Edited by:
John Gunn
Pamela J Taylor

forensic Psychiatry

clinical, legal and ethical issues

Second Edition

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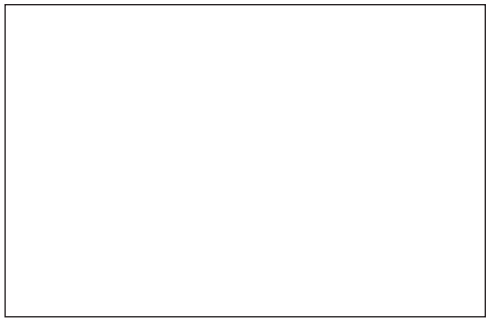

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Co-author of the treatment in non-health services chapter 24, and lead authorship on some of the prison sections.

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As a career UK Home Office civil servant, Nigel transferred to C3 Division, dealing with mentally disordered offender policy, in 1993, and worked for the Home Office on the review of the 1983 Mental Health Act from its inception in 1998 to the implementation of the 2007 Act. Nigel's determination to protect the old policy of diversion for mentally disordered people who offend won him few friends outside forensic psychiatry, but the policy survived in law, popularity notwithstanding.
Contributions on legal administration to chapters 3 & 4

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Contributed to Scottish section chapter 4. Co-author of the international comparative law and services chapter (5), with particular contribution of the Scottish sections; author of the Scottish service commentaries in the health services and non-health services chapters 23 & 24.

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Founder of the Zito Trust to raise awareness of the problems with the implementation of community care policy, Jayne studied fine art and art therapy and became a manager in mental health services in Hertfordshire. In 1992 her husband Jonathan was stabbed and killed at a tube station. Jayne terminated her studies in social work to successfully lobby for an inquiry into the care of the patient who killed her husband. The report was published in 1994 (Ritchie et al.). The Zito Trust closed in 2009, and Jayne has trained as a counsellor and is a non-executive member of the Devon and Cornwall Police Authority.
Co-author of the sections on independent sector and voluntary organisations in the chapter on victims and survivors 28.

Acknowledgements

It is, as ever, impossible to express sufficient gratitude to everyone who has helped us in some way with this book. Our generous and gracious authors are only the most visible. So many people, from so many walks of life have contributed – some have stimulated us with as little as a passing comment, many have helped with much, much more. Although in forensic psychiatry we are profoundly concerned with public safety, still our patients and offenders who may need help from mental health services have to be at the centre of everything, and we thank all those among them who, knowingly or not, have inspired us to think and work harder towards collating what we know more effectively and clarifying the areas where there is still so much to be done.

After that, our gratitude spills out in no particular order – as the weeks have passed, different people would seem to top the list, and it is frustrating that we are not going to be able to name them all. First equal, though, we must thank our long suffering publishing teams and our readers – and simultaneously apologise for the length of time it has taken us to produce the completed book. It was our original publisher – Butterworth Heinemann – that set us off with the plea that we update the first edition 'it won't take long, most of it is already there and it simply needs modification to bring it up-to-date'. We resisted at first, so it is hard to say exactly when the process started, but we probably began serious work on the second edition about 10 years ago. Our book has, therefore, now taken a year or two longer to produce the *King James's Bible*! Much of the slow pace was occasioned, to our frustration, by the inordinate delay in the ever promised new mental health legislation for England & Wales, caught in a battle between law and order minded politicians and the so-called *Alliance* – of many clinical and legal professionals, criminal justice and social agencies, third sector organisations and a wide range of patients, other service users, including survivors of criminal attacks, and their families or carers. Chapter 3 explains.

There have, however, been other reasons, too, for the apparent tardiness. One important one is the low status given to textbook writing by universities, where it seems most shocking, and many other relevant employers. This problem was not present 20 years ago, but now potential authors are often instructed by universities to stop wasting time on textbooks and write research grant applications instead. One or two potential authors, therefore, felt they had to decline project-textbook, but most of those invited did contribute and our gratitude is all the greater for the fact that they all worked long and hard out of their regular working days to provide the text. We had countless midnight email conversations over tricky points, and are less amazed that delivery dates fell behind than that any were achieved at all. The most important characteristics that this edition has in common with the first edition are that we have tried to recruit experts of the highest calibre and then work through an iterative process so that we could both truly understand what each had to convey and present a coherent thread through sometimes different, sometimes frankly conflicting, approaches in this complex field. We have felt both privileged and, briefly, wise as we completed hard debated chapters. We hope that some of this excitement remains for readers.

The good-news part of the length of time we have all taken over the text is that so much has changed and moved forward, so, in a good way, our Butterworth Heinemann friends were proved wrong. There are very few places in the textbook where we were able simply to do a little gentle updating. Almost all parts of the chapters with more-or-less original titles have been completely rewritten, and there are now richly informative chapters which were unthinkable given the state of knowledge in the field 20 years ago. The genetic influences chapter is probably the most technically difficult of these, but represents enormous strides in understanding mechanisms even if it will be a while before this work will progress to testable models for intervention. Developments in the measurement of disorders of brain structure and function have similarly meant that an area that formed a small part of one chapter in the first edition now has a full chapter in the second. It is, however, widespread development in service and treatment provisions that has brought the work on intellectual disability to a similar level. Other reasons for completely new chapters are less happy – older people are beginning to swell criminal statistics and need specific attention. More terribly, there have been such errors, dysfunctions or frank abuses of position by professionals expected to work towards the health and safety of all with whom they come into contact that we thought it important to consider how we can recognise difficulties at an earlier stage and, as far as possible, avoid breaching professional standards ourselves. These ventures have all added to the production time. Nevertheless, we remember with gratitude all the work our first edition authors did, because without that pioneering effort we would have had nothing at all to build on. Some of those authors are still clearly with us.

Traces of the rest who could no longer write, for a whole range of reasons, not least that a few have sadly died, remain in the text and we have tried to acknowledge them all, chapter by chapter. All first edition authors are listed in small type in the heading for each relevant chapter; we remain in their debt.

The publishing world seems to be in a constant state of turmoil. Since this project began we have been working with Butterworth Heinemann, Edward Arnold, Hodder, and now Taylor & Francis. Our longest spell was with Hodder and we are particularly grateful for the help and encouragement given by first Philip Norman, and then Caroline Makepeace of that company. They were ably assisted by Clare Patterson, then Joanna Silman. We mourned the fact that Susan Devlin, who had nurtured us through the first edition, had long since moved on, but then Philip and Caroline kept us going. Caroline went with the book to join Taylor & Francis, and we are delighted that she will share its final emergence with us. She also brought in further essential help. Carolyn Holleyman was our copyeditor. Sarah Binns was the indefatigable, wise and wonderfully sensitive reader of the first proofs. Mimi Williams has steered us through all the final proof entries to an accurate rendition of the finally agreed text, and a real book. Sybil Ihrig compiled the index. A complication of the digital age is that rarely do these people, working on such vital technical tasks, meet one another, or us, and the work is accomplished 'online' and in various countries. All of them have coped cheerfully with this cyber world, although we know that from time to time our pedantry and slowness have created frustrations. We thank them so much.

Back in our offices, two psychology undergraduates – Emma Smith and Katie Sambrooks – worked tirelessly checking references. Secretarial help is a scarce resource, so that has put a heavy burden on those who have worked with us. In Cardiff University's School of Medicine, Katarina Dienerova became a founder member of the team, helping with the initial structuring and mailings to prospective authors; Ceri Allen has subsequently helped with chapter manuscripts and references and Sue Cody added to our sense of security in the final versions of text with her proofreading skills. In the allied clinical services, at the Caswell clinic, Karina Sansom has been an unfailing support. They have all been essential to the task.

At a time when books are so little value in terms of university ratings, we are very grateful to the support we have had from the Institute of Psychological Medicine and Clinical Neurosciences in the School of Medicine of Cardiff University, and particularly Professor Michael Owen as head of department. He might be surprised to hear that his approach to the science of the genetics of mental disorder was an inspiration, but it has been. We are constantly inspired by other colleagues, too, in all parts of this country and others, as will be evident from the geographical spread of our authorship, but in clinical practice, influences are necessarily closer. Closest of all have been Tegwyn Williams, Emma Clarke, Jan Hillier, Gaynor Jones, Mark Janas, Sian Koppel, and Roger Thomas, our continuing professional development (CPD) peer group. One of us is more in evidence than the other, but we have both learned a lot from you all, and only ask that this book may count for a few CPD points! Our psychology colleagues, led by Ruth Bagshaw, our social work colleagues, led variously by Heather Edwards and Ray Elliott, our nursing colleagues, for most of the time led by Mike Sullivan, and our occupational therapy colleagues, again for most of the time, led by Sian Dolling have all, contributed in this way, too, while the Wales Strategic Review of Secure Mental Health Services came just at the right time for enhancing our knowledge and thinking about this area, under Ted Unsworth's tirelessly diplomatic and wise leadership.

We return to our authors. They have laboured hard for very little reward other than joining in the project they must have believed in at some level. Presumably, like us, they think that education is still of prime importance and good practice depends upon accurate and detailed knowledge. On this occasion we were even privileged to have among our company the president of the Royal College of Psychiatrists. We give special emphasis to child development and its management in this book as it is the key to good forensic psychiatry and Professor Sue Bailey had written an important piece for *A Handbook of Forensic Mental Health* which she was willing to use as the basis of our chapter on child and adolescent forensic psychiatry. We are therefore extremely grateful also to her co-author, Bill Kerslake, and especially to Keith Soothill as lead editor of that handbook and Willan, the publishers, for permission to transcribe portions of that text and a diagram into our chapter 19. In that chapter we have also copied a diagram from Professor John Muncie's book *Youth Crime, third edition* with John Muncie's kind permission. We have also copied a large section from Helen Marshall's translation of the paper by Robert Gaupp called 'The scientific significance of the case of Ernst Wagner' from Hirsch and Shepherd's *Themes and Variations in European Psychiatry*, with the kind permission of Professor Stephen Hirsch.

Finally we acknowledge the care and compassion for mentally disordered offenders which can be shown by the criminal justice system. Knowing that mental health workers are not alone in wanting to contribute to the relief of suffering and a simultaneous prevention of crime keeps us going when so many difficulties, such as small and reducing resources and

rejecting attitudes, might otherwise drive us to give up. A judge's remarks made when sentencing a young perpetrator of a very serious crime illustrate this and are worth placing on long-term record:

> *I can only hope, by the time that you are considered for release, that some of the people who should be responsible for your care in the community take their responsibility and do so. I say that because I remain concerned that your mental illness causes you to be a serious risk to the public and also because, as with anyone else, you deserve to have the best care and treatment you can possibly expect while co-operating with those authorities. Therefore, I hope that whoever formulates your release, will bear those concepts in mind, understanding that it may be, as a result of the number of times you have come before the court and the pattern that you have established, that you need more care and more supervision than had originally been envisaged."* Nadine Radford QC (with permission).

Pamela Taylor and John Gunn

Preface

This textbook is intended to be of practical assistance in the assessment, management and treatment of offenders with mental disorder and other victims. It is not a comprehensive encyclopaedia, and is certainly not the last word on our subject, but it does try to draw extensively on the growing body of knowledge which is relevant and available. Inevitably it is biased. First, it has a medical bias, because we are doctors, and so are many of our authors. Other professionals have contributed substantially, and we are very attached to a multidisciplinary perspective, but it would be disingenuous and unfair to other disciplines to pretend that the prevailing view in this book is anything other than a medical one. The second bias affects parts of the book more than others. An essential component of forensic psychiatry is the engagement between psychiatry and the law. Criminal and mental health law, areas of legal practice which most concern us, to some extent the culture which underpins these areas, and the services which relate to them are country bound. Many of the authors are from the United Kingdom, and so the emphasis in the legal and service chapters is on the situation in England and Wales, with commentaries from other parts of the UK. UK legislation and common law practices have influenced many other systems around the world, and, notwithstanding the major differences in court practice, UK legislation has more recently been increasingly subject to wider European principles, particularly with respect to human and legal rights. Nevertheless, although we have tried to draw out alternative practices wherever relevant, all through the text, and have a substantial international comparative chapter, it has to be acknowledged that, rather than offering sufficient expositions of work in any other country we can only achieve with certainty one important purpose here – that of reminding us all that there are many ways of legislating and providing services, and no single 'right way' of proceeding. The more theoretical and disorder based chapters, by contrast, draw fully on international literature.

In addition to theory and evidence, we, and many of our clinically trained authors, draw on our experience to try and make at least some links, as we would in clinical practice, between the evidence base from groups as reported in the literature and the evidence base from the individual in front of us at the time of an assessment or in treatment. This, however, means some other biases – according to our range of expertise. Most of the text is intended for forensic clinicians who work with adults. It is essential that we consider child and adolescent psychiatry, and we do so, but this inevitably means that the 'super specialty' of forensic child and adolescent psychiatry is much less thoroughly covered. It is unfortunate that, to some extent, this coincidentally reflects the current position in the UK; specialist forensic child and adolescent hospital facilities are seriously underprovided. This is also true for forensic psychotherapy – another 'super specialty', of great importance to maintaining the effectiveness of treating clinicians in this field as to treating the offender-patients; in this case the specialist services tend to be geographically limited. We touch, too, on vital overlaps with other recognised specialties – the psychiatry of intellectual disability and of old age – and expert areas such as the treatment of substance misuse disorders.

