with offending

re sexual offending – awareness of rules re social norms, poor social competence (acts that are friendly deemed to be aggressive), impulsive expression of emotion.

?increased detection rates with LD / lack of support in CJS

6 x more likely to be picked up for a sexual offence

10% convicted for fire setting have an LD. Low intelligence, at age 3 -> predicts offending up to age 30. CM LD increases the risk of offending associated with other conditions.

LD sex offenders have low preference for age/sex of victim so greater tendency for victims to be young and male. Typically, these are usually unplanned and the offender does not know the victim.

Acquired brain injury

Link between this and offending – link may not be causal as many offenders have traumatic brain injuries.

5-15% gen pop, 22-50% forensic pop

Frontal lobes – personality changes – planning/organization – causing disinhibition.

Genetic factors predispose – poor PM functioning, substance misuse.

Also predisposes to suicidal behaviour.

Post concessional syndrome

Abate within 6 months, can predispose to violence.

Physical symptoms – headaches/dizziness

Psychological symptoms – anxiety, depression, irritability, aggression

Cognitive symptoms –concentration/confusion/impaired judgment/ amnesia

Associations with offending b

* cognitive impairment – recognition of social boundaries
* impulse control deficits
* increased aggression/ personality change / personality change
* poor social judgment
* increased vulnerability to involvement in criminal activity
* CM ASPD/psychopathy
* Disinhibition

Epilepsy and sleep disorders

Epilepsy/sleep rarely associated with violence. NB automatisms.

1% pop

1-2% prisoners

parasomnias

2-25% gen pop

20-30% - have CM psychiatric disorders.

No association between sleep disorders and mental d.

No general increase in violent acts with epilepsy, however, complex b outside. Violence in epileptics is usually due to other factors. –

Ictal violence rare, but more likely in partial vs. t-c seizures. – abnormalities that cause complex partials – temporal lobes

?episodic dyscontrol syndrome – lack of memory for explosive violence

?explosive PD

Assessing the link between violence and epilepsy

* neuro review
* EEG to confirm epilepsy
* TV EEG + hx to rule out sleep automatism / observe aggression
* The violent act should be characteristic of a seizure
* Any obvious motive / planning should be considered
* Concealment of the offence
* Whether it is senseless / out of character

Sleep disorders (parasomnias)

Common component of psychiatric disorders, but distinct from sleep walking / other parasomnias e.g. sleep terrors and nightmares. These disorders are commoner in children.

Sleep disorders and violence

Commoner in males

Usually hx of parasomnias including nocturnal enuresis

Sleep deprivation/ cannabis/ alcohol and caffeine – precursors to sleep walking

Victims are usually known

Sleepwalker not hearing cries / recognize victim

REM / NREM (either can occur)

Nocturnal epilepsy could be considered as a differential

Assessment of link between violence and sleep disorders

* Hx of childhood parasomnias
* Is the violence preceded by a period of stress?
* Did arousal from sleep occur soon after the sleep onset?
* Is there Evidence of complex, goal directed b?
* Is the victim known/loved?
* Was there evidence of recognition of victim?
* Was there a period of confusion after the attack?
* Is there amnesia for the event?
* Was there a motive/premeditation/planning?
* Was there any concealment of the offence?
* Was the offence senseless or out of character?
* Was the violence preceded by a period of poor sleep?

Organic disorders: dementia and delirium

* Cortical : alz d, pick’s d
* Subcortical: Parkinson’s, Huntington’s, Wilson d
* Cortical- Subcortical: Lewy body
* Multifocal: CJD

30-40% psychotic problems

50% anxiety/depression

Cognitive deficits vary with type

BPSD – physical aggression, but no confirmed association between dementia and serious violence. ?some sexual offending more common in elderly ppl w CM dementia vs. other psychiatric probs.

Generally more minor offending than serious if occurs.

Should be considered for those older adults, when presenting with aggression / offending. Also alcohol abusers, and those who complain of amnesia for the offence.

BPSD mgmt

-aromatherapy

-validation therapy

-psychological

-structured social interaction

-pharmacotherapy

-if associated with extreme distress – s/t antipsychotic (<12 weeks)

- in mod/severe Alz D – memantine, low risk aggression – citalopram/carbamazepine

longer term Rx above meds but– review every 12 weeks

Delirium

Think CORPSE – wide causation

Can be associated with aggression – adhere to rapid tranquilizer policy.

Malingering and factitious disorder

Conscious / intentional feigning of sx’s of illness, vs. somatoform disorders where the patient is unaware of the psychological origin of their expressed sx’s.

1% pop

0.4-0.8% psychiatric pop

Clear external gain – malingering, the motivation is internal – is not apparently aware, even though deliberately feigning symptoms – factitious d.

Some suggest using prolonged admission, use of various instruments SIRS, SIMS, and the TOMM. Polygraphs used in US.

Co morbidity

Data is limited on rates of CM, claims of amnesia amongst offenders – difficult to distinguish genuine vs. simulated amnesia e.g. TOMM

Malingering -some association with antisocial PD and psychopathy, especially amnesia for an offence.

Offending association

No real association – unless offence itself when malingering is an offence in itself. E.g. benefit fraud etc

Factitious disorder – mother’s harming their children or healthcare workers killing patients/elderly.

Malingering as a consequence of offending

Criminal responsibility –> unfit to plead – avoid punishment / hospital. This should be considered.

Forensic assessment

Process:

* Understand context
* Gather information
* Specialized tests – PD, attitudes, intelligence, or other neuro / psychological functioning
* Biological tests or other ix – CT, MRI, EEG, gen med conditions id
* Diagnosis and individualized formulation
* Risks of various harms
* Construct treatment + risk mgmt plans

PD assessment:

Usually through hx, examination, and the use of a structured assessment.

There are a variety of tools available for assessment, and multiple assessments often more reliable than single ones.

No scale to measure severity, but assessed on domains of social functioning or co morbidities (i.e. SMI’s).

Clusters important 60-70% forensic inpatient pop – narcissistic, antisocial, borderline, paranoid PD or traits of them.

Note normative scores not standardized for a forensic population.

Note cultural factors – created for western cultures.

Psychopathy

(see previous) – usually done via a PCL-R

Sexual offending

Sexual b and attitudes with mental state and personality.

Reported deviant fantasies or abnormally high sexual arousal important.

Some sex offenders develop depression before/after/during treatment so needs to be assessed.