We have a complete chapter on victims. We see them as at the heart of forensic psychiatry. The prevention of harm to others is one important aim of forensic psychiatry. Victims not only have their own set of medico-legal problems, but some of them turn their fears and their anger back on to society in antisocial reactions. Some adults have a complete personality change as a result of trauma. Victimization during childhood often seriously affects the development of the growing personality. Most offender-patients are themselves victims in one way or another.

Although we acknowledge the medical bias in the text, it is not written exclusively for medical practitioners. We aim to provide information which will also be helpful to nurses, psychologists, social workers, probation officers, lawyers, politicians and police officers, among others. This is a tall order, but we believe that, for example, it is useful for a probation officer to have ready access to a medical perspective. We urge our students and trainees to read into other disciplines. We hope that members of other disciplines will urge their students to read this book. We hope, too, that professionals who are dealing with a healthier population than we usually do will find some assistance from a closer understanding of the extent of the psychopathology, its development and management among many offenders. Other aspirations are that forensic psychiatry will begin to contribute to the prevention of disease and to the prevention of a part of the spectrum of antisocial behaviour. This could not be, however, without effective communication throughout psychiatry, with other clinical disciplines and with other relevant agencies, promoting mutual understanding and cooperation. Effective multidisciplinary and multi-agency work emerges from the advantage of real differences between the disciplines only

when their members understand each other's strengths and limitations, and are confident in this knowledge and in comfortable, accurate and regular communication.

A comment is needed on one or two matters of style. First, author attributions: it has been impossible to acknowledge everybody who has contributed ideas and inspiration to this book. We have tried, however, to attribute correctly and fairly everyone who has written something original for the book. Some people have done much more than others and all have been subject to editing, mainly to try and minimise repetition in a lengthy volume, but also to achieve consensus where possible. A consensus approach was harder with some chapters than others, but where more extensive negotiation was needed to agree the script, we think we finished with much better chapters than ever we would have had if left to write the material ourselves and without challenge; we ourselves have been learning throughout the process. The attributions at the heads of the chapters are intended to reflect this. Most contributors are listed in alphabetical order at the beginning of each chapter to which they contributed, but within the chapters we have tried to avoid demarcations. We also introduce the authors in alphabetical order at the front of the book, and here provide a clearer indication of their contribution. This second edition of the text is largely new, and some of the chapters did not exist at all in the first edition, but we remain grateful to all the first edition authors who paved the way with us for this volume. Many were brave enough to write with us again, some are long since retired and some no longer with us at all. We have also listed all of them at the front of each chapter to which they originally contributed.

Our referencing is based on the Harvard system. We have included (we hope) a complete list at the end of the book giving full journal titles and publishers' names where appropriate. Readers should also be able to use this list as an author/article index. 'Cases cited' are referred to in the text by an identifying name. This name may have no meaning or significance beyond this textbook, but it will lead to the alphabetical list of legal references, which can also be used as an index. Where appropriate some of the references are given as World Wide Web addresses. We are conscious of the ephemeral nature of such references but some materials, for example, some government documents, are published only in this format. In any case we urge readers to use search engines (e.g. Google) and Wikipedia – to amplify their studies. Both have limitations, and Wikipedia acknowledges some inaccuracies. Both are useful for initiating searches for knowledge, but students and other surfers must not assume that if information cannot be retrieved by computer it does not exist! Some journals are now archiving all their old material for computer access but they are in the minority. We have included many important references which still require a visit to library shelves.

This edition has the advantage that it is published on paper and electronically. The electronic version includes links which should give direct access to the Web by clicking on them. We say 'should' because web pages are ephemeral – here today, gone tomorrow. UK government departments, for example, almost pride themselves on constantly changing their web sites. As we wrote the book links disappeared, web pages changed. All we can say is that the links given worked the last time we checked them. If a link is now missing or 'broken', a conventional search will usually find a more recent address or a message that the page has been deleted.

Abbreviations have been obsessionally listed and defined. This is partly to help non-medical readers but, as acronyms have multiplied, we found we needed them ourselves. Sometimes we have been quite conflicted about the use of abbreviations. An example is the use of PD for personality disorder. It is so much shorter to write this, but we have a sense that this is an abbreviation which may serve as a dehumanising device, and it reinforces reification (see Introduction page 8), so we have used this abbreviation sparingly. Otherwise we have tended to follow standard practice of spelling out a word or phrase in full on its first use in the text, and then using its abbreviation.

Our references give a reasonably comprehensive entrance into the factual and academic literature pertinent to forensic psychiatry. They omit, however, that wider literature which should be read for other insights: plays, novels, poetry and opera. There would be so much to include here – everything from Shakespeare's *Othello*, to Pushkin's *Queen of Spades*, from Ibsen's *Hedda Gabler* to Fowles's *The Collector*. Murray Cox, for many years a consultant psychotherapist at Broadmoor hospital and an honorary research fellow of the Shakespeare Institute at the University of Birmingham, never tired of using Shakespeare to illuminate inner processing of ideas and feelings – on the part of patients and observers, including therapists (Cox and Theilgaard, 1994). Furthermore, he was instrumental in getting leading national theatrical companies to perform Shakespeare for the patients (Cox, 1992), after which the actors joined groups with patients and staff to discuss something as difficult as their responses to *King Lear*. Gordon et al. (2007) considered the legacy of this work to that date.

In the preface to our first edition we included an extract from the remarkable early nineteenth century English poem *Peter Grimes* by George Crabbe (e.g. Opie and Opie, 1983).

He fished by water and he filched by land; ...
But no success could please his cruel soul,
He wished for one to trouble and control,
He wanted some obedient boy to stand
And bear the blow of his outrageous hand,
And hoped to find in some propitious hour
A feeling creature subject to his power ...
Some few in town observed in Peter's trap
A boy, with jacket blue and woollen cap; ...
Pinned, beaten, cold, pinched, threatened and abused –
His efforts punished and his food refused – ...
The savage master grinned in horrid glee ...
For three sad years the boy his tortures bore,
And then his pains and trials were no more ...
Another boy with equal ease was found,
The money granted and the victim bound
And what his fate? – One night it chanced he fell
From the boat's mast and perished in her well,
Then came a boy, of manners soft and mild – ...
His liquor failed and Peter's wrath arose –
No more is known – the rest we must suppose, ...
The mayor himself with tone severe replied –
'Henceforth with thee shall never boy abide,' ...
The sailors' wives would stop him in the street,
And say, 'Now, Peter, thou'st no boy to beat' ...
He growled an oath, and in an angry tone
Cursed the whole place and wished to be alone ...
Cold nervous tremblings shook his sturdy frame,
And strange disease – he couldn't say the name,
Wild were his dreams, and oft he rose in fright,
Furious he grew, and up the country ran,
And there they seized him – a distempered man.
Him we received, and to a parish-bed,
Followed and cursed, the groaning man was led ...
The priest attending, found he spoke at times
As one alluding to his fears and crimes; ...
'But, gazing on the spirits, there was I.

They bade me leap to death, but I was loath to die:

And every day, as sure as day arose,

Would these three spirits meet me ere the close'...

...– but here he ceased and gazed

on all around, affrightened and amazed; ...

Then dropped exhausted and appeared at rest ...

Then with an inward, broken voice he cried,

'again they come' and muttered as he died.

Thus is set out the career of one who might now be imprisoned, so that psychiatrists can declare that he has 'no formal mental illness' and is quite unsuitable for the parish bed. Clearly, this was based on an astute real life observation; a man who had an abnormal relationship with his father, became a young delinquent, found a way of acquiring young boys and sadistically controlling and then killing them and, when reviled, became increasingly isolated, then psychotic, ending his life in an institution. This story is so powerful that it has also been dramatized in operatic form, under the same title, by Benjamin Britten and the librettist Montagu Slater.

Here we also want to draw attention to the remarkable American author Herman Melville, perhaps best known for *Moby Dick* published in 1851; Melville also wrote some remarkable novellas which illustrate truths which are not always immediately noticed in patients. Perhaps the most obvious of these short stories is *Bartleby, the Scrivener*. Bartleby is a clerk who works for a Manhattan lawyer who is engaged to do nothing but copy manuscripts. This suits Bartleby perfectly and all is well until he is asked to deviate a little and do some proofreading. He simply replies 'I would prefer not to' and it is soon apparent that his limitation leads to conflict within others; the narrator, his employer, clearly has some sympathy for the man, but eventually finds him intolerable. Finally, the pressure to be flexible leads to the vulnerable Bartleby's psychological collapse. He ends up doing nothing and sleeping rough, finally dying of starvation. The story is a great stimulus to psychological discussion as to his condition.

Melville also has another psychological novella up his sleeve, this time concerned with a range of complex emotions present on a British warship in the Napoleonic Wars. *Billy Budd* is a Christ-like character who is stigmatised by his stammer which can lead to outbursts of rage. The story also deals with homosexual jealousy and bullying by a cruel Master at Arms of limited ability. Billy, unable to defend himself verbally, has a fit of rage and kills the Master at Arms, who has wrongly accused him. The apparently fair-minded captain is tormented by his conflict between his humanity and his duty to naval law. As with the Crabbe poem, Benjamin Britten picked up the power of this story and brilliantly portrayed it in an opera of the same name. A 2010 production of the opera at Glyndebourne was reviewed in *The Independent* by Anna Picard in the following terms:

Pressed into service on HMS Indomitable, blithely ignorant of the mutinous associations of the name of his former ship, The Rights o' Man, Billy Budd doesn't know how old he is. Abandoned at birth, he is a motherless child – cousin to Peter Grimes's workhouse prentices. .....What is Billy's defect? His stammer? His innocence? Why is Claggart set on his destruction? ..... (Michael) Grandage's handsome, disciplined, period staging returns to the interior moral tragedy of Herman Melville's novella, eschewing the "sexual discharge gone evil" that librettist E M Forster believed to be the core of Claggart's ..... malevolence. De-sexing his sadism puts the focus on institutional brutality: the floggings, the press gang, the tension of a mass of men adrift in a vessel with no purpose but to attack an enemy few of them will ever see..... my angry contempt....was for the Captain, Vere. He exemplified Edmund Burke's statement: The only thing necessary for the triumph of evil is for good men to do nothing.

These books and operas seem particularly relevant for forensic psychiatry. When studying textbooks and Acts of Parliament has induced lethargy and boredom, trainee and specialist alike could do worse than immerse him or herself in Britten's operas, Melville's stories and other such works.

John Gunn

Pamela J. Taylor

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Legislation*

* This list itemises the legislation referred to in the text. It is in chronological order within the jurisdictions shown to illustrate the way in which law has grown in forensic psychiatry.

List of Abbreviations

5-HIAA	5-hydroxy-indole acetic acid
5-HT	5-hydroxytryptamine/serotonin
5-HTT	5HT transporter
A	adnenine, one of the four nitrogenous bases in the repeating units (nucleotides) in a strand of DNA
A&E	Accident and Emergency departments (UK)
a^2	relative contribution of additive genetic influences on a phenotype
AA	Alcoholics Anonymous
AAFS	American Academy of Forensic Sciences
AAI	Adult Attachment Interview
AAPL	American Academy of Psychiatry and the Law
ABA	applied behavioural analysis
ABS	Australian Bureau of Statistics
AC	approved clinician
ACC	Association of County Councils
ACCT	Assessment, Care in Custody and Teamwork system (prisons in England and Wales)
ACE	Assessment of clinical expertise
ACE	Assessment Case Management and Evaluation System (Gibbs, 1999; Raynor et al., 2000)
ACGME	Accreditation Council for Graduate Medical Education
ACMD	Advisory Council on the Misuse of Drugs (UK)
ACPO	Association of Chief Police Officers
ACSeSS	Admission Criteria of Secure Services Schedule
ACT	acceptance and commitment therapy
ACT	Assertive Community Treatment
ADH	alcohol dehydrogenase
ADHD	attention deficit hyperactivity disorder
ADSS	Association of Directors of Social Services
A + E	accident and emergency
ÆSOP study	Aetiology and Ethnicity in Schizophrenia and other Psychosis study (Europe)
AIAQ	Anger, Irritability, and Aggression Questionnaire
AIDS	acquired immunodeficiency syndrome
AIP	adaptive information processing
AKA	also known as
ALDH	aldehyde dehydrogenase
ALI	American Law Institute
AMA	American Medical Association
AMHP	approved mental health professional
AMP	approved medical practitioner – training and special experience in the diagnosis and treatment of mental disorder
AP	antisocial potential
APA	American Psychiatric Association
ASB	antisocial behaviour
ASBO	antisocial behaviour order
ASP	affected sibling pairs
ASPD	antisocial personality disorder
ASRO	addressing substance related offending
ASSET	Young Offender Assessment Profile

ASW	approved social worker
ATD	acute tryptophan depletion
AUC	area-under-the-curve, a statistical measure of receiver operator characteristics (ROC)
AUDIT	Alcohol Use Disorders Identification Test (Saunders et al., 1993)
BAP	British Association of Psychopharmacology
BC	Before Christ
BCS	British Crime Survey
BDH	Buss–Durkee Hostility Inventory
BDNF	brain-derived neurotrophic factor
BIS	Barrett Impulsivity Scale
BMA	British Medical Association
BME	black and/or minority ethnic status
BMJ	*British Medical Journal*, renamed *BMJ*
BNF	British National Formulary (http://BNF.org)
BPD	borderline personality disorder
BPRS	Brief Psychiatric Rating Scale (Overall and Gorham, 1962)
BVS	Brøset Violence Checklist (Almvik and Woods, 1998)
BWS	battered woman syndrome
c	*circa* (Latin) = around or approximately
C	cytosine, one of the four nitrogenous bases in the repeating units (nucleotides) in a strand of DNA
CALM	Controlling Anger and Learning to Manage it, a CBT based treatment programme
CAMHS	child and adolescent mental health services
CARAT	Counselling Assessment Referral Advice and Throughcare service (for substance misusers in prison)
CARAT	Counselling, Assessment, Referral and Advice
CART	classification and regression trees
CASC	clinical assessment of skills and competencies (a tool)
CASK	caregiver associated serial killings
CAST	Creative and Supportive Trust (a voluntary organization)
CaStANET	Cardiff Study of All Wales and North West of England Twins
CAST-MR	Competence Assessment to Stand Trial – Mental Retardation (Everington and Luckasson, 1992)
CAT	cognitive analytical therapy (Ryle, 1993)
CAT	computerized axial tomography
CATIE	Clinical Antipsychotic Trials of Intervention Effectiveness (US National Institute of Mental Health funded trials of antipsychotic medication)
CBD	case based discussion
CBNT	cognitive behaviour nursing therapy
CBT	cognitive behaviour therapy
CCJS	Centre for Crime and Justice Studies
CCT	client-centred therapy
CCT	completed certificate of training
CCTV	closed circuit television
CDRP	Crime and Disorder Reduction Partnership
CDVP	Thames Valley Community Domestic Violence Programme
CEMACH	the Confidential Enquiry into Maternal and Child Health
CESDI	Confidential Enquiry into Stillbirths and Deaths in Infancy
CGI-I	Clinical Global Impression Rating of Improvement
CHAID	Chi-squared automatic iteration detector, a statistical technique used in developing the COVR (*qv*)

CHIRRP	Canadian Hospitals Injury Reporting and Prevention Programme
CI	confidence interval, representing the generally accepted confidence limits in relation to an odds ratio
CIRCLE	Chart of Interpersonal Relations in Closed Living Environments
CISH	(National) Confidential Inquiry into Suicide and Homicide by People with Mental Illness (England and Wales)
CIS-R	Clinical Interview Schedule-Revised
CISS	Christo Inventory for Substance-misuse Services (Christo, 2000)
CJITs	Criminal Justice Integrated Teams
CJS	Criminal Justice System
CJ(s)A	Criminal Justice (Scotland) Act 2003
CL(I)A	Criminal Law (Insanity) Act
CM(T)	contingency management (therapy)
CNS	central nervous system
CNV	copy number variants
COMT	catechol-O-methyl transferase
CONI	Care of Next Infant scheme
COVR	The Classification of Violence Risk ©, (Monahan et al., 2005a)
CP	case presentation
CPA	Care Programme Approach (Department of Health, 1990b, 1995, 1999b)
CPD	continuing professional development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPR	Civil Procedure Rules
CPRS	Comprehensive Psychopathological Rating Scale (Åsberg et al., 1978)
CPS	Crown Prosecution Service
CP(s)A	Criminal Procedure (Scotland) Act (1995)
CPT	cognitive processing therapy (CPT)
CPT	Committee for the Prevention of Torture, Inhuman and Degrading Treatment or Punishment (Council of Europe)
CQC	Care Quality Commission
CRF	corticotrophin-releasing factor/hormone
CRS	Civil Registration System (Denmark)
CS	conditioned stimuli (see also US, unconditioned stimuli)
CSCP	Cognitive Self Change Programme
CSF/csf	cerebrospinal fluid
CT	cognitive therapy
CT	computerized tomography
CTO	Compulsory Treatment Order
CUDIT	Cannabis Use Disorders Identification Test (Adamson and Sellman, 2003)
CWSU	Cardiff Women's Safety Unit
DARE	Database of Abstracts of Reviews of Effects, a database of systematic reviews not confined to randomized controlled trials
DASA	Dynamic Appraisal of Situational Aggression (Ogloff and Daffern, 2006)
DAT	Drug Action Team
DBT	dialectical behaviour therapy
DC	District of Columbia
Dept.	department
DESNOS	Disorders of Extreme Stress Not Otherwise Specified
DFSA	drug-facilitated sexual assault
DH	Department of Health (England)

DHSS	Department of Health and Social Security (England)
DHSSPS	Department of Health, Social Services and Public Safety (Northern Ireland)
DIP	Drug Interventions Programme
DMP	Designated Medical Practitioner
DNA	deoxyribonucleic acid, which contains the genetic instructions for the development of living organisms
DoH	Department of Health (England)
DoJ	Department of Justice (Northern Ireland)
DOL	deprivation of liberty
doli incapa	incapable of crime (Latin)
DOM	Director of Offender Management
DPCR	Danish Psychiatric Central Register
DPP	Detention for Public Protection
DRROs	Drug Rehabilitation Requirement Orders (Criminal Justice Act 2003)
DSM	*Diagnostic and Statistical Manual*, the US based disease classification system, often referred to with a number as a suffix to indicate the edition (e.g. *DSM-II*, *DSM-III*, *DSM-III-R*, *DSM-IV*)
DSM-III-R	*Diagnostic and Statistical Manual*, 3rd edition revised.
DSM-IV	*Diagnostic and Statistical Manual* (of Mental Disorders), 4th edition (American Psychiatric Association, 1994)
DSM-IV TR	*Diagnostic and Statistical Manual* (of Mental Disorders) 4th edition revised
DSM-V	*Diagnostic and Statistical Manual of Mental Disorders,* 5th edition
DSPD	dangerous and severe personality disorder
DT	delirium tremens
DTI	diffusion tensor imaging
DTTOs	Drug Testing and Treatment Orders (Crime and Disorder Act 1998)
DUDIT	Drug Use Disorders Identification Test (Berman et al., 2005)
DVCV Act 2004	Domestic Violence, Crime and Victims Act 2004
DVLA	Driver and Vehicle Licensing Agency (UK)
DZ	dizygotic, twins developed from two different eggs
E	environment
e^2	Relative contribution of non-shared environmental influences on a phenotype
ECA	Epidemiologic Catchment Area study (USA)
ECF	Executive Cognitive Function
ECHR	European Convention on Human Rights or European Court of Human Rights according to context
ECS	The Exceptional Case Study, a US based study of assassins or people who threaten
ECT	electroconvulsive therapy
Ed./ed.	editor/edited
EE	expressed emotion
EEG	electroencephalogram, recording of the electrical traces of brain activity
e.g.	*exempli gratia*, Latin: = for example
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMDR	Eye Movement Desensitization and Reprocessing
EMG	electromyography, recording of the electrical traces of skeletal muscle activity
EPA	Enduring Power of Attorney
EPQ	Eysenck Personality Questionnaire (Eysenck and Eysenck, 1975)
EPS	extrapyramidal signs
ER	emergency room
ERASOR	Estimate of Risk of Adolescent Sexual Offense Recidivism
et al.	and others (Latin)
ETS	Enhanced Thinking Skills (Clark, 2000)

EU	European Union
f	feminine/female
FACTS	Forensic Adolescent Consultation and Treatment Service
FDA	Federal Drugs Agency, the body in the USA which approves drugs for prescription in medical practice.
ff	and the following pages
FGA	first generation antipsychotic medication, also referred to as 'typical' or 'conventional' antipsychotics/neuroleptics (see Chapter 23)
FII	factitious and induced illness (Munchausen syndrome by proxy)
FIP	family intervention project
FIPTS	Forensic Intensive Psychological Treatment Service (S. London)
FIRS	Fire Interest Rating Scale
FME	forensic medical examiner (formally police surgeon)
FMH/fmh	forensic mental health
fMRI	functional magnetic resonance imaging
FOTRES	Forensic Operationalized Therapy/Risk Evaluation System (Urbaniok, 2009)
FSAS	Fire-Setting Assessment Schedule (Murphy and Clare, 1996)
FTAC	Fixated Threat Assessment Centre, a UK based unit for assessment and management of people who threaten, mainly public figures
FTD	frontotemporal dementia
g	gene
G	guanine, one of the four nitrogenous bases in the repeating units (nucleotides) in a strand of DNA
G/g	gram
GABA	gamma aminobutyric acid
GAF	Global Assessment of Functioning Scale
GAM-anon	Gamblers Anonymous
GHB	gamma-hydroxy butyric acid
GHQ12	General Health Questionnaire 12 (Goldberg, 1992)
GMC	General Medical Council
GnRH	gonadotropin-releasing hormone
GP	General Practitioner (primary care physician; family doctor) (UK)
GPI	general paralysis of the insane (a neuro-psychiatric complication of syphilis)
GSS	Gudjonsson Suggestibility Scales (Gudjonsson, 1997)
GWA	genome wide analysis
GWAS	genome wide association studies
HAC	Health Advisory Committee for the Prison Service
HCR-20	The Historical Clinical and Risk Management Scale
HIA syndrome	hyperactivity-impulsivity-attention deficit syndrome (Loeber, 1988)
HIPP	Health in Prisons Project (World Health Organization)
HIV	Human Immunodeficiency Virus
HIV/AIDS	acquired immunodeficiency syndrome, a disease of the human immune system
HM	Her Majesty's
HMAG	Her Majesty's Attorney General
HMCS	Her Majesty's Court Service
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
HONOS	Health of the Nation Outcome Scale for Secure Services
HPA	hypothalamo-pituitary-adrenocortical (hormonal regulatory system)
HPRT	hypoxanthine guanine phosphoribosyl transferase
HRP	Healthy Relationships Programme

i.e.	*id est* Latin = that is to say
IAS	Institute of Alcohol Studies
ibid	*ibidem* Latin = same as above
ICAP theory	Integrated Cognitive Antisocial Potential theory (Farrington, 2005b)
ICD	International Classification of Diseases (World Health Organization)
ICD-10	International Classification of (Behavioural and Mental) Disorders, 10th edn (WHO, 1992)
ICT	Iterative Classification Tree, the outcome of iteration analyses as produced in development of the COVR (*qv*)
ICVS	International Crime Victims Survey
ID	intellectual disability
IDAP	Integrated Domestic Abuse Programme
IDTS	Integrated Drug Treatment System
IED	Intermittent Explosive Disorder
IIP	Interpersonal Problems (Horowitz et al., 1988)
IM	intramuscular
IMB	Independent Monitoring Board (formally, Board of Visitors, Northern Ireland)
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
IPCC	Independent Police Complaints Commission
IPDE	International Personality Disorder Examination (Loranger, 1999)
IPP	indeterminate sentence for public protection
IPT	Imaginal Provocation Test (Novaco, 1975; Taylor et al., 2004)
IPV	intimate partner violence
IQ	intelligence quotient
IRA	Irish Republican Army
IRS	Integrated Resettlement Support
ISTD	Institute for the Study and Treatment of Delinquency
IV	intravenous
JG	John Gunn
JP	Justice of the Peace
J-SOAP	Juvenile Sex Offender Assessment Protocol
KJV	The King James version of the Bible
LD	linkage disequilibrium
LMV	Life Minus Violence programme
LOD	log of the odds that two gene loci are linked
LPA	Lasting Power of Attorney
LSD	lysergic acid diethylamide
LSR-I	Level of Service Inventory-Revised (Andrews and Bonta, 1995)
m	million
m	masculine/male
M	Morgan, 100 centiMorgans (cM), a measure of the distance between loci on a gene
MacCAT-T	MacArthur Competence Assessment Tool for Treatment (Grisso et al., 1997)
MACT	manual assisted cognitive (behavioural) therapy
MADS	Maudsley Assessment of Delusions Schedule (Taylor et al., 1994)
MAO	monoamine oxidase inhibitor, neurotransmitter (in two forms)
MAO-A	monoamine oxidase-A, a neurotransmitter
MAO-B	monoamine oxidase-B, a neurotransmitter
MAOI	monoamine oxidase inhibitors (a class of antidepressant drug)
MAO-LPR	monoamine oxidase linked polymorphic region
MAP	Maudsley Addiction Profile (Marsden et al., 1998)
MAPPA	multi-agency public protection arrangements