Conviction helpful for i/o work

Attitudes assmt- cognitive distortions (errors in thinking – ignore victim, justify b) and schema (theories re the world around them)

Behaviour – review of records

Clinical interview

* sexual development and early sexual experiences
* masturbation- frequency/fantasy/public/private
* sexual partners – number/gender
* consideration of paraphilia and deviant sexual interests
* sexual preoccupations
* strength of sexual arousal
* violence in sexual relationships (actual and fantasized)
* use of pornography (sexual violence – type more likely to offend)

Psychological test domains

Anger and violence

Blame attribution – cognition – in relation to remorse

Executive function –

Intellectual functioning

Malingering

Memory

Personality

Pre-morbid functioning

Sexual deviancy

Suggestibility and compliance

Traumatic experiences

Formulation:

* developmental fx – genetic f, exposure to fear/loss, disrupted attachments and chronic fear predisposes to mental disorders.
* Antisocial fx / values - b or unemotional attitudes in pre teens – indicators of +ve response to care – good resilience factors
* Later attachment hx – adult relationships -> intense/unstable/conflicted (BPD) or distant, cruel or exploitative (ASPD). Is this relevant to the i/o
* Impaired reality testing at the time of offence – cognitive distortions vs. delusional b’s – how much is this their world view vs. situational? Drugs/alc relevant?
* What’s their view re the offence – shocked/denial? – what psychological defences using at i/v and what were they using at time of offence?
* RF's for violence - ?relevant to inpatient settings (i.e. females if difficult rel with mother) and therapeutic rels

Formulation types:

* Biopsychosocial – Ps + b, p, s
* Cognitive behavioural – NAT -> th’s. emotions, sensation, behaviours
* Narrative -> individualized/unstructured
* Psychodynamic -> psychodynamic – defences/drives/ internal objects
* Legal – means, motive, opportunity

Prison

Inreach 2000’s – iceberg effect re prisoners + MD.

‘Patient or prisoner 1996’ – equivalence

recommendations – 1999 –‘The future organization of prison health care’ shared responsibility – joint responsibility

2003 – announced complete takeover of health in 2006 via NHS

18% reduction in suicide 2004-5 – MF – inreach, ACCT, dilutional,

problems – varied training (not necessarily forensic), capacity issues, pd treatment, unpredictable release dates

constraints – internal – info / details and external – prison

philosophy – care vs. control

drug and alcohol

resources

lack of standards

Aftercare -

Psychosis 10% men; 7% women

Neurosis: 40% men; 75% women

Personality disorder 75% men on remand, 50% sentenced

Illicit substance– 85% men, 70% women

* court assessment
* transfer / gate keeping
* parole board

(make prisoner aware of nature + purpose)

use: PO/IMR/notes/healthcare staff/disciplinary + wing records/ acct forms

NB Egdell re breaching confidentiality if risk of serious harm/offence

Women –

Courts may pathologise women offenders (more than men)

-more likely to have non custodial

-acquisitive

-less contribution to violence stats

-ASPD comparatively uncommon

-++ risk with BPD and unmet social needs

-psychosis a greater RF for violence in f vs. m

-violence – in context of relationships – stranger- v rare

-violent women – were often exposed to v as children / adults

Children

N.B. SAVRY (like HCR 20 for children)

Needs assessment – ONSET / ASSET used by YOT

Witness competence –area of dangers ethically, possibly exceeding area of expertise.

Victim assessment and suggestibility – specialized areas

Suggestibility – tendency to incorporate into memory the suggested info, and a sensitivity to critical comments about earlier performance.

NB Gudjonsson’s scales to assess this

Risk assessment

Clinical judgment vs. actuarial (over reliance on static factors/ not resilience factors) and SCJ ..

[see risk assessment work on the P’s]

* actuarial – based upon statistical estimates of risk in groups of ppl
* clinical – judgment either structured (using some actuarial measurements i.e. HCR 20) or unstructured

Other risks:

Absconding/escape

Drug use

Neglect

Vulnerability

Non-adherence

Relapse

Others e.g. property damage

Risk management:

Requires knowledge of individual, and factors that increase or decrease the likelihood of behaviours in certain situations

Violence

++ past hx best predictor

*biological*

mental disorder - TCO

intoxication

response to psychiatric treatment

*psychological*

personality – sadism, callousness, affective instability, impulsivity and psychopathy

personal resources – planning, stress tolerance, problem solving

personal/cultural attitudes towards violence

insight into mental disorder (compliance)

specific intent (grievances, resentment etc)

*social*

developmental factors – (maltreatment, exposure)

social resources- f n f

opportunity to act violently – destabilisers, availability of victims and access to weapons/ criminal peers

monitoring/supervision – agencies

SCJ – HCR 20, RAMAS, SDRS, OASys, SARA

Actuarial –VRAG/PCLR

Risk of sexual offending

Most offenders do not have a MI, and only some have PD. Link between psychosis + mania and sexual violence. Attempt to relate MD to sexual violence.

*Clinical assessment*

Hx + MSE &..

Psychosexual hx:

Hx of being a victim in childhood

Presence of violent sexual fantasies

Sexual behavior

Attitudes towards women and attitudes re sex with children

Co morbid mental disorders

Alc + SM

LD + PD

SCJ

SVR20/RSVP

Static / dynamic factors- actuarial + clinical formulation

Actuarial

Address static factors – stat probability of recidivism in a group. No risk management factors.

E.g. static 2002 and risk matrix 2000.

Psychological evaluation

Dynamic factors (change over time) – focus of programmes:

Cognitive distortions

Fantasies and deviant sexual arousal

Sexual preoccupation

Interpersonal relationships

Intimacy deficits

Anger

Impulsivity

Emotional regulation

PCL score highly predictive of recidivism (v + s)

*Penile plethysmography (PPG)*

Questionable validity

Possibility of false negatives due to control/avoidance.

*Polygraphy*

Helpful potentially in supporting the mgmt of offenders but very controversial

Internet pornography offences

No clear associations with contact sexual offences – need to consider other relevant factors though

*Exhibitionism*

Higher risk of contact offences – multiple places, phys contact, erection or masturbation.

NB rrasor quick review of sexual offending risk

Various tools – SCJ/actuarial

Risk of suicide/self harm

3rd most common loss of life years

11/10000 per yr

gen psych 15% die by suicide

RF's for completed suicide

MI

Past self-harm – 50% have made a previous suicide attempt

Cognitive factors – hopelessness, impulsivity, aggression, dichotomous thinking, cognitive constriction, problem solving deficits, overgeneralised thinking, hopelessness

Reason for hopelessness – terminal illness, prospect of imprisonment, loss of relationship

Social isolation

Losses – financial, personal, status

Stated intent – 2/3 have informed others of intention

Older age

Conflicts

Being male

Physical ill health

Economic factors – unemployment/poverty

Criminal hx

Incarceration

Assmt

Historical f – impulsivity, mood swings, impulsivity, aggressive b

Precipitant – life problems etc

Protective f – family/religion

MSE – mental disorder assessment

Current intent

Plans/preparation (saving tabs, access to means)

Homicidal th’s

If threatened suicidal b – risk hi

Consider beck suicide index or risk mgmt

Obtain collateral hx to validate

Higher risk

Lethality of method

Isolation

Timed so intervention/help unlikely

Precautions against discovery

Preparations for death and act

Communicating intent prior to attempt

Premeditation

Leaving a note

Not seeking help after

Anger at failure of attempt

Admission of ongoing intent

Other specific risks

Fire setting

Only a small proportion receive a conviction

Fire setting associated with:

Previous fire setting

Aggression, frustration and boredom

Lack of employment

Parental ill health/conflict

Poor social skills

Binge drinking

Low level of supervision

Abuse

In adults:

Alcohol dependence

ASPD

Long lasting enuresis in childhood

Psychosis

Ld

Hx of sexual abuse in women

Meanings:

Revenge

An opportunity for self-harm/suicide

A way of controlling others

Sexual gratification

Reducing tension

Assmt on state before/after/during

Cognitive distortions and emotional arousal

Hostage taking

?response to frustration, i/o or attempt to manipulate ppl

HCR 20 + functional analysis , scenarios etc

Leave/absconding/escape

Factors incl: young

Male detained pts

Previous absconding

Diagnosis of schizophrenia

Multiple admission

Longer total hospital admission

Previous hx of violence

Season

Victimization and exploitation

Incr risk – formulation on hx + circumstances of victimization

Other risks

Drug /alc use

Self Neglect

Operating machinery

Vulnerability

Non-adherence

Relapse

Others e.g. property damage / acquisitive offending

NB – risk instruments for MD offenders validity wise

Should be used by trained professionals – others such as ASSET and OASys can be done by non health care professionals.

Treatment

Aims

* prolong life
* improve quality
* reduction in risk

Principles:

Reed report –

* Individualized
* Based in the community wherever possible
* Provided as close as possible to the patient home
* Least restrictive environment
* Aimed at maximizing rehabilitation and the prospect of independent living

Also consider severity and likelihood of harms the treatment may cause.

Duty to society vs. duty to the patient.

Coercion

Objective – actual restriction

Perceived – pts experience if lacking control/influence

MacArthur perceived coercion scale (MCPCS)

Ultimately coercion can affect the therapeutic relationship that can reduce / adversely affect outcomes.

Therapeutic use of security

Physical – fence/locks/ soft cutlery.

Relational – training, good communication, meaningful activities

Procedural – searches, investigating and learning from incidents, staff pre employment checks, other clinical governance arrangements and risk mgmt.

Level of security = MDT balance security vs. therapeutic objectives

Security level should be continually assessed: obs, searches etc

NB Possible loss of relational security as stepped down into a lower level of security

Obs:

General – location known at all times, but not within eyesight/

intermittent- at risk of violence/attempting suicide/

within eyesight – hi & imminent risk of violence /suicide,

within arms length- hi risk of acting v quickly – if opportunity arises – e.g. swallowing a small object within reach

Leave:

-stability of mental state & risks

-insight

-rapport with staff

-engagement with treatment and rehabilitation

-their past behaviour on leave

Leave forms should state purpose/conditions – add drug testing

Leave is not the same as parole

State purpose/destination/escorting/transport arrangements &

Therapies

Focus: diagnosis, psychopathology, index offence, and rehab needs.

CBT – conscious cognitive distortions/ assumptions incl psychotic b

DBT – dysregulation/impulsivity

MBT – capacity to consider ones own state of mind, enhances awareness of others’ mind - BPD

Family

Interpersonal – adjunct to meds, reintegrate relationships to improve m/state

TC – HMP Grendon, Send, Dovegate

MI – PCPAM

Arts psychotherapy – improve creativity/expression

Structured therapies – psychoed -

Psychodynamic – unconscious attitudes, relationships patterns. Empathy and perspective taking best done in groups.

Offender behaviour programmes – risk, responsivity and needs vs. good lives model of care for sexual offenders.

NB Victim rights for MDO's

Management of violence & aggression

Prevention -> de-escalation -> restraint -> seclusion

Physical treatments

ECT:

Severe & Rx resistant:

* Depression
* Mania
* catatonia

Neurosurgery:

Severe, untreatable mood disorders

Severe, untreatable OCD

+ pt competent and consents

Medication:

Rapid tranquilization – when psychological/behavioural treatments do not work

Preferably – use the same as prescribed to limit polypharmacy

Accuphase – not responded to short term IM – but takes at least 2 hrs to have effect + risk of dystonia (avoid with neuroleptic naive pts)– last up to 72 hrs.

Antipsychotics – effect on violence – reduce Auditory hallucinations + perplexity (i.e. a belief that everyday situations possess a special, usually sinister, meaning intended uniquely for the individual).

Clozapine esp. helpful as is depot (adherence issues).

PD

No effective drugs to treat in itself – however can be used to treat/prevent cm MI -> i.e. mood disorders / transient psychotic symptoms. Treatment to target symptom domains vs. the actual diagnosis:

* Cognitive/perceptual – low dose a/p
* Affective – mood stabilizer / a/d
* Impulse behavioural – SSRI
* Anxious – SSRI/anxiolytic

Meds should not be used routinely – but always considered for CM MDs.

Disturbed / violent behaviour in LD

Meds primarily for CM MIs. Note that there is some evidence to support the use of carbamazepine to reduce aggressive b in LD.

Antilibidinals

Paraphilias, sexual offenders, or show sexually inappropriate behaviours.

* MPA or CPA – anti androgens – reduce testosterone, LH, FSH.

Reduce sex drive but side effects incl – depression, feminization, gynaecomastia + wt gain. Only used as adjunct to psychological treatment.

* GnRH analogues – triptorelin – sexual deviance and hypersexuality. More potent, than CPA or MPA- and less side effects,
* SSRIs – possible role in managing sexual urges/fantasies, which have a (phenomenological) resemblance to obsessive thoughts.
* Antipsychotics are generally not used.

Physical health

Scz - 20 years less lifespan.

Hi rates – smoking, obesity, weigh gain, CM illness

Clear guidance for antipsychotic prescription – in terms of monitoring.

Nutrition, exercise, smoking, weight loss – main target areas for health promotion.

Risk management (see risk management docs)

* individualised
* based upon sound risk assessment
* air on side of caution to fully assess risks
* collaborative
* multiagency
* regularly reviewed via MDT
* treat underlying cause
* good communication
* proportionate and justifiable

Management of violence

Structured risk assessment

Formulation

Not a tick box exercise

MI and violence

* Symptom control – will often directly reduce the risk of violence
* Non compliance – not acceptable in hx of violence
* Use legal powers to ensure compliance
* Intervene early – risk indices
* Treatment and rehab better -longer term admission in some better than repeated brief ones

SM & violence

* Use can often result in recall if SM is established as causing a relapse.
* Consider setting conditions based on SM testing + abstinence- with understanding that a breach would result in reassessment as an inpatient.

Generic

* Act early!
* Set operationalised criteria for interventions and recall/readmission + place into care plans. Make pts aware.
* Use specialized forensic services – i.e. forensic when risks are high
* Share assessments openly with carers, pts and relevant services NB confidentiality
* Do not overly focus about correct diagnosis – focus on treatment, risk assessment and mgmt being aware of all possible scenarios re differentials.
* Observe carers concerns –
* Cannot be completely prevented

Absconding/escape

* observe pts general characteristics
* higher risk at certain times (seasonal variation)
* highest at early afternoon around 3pm – handovers
* first days/wks
* periods of leave planned in advance
* logged and planned
* description of patient in terms of clothing, photographs etc.
* escorting staff have mobiles
* leave terms gradually reduced
* staff should be able to contact pts on leave and visa versa
* the earlier absconding is detected the greater the chance of locating the pt quicker
* wards should have up to date photos and absconding plans

On absconding..

* Notify police- pt clothing/brief risk assmt, info on their mental state, legal status, time and location where they were last known to be, any other relevant info (addresses they might have gone)
* Send trained staff to likely location
* Inform potential victims; including MoJ
* Plans for management after return: including placement review and observations
* Post incident debriefing

Fire setting

-functional analysis of past f setting– Antecedents, behaviours, consequences – motivation and RF's – rel to m/state or MD

- regular room searches

- smoking + lighters supervised

- debrief / move pts safely

* consider fire service – ‘face up’ – fire safety programme – awareness – harmful consequences of actions
* psychologically – (group) work on self esteem / assertiveness – can help

Exploitation/victimization

Incident of abuse (physical, emotional, sexual, material, discrimination, maltreatment or financial) – safeguarding – powers in E+W to remove to place of safety.