MAPPP	Multi-agency Public Protection Panel
MASRAM	Multi-Agency Sex Offender Risk Assessment and Management Arrangements (Northern Ireland)
MATCH (Project)	Matching Alcohol Treatments to Client Heterogeneity (a multi-site clinical trial based in Connecticut, USA)
MBT	mentalization based therapy (Bateman and Fonagy, 2006)
MCA	Mental Capacity Act 2005
MCMI-III	Millon Clinical Multiaxial Inventory, 3rd edition (Millon, 1994)
MCN	managed clinical network
mCPP	meta-chlorophenylpiperazine
MDO	mentally disordered offender
MDT	mode deactivation therapy
Met	methionine, one of the 20 essential proteinogenic amino acids in the genetic code
mg	milligram
MH/mh	mental health
MHA	Mental Health Act
MHA 1959	Mental Health Act 1959 (England and Wales)
MHA 1983	Mental Health Act 1983 (England and Wales)
MHA 2001	Mental Health Act 2001 (Ireland)
MH (C+T)(s)A	Mental Health (Care and Treatment) (Scotland) Act (2003)
MHA 2007	Mental Health Act 2007 (England and Wales)
MHAC	Mental Health Act Commission
MHC	major histocompatibility complex
MHO	Mental Health Officer
MHRB	Mental Health Review Board
MHRT	Mental Health Review Tribunal
MHT	Mental Health Tribunal, First Tier Tribunal (Mental Health)
MHTR	Mental Health Treatment Requirement, condition attached to a community sentence for offenders with mental disorder under the Criminal Justice Act 2003, England and Wales
MHU	Mental Health Unit
MI	motivational interviewing
MI5	Military Intelligence (Section 5) (mainly UK)
MI6	Military Intelligence (Section 6) Secret Intelligence Service (Worldwide)
mini-ACE	mini Assessment of clinical encounter
mini-PAT	mini peer assessment tool
ml	millilitre
MMPI	Minnesota Multiphasic Personality Inventory
MMPI/MMPI-II-PD	Minnesota Multiphasic Personality Inventory/MMPI-II-Personality Disorder Scales (Morey et al., 1985)
MOAS	Modified Overt Aggression Scale (Sorgi et al., 1991); the original OAS was devised by Yudovsky et al. (1986)
MoD	Ministry of Defence
MoJ	Ministry of Justice
MP	Member of Parliament
MPA	medroxyprogesterone acetate
MPhil	Master of Philosophy (research degree)
MRI	magnetic resonance imaging
mRNA	messenger RNA
MRS	magnetic resonance spectroscopy
MSU	medium security unit
MWC	Mental Welfare Commission for Scotland

MZ	monozygotic (twins developed from the same egg)
N or n	number in sample
NA	Narcotics Anonymous (international)
NAA	N-acetyl aspartate
NACRO	National Association for the Care and Rehabilitation of Offenders – a voluntary organization
NAS	Novaco Anger Scale (Novaco, 2003)
NCCMH	National Collaborating Centre for Mental Health (part of NICE)
NCEPOD	the National Confidential Enquiry into Patient Outcome and Death
NCG	National Commissioning Group
NCI	National Confidential Inquiry into Suicide and Homicide (www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci)
NCISH	National Confidential Inquiry into Suicide and Homicide (UK)
NCR	National Crime Register (Denmark)
NCRS	National Crime Recording Standards
NCVO	National Council for Voluntary Organizations (England)
NCVS	National Crime Victimization Survey (USA)
NDPB	non-departmental public body
NEMESIS	Netherlands Mental Health Survey and Incidence Study
NESARC	National Epidemiologic Survey on Alcohol and Related Conditions (USA)
NGRI	not guilty by reason of insanity
NHS	National Health Service (UK)
NHSE	National Health Service Executive
NI	Northern Ireland
NICE	National Institute for Clinical Excellence (England)
NIDA	National Institute on Drug Abuse (USA)
NIMHE	National Institute for Mental Health in England
NIPS	Northern Ireland Prison Service
NMC	Nursing and Midwifery Council
NOMS	National Offender Management Service
NPIA	National Police Improvement Agency
NPSA	National Patient Safety Agency
NPY	neuropeptide y
NSF	National Service Framework
NSPCC	National Society for the Prevention of Cruelty to Children
NTA	National Treatment Agency for Substance Misuse (an NHS organization for England only)
NTORS	National Treatment Outcome Research Study (UK)
NZ	New Zealand
OAS	overt aggression scale
OAS-M	Overt Aggression Scale-Modified
OAS-R	Overt Aggressive Symptom-Revised
OASyS	offender assessment system
OBP	offending behaviour programmes
OCD	obsessive-compulsive disorder
OCJR	Office for Criminal Justice Reform
OGRS	Offender Group Reconviction Scale
OHPA	Office of the Health Professions Adjudicator
OLR	order for lifelong restriction (Scotland)
OM	offender manager (probation officer working directly with a convicted offender) (England and Wales)
ONS	Office for National Statistics
op cit	*opus citatum* (the work cited) (Latin)

OPCAT	operational protocol on the convention against torture
OPD	operational psychodynamic diagnostics (Cierpka et al., 2007; OPD Task Force, 2008)
OR	odds ratio, a statistical term indicating likelihood
OSAPs	offender substance abuse programmes
p.	page or plural according to context (see also pp.)
PACE	Police and Criminal Evidence Act 1984
PACS	Profile of Anger Coping Skills (Willner et al., 2005)
PACT	Prisoners Advice and Aftercare Trust
PAI	The Personality Assessment Inventory (Morey, 1991)
PALS	Patient Advice and Liaison Service
para.	paragraph
PAS	Personality Assessment Schedule (Tyrer, 2000)
PAS-R	Personality Assessment Schedule, rapid version (Tyrer and Cicchetti, 2000)
P-ASRO	Prisons – Addressing Substance Related Offending Programme
PBNI	Probation Board for Northern Ireland
PCL-R	Psychopathy Checklist – Revised (Hare, 1991); factor 1 affective, factor 2 lifestyle
PCL-SV	Psychopathy Checklist, Screening Version
PCSOT	post-conviction sex offender testing
PCT	primary care trust
PD	personality disorder
PDP	potentially dangerous persons (Northern Ireland)
PDQ4+	Personality Disorder Questionnaire 4+ (Hyler, 1994)
PE	prolonged exposure (CBT)
PERI	Psychiatric Epidemiology Research Interview (Dohrenwend et al., 1986)
per se	in itself (Latin)
PET	positron emission tomography (see also SPET)
PhD	Doctor of Philosophy (higher research degree)
PI	Provocation Inventory (Novaco, 2003)
PICLS	prison mental health in-reach and court liaison service (Ireland)
PICU	psychiatric intensive care unit.
PIPE	psychologically informed planned environment
PITO	Police Information Technology Organization
PLOS	*Public History of Science* – open access journal
PMETB	Postgraduate Medical Education and Training Board
PMMT	prison-based methadone maintenance treatment
PMRS	prison medical record system
PNBI	Probation Board for Northern Ireland
PORT	the schizophrenia Patient Outcomes Research Team, a US based review group (e.g. (Dixon et al., 2009)
pp.	pages
PPANI	Public Protection Arrangements (Northern Ireland)
PPG	penile plethysmograph
PPI	Psychopathic Personality Inventory
P-ASRO	Prison – Addressing Substance Related Offending
PsyD	Doctor of Psychology (degree)
PTA	post-traumatic amnesia
PTSD	post-traumatic stress disorder
QACSO	questionnaire on attitudes consistent with sex offences (Broxholme and Lindsay, 2003; Lindsay et al., 2007)
QT_C	The interval between the Q and the T in an electrocardiogram crudely corrected for the speed of the heart

qv	*quod vide* (Latin) = see text elsewhere in chapter
r or R	Pearson's product moment correlation coefficient
R&R	Reasoning and Rehabilitation (Porporino and Fabiano, 2000)
RAO	Risk Assessment Order (Scotland)
RAP	resettlement and aftercare provision
RAPT	Rehabilitation of Addicted Prisoners Trust
RATED	Risk assessment tools evaluation directory
RC	responsible clinician (a technical term for the person in legal charge of the case of a detained person under mental health legislation in England and Wales; this person may be a psychiatrist, but may be any other qualified clinician who has had the necessary training)
RCT	randomized controlled trial
REBT	rational emotive behaviour therapy
RECON	Relationship and context based
REM	sleep: rapid eye movement sleep
RMA	Risk Management Authority (Scotland)
RMO	responsible medical officer (a technical term with similar meaning to RC (qv) but referring only to a psychiatrist with special training; in current use in Scotland, used in England and Wales before the Mental Health Act 2007)
rMZ/rDZ	resemblance rates between mono- and di-zygotic twins
RNA	ribonucleic acid, similar to DNA, but with some structural and functional differences. Has a role, and some influence on gene expression
rnhs	representative national household survey (US)
ROC	receiver operating curve
ROC	receiver operator characteristics, a signal frequency measure, commonly applied to evaluation of risk assessment
RP	relapse prevention
RQIA	Regulation and Quality Improvement Authority (Northern Ireland)
R R	relative risk
RSVP	Risk for Sexual Violence Protocol
s.	section of an act
SA	*Staphylococcus aureus*
SAP	Standardized Assessment of Personality (Pilgrim and Mann, 1990; Pilgrim et al., 1993)
SARN	Structured Assessment of Risk and Need
SCAN	Schedule for Clinical Assessment in Neuropsychiatry (WHO, 1992b)
SCH	secure children's home
sch.	schedule (usually of an act of Parliament)
SCID	Structured Clinical Interview for DSM-IV Axis I and II disorders
SCID-II	Structured Clinical Interview for DSM-IV Axis II disorders (First et al., 1997)
SCL	symptom check list (usually with 90 items)
SCT	supervised community treatment
sd	standard deviation
SDAs	service discipline acts
SDPs	Short Duration Programmes
SEP	supportive expressive therapy
SES	socioeconomic status
SFT	Schema focused therapy (Young 1994; Young et al., 2000)
SGA	second generation antipsychotic, also referred to as atypical antipsychotics/neuroleptics (see Chapter 23)
SHAPS	Special Hospitals Assessment of Personality and Socialization (Blackburn, 1986),
SIDS	Sudden Infant Death Syndrome ('Cot Death')
SMI	severe mental illness

SMS	short message service (on a telephone)
SNAP	security needs assessment profile
SNP	single nucleotide polymorphism
SOAD	second opinion appointed doctor
SOGS	South Oaks Gambling Screen
SONAR	Sex Offender Needs Assessment Rating
SOTP	Sex Offender Treatment Programme
SOVA	Safeguarding of Vulnerable Adults – voluntary organisation
SPECT	Single Photon Emission Tomography
SPET	Single Positron Emission Tomography
SPQ	Schizotypal Personality Questionnaire (Raine, 1993)
SRA	Structured Risk Assessment
SRB	suicide related behaviours
ss.	sections
SSKAT	Socio-Sexual Knowledge and Attitudes Test (Wish et al., 1980)
SSRIs	selective serotonin reuptake inhibitors (a class of antidepressants, international)
STAI	State-Trait Anxiety Inventory
STAIR-MPE	Skills training in affective and interpersonal regulation plus modified prolonged exposure
Staph aureus	*Staphylococcus aureus*
STAXI	Spielberger State-Trait Anger Expression Inventory (Spielberger, 1996)
STC	secure training centre
STEPPS	Systems training for emotional predictability and problem solving
SUD	substance use disorder
SUDS	Subjective Units of Disturbance Scale (Wolpe, 1982)
SUIDS	Sudden Unexpected Infant Death Syndrome ('Cot Death')
SVP	sexually violent predator
SVR-20	Sexual Violence Risk – 20 scale
T	thymine, one of the four nitrogenous bases in the repeating units (nucleotides) in a strand of DNA
TAU	treatment as usual
TBI	traumatic brain injury
TBS (Terbeschikkingstelling)	(Dutch – available to the government)
TC	therapeutic community
TCO (sometimes written T/C-O)	threat control override symptoms (of psychosis)
TF-CBT	trauma focused CBT
TFCT	trauma-focused cognitive therapy
ToM	Theory of Mind
TPH	tryptophan hydroxylase
TSO	The Stationery Office (UK Government Printer)
TTD	transfer for treatment direction s136 MH (C + T)(s) Act 2003
UK	United Kingdom of Great Britain and Northern Ireland
UKATT	United Kingdom Alcohol Treatment Trial
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
UKDPC	United Kingdom Drugs Policy Commission (UK)
UN	United Nations
us	unconditioned stimuli
USA/US	United States of America
val	valine, one of the essential proteinogenic amino acids in the genetic code
VCU	Victim Contact Unit (run by Probation Boards in England and Wales)

VIM	violence inhibition mechanism
ViSOR	Violence and Sexual Offenders Register
viz	*videlicet* (*videre licet*), Latin = that is, namely, or to wit
VLO	Victim liaison officer (probation officer with special training in work with victims of crime (England and Wales)
VOC	Validity of Cognition Scale (Shapiro, 1989)
VRAG	Violence Risk Appraisal Guide (Quinsey et al., 1998)
VRP	Violence Risk Program (Gordon and Wong, 2000; Wong et al., 2007, 2007)
VSO	voluntary sector organization
WAIS	Wechsler Adult Intelligence Test (Wechsler, 1999)
WARS	Ward Anger Rating Scale (Novaco, 1994)
WE	Wernicke's encephalopathy
WFSBP	World Federation of Societies of Biological Psychiatry
WHO	World Health Organization
WMA	World Medical Association
YJB	Youth Justice Board
YOI	Young Offenders' Institution
YOT	Youth Offending Team

1
Introduction

John Gunn and Pamela J Taylor

Forensic psychiatry is the prevention, amelioration and treatment of victimization which is associated with mental disease. (Gunn and Taylor 1993)

FORENSIC PSYCHIATRY

Forensic psychiatry is often regarded simply as that part of psychiatry which deals with patients and problems at the interface of the legal and psychiatric systems. Several definitions of it exist, partly reflecting its complexity. The definitions have a common core, but each highlights some special aspect of the work. The Royal College of Psychiatrists (2010) emphasizes *working with others* to assess, manage and treat people with mental disorders associated with offending and dangerous behaviour, and that recognition as a specialist in forensic psychiatry follows from specialist training which builds on more general psychiatric training. The American Academy of Psychiatry and the Law (AAPL) (2005) says:

> *Forensic Psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment.*

For us, forensic psychiatry is more than that. We recognize all these features, but we see it as essential to include thinking about victims of crime, abuse, neglect and deprivation. This is partly because we envisage a duty to help them for their own sake, and partly because this, in turn, is at the core of prevention of harm or its repetition against others and, indeed, against self. So often there is ambivalence as to who will sustain the most physical harm – the aggressor or his/her target, but always there are waves of other people affected – lovers, children and other family as well as the great mass of the wider public who must pay in some way for the disruption.