Interagency work

* Conflicting issues
* Disclosure based on Egdell – significant risk of serious harm to public
* Helpful and necessary to work collaboratively

MAPPA

Work together to manage the risk of harm to other posed by offenders especially MDO's. Various categories.

MARAC

Domestic violence and coordination of safeguarding efforts in a multi agency fashion.

Forensic Structure

* Prison inreach – 87% of prisons have these – links with 1ry care
* Community Forensic – emphasis on step down
* Low secure – MDO’s ltd violence/absconding risk
* Medium secure – high risk MDO’s
* High secure – grave and immediate risk
* DSPD – since 2001 - £140 million – now being disbanded in favour of PD strategy / PIPES / community interventions

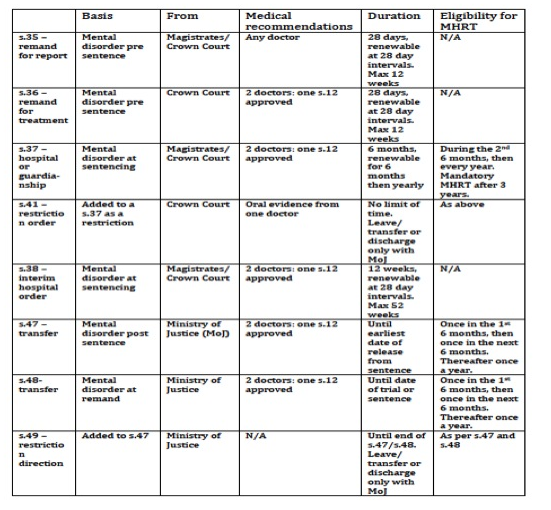
c..4500 beds in forensic vs. 13000 for generic services

Forensic pathway:

When charged with an offence by the Police…  
  
When an individual is charged with an offence by the police, they are usually bailed until their court hearing. There would be a requirement to attend Court at a certain date (often attached with several conditions). If bail is not granted by the police: the court hearing takes place at the earliest possible time.   
  
If an individual is suspected to have a mental disorder, or have difficulty in their understanding of questions or their answers, PACE guidelines should be used. This means that if an individual is detained: an ‘appropriate adult’ should be informed and asked to attend the police station.  
  
The police send their information to the Crown Prosecution Service (CPS) who then decide if the prosecution should continue. The CPS continue prosecution if the public interest outweigh any other concerns.  
  
If the police are concerned regarding the mental health of a person they have found in a public place, they may detain him/her under a Section 136 (for 72 hours. The individual would then be assessed under the Mental Health Act and if necessary, admitted to hospital either formally (under sections 2, 3 or 4 usually) or informally (voluntarily).  
  
After the first hearing, the individual can be bailed into the community (with certain conditions) or remanded into custody depending on the severity of the offence, amongst other factors.  
  
If the matter is relatively minor (a 'summary offence'), then the trial will take place at the magistrates' court.   
The most serious offences ('indictable-only offences') will be tried in the Crown Court.   
  
The Magistrates court will consider the case and under normal circumstances bail is granted. If there are any concerns (such as the need for a medical report) and there are concerns over risk, the individual may be remanded into custody.  
  
Before the Trial…  
  
Magistrates or Crown Court can choose to remand an individual to hospital for assessment of their mental health for a period of 28 days, up to a maximum of 12 weeks under a Section 35. The purpose of this would be to provide the court with a report on the individual’s mental disorder.  
Crown Court can remand to hospital for treatment under Section 36 lasting 28 days and renewable up to 12 weeks in total. This is in practice rarely used and up to March 2007, there were only sixteen recorded cases of its use.   
  
A magistrates court has no power to make a restriction order.  If the court is satisfied that the conditions exist in which it could make a hospital order under Section 37, but also feels that a restriction order should be added, it can commit an offender to the Crown Court under Section 43.  The magistrates court may direst that the offender be detained in a hospital under Section 44 pending the hearing of the case by the Crown Court.  
  
If an individual is placed on remand (i.e. unsentenced) to prison (into custody), a Section 48 could be considered to transfer to receive urgent treatment in hospital. The Ministry of Justice (MOJ) has to agree and issue the transfer direction, with a bed required within 14 days of the secretary of state approving its use.   
  
A restriction order under Section 49 can be added, by the Ministry of Justice to the Section 48, creating a section 48/49, is mandatory for cases where criminal proceedings are involved. This is usually added because of if there are significant concerns over public safety, and will imply restrictions for leave,  transfer  and discharge, which the MOJ would oversee.  
  
Fitness to Plead  
  
If Crown Court finds unfitness to plead, there will be a 'trial of facts' to decide whether the individual committed the accused act. If they find that the individual did commit the act, a hospital order (section 37 with or without restrictions), a 'supervision order' or 'absolute discharge' may be sought. A supervision order allows an individual to receive support and treatment, usually with the aide of a social worker. Absolute discharge may be considered if the offence is relatively trivial and there is no further action required.  
  
At Sentencing..  
  
After the court completes its case, and sentences the individual, if they have a mental disorder a Section 37 ‘hospital or guardianship order’ may be considered.   
  
Little use has been made of guardianship orders (probably due to the availability of supervision orders) but their purpose is primarily to ensure the offender receives care and protection rather than medical treatment in the community, although the guardian has the power to require the offender to live at a specific place, to attend specific places at specified times for medical treatment, occupation, education or training, and to require access to the offender to be given at the place where the offender is living to any doctor, approved social worker or other person specified by the guardian.  the order would last initially for six months but the Responsible Clinician (RC) can also renew the section at the end of the first six months, again at the end of a second period of six months, and at yearly intervals thereafter.                                                                                                                                                              In very serious cases where a hospital order has been given, the Crown Court may add a 'restriction order' (section 41). This can be added to a hospital order and has no time limit.   
  
If a restriction is not added the order would last initially for six months but the Responsible Clinician (RC) can also renew the section at the end of the first six months, again at the end of a second period of six months, and at yearly intervals thereafter.   
If a restriction is added the RC would require the permission of the Ministry of Justice to allow leave or discharge from hospital, and the hospital managers have no power to discharge. Discharge could occur either absolutely or conditionally.   
If the individual is discharged conditionally, he/she is then subjected to compulsory aftercare: which involves both social and medical supervision.  
  
If Crown Court convicts the individual, but delays sentencing for an assessment to be carried out as to whether a full hospital order under Section 37 is appropriate, an interim hospital order could be applied (Section 38). This lasts for 12 weeks initially and is renewable for further periods of up to 28 days for a total of not more than 12 months. If necessary this can be converted to a hospital order at review.   
  
A Crown Court can also impose a hospital direction under Section 45A.  This section empowers the court, when imposing a prison sentence on a mentally disordered offender convicted of an offence other than one of which the sentence is fixed by law, to give a direction for immediate admission to, and detention in, a specified hospital together with a direction that they be subject to the special restrictions set out in Section 41 (a limitation direction).  The RC will have the option of seeking the patient’s transfer to prison at any time before their release date if no further treatment is necessary or is likely to be beneficial.   
  