> *Now nothing mattered: going or not going to Vozdvizhenskoe, getting or not getting a divorce from her husband…The only thing that mattered was punishing him. When she poured out her usual dose of opium, and thought that she had only to drink off the whole bottle to die, it seemed to her so simple and easy that she began musing with enjoyment on how he would suffer, and repent and love her memory when it would be too late.*

Finally, Anna Karenina's punitive drive was more violent and bloody, under a train:

> *…exactly at the moment when the midpoint between the wheels drew level with her, she threw away the red bag, and drawing her head back into her shoulders, fell on her hands under the car, and with a light movement, as though she would rise immediately, dropped on her knees. And at the instant she was terror-stricken at what she was doing. 'Where am I? What am I doing? What for?' She tried to get up, to throw herself back; but something huge and merciless struck her on the head and dragged her down on her back (Tolstoy, 1873–7).*

In this book we include a substantial chapter on the problems of victims and how they may be helped to survive and recover. In the first edition, we offered the definition of forensic psychiatry with which we open this chapter, which seemed to us to be fundamental, which we hoped would lead to more and better therapeutics in this field and which we think may now be regarded as more central than ever to the field. We set out some of the reasons for that below, and expand further on the position in chapter 28. A European definition of forensic psychiatry incorporates this broad approach (Nedopil et al., 2012); forensic psychiatry is

- a specialty of medicine, based on a detailed knowledge of relevant legal issues, criminal and civil justice systems;
- its purpose is the care and treatment of mentally disordered offenders and others requiring similar services, including risk assessment and management, and the prevention of future victimization.

Although this definition does not explicitly refer to medico-legal work, it is presumed within the construct of management. The emphases are on service, on breadth of knowledge and on prevention; the reference to medicine is to capture the concept of a holistic approach with a recognized ethic.

Soon after the current models of forensic mental health service delivery started developing in the UK, one of us proposed a list of seven core skills for forensic psychiatry, as supplements to general psychiatry and basic knowledge of the other recognized psychiatric specialities (Gunn, 1986). We regard research mindedness for all and actual research for some, together with training skills and a capacity for

acknowledging an indefinite need to continue learning as additional background necessities. The seven specialist skills proposed were:

- the assessment of behavioural abnormalities;
- the writing of reports for courts and lawyers;
- the giving of evidence in court;
- understanding and using security as a means of treatment;
- the treatment of chronic disorders, especially those which exhibit behavioural problems, including severe psychoses and personality disorders;
- a knowledge of mental health law;
- skill in the psychological treatments (particularly dynamic and supportive psychotherapies) of behaviour disorders.

Subsequently, the Royal College of Psychiatrists (2010), in setting specialty standards for the General Medical Council and for training purposes, has adopted a competency based approach, which, essentially, builds on these (table 1.1, below).

A VICTIM-CENTRED APPROACH

Most patients who come to forensic psychiatrists are victims of one sort or another. Many have often suffered multiple victimizations, from childhood through into adult life. Early deleterious childhood experiences include poverty, social deprivation, inconsistent discipline, violence and/or sexual abuse, and, once a pattern becomes established, affected individuals often continue to suffer victimization through adult life too. Both our contextual chapters – on the psychosocial milieu and on genetics – as well as the more clinically oriented chapters are pervaded by such issues. One of the great markers of progress since our first edition has been evidence for what was then a largely presumed interaction between harsh psychosocial experience and individual characteristics. Much information about links between early trauma and crime comes from retrospective surveys, but Widom (1989) paved the way towards a more strongly based acceptance of the links with her prospective study of children who had suffered verified abuse, later also showing their vulnerability

Table 1.1 Requirements for competency in formulation at general and specialist levels of training. (Extracted from Royal College of Psychiatrists, 2010b)

The task	Assessment methods	GMP domains
Formulation *at the general level*		
Knowledge		
Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of common psychiatric disorders that affect adult patients	CBD*, CP, CASC	1
Skills		
Integrate information from multiple sources to formulate the case into which relevant predisposing, precipitating and protective factors are highlighted	CBD, CP, CASC	1
Attitudes demonstrated through behaviours		
Provide explanation to the patient and the family which enables a constructive working relationship	ACE, mini-ACE, CBD, CASC	1
Formulation *at the forensic psychiatry level*		
Knowledge		
Understand the balance between the primary duty of care to patients and protecting public safety and take proper account of this in professional decision-making	ACE, CBD, CP supervisor's report	1
Understands the philosophy of retribution, incapacitation, deterrence		
Skills		
Ability to collate and integrate information from clinical, risk and legal evaluation into a detailed formulation	CBD, CP, supervisor's report	1
Ability to develop a psychodynamic formulation		
Attitudes demonstrated through behaviours		
Recognizing the contribution of multi-disciplinary team members and other agencies in assessing patients, incorporating patient perspective	CBD, CP, supervisor's report, mini-PAT	1

*Abbreviations:
ACE: assessment of clinical expertise
CASC: clinical assessment of skills and competencies tool
CBD: case based discussion
CP: case presentation
mini-ACE: mini assesment of clinical encounter
mini-PAT: mini-peer assessment tool
GMP domain: good medical practice domain; for the list of seven seen main text.

to developing mental health problems, including substance misuse, and to completing suicide (Widom and Maxwell, 2001). Nevertheless, risk implies that such progression is not inevitable; Caspi et al. (2002) demonstrated the protective effect of the X-linked gene which encodes monoamine oxidase A (MAOA) in a New Zealand birth cohort study, and were thus able to include prospective or contemporaneous evidence of abuse. In a study with an independent sample, Fergusson et al. (2011), albeit with retrospective victim data collection, confirmed that the combination of experience of abuse in childhood and having low-activity MAOA was significantly associated with later offending and violence, even after controlling for potentially confounding factors such as low socioeconomic status or family dysfunction. None of this is to imply, however, that simple gene–environment interactions provide sufficient explanations for the range of pathways into and out of mental disorder and offending. There is evidence that mental disorder, albeit mainly later mental disorder, is in itself a vulnerability factor for becoming a victim (e.g. Chapple et al., 2004; Teplin et al., 2005; Walsh et al., 2003; and see chapter 14).

Our concept of a victim-centred approach is heavily weighted towards amelioration of symptoms for the victim, restoration of healthy social function, and towards prevention of tertiary problems such as crime. Apart from the possibility of preventing individuals moving from victim to perpetrator status, this last means learning from victims and survivors of crime and building the resultant knowledge into public health models (see also chapter 28). Particularly outside the UK, forensic psychiatrists and psychologists put a lot of emphasis on their work in civil law suits for compensation following accidents. This too is important work, and we do not wish to underplay its value in providing some victims with compensation, particularly when criminal proceedings will not occur and the only recourse against the perpetrators of the harm lies in making them pay financially. Nevertheless, we suggest that while such work may be necessary, it is not sufficient for the victims. Nor is it only victims of crime who have needs beyond financial compensation. When, in the late 1980s, we set up a clinic for the victims of transport disasters such as the sinking of the *Herald of Free Enterprise*, and soldier victims who had been blown up in Northern Ireland, we were concerned and surprised by the number of them who went on to commit violent acts themselves. Almost none of them had ever done such a thing before, and yet one or two attracted substantial prison sentences after being convicted of such offences (see Dooley and Gunn, 1995; Duggan and Gunn, 1995 for a psychological analysis of the sample).

For victims of crime there are also structures by which they may influence the justice process and, perhaps, engage with the criminal justice system in enhancing their own safety. In England and Wales, for example, victims of crime have rights in law to submit statements to the sentencing court and then, when a person has been sentenced to prison or directed to hospital after conviction, to have knowledge about review and release dates and to change conditions of release, for example by requesting an exclusion zone for the offender's movements (see also chapter 28). They are able, for example, to make submissions to the Parole Board and/or to Review Tribunals. Possibly bringing some peace of mind about safety, such processes also offer the victim a chance to feel more in control again of his or her life. These sound ideas and requirements, however, require both adequate financial resources and skilled people to support the victim through the process. In some states of the USA, the expenditure is on supporting a perception that victims of serious crime want or need a more punitive approach; some murderers are executed there, and the relatives of the murdered person may watch the perpetrator being killed. There is, in fact no evidence that such processes help victims in any way, while Prejean (1993) offers anecdotal evidence to the contrary. Once the surviving relatives have had their hate object taken away, then a possibly key coping strategy has been removed, and still neither the state nor any other party provides them with any practical or psychological help for recovery. Not all, but many such people need both the latter, to overcome the psychic trauma of being a victim. The Royal College of Psychiatrists motto, 'there is no health without mental health' is particularly apt in this context.

CONTEXT

'The trouble is he's crazy, the trouble is he drinks' (The Jets, *West Side Story*, Sondheim and Bernstein, 1957). The mix of truth and cynicism attributed to the 'JDs', as they call themselves, in the musical *West Side Story* draws attention to the difficulties facing professionals in psychiatry, social services and the criminal justice system, and indeed facing the clientele themselves. It is worth catching the whole song, which follows the mocking youths' perceptions of how each party to the criminal justice, psychiatric and social process washes its hands of them in turn (www.westsidestory.com/site/level2/lyrics/krupke.html). It is not only 'juvenile delinquents' who truly have wide ranging needs, while barely recognizing them in any real sense and evoking ambivalence in those who have to try and meet those needs, but also people with the complex mix of mental disorder, particularly personality disorder, and offending.

Our focus in this text is on disorders of mental health and their relevance in the criminal justice system, but, in order to provide an adequate service, forensic psychiatrists need a much wider knowledge of medicine than psychiatry alone, and an acquaintance with a wide range of other fields beyond even those often referred to as 'allied professional' fields, such as psychology, nursing and social work. Colleagues from each of these professions have helped us to write this book. In the wider

group of relevant subjects we would include law, criminology, ethics and philosophy.

Starting from a medical perspective, many disorders of physical health are more prevalent among offenders and in turn have implications for how offenders are managed. The most obvious lies in the reason for the old prison medical service in the UK – control of infections (see also chapter 25) – and it remains true that infections are more common among prisoners than in the general population. This is just one of the many reasons why some public health knowledge and skills, and links to public health physicians are all of value. More is known about the health of prisoners than other offender groups, with the sobering recognition that, worldwide, mortality (all causes) is higher, age for age, among prisoners than in the general population (Fazel and Baillergeon, 2011). It is arguable too that, where people are detained in institutions, there is some onus on the detaining authorities to safeguard or even improve the health of their detainees. This may be, paradoxically, particularly hard to achieve in specialist forensic mental health services, where drug treatments which are specific for the psychoses, and often helpful in ameliorating some of the distress and behavioural disturbance associated with the kind of personality disorders suffered by people admitted to such services, have the potential for precipitating serious metabolic disorders. The public health skills which we have just flagged as important for individuals, are also of central importance in preventing victimization and crime (see chapter 28).

Psychiatrists have developed specialties within psychiatry, some of which are fully recognized in the UK as requiring defined and scrutinized specialist training and some which are called subspecialties, requiring particular knowledge and skills, but which are treated less formally in terms of the way in which people acquire those skills. Most are highly relevant to forensic psychiatry. The 'recognized specialities' are general adult psychiatry, forensic psychiatry, child and adolescent psychiatry, psychotherapy, the psychiatry of learning disability and old age psychiatry, while the subspecialties are addictions psychiatry, liaison psychiatry and rehabilitation psychiatry. Without a firm foundation in general adult psychiatry training, there could be no forensic psychiatry. An understanding of developmental processes is so important that a good grounding in child and adolescent psychiatric training is invaluable, but the needs of young people differ sufficiently from the needs of adults that a 'superspecialty' of child and adolescent forensic psychiatry has grown up, coupling higher/advanced training in forensic psychiatry with higher training in child and adolescent psychiatry, lengthening the process by about 12 months to accommodate the extra knowledge and skill development required. Forensic psychotherapy has developed in a similar way, linking recognized training in forensic psychiatry with recognized training in psychotherapy. Forensic learning disability psychiatry is emerging too.

Criminology

British forensic psychiatry has roots, not just in law and in medicine but also in criminology. For some people in continental Europe, Lombroso (1876) is the founder of criminology, with theories of atavism and degeneracy. A prison medical officer, Charles Goring (1913), went to good deal of trouble, using a large sample of British prisoners, to refute Lombroso's ideas. Modern British criminology emerged in the 1930s (Garland, 1988), with the founding of the Association for the Scientific Treatment of Criminals in 1931, before becoming the Institute for the Scientific Treatment of Delinquency (ISTD) in 1932. This led to a 'psychopathic clinic' the following year. In 1937 this became the Portman Clinic, which is still a specialist outpatient psychotherapy unit for people with antisocial behaviour, and especially for men who commit sex offences.

The ISTD separated into two parts in 1951, forming the Institute for the Study and Treatment of Delinquency and the Scientific Group for the Discussion of Delinquency. The latter became the British Society of Criminology in 1961. In its early years the British Society of Criminology looked to psychiatrists to play a prominent part in its affairs, but this slowly changed as criminologists began to question the importance of psychoanalytic theory and as psychiatrists became less interested in psychodynamics and more interested in organic and pharmacological problems. The ISTD had a further metamorphosis in 1999 becoming the Centre for Crime and Justice Studies (CCJS; www.crimeandjustice.org.uk).

Psychiatry and criminology may have grown apart in some respects, but a knowledge of the science of studying patterns in criminal behaviour and the impact of any interventions on these remains important to clinicians as well as criminal justice agencies. Criminologists, often with a grounding in psychology, have pioneered longitudinal, prospective studies of birth cohorts or cohorts of schoolchildren so that a more coherent, evidence based view of pathways into crime has become possible. In chapter 7 David Farrington writes principally about the cohort to which he has devoted his research career, but also references a range of other such studies which have been conducted worldwide. With the added value of genotyping, many of the studies referred to in the genetics chapter follow a similar model. It is mainly to criminologists and social scientists that we turn for evidence of the impact of the various methods of punishment employed by the courts – do they deter? Do they reduce recidivism? Does imprisonment have any harmful impact on prisoners? Psychiatrists are not at the centre of determining such policies, but if they are to work in such institutions as prisons, and have the potential for influencing practice there, they need to be aware of the outputs from both the Home

Office Research Unit (www.homeoffice.gov.uk) and the Ministry of Justice (www.justice.gov.uk) for the UK and from similar governmental bodies in other countries. Inspectorate reports for prison and probation, and occasional relevant reports from the National Audit Office (www.nao.org.uk) can also be useful. The medical profession has a central role in same debates. Since our last issue, for example, Donohue and Levitt (2001) found evidence in the USA of falling crime rates roughly 18 years after abortion was legalized. Other researchers have argued that their statistics were flawed (e.g. Foote and Goetz, 2008), while the position in England and Wales is that a crude link was found using recorded crime data from 1983 through 2001, which did not hold up after allowances were made for other key variables (Di Tella et al., 2008). Nonetheless, these authors consider that the issue is worthy of reflection given the likelihood that wanted children in stable homes are less likely to get caught up in offending than unwanted children placed in care.

Psychological input to criminal justice services is nowadays much more prominently from psychologists than psychiatrists. They have largely driven the development of formal risk assessment tools for the individual and intervention programmes mainly for groups. The group programmes aim to change the thinking of offenders as a stepping stone to them reducing or giving up their criminal behaviours. They have especially focused on sex offending, violence and illicit drug use. We explore examples of such programmes both in the respective behaviour and disorder chapters and also in chapter 25 on services in the criminal justice system. This is essential and welcome work, filling a gap where psychiatrists have largely abandoned people with mental and behavioural disorders, and it has been subject to research evaluation, but with results that remain open to interpretation and debate (Ho and Ross, 2012; Mann et al., 2012; Hickey, 2012). The programmes might be more effective if less rigid and more supported within a multidisciplinary clinical framework. Of perhaps more concern, however, is that such programmes are now being brought across from prison and probation where many people have no mental disorder or personality disorder, to hospitals where the commonest mental disorders are in the schizophrenia spectrum. They may well prove helpful for some, but need fresh evaluation which takes account of the even greater complexity of presentations among people who are hospitalized after offending. It is vital that psychiatrists play a full part in such evaluations.

Economics

Forensic mental health services are expensive, how can such costs be justified? This is a pertinent question at a time of economic stress in many developed countries which have such services, but also one which general psychiatrists in the UK have been asking ever since the surge in development of medium security units specifically and forensic psychiatry, in particular, in the decades since the Butler report (Home Office, DHSS, 1975). At the time of the first edition of this text, in 1993, there were just over 1,700 high security hospital beds, many of them provided in substandard facilities, and just over 650 specialist medium security hospital beds. By 2007, although the distribution of beds had shifted away from high to medium security, still the overall number of specialist secure beds available at any one time had about doubled (Rutherford and Duggan, 2007), not counting newer categories of 'low security', which may or may not have forensic psychiatric specialists involved. Scotland and Northern Ireland have developed medium security hospital services for the first time. It is arguable that such secure hospital service development is merely paralleling the rise in the prison population, in which rates of mental disorder are high; it is also arguable that neither health nor criminal justice services are using community provisions enough, and that their efforts directed at diversion of people with mental health problems should be increased (Bradley, 2009; see also chapter 25). A great deal depends on measured outcomes, which should include safety of the patient and public alike, but will include other measures too.

Bennett (2008), from the Centre for Crime and Justice, argues that there has been a shift, at least in the criminal justice system, from the optimism about the rehabilitative potential of criminals to conservative and defensive policies because of the enhanced importance given to the concept of dangerousness by the public and politicians alike, and this is costing society both in immediate financial terms as prison numbers escalate but also in 'moral impoverishment'. The National Audit Office (2010) confirms the poor return for investment with respect to short-term prison sentences. It may be that some of this sort of thinking has pervaded health service developments too, although in forensic psychiatric services, admission is reserved for people who really cannot be managed elsewhere and length of stay in an institution is rarely short. Difficulties in understanding real costs in this field lie in the extent of the ramifications of the effect of violent crime. As Cohen (1994) showed, they cross government departmental boundaries, affecting not only the criminal justice system in court and sentencing costs, and healthcare systems in managing the effects of the violence, but also social care systems in providing for loss of earnings and potential, perhaps if a parent is killed, taking on the cost of rearing the children and so forth. If, say, a secure unit bed really could reduce such costs, then it might seem cheap at the price in the absence of intergovernmental department competition for funds. In a US study of what the public actually wants (Cohen et al., 2006) a nationally representative sample

of people were asked to trade off crime prevention and control policies and tax rebates. There was overwhelming support for increased spending on youth prevention, drug treatment for non-violent offenders and the police, and respondents would not request a tax rebate if this is how their money were spent. They would not, however, endorse new money for building more prisons. They were not asked about secure hospitals, but perhaps they would fit within the treatment and prevention modes that seemed to be favoured.

Philosophy

Evil

> *Evil is doing things that hurt people when you know they wouldn't want you to do them.*

This was said by a behaviourally disordered patient of limited intelligence, but he has captured a useful perception of evil – and one of the commonest – intent to hurt when, in essence, you know it is wrong.

Textbooks of psychiatry do not usually mention the subject of evil; that is interesting in itself considering that it is such a widespread human concept. We do not believe that a textbook of forensic psychiatry can escape entirely from touching on this topic. In the trial of the co-called 'Yorkshire Ripper', a central feature was the question of whether the defendant was mad or bad (*Coonan 1 and 2*). An *Observer* correspondent (Read, 24 May 1981) wrote:

> *If one believes in the Devil, not as an abstract idea, but as a real being with the power of Satan in the Book of Job to 'roam about the earth' then it is possible to postulate demonic possession of a murderer like Sutcliffe … It seemed plausible that some other being had entered into him – not the spirit of God as he claimed, but some demon with an ironic sense of humour … If this was true then the contentions of both prosecution and defence would have been right. Peter Sutcliffe might have been both evil and mad.*

This debate between madness and evil permeates much of forensic psychiatry; we do not always recognize it, but practitioners should be aware of it. In this context, the word is for the language of the layman and the politician, or perhaps prison governors. The governor of Strangeways prison blamed the 1990 prison riot on the work of the devil! Serious contemplation about evil or 'wickedness' is generally seen as the purview of religious leaders or philosophers, although reviewers have questioned whether even they remained interested. Midgley (1984), a philosopher, found her book on *Wickedness* greeted with the following observation from *The Spectator* (printed on the fly leaf of her book):

> *This topic raises so many problems that social scientists have lately tended to sweep it right under the carpet, reducing wrong-doing to mental illness, social conditioning, or a figment of the punitive imagination, while philosophers have concealed it behind a decent veil of general scepticism.*

Note the '*reducing* of wrong-doing to mental illness' (our italics). Midgley herself concluded that evil is actually a negative, a void – the absence of good:

> *Evil, in spite of its magnificent pretentions, turns out to be mostly a vacuum.*

This has some resonance with Arendt's (1963) concept of 'the banality of evil', a term coined in her description of Eichmann, a Nazi war criminal who was allegedly of low intelligence but otherwise found by several experts who examined him to have no mental abnormality; she suggested that his life was so empty that he may have preferred to be executed than live as a nobody. We cannot say whether this was an appropriate interpretation of the facts or not; the essential point is that there is a school of thought that views evil not as the domain of monsters and psychopaths, but of ordinary people and voids which have to be filled, perhaps by brutal and destructive ideologies which appear to them to be strong and decisive and/or to link them to other humans or powers. The experiments testing the extent to which 'ordinary people' are prepared to engage in damaging acts against others in order to keep in with authority (Milgram, 1974) or the group milieu (Zimbardo, 2007) perhaps provide some support for this. The idea of a 'normal' person being responsible for monstrous behaviour is so disturbing that it has provoked academic arguments against the position, but it is behind many of the difficulties faced by forensic psychiatry and psychology – and indeed general psychiatry and clinical psychology. There remains an expectation that we must find that monstrous behaviour is mad, or, if not that, then a construct such as 'psychopathic' will do. Notwithstanding Spence's (2008a) thought-provoking editorial 'Can pharmacology help enhance human morality?', we think that it is generally important to avoid amalgamating the language of morality with the language of medicine and science. It probably does more to further stigmatization of people with various mental disorders, but we nevertheless share Gilligan's (1996) concern to understand monstrous – or in his terms violent – behaviour in psychological terms:

> *But even the most apparently 'insane' violence has a rational meaning to the person who commits it…*
> *And even the most apparently rational, self-interested, selfish or 'evil' violence is caused by motives that are utterly irrational and ultimately self-destructive…*
> *Violent behaviour, whether it is 'bad' or 'mad', is psychologically meaningful.*

We return, then, to the construction of evil as an absence of goodness – ordinary or not this seems to us to side-step

the question, because it leaves the problem of understanding goodness. Midgley argued against the view of evil as an outside agency:

> *It seems necessary to locate some of its sources in the unevenness of (the) original equipment (i.e. our bodies and minds).*

She commended Freud's notion of a destructive force within us, a death wish (Freud, 1920), but also noted that it is an idea akin to demonic possession. She highlighted Darwin's profound view that any animal whatever, endowed with well-marked social instincts, would inevitably acquire a moral sense or conscience as soon as its intellectual powers had become as well, or as nearly as well developed, as in man (Darwin, 1883), but she went on almost to equate evil with Fromm's concept of necrophilia: 'the attraction to what is dead, decaying, lifeless and purely mechanical' (Fromm, 1973). Fromm himself (1964), a psychoanalyst, had earlier chosen the term 'malignant narcissism' for what he regarded as the most severe form of pathology accounting for destructiveness and cruelty, a concept taken up as well by Kernberg (1975) and Scott Peck (1983), also medical analysts, and eventually taken over by the concept of psychopathy (Cleckley, 1976; Hare, 1980). So, psychiatrists and psychologists have perhaps been complicit in linking psychopathology and evil. This debate is furthered in much more detail than we can accommodate here in an issue of the journal *Philosophy, Psychiatry and Psychology*, with Ward (2002) and Mullen (2002) among the contributors. One other important problem, however, to which we will return in the context of concepts of mental disorder, is the tendency to regard evil as 'a thing'. This error of reification risks returning to ideas of evil as a 'force' or a 'possession', to which Hampshire (1989) comes close:

> *The notion of evil is the idea of a force, or forces, which are not merely contrary to all that is more praiseworthy and admirable and desirable in human life, but a force which is actively working against all that is praiseworthy and admirable.*

On the one hand this is not far from the witch manias and other strange ideas that affected whole populations in the sixteenth and seventeenth centuries (Mackay, 1869), and on the other hand almost suggests a solution in quantum mechanics; this hardly seems likely!