After Sentencing..  
  
If a sentenced prisoner requires transfer from prison to hospital, a section 47 (transfer section) can be used. In practice, The Ministry of Justice, usually adds a 'restriction direction' (section 49), which prevents the hospital from discharging the individual.   
A sentenced prisoner can be detained in hospital for longer than the individual’s sentence tariff. If the prisoner was given a fixed term sentence, the Section 49 restriction is removed after the expiry of the sentence: and the Section is converted ‘notionally’ to a Section 37.

[see [www.mentalhealthact.weebly.com](http://www.mentalhealthact.weebly.com) for additional details]

‘Forensic’ Sections



Ethics

Think 4 principles:

1. Non maleficence
2. Beneficence
3. Autonomy
4. Justice

Information sharing is significant risk of serious harm – good to caveat conversations. (*R v Egdell*)

Conflicting roles/duties – especially in terms of court reports / court settings

Coercion is relevant

NB requirement to ‘cooperate’ via CJA 2003

Potential clinical scenarios requiring ethical consideration

MAPPA – ethical guidance available re confidentiality generally 2006, and related to MAPPA. Usually sensible to seek advice with GMC if unsure but concerned.

The Court system/process

* *Supreme court* – highest level of court – final court of appeal
* *Appeals Court* – appeals on points of law- trial mistook or misinterpreted the law
* *Trial courts* – divided into court for criminal matters / court for civil matters (family, administrative, general law, equity courts). Different levels – higher-level trial courts to review lower level trial courts.
* *Tribunals* – less formal, more quickly and lower cost. Each tribunal serves different areas.

Judicial review available to review decisions – legality and reasonableness specifically.

Standards of proof

Non-criminal hearings – facts required to be proved on *the balance of probabilities.*

Criminal courts – *beyond reasonable doubt*- psychiatric defences usually on the balance of probabilities.

Criminal activity

Main categories:

* Offences against the person e.g. assault
* Sexual offences e.g. rape and indecent exposure
* Public order offences e.g. affray
* Possession offences e.g. offensive weapons in public or drugs
* Property offences e.g. criminal damage, arson
* Offences of dishonesty e.g. theft, fraud, deception
* Offence against the state e.g. treason, terrorism
* Regulatory offences e.g. breach of bail conditions, driving offences
* Inchoate /incomplete offences e.g. attempt to rob, conspire to rob

To be prosecuted – ‘*beyond reasonable doubt’* –

+ actus rea (wrongful act) and mens rea (guilty mind) – capable of forming and did form a relevant state of mind at the time of the actus rea.

Actus rea – affected / acquitted

Justification -Self defence / prevention of the crime

Defence - Duress/necessity/insanity

Basic intent – general sense of intending to do something

Specific intent– intention there to cause harm

Recklessness – consequence of action not foreseen

Negligence – relates to when harm could be envisaged

Mistaken belief – mistaken belief negates component of the offence

Wilful blindness – e.g. driving uninsured

Strict liability – no requirement for mens rea e.g. parking, TV without a licence

Criminal responsibility - Age 10 in E&W

Mental Disorder -

At the time of proceedings

* unfit to plead / stand trial – severe Alzheimer’s –problems concentrating and/or understand proceedings

At the time of offence

* prevent forming *mens rea* – at the time of offence esp. intent
* or give rise to a defence – insanity/automatism or partial defence of diminished responsibility.

Incapacity due to Intoxication –unintended (spiked) vs. involuntary – makes complex defence

Being a party to an offence

I.e. ichoate offences - Incomplete offences –

* Attempted to complete an offence e.g. robbery/threat -
* Aiding / abetting e.g. murder – supplying a weapon knowingly
* Inciting encouraging – counselling or procuring - e.g. inciting terrorism
* Conspiracy e.g.. Planning an act even though it does not transpire/occur

Mental element requirement is different for ichoate vs. main/’complete’ offences

Duress – works by the defendant acting in a way as a result of threats / circumstances -

Joint enterprise – accomplice involvement

Entitlement to control – stopping the driver from driving

Self defence – necessity – necessary

Reasonable force – force has to be proportionate

Mental disorder assessment is not relevant in identifying ability to rationalise the risks of actions.

Partial vs. full defences

Defences – limit the defendants liability for their crime

Partial defences –

DR, provocation, killing someone wanting to die

* *Diminished responsibility* – similar to insanity and def excused from criminal responsibility because of mental disorder present at the time.
* *Provocation* – provoked by victim – did/said
* *Killing someone wanting to die* – e.g. suicide pact – unsuccessful – manslaughter vs. murder

Full defences –

These include: Insanity, automatism (see on) and duress

1. *Insanity* – MD so severe that they were incapable of having criminal responsibility for their b, as they did not understand the true nature of what they did.
2. *Automatism* – acting without conscious control
3. *Duress* – coercion/necessity

Mistake

A mistake does not act as mitigation usually – occasionally a defence if rationale is delusional

Potential defences:

1. General defence of necessity – broader than defence of n]duress – does not require a fear of death or serious harm..

2. Mercy killing – partial defence – euthanasia type proposal

3. Proposal of excessive force in self-defence avoiding mandatory life sentence.

Homicide

Murder: kills unlawfully with intention – mandatory life.

Manslaughter : kill recklessly, negligently, or through an unlawful act.

Voluntary – pleading a partial defence to murder

Involuntary – reckless/criminal negligence

Infanticide: intentional killing by the mother of a child up to 12 months – partial defence.

Defences to murder

Partial defences are only accepted

* diminished responsibility
* loss of control/provocation
* infanticide
* killing in pursuance of a suicide pact

Assault / non fatal violent crime

Severity:

1. Wounding with intent to cause GBH – s18 up to life imprisonment
2. Unlawful wounding and inflicting GBH – s20 – intention/recklessly – max 5 yrs imprisonment
3. Assault causing ABH – any injury interfering health/comfort of the victim – not transient/trifling – max 5 yrs
4. Battery – intention/recklessly – touching/applying force another person – max 6 months
5. Common assault – causing a person to fear an immediate touching/applications of unlawful force or doing this max 6 months
6. Aggravated assaults – offences where aggravating factor is present – therefore sentence is greater.

Sexual offences

* Rape
* Sexual assault
* Indecent exposure
* Against society – outraging public decency
* Child offences

Arson and criminal damage

90 deaths/yr in UK

annual cost £2 billion

association with MD important

4 categories:

* youth – vandalism; young children – accidental
* malicious – using fire as a weapon/malicious damage
* psychological –i.e. emotional: communication of frustration/pain/hostility
* criminal – covering up evidence of other crime, fire for financial gain

Offences

Criminal damage

Arson

The mental component – intending to destroy / being reckless

Aggravating factors – intending to endanger the life of another – as to whether the life of another would be thereby endangered

* arson with intent (intent often hard to prove)
* reckless arson
* simple arson

Public order offences

* Riot
* Violent disorder
* Affray
* Threatening abusive / insulting words
* Disorderly conduct / intoxication in a public place

Breach of peace – violence used/threatened and/or disorder occurs – arrested / removed to prevent a Breach of Peace. Not an offence itself those people arrested could be bound over – i.e. Must pay court money that they lose if they offend.

Acquisitive offences

* Theft
* Burglary
* Robbery
* Blackmail/extortion
* Handling stolen goods
* Fraud/dishonesty/making off without payment

Juvenile offences

High rates of offending

Status offences – not illegal if committed by adult

Index offences – all others

Other offences

* Care of children – consideration in family court
* Care of psychiatric pts – criminal/professional sanctions
* Cruelty to animals – antisocial pd / CD in children
* Terrorism/treason – threats to royal – treason - etc – some long term terrorist detainees MI issues
* Threats to kill – max 10 yrs – hard to prove – intends the victim to fear that it will be carried out.
* Stalking + harassment – injunctions lesser burden of proof, other legal sanctions – restraining orders – high CM with MD –
* False imprisonment –
* Poisoning – often hard to detect
* Contempt – disobeys/disrespects court

International law crimes:

Humanity/war crimes

Cautions – minor offences – no public interest in prosecution/clear evidence of guilt

1st offence – reprimand -> warning for young + YOT involvement

Fixed penalties – traffic wardens / theft/ public order etc

Conditional caution

Sentencing:

1. Once the individual’s criminal responsibility is established
2. Guilt is also proven
3. And is a response via the CJS to the offence

Sentencing – laid out by sentencing advisory council + CoA direction and Lord Chief Justice.

Consider – seriousness/aggravating factors e.g. committing offence on bail/mitigating factors e.g. provocation/ ancillary orders e.g. compensation order or binding over

NB special rules for sentencing children

Types of sentence:

* Determinate
* Indeterminate

Life sentences –

Mandatory – murder – no discretion to pass an alternative

Discretionary – serious offences – manslaughter/aggravated burglary

Minimum tariffs –

Set by a trial judge subject to appeal

Release on licence –

Application to parole board to be released from prison. Liable then to recall to serve the rest of their prison sentence, if they breach their licence conditions.

Required to regularly report to the probation officer.

IPP's (indeterminate sentence for public protection)

Convictions for serious + violent offences - IPP’s comprise a minimum term of imprisonment + licence of at least 10 yrs. After 10 yrs – can apply to parole board 1 x yr for their licence to be revoked.

A small proportion of children/young adults have sentencing options that are equivalent.

Determinate prison sentences

These are sentences that have fixed tariffs.

Based on seriousness of the offence

Up to 8 yrs are released automatically on licence at the parole eligibility date.

Extended sentences for public protection

Serious sexual/violent crime – extended sentence licence period – up to an extra 5 yrs (8 for serious sexual cases). Provided this does not exceed the max sentence for the offence.

Others

* Suspended – up to 12/12 – can be suspended – no need to serve the sentence unless reoffend within a certain period of time.
* Intermittent custody – pilot – weekend in prison – weekdays on licence
* Custody plus – prison + community sentences
* Early release up to 135 days early on home detention curfew
* Note also s.**4**5A – as seen above

Community sentences

Single community order added to a variety of different requirements the equivalent for children – youth rehabilitation order.

E.g. mental health, DRR, education etc

Fines – court ordered – part of offender’s punishment

Conditional discharge

No immediate punishment but if reoffends within a specified time period – sentenced for the old + new offence.

Binding over

Court believe risk of violence in the future – refrain from certain acts for a period and pay money which they will lose if they breach the order.

Absolute discharge

No punishment; but criminal rec remains.

Mental health disposals

Mental Health disposals include –

1. hospital
2. accept outpatient treatment/ intervention order
3. hybrid order (s.45A)

Ancillary orders

May combine with additional orders.

* Compensation orders
* Banning orders
* Orders – confiscation/deprivation/forfeiture
* Disqualified from driving
* Parenting orders
* Orders for restitution – restore property
* Restraining orders
* Sexual offences prevention orders (SOPO)
* Violent Offender orders
* ‘injunctions applied by courts’
* Registration – MAPPA / sex offenders register
* Cost orders – pay proceedings for both parties

Civil orders

* Referral orders for children
* ASBO's / Acceptable b contracts
* Child safety orders
* Child curfews

General Points about the Mental Health Act

What is the Mental Health Act 2007?

This is legislation that provides power to formally admit people with a mental disorder in the community or forensic settings to hospital. This can be necessary when an individual has a mental disorder and needs hospital for assessment or treatment and either refuses to be admitted or lacks capacity to agree to admission. It is used within England and Wales.  
  
What is a Mental Disorder?

This is defined as '*any disorder or disability of the mind.'* Although learning disabilities are included in the definition of mental disorder, it must be '*associated with abnormally aggressive or seriously irresponsible conduct'* for detention to occur. Examples of a mental disorder include: personality disorder, schizophrenia or depressive disorders.  
  
Are there any exclusions to the Mental Health Act?

Alcohol and drug dependency are excluded from the Mental Health Act.  
  
What does detention under the Mental Health Act mean?

It means that a person has been placed (usually) in hospital in order to receive appropriate treatment for a mental disorder.  
  
What are the criteria to become subject to the Mental Health Act?

Firstly, the person needs to be suffering from a *mental disorder*.  
This needs to be of a *nature* (its likely duration and outcome) or *degree* (the current effect on the individual) to require detention in hospital for treatment or assessment. There also needs to be concern over the *risks* of the person to themselves or others. For the longer lasting sections, there is a requirement that *appropriate medical treatment* is available for an individual for their mental disorder.  
  
Who can detain people under the Mental Health Act?

For Section 4 - one doctor + an approved mental health professional or nearest relative. For Section 5(2) - one doctor. For Section 5(4) - one registered mental health nurse. For Sections 2, 3, 7- two doctors + an approved mental health professional or nearest relative. For Section 136 - a police officer. For Section 135 - a magistrate. For the forensic sections (Sections 35, 36, 37, 37/41, 47, 47/49, 48, 48/49) there is a requirement for the Court to make the order and that medical evidence is provided by one or two doctors. 

What is the nearest relative and their powers?

The Mental Health Act gives certain powers and responsibilities to the nearest relative. Not every patient will have a nearest relative. If there is one, the approved mental health professional would have informed the person of this at the time of the section. For non-forensic sections, the nearest relative has the right to discharge the patient. If they do so, the Responsible Clinician will have 72 hours to consider whether it is safe to allow the discharge.  
      
What rights do people have under the Mental Health Act?

People detained under the Mental Health Act have the right to access appeal via a *Mental Health Review Tribunal* or *Hospital managers panel.* These bodies can review whether the detention criteria are met. Detained individuals can access an Independent Mental Health Advocate (IMCA) who can offer support. The *Care Quality Commission* has an independent role to monitor the use of the Act as well as the care that people are offered.  
  
How long does each Section last?

6 hours - Section 5(4) within hospital  
72 hours - Section 5(2), Section 4, Section 135, Section 136, *Recall* of Community Treatment Order  
28 days - Section 2, Section 35, Section 36  
6 months - Section 3, Section 37, Section 47, Community Treatment Order (S17A-G) and Section 7 (Guardianship)  
  
How can people appeal against their detention?

The appeal can be done through:  
1. Mental Health Review Tribunal or    
2. Hospital Managers panel  
The Mental Health Review Tribunal is independent of the hospital and patients are entitled to legal aid. A patient can also appeal against their section to the Hospital Managers. Frequently, the managers are appointed by the Trust Board.  
  
What about treatment under the Mental Health Act?

The Mental Health Act is used for the treatment of mental disorders and does not usually physical health problems. This is covered by Section 57 (Neurosurgery - rarely used), Section 58 (Medication), Section 58A (ECT), Section 62 (Urgent treatment). Treatment (usually medication) under the Mental Health Act can be given for the *first three months* to detained individuals with / without their consent. (Under Section 63).  
After *three months* and if the individual refuses treatment or lacks capacity: a Second Opinion Approved Doctor is required to authorise further medical treatment. There are different rules about treatment for community patients and for ECT (Electroconvulsive Therapy).   
  
What about leave from psychiatric hospital?

This can be arranged for non restricted (long term) sections via Section 17. If leave is to be for 7 days or more, a Community Treatment Order should be considered by the Responsible Clinician. For restricted patients, leave has to be applied via the Ministry of Justice by the Responsible Clinician.   
  
How does discharge take place?

For non offender patients (Section 2, Section 3 or CTO): discharge can usually take place by the responsible clinician, managers’ panel, and mental health review tribunal or nearest relative. The section could also expire after elapsing or in section 3: this can be converted to a Community Treatment Order. A CTO can be revoked when an individual is admitted to hospital, into the original detaining section (e.g. section 3).  
  
For forensic patients (where there is no nearest relative in the statute): discharge can be discharged by a number of methods (including the above):

* court making a decision to discharge (usually supported by medical recommendation)
* medical recommendation that an individual does not require further assessment

In restricted patients (S49 or S41), the powers of discharge are limited by the Ministry of Justice or MHRT.

Psychiatric court issues

1. **Fitness to Plead** - This is laid within the Pritchard criteria (R v Pritchard 1836) and requires evidence from two doctors and is determined by a judge.   
  
It includes the ability:-

* to comprehend the course of proceedings on the trial;
* to be able to challenge any jurors to whom he may object;
* to comprehend and give evidence;
* to instruct their legal representative

If an individual is unfit to plead, there is a "trial of facts." If the jury are unsatisfied that the defendant did the act, they must return a verdict of acquittal. If the defendant is found guilty 'on the facts,' then there are 4 options available to Court:  
  
i. An absolute discharge  
ii. A supervision order - places an individual under the care of a social worker for a time  
iii. A hospital order, with or without restrictions  
iv. The hearing can be postponed, until the individual is fit to plead (with the option of S.35, S.36, S.48 or S.38)  
  
Mutism by malice or by visitation of God can often be explored. If it is found that the individual is mute ‘by malice’, then the case proceeds with a 'not guilty plea' entered on the individual’s behalf. If mute ‘by visitation of God,'  (deaf and dumb), then the question of fitness to plead will arise with a view to disposal under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991. A magistrates court does not have the same powers, and can be dealt with by a s.37(3) of the Mental Health Act, where a trial of facts in undertaken and if found to have committed the offence, a hospital order is utilised.  
  
  
Psychiatric Defences

i. Insanity - aka the "special verdict" - This was established following the case of Daniel Mc'Naughten who was found not guilty on the ground of insanity of murdering Sir Robert Peel's secretary in 1843. The grounds for insanity were met, since he was:  
  
*"labouring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know it was wrong."*  
  
This is an infrequently used psychiatric defence (c. 10-15 times a year).   
  
The possible outcomes of the finding of an insanity verdict (through the Domestic, Violence, Crime and Victims Act 2004) include the following:

* A hospital order S.37 +/- restriction order S.41
* A supervision order
* Absolute discharge

ii. Infanticide - Applying when a woman kills her child under the age of 12 months. This was established in 1922, prior to the partial defence of diminished responsibility. This enables a women charged with child killing whilst suffering from post natal depression or any other severe mental illness to escape conviction for murder.  
At the time, "*the balance of her mind was disturbed by reason of not having fully recovered from the effects of giving birth to the child or by reason of the effect of lactation consequent on the birth."*

The Court has a wide range of disposals and imprisonment is rare.   
  
iii. Diminished Responsibility - This was established through Section 2 of the Homicide Act 1957, to mitigate sentences from life imprisonment for murder. The use of this defence: results of a charge of murder being accepted as a plea of guilty to manslaughter (sentencing is at the judge's discretion). The accused should suffer from an abnormality of mental functioning: which arose from a recognised mental condition. This is a question that the jury must answer (on the balance of probabilities) based upon medical evidence.  
The success of this defence would usually result in a restricted hospital order, but there are other disposal options including: imprisonment, probation or supervision orders.   
  
iv. Automatism - Defence used when an individual claims that they lack mens rea (or basic intent) for their offence because the act was involuntary and beyond their control. 2 types:  
a. *insane* - due to a 'defect of reason' and is subject to the McNaughten rules. Examples include epilepsy, narcolepsy and dissociative states.  
b. *sane* - for example, hypoglycaemia, head injury or sleepwalking. [see on]

Victim rights re MDO’s

Whether discharge should be subject to conditions/supervision requirements

If so, details are made available and are to be informed:

1. When discharged
2. What conditions / supervision there will be

N.B. – MDT SW – take on role of liaising with past or potential victims in order to assess needs/rights

Criminal Justice System (CJS)

Detection & investigation

Police (civilian) &…

* SOCA ->now known as the National Crime agency – (2011) – focus on major criminal gangs
* Royal military police –
* Specialist intelligence agencies – MI5 etc
* UKBA & HMRC

Prosecution

CPS- public prosecution of individuals charged with an offence – take ix beyond police + preparing / presenting cases for court.

Trial

Criminal trial courts – magistrates (less serious) + crown (more serious).

Sentences

* Imprisonment
* Community sentences
* Fines
* Supervision
* MH orders

The main functions of a psychiatrist:

* s136 / MHA assessment
* advising on diversion from custody and reviewing healthcare needs
* fitness to be interviewed
* advising on need for an appropriate adult at i/v

At arrest..

Review by FME (forensic medical examiner) - ?need for MHA assmt + fitness to be interviewed

Appropriate adult (e.g. social worker) used when vulnerable or has a mental disorder (see PACE regulations). Should be there for Under 18s or the vulnerable.

?harmed by the i/v or whether the evidence obtained would be unreliable

e.g. fitness to be interviewed questions:

* Do you understand why you have been arrested
* What does the caution you were given mean?
* What do the police want to find out in the interview?
* What impact might it have if you said … I’m guilty?
* What would you do if you did not want to answer a question?

Options for vulnerable suspects:

* Charge and bail
* Charge and remand
* Police bail to return to the police station
* Release
* Arrange admission to psychiatric hospital

Attempts to support court understanding can be supported- for example via: sign language, providing information slowly, in writing and orally, advocacy presence, frequent breaks.

Investigative psychology

Offender profiling – draw an understanding of the mind and the characteristics of the perpetrator.

3 methods:

* clinical practitioner approach: extrapolating expertise to profiling
* the criminal investigative approach – specialist approach
* statistical/actuarial approach – academics examining patterns

..the evidence is limited for psychological or other such profiling..

Prison services

* secure / closed prisons
* resettlement or open prisons
* juvenile and YOIs

£20k - £50K per year as a cost

recidivism is high – around

Prison layout

-reception

-first night centre

-number of wings

-vulnerable prison area

-segregation unit

-special unit – hi risk of violence/escape

-healthcare centre

-education & training centre

-workshop

-indoor/outdoor recreation

-visitors centre

GP/psychiatrist/drug team

Youth custody services

*YOIs –*

Young offenders 18-21; juvenile offenders 15-17

*Secure training centres & detentions schools-*

Young offenders up to the age of 17. In E+W: 4 in E+W – 9%

Higher relational security vs. YOI

*Secure children’s home*

Young offenders (12-16) – 8% of young ppl held in secure state

Adolescent secure hospitals – 6 units in the country – medium secure hospitals.

Parole boards

* Providing ‘professional’ reports – advise on case management/progress
* Providing independent reports – advise on risk in the community: ‘expert’
* Sitting as a parole board member –

Probation

Shift in 1990s to punishment

70% of supervised offenders

30% on licence

Includes: risk assmt, OASys and mgmt of risk thru OBP’s

Roles:

* Assessing offenders prior to sentence
* Monitoring progress of offenders that are sentenced in prison
* Advising the parole board
* Supervision of offenders released on licence & recall
* Supervising compliance with community sentencing & reporting breaches to court
* Advising offenders on services/resources locally
* Directly providing support e.g. via psychological programmes etc

*YOT*

* 10-17 yr olds
* multiagency staff
* vs. National Probation Service – it is more emphasized on welfare, education, referral (i.e. reparation) orders involving the victims/ community.

*NOMS*

Joins up prison and probation services + conducts research/ advises govt. on strategy.

Reoffending (i.e. recidivism)– problems with collecting the data to get an accurate picture.

Approximate reoffending rates after 1 year:

* Imprisonment: 51%
* Community sentences: 37%
* Restriction orders: 6%

*MHU* –concerned with MoJ MDO’s on s.41’s and directions.

Restricted pts – RC –in order to authorise leave requires MoJ approval

Must be informed if any significant risk behaviours.

Transfer – require MoJ

After CD – conditions designed to manage relevant risk factors:

* residence
* compliance
* attending visits / appointments
* drug screening
* exclusion zone

3 monthly reports by RC and SS

Recall

Relapse/breech – may be recalled. Recall by MHU – on advice of supervisors/on their own.

Recall usually if admitted >6/52 if informal and if concerned about the behaviour

MAPPA

Interagency organisation, joint management those of a serious harm to the public.

* Category 1: sex offenders – all on the SOR + those convicted/cautioned with a hi risk
* Category 2: violent offenders – sentenced to at least 12/12 imprisonment or hospital order
* Category 3: potentially dangerous offenders – cautioned/convicted for an offence indicating that they are capable of serious harm. (only managed for 3/12 unless allocated to category 1/2)

Sharing information

MAPPA promotes this – note Egdell test – breach requires ‘significant risk of serious harm to others.’ Thus reports should be outlined in this way and spliced appropriately.

Assessment of the risks posed by offenders

Focus on those at highest risk

Measures put in place for victims

Management of the risk from offenders

3 levels:

Level 1 – normal agency management 1/2 agency involvement (majority)

Level 2 – high/v high risk of harm – 23% of MAPPA offenders

Level 3 – highest risk of harm – 2% of MAPPA offenders

Psychiatric Legal points

Fitness to plead

Is required for a trial to occur. Fitness to plead relates to the mental abilities to comply with trial proceedings. Physical conditions such as deafness / muteness are also relevant. There is a presumption of fitness and tests of cognitive ability are relevant + neurological, psychotic or LD.

Note R v Pritchard criteria

The level of evidence required is on the ‘balance of probabilities’

‘Test’

Unfit if incapable of:

* understanding the charge/charges
* deciding whether to plead guilty / not
* exercising the right to challenge jurors
* instructing solicitors and counsel
* following the course of proceedings or
* giving evidence in his own defence

Various problems with this approach… [add summary]

Criminal Procedures Act 1964 (91, 04)

* 2 medical practitioners give evidence
* if raised by prosecution – ‘beyond reasonable doubt’, if defence – ‘balance of probabilities’
* determined by judge in crown court

Delaying a trial..

-an option for treatment to improve FTP status

-even when FTP but mentally unwell – best to delay the trial – advise delay based on ‘natural justice’ grounds.

Outcomes:

If unfit –

Trial of facts.. (determine actus rea part)

hospital order, guardianship, supervision order and absolute discharge.

If during trial of facts – did the acts or omissions alleged – not necc a conviction.. if later found FTP –can be tried.

Unusual in practice – as memories/samples/documents lost.

Fitness to give evidence

Concerns that witnesses are unfit – or unreliable

Esp. extremes of age, LD etc.

Tests (derived from case law):

* Understand the question
* Apply their mind to answering them
* Convey intelligibly to the jury the answers they give

Various criticisms e.g. does not support milder levels of MD

Fitness to attend court – i.e. if acutely psychotic/suicidal etc. indicate if unfit asap to clerk of court + likely timeline.

Confessions

* generally seen as an admission of guilt
* 3 types of false confessions: voluntary false confession, coerced-compliant confession, coerced-internalised confession.

Factors influencing false confessions

*Situational factors* – effects of custody/isolation – e.g. process of police interrogation

*Individual factors* – include mental disorder, incapacity etc.

N.B. PACE guidelines usage

May require an assessment for whether or not false confessions have been obtained. This involves reviewing transcripts- and assessing vulnerabilities, cognitive status, intelligence and mental disorder.

Capacity to form intent

Often requested by court for psychiatrist review.

Whether / not have formed a particular intent.

The legalities involve:

1. mens rea for the offence or recklessness
2. the jurisdictions

Symptoms preventing the formation of relevant mental thought processes:

* specific delusions relevant to the situation
* an abnormal mood state (severe depression or severe mania) or associated psychomotor changes, or impaired concentration
* severe cognitive impairment – dementia/chronic scz

This does not include voluntary intoxication – doctrine of prior fault – that the person should foresee this.

Automatism

Total lack of control of body – body moves involuntarily

Insane vs. non insane

Insane – resulting in insanity outcomes – guilty as a result of insanity

Non-insane results in acquittal

Legal tests are based upon:

* Mens rea for offence – specific intent
* Jurisdiction -

|  |  |
| --- | --- |
| **Insane** | **Non-insane** |
| Epileptic fit | Concussion after head trauma |
| Arteriosclerosis causing transient ischaemia | Hypoglycaemia |
| Parasomnias e.g. sleepwalking |  |
| Dissociation | Dissociation pptd – by an unusual external stressor |

Intrinsic vs. extrinsic – not relevant medically, only legally

Involuntary intoxication

N.B. prior fault rule (for example, failing to take proper medicaiotn or drinking alcohol to excess)

If voluntary – unlikely to act as a defence

Involuntary intoxication includes:

* someone placing something unbeknownst to the defendant
* drugging e.g. rohypnol (flunitrazepam)
* taking a drug prescribed by a medical practitioner
* using a substance that is not dangerous but in a reckless manner
* using a substance when they are dependent – irrestible impulse to take it

..can be used as a mitigating factor to reduce sentencing or acquittal.

Voluntary intoxication may influence the ability to form intent.

Amnesia

* ?indicate abnormality at the time of offence
* issue of credibility
* relevance to FTP. FTI and reliability esp amnesic syndrome

+ further information on

1. insanity
2. diminished responsibility
3. duress, coercion and necessity