There is no escaping, however, that forensic psychiatrists have to work in a context in which a moral perspective on behaviour exists. It may be that different views can legitimately coexist. This is sometimes difficult to accept, partly because if each view leads to action, then one view must prevail, as usually only one action can be taken at a time. This type of conflict can be particularly evident in court. To return to the Yorkshire Ripper trial, the moral argument that his behaviour was wicked led inevitably to his condemnation and imprisonment, whilst the view that he suffered from a disease led to hospital care (albeit indefinite secure hospital care) and an attempt to treat and change him. For some offences, courts are perhaps more likely to be able to take a little bit of the moral view and a little bit of the medical view. The depressed shoplifter, for example, may be found guilty, given a moral lecture and then handed over to doctors for treatment.

Society construes individuals as having moral responsibility, guilt, blame in terms of their goodness, and badness. Admittedly, in court, 'insanity' and other forms of mental ill health, concepts borrowed from a different language, are allowed as partial or complete 'excuses', but the very word excuse indicates that this too is done on moral grounds. Responsibility, then, a topic of much interest to lawyers and one on which they frequently consult the psychiatrist, is actually a question of morality. This is why we advocate that when debates about responsibility occur in court, those debates should be conducted by lawyers and laymen alone; the physician is likely to talk at cross-purposes and, in any case, is no expert in morality, even if the excuse which is being imputed is one of mental disorder. All the doctor can do is to give an objective medical view, suggest a medical remedy when appropriate and see whether the moral arguments will accommodate such positions in the case at issue (see Gunn, 1991 for further discussion).

We have emphasized the different perspectives of medicine and the law because we are doctors. In dealing with offenders who do not have a mental disorder, or whose mental disorder is largely irrelevant to their offending, many of the same principles apply to sociological constructs and social work interventions that may be advanced. The greatest potential for medico-legal conflict in the criminal court perhaps lies between the moral and the pragmatic – punishment or excuse on the one hand, and the pragmatics of working towards real prevention of harm on the other.

MEDICAL LANGUAGE

Medical Terminology

Words, phrases and terms which are of great importance in psychiatry and psychology are largely concerned with the way that people think, feel and act. Important clinical or legal decisions may hang on a particular term. Indeed, particular terms are chosen to have particular effects. In Britain, for example, it is not rare to find that a person may be labelled as suffering from, say, 'schizophrenia' until s/he is arrested for an offence or series of offences, whereupon the diagnosis changes to, say, 'personality disorder' (Taylor and Gunn, 2008). One reason for this is that most people accept that schizophrenia is a medical problem and merits health service care and treatment, whereas, unfortunately, there is less consensus about the best approach for people with personality disorder. It is easier to argue that such disorders are untreatable, and so no business of clinicians; perhaps non-medical social support, or maybe imprisonment, would serve instead.

Doctors, including psychiatrists, develop many technical terms and they give technical (largely private) meanings to words in the vernacular. Lawyers do the same, sometimes using the same words as the psychiatrists, but with different meaning. Yet the vernacular is important. Medicine, psychiatry, psychology and the law are rooted in it, and such disciplines are invented by the needs of ordinary people. Psychiatrists did not invent mental disorder. Mental disorder is a common experience, and psychiatrists and allied professional clinicians were invented to treat it. In the *Shorter Oxford Dictionary* there are definitions for most of the contentious words of psychiatry, examples including:

Illness: Badness, unpleasantness. Bad or unhealthy *conditions* of the body. Disease, ailment, sickness.
Disease: An absence of ease. A condition of the body or some part or organ of the body in which its functions are disturbed or deranged. A morbid *condition* of the mind or disposition. An ailment.
Disorder: An absence or undoing of order. Confusion. Irregularity. Disturbance. Commotion. Disturbance of mind. An ailment. Disease.
Disturb: To agitate and destroy. To agitate mentally, discompose the peace of mind. To trouble, perplex.

Although occasional reference to 'mental disturbance' may be made by people keen to avoid either disease or disorder concepts, reference to someone as 'psychologically disturbed' is close to playground or street slang. If the word disturbance has any meaning in clinical practice, it is as an indication of grounds for concern before much detailed understanding has become possible. We will not dwell on this word further.

Several points emerge from this list. First, the vernacular terms are almost interchangeable, secondly they appear to place equal weight on body and mind and, thirdly, several of the definitions include moral aspects; this is especially true for 'illness'.

Does all this matter when psychiatry can develop its own technical language? It does, because psychiatrists have to communicate with laymen. If a distraught family brings a suffering relative who is no longer coping with everyday life to a clinic, it is confusing, even hostile, to tell them to take him/her away again because s/he is not 'ill'. It is confusing because they probably would not have brought their loved one to the clinic unless they had come to the considered view that s/he is ill, and it is hostile because it means that the plea for help is being rejected. It might even be regarded as a betrayal of professional obligations if a distressed person volunteers himself for treatment and the assessing doctor makes no arrangement to help. These are illustrations of a political aspect of terminology. There is an underlying, perhaps ill-formed policy in the doctor's mind about how s/he will or will not deal with some kinds of case. This policy is then expressed in apparently technical language which either prevents arguments or shifts them on to obscure ground. It is important to recognize this tendency, because of the way in which psychiatrists make diagnoses. Usually, they decide on the diagnosis in the first few minutes of an interview, and spend the rest of the interview confirming this impression (Kendell, 1973).

It soon became clear in the construction of this book that terminological differences were just as prominent amongst our small group of similarly trained authors as anywhere else. In fact, even before getting to the nomenclature of disease, we found differences in what to call the person needing our services – patient, client or service user? In these terms, we think that there is a distinction to be made between a person for whom the only task is assessment and the person who is in treatment. The former may even have commissioned the report, and there is a case for referring to such a person as a client. The person who is in treatment has a very different kind of relationship with service providers and, it is arguable, different expectations and rights, so the term patient seems to us to be more appropriate. Everyone is a service user in some way, so that seems over-general to be useful. A concern that we have, which we believe to be shared by those professionals who are uncomfortable with the word 'patient' is that there is, again, a risk that such terms serve to distance and dehumanize, so although we have used the terms client and patient these ways throughout the text, more often than not, we hang on to the words 'person who' and the slightly cumbersome 's/he' and 'his/her' rather than 'they' to keep sight constantly that all those who we work for are, first, people like us.

In a textbook it is important to have some consistency in the use of language, and to have definitions or explanations which the reader can understand, if only to disagree. We have not entirely achieved this, we doubt whether a multi-author book ever could, so next we shall set out how we have struggled ourselves with a few other common words and ideas used in psychiatry.

Reification

In preparation for that we have a preliminary semantic consideration. Science and medicine are concerned not just with tangible objects but also with ideas. Ideas are essential and powerful for progress. They are human cognitive constructions which enable us to think and converse, they may lead to actions but they do not live outside our brains and minds, they are not real in the sense that a piece of furniture is real. The furniture may have begun as an abstract idea in somebody's head but the object generated by that idea is tangible.

All illnesses are abstract concepts. Pneumonia, for example, is not a thing. The *Pneumococcus* organism is a thing, but the term 'pneumonia' is an idea, a way of describing its effect on an afflicted person. The terminology helps

us to understand something of the individual's problems, and how they might be helped, by reference to a body of technical knowledge, but the illness does not have substance and visibility like Mrs Brown, who suffers it, or the organisms that have invaded her.

Most of the time this philosophical issue is unimportant but it can, on occasion, lead to significant error if strong ideas are dealt with as though they were real things.

Mental illness

Mental illness is a term which is so widely used and so little agreed upon that we have kept its use in this textbook to a minimum. As with 'psychopathic disorder', its use even within the framework of mental health legislation is largely over. Illness is an evaluative term. It is something undesirable which happens to animals, but a term mainly reserved for human beings. There the consensus ends. It is not even clear whether physical illness and mental illness are both subcategories of the same broad category (Fulford, 1989), but that is how we shall regard them here. Having problems recognized as illness is the key to accessing important provisions and actions, yet illness remains undefined and is largely what the admitting/treating psychiatrist says it is. For Szasz (1962), it is a 'myth':

> *Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social, and ethical problems in living... Human behaviour is fundamentally moral behaviour.*

We largely reject this view of mental illness. As we have just described, we accept that human behaviour may be viewed in moral terms but that this does not, as Szasz believes, invalidate a medical view of human behaviour. The two views may run in parallel. Another potential source of confusion about the term 'illness' lies in the idea that illness is not merely a state or 'condition', but creates a social role (Parsons, 1951). Someone who is 'ill' is excused duties, and is treated differently from the healthy person, although, in turn that person has a new and specific duty – to engage in activities to get well. Problems may arise if medical examinations and tests are negative and the status of illness is removed. Occasionally, the reverse may occur and others will say 'you are ill' and, despite protests from the sufferer, normal social responsibilities may be removed and the new role instated instead. It is this social aspect of the term 'illness' with its removal of ordinary duties and responsibilities and the substitution of new ones – including that of submission to medical care – which makes the term so central to psychiatry, and so objectionable to some – including Szasz. S/he who has a mental disorder may, in some circumstances, be forced into the sick role under the powers of mental health legislation. For these complex social reasons we have tried to minimize the use of the term 'mental illness' in this book and use the term 'disease' or the less explicit, but more widespread term 'disorder'.

Before leaving concepts of illness though, the strange expression 'formal mental illness' which has crept into modern British psychiatry requires comment. It is difficult enough to determine what is meant by a mental illness let alone a 'formal' one. What could this be? One possibility is that the term derives from misguided use of the word 'formal'. In psychiatry the term 'formal thought disorder' may be applied to refer to a disorder of the form of thoughts. Are clinicians trying to say that there is a disorder in the form of health? Scadding (1990) advanced a more likely explanation. He referred to a study of the use of psychiatric terms in general practice (Jenkins et al., 1988) and said (of general practitioners):

> *Faced with a patient in whom mood changes accompanied by various social and economic stresses and recognized physical diseases, they preferred to describe the situation in informal terms, rather than commit themselves to a formal diagnosis which would imply that the changed mood should be regarded as due to a postulated 'mental disorder'.*

Perhaps the psychiatrists who say their patients have 'no formal mental illness' are indicating, like the general practitioners, that they recognize the features of mental disease, but are not prepared to make a diagnosis. Given the context in which this jargon arises, it may further mean that the doctor is not prepared to offer the social status of illness, is not prepared to allow any medical excuses for the patient's behaviour, and is not prepared to provide or recommend treatment. In other words, s/he would be using the jargon as a political statement. It seems to us that the correct response to the assessment of 'no formal mental illness' should be: but does s/he have medical problems at all? If so, what medical problems *does* s/he have? If not, please state that plainly. If s/he does have a medical problem, is there any medical intervention that would help? If so, are you in a position to offer it? If not, where and how can it be accessed?

Disease and disorder

Boorse (1975, 1976) argued that disease is a value-free term and that illness is a subcategory of it with value attached. Thus, most of us live with minor disease (e.g. haemorrhoids), but only severe diseases make us ill. Diseases can be identified objectively, he said, but illnesses are subjective and have social consequences. Disease is a term that is not very commonly used in psychiatry. Although psychiatrists regularly refer to the *International Classification of Diseases*, they then refer to the individual diseases as 'disorders' or 'diagnoses'. The fourth edition of the *American Diagnostic and Statistical Manual* (*DSM-IV*) does not apply the term

disease to any purely psychiatric condition; its favoured term is 'disorder', which is defined as:

> *A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress... or disability... or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom... Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of the dysfunction in the individual. (American Psychiatric Association, 1994)*

The American manual stresses that diagnostic lists are classifications of mental disorders, not of people; the diagnosis does not define the person. Thus, potentially stigmatizing terms such as 'schizophrenic' or 'alcoholic' should be avoided. Where there is a disorder, it is much better to say 'a person with schizophrenia' or 'a person with alcohol dependency'. This important point is too often disregarded, yet it is central to any therapeutic endeavour. Psychiatry is not alone in objectifying people with health problems in this disparaging and inaccurate way, but it may have more serious consequences. Rogers (1961), whose work included extensive experience with problem and delinquent children and adolescents, noted:

> *If, in my encounter with him, I am dealing with him as an immature child, an ignorant student, a neurotic personality, or a psychopath, each of these concepts of mine limits what he can be in the relationship.*

In a brief, but masterly, review of the disease concept in psychiatry, Clare (1986) pointed out that two views of disease have existed since ancient Greek times. Hippocrates saw disease as a cluster of signs and symptoms occurring together – so frequently as to constitute a recognizable and typical picture. This syndromic perspective does not deal with aetiology, and is similar to the operational approach of the international and American diagnostic manuals. Plato, by contrast, envisaged diseases as separate entities, as having an existence of their own separate from the people afflicted by them, and thus a recognizable cause and natural course. Clare concluded:

> *Psychiatry lacks an accepted nomenclature or list of approved terms for describing and recording clinical observations. It also lacks a reliable system of classification. Nevertheless, the broad consensus within psychiatry at the present time is that the advantages of the disease approach, the diagnostic exercise, and the present rudimentary classification systems outweigh the disadvantages and that the early results of attempts to improve the situation are encouraging.*

One function of the disease concept in medicine is to avoid the political use of terminology. Can we escape from it? Not entirely, and, indeed, the American DSM system has come under particular criticism in this respect. Mayes and Horwitz (2005) argue that *DSM-III* was strongly influenced not only by professional politics, but also by government and health insurers, valuing this approach to demonstrate the effectiveness of what they were doing. In addition, they suggest, the multiplicity of diagnoses generated was principally advantageous to if not driven by pharmaceutical companies. In 1952, *DSM-I* included just 106 diagnoses; by 1987, *DSM-III-R* included 292 diagnostic categories, a growth which Mayes and Horwitz do not believe was reflective of a growth in relevant science. Now, we await *DSM-V*, which is trailed as being more open to incorporating scientific advances and as having:

> *the potential for adding dimensional criteria to disorders, the option of separating impairment and diagnostic assessments, [the means to meet] the need to address the carious expressions of an illness across developmental stages of an entire lifespan, and the need to address differences in mental disorder expression as conditioned by gender and cultural characteristics (Regier et al., 2009).*

For us, Wing (1978) offered one of the best expositions on how to be more scientific about diagnosis:

> *Putting forward a diagnosis is like putting forward a theory. It can be tested. Is it useful or not?... The first requirement of a disease theory is the recognition of a cluster of undesirable traits or characteristics that tend to occur together... The second essential element in any disease theory is the hypothesis that the cluster of traits is 'symptomatic' of some underlying biological disturbance.*

Scadding (1990) emphasized the biological disadvantage of disease, and so defined it as the sum of the abnormal phenomena displayed by a group of living organisms in association with a specified common characteristic, or set of characteristics, by which they differ from the norm for their species in such a way as to place them at such disadvantage (Scadding, 1967). He argued that if the criterion of biological disadvantage applies, then 'there should be no doubt about the propriety of medical intervention'. He recognized that short-term distress, such as follows most bereavements, may be biologically adaptive, but this would not rule out medical assistance if the bereaved person wanted it and it would offer him/her some advantage. He also recognized a grey area where doctors will disagree about the degree of biological disadvantage. Here, his good advice can be taken straight into the heart of forensic psychiatry for he pointed out that it matters not whether a patient's symptoms are conceived of as part of a disease or merely as a response to social circumstances, the

symptoms still merit medical attention. Of course, all this becomes much more complicated when *compulsory* treatment has to be considered.

As a psychologist, Ausubel (1961) took a slightly different perspective again. He made no distinction between 'illness' and 'disease', but he firmly tackled the Szasz (1962) view, which was just emerging at that time, that only physical lesions constitute disease. Rather, he noted the subjectivity of all disease assessments, whether physical or mental. He accepted Szasz's view that neurotic and personality disorders may be in some way regarded as expressions of problems in living, but suggested that it is nevertheless possible to construe a syndrome in these social terms and simultaneously construe it in medical terms also. Manifestations of impaired functioning, adaptive compensation, and defensive over-reaction also occur in physical disease.

Psychopathic disorder and psychopathy

We have tried, wherever possible, to avoid using the term 'psychopathic disorder' or, worse, 'psychopath'. Originally the term meant mental disease in general, but it has gradually become corrupted to a pejorative and stigmatizing term which is used quite widely by lay people and professionals alike as a means of rejection. No diagnostic system uses such terms, and with the shift in UK mental health legislation to having a single broad legal category of mental disorder there will soon be no justification even in legal terms for continuing with these words. Patients who were once labelled in this way can always be described in other ways which are more positive and may lead to progress. There remains a case for using the term 'psychopathy', providing that it is used in its very specific sense. The origins of the concept lie in Cleckley's (1976) attempt to medicalize various forms of unusual behaviour in his book *The Mask of Sanity* (first published in 1941). Through a series of detailed case histories, he wanted to draw attention to what he considered to be *forme fruste* of psychosis which lurked under a cover of normality. Hare derived an assessment device based on the Cleckley criteria, the Psychopathy Checklist-Revised (PCL-R; Hare, 1991; for quick reference, see http://en.wikipedia.org/wiki/Hare_Psychopathy_Checklist). The most defining criterion is, essentially, an affective disconnection not unlike that seen in some people with schizophrenia, which seems to limit the capacity of sufferers to perceive fear and distress in others; the more behavioural dimension really only provides for a systematic way of rating repeated antisocial behaviours. We discuss the concept of psychopathy in greater detail in chapter 16, but here we want simply to stress that it is a product of scores on a scale, and the literature is inconsistent in use of defining cut-off scores. Our preference is to refer more precisely to psychopathy checklist scores in *research literature* and higher scorers and lower scorers in clinical dialogue. Originally designed as a dimensional instrument, there are international differences in an accepted cut-off indicative of 'pathology'.

Insight

Lewis (1934) complained that little had been written about insight as part of a psychiatric problem. He defined complete insight as 'a correct attitude towards a morbid change in oneself', but went on to point out that it is very difficult to define what is meant by a 'correct attitude', and that, in these terms, insight may be as limited among those with physical disease as among those with mental disease. He also disliked the neurotic/psychotic dichotomy with the implication that loss of insight is necessarily confined to patients with psychosis, and he showed distaste for those who ask whether something is 'not really psychotic' or 'only neurotic', arguing:

> *It is I think correct to say that gross disorders of insight are often found in neuroses... The obsessional's attitude towards his illness or to any special symptoms is vastly different from that of his wife, or his friend, or his doctor... As for the hysteric – who would suppose that a girl with dermatitis artefacta has a healthy or normal attitude towards her symptom?*

Lewis (1934) also recognized that the clinician should be aware that acquisition of insight is far from straightforward as an indicator of outcome for a particular patient. Limited insight into illness, he thought, might be an advantage in some cases, because it may lead the patient to repudiate the disease. For patients in forensic mental health services, there is an added complexity – acquisition of accurate insight into their position may be psychologically unbearable. If, for example, in the most extreme form of his psychotic state a man kills something he truly believes to be a source of evil which is destroying the person he loves most, his mother, but in fact kills her, he is himself protected from the enormity of his act by his certainty in his 'saviour' role; insight brings him to a position in which not only must he grieve the loss of the person he was trying to save, but that he was, in reality, the only agent of her death.

In the second edition of the *Oxford Textbook of Psychiatry*, Gelder and colleagues (1989), having defined insight for those with mental disease as 'awareness of one's own mental condition', stressed that it is rarely simply absent or present but rather its presence is matter of degree. They suggested that the concept be unpacked into four components:

1. Is the patient aware of the phenomena noticed by others?
2. If so, does s/he recognize that these phenomena are abnormal?
3. If so, does s/he consider that they are caused by mental illness?
4. If so, does s/he think s/he needs treatment?

In a review David (1990) carried this idea forward and developed an assessment schedule for what he regarded as the three dimensions of insight:

1. awareness of illness;
2. the capacity to relabel psychiatric experiences as abnormal; and
3. treatment compliance.

The measurement of insight is a fundamental part of the Maudsley Assessment of Delusions Schedule (MADS; Taylor et al., 1994). This extends the range of enquiry not only to a patient's self-selected most important delusion, in which such independent variables as the patient's capacity to express his/her belief to others is rated, but also to the patient's possibly related antisocial action(s) when these occur. Separate enquiry is made about his/her understanding of the moral, legal, risk engendering and provocative implications of his/her act. In the evaluation of the schedule with actively psychotic patients these items did not co-vary.

Why should it be so important to separate out the components of insight? While Lewis's (1934) vision of a continuum between full insight and no insight is useful, the elemental approach recognizes that components of insight may be differentially impaired. One patient may adhere perfectly to his or her treatment régime and yet insist that s/he has no illness, disease or disorder – whatever we want to call it, while another may accept s/he has, say, schizophrenia and may even feel a bit better with medication, but still insist that this is not going to make any difference to the effect of the machines that are destroying her/his brain.

This leads us to a further problem that judgment about whether a patient has insight is subjective, and will depend not only on the skill of the clinician but perhaps also on the clinician's own attitudes and beliefs. To compound the difficulty further, discrepancy in ratings between patient and observer and even two observers does not necessarily mean that any one of them is wrong, but rather that each has only a partial picture. This dilemma is just one of the many reasons why the multidisciplinary team is so important to forensic mental health practice – first it brings the chance of recognizing that there are different perceptions of the individual's state, and also provides for testable clinical hypotheses which will help reconcile them.

Sometimes discrepancies in perception of symptoms or actions reflect complex interactions; sometimes they do lead to realization that in some aspect of their condition, a patient may be dissembling. One of us, for example, had a patient with schizophrenia whose delusions remitted with depot medication, but he continued to be agitated. Whilst denying this, he drank heavily and claimed that each drink had been the last, just a few hours before getting drunk again. He claimed that he was fit for work, or that he was studying, yet he spent most of his day doing nothing, or drinking, in spite of prompts by nurses. The patient charmed casual observers, who agreed with him that he had 'recovered' and no longer required treatment, but consistent observations and objective measures of his alcohol levels helped him as well as the staff looking after him to recognize his poor insight in this respect. By contrast, in a study of delusions, it was observed that rather weak correlations between patient accounts of beliefs and action on them and relative-informant accounts given independently to researchers did not invalidate the beliefs (Wessley et al., 1993). For those patients who were talking about their beliefs, accounts were similar, but many patients were very reticent in this respect, and while aggressive actions were consistently reported and observed, when a patient's actions were avoidant or subtle, these were often not noticed. They could, however, be elicited by a trained clinical researcher. One patient, for example, had taken to wearing a green tie, which was a deliberate act of immense personal significance in the context of his delusion, but it was an act that had gone unobserved and had not been placed in a clinical context.

There is one particular question which relates to insight among offenders and offender patients which needs research, but gets no such attention and that is remorse. Some still expect prisoners and offender patients to show remorse for their offence before discharge can be agreed. It remains unclear, however, whether remorse can be measured with reliability and validity, and, to the best of our knowledge, there are no data confirming that people who do have this doubtfully measurable capacity have better outcomes with respect to reoffending than those who do not. Nevertheless, we think that if this is treated as a question about accurate insight, effort to establish such capacity is likely to be helpful. A useful starting point is to ask to what extent the patient understands the effect of his/her offence on other people – those directly involved and society as a whole. It is not enough to ask the patient about his/her guilt feelings, although this is a useful component of the process as patients carrying a substantial burden of guilt may themselves be vulnerable. Exploration with the patient of steps that, with hindsight, s/he could have taken to prevent the harm s/he did, and how s/he might be able to apply such knowledge in the future is also a useful strategy. Application of our victim-centred approach in practice may provide further evidence of a patient's progress in this respect. A first step is to engage the patient in an exercise about talking with his or her actual victim 'X' in respect of interpersonal violence. The patient is asked to think about what s/he did to X and then talk about it to the assessor/therapist as if the assessor were X (or, where X was killed, then a specified close relative or partner of X). The assessor must then consider the quality as well as the content of the patient's account.

A majority of patients in secure mental health services have harmed someone from their immediate social circle.

Once the treating clinician is satisfied that the patient can cope appropriately with the 'as if' interaction about what s/he did, it may be appropriate to support some replication of the interaction with the actual victims in a few cases. Certainly there will be a task to reconcile perceptions of how relationships may be as the patient moves on. Through misplaced good intentions, or perhaps fear, relatives and friends may be responsible for compounding failures to develop insight. Some are scared of aggressive repercussions if, for example, they tell the patient that s/he will never again live in the family or marital home. Some feel that the patient has already had to cope with so much that is bad that they do not want to remove hope that such a desired option remains available, but they are nevertheless clear to staff that they will not countenance the patient living at home again. Such patients have little chance to gain accurate perceptions of their new social circumstances, and thus begin to plan in an insightful and practical way. It is very rare that direct work with stranger victims occurs, but there are tasks to be done on recognition that such survivors may or do not want the patient to return to the community in which the offence occurred, and that they have rights in that respect.

Treatability

Since the passage of the Mental Health Act 2007, the vexed question of 'treatability' of some kinds of mental disease has become less contentious as certain requirements of the basic legislation – the Mental Health Act 1983 – have been removed. Nevertheless, debates about whether a person may be untreatable continue. There is a case for genuine concern on at least two grounds – first the position of the patient and second the near constant state of shortage of services.

From a patient perspective, it is important that any treatment under any circumstances is theoretically sound and/or evidenced-based; if coercion is to be used in delivering that treatment it is arguable that the evidence for its effectiveness should be particularly strong. Nevertheless, treatability should not be confused with curability. Many diseases are incurable, but they can usually be treated with great benefit to the patient. Specific treatments may be effective, but only partially so, or only so for a finite period of time. In addition, the patients may be treated with nursing, palliatives, support and environmental adjustment. Accepting a role more limited than that of 'curer' is difficult for some doctors, who may have been given inappropriate notions of medical omnipotence at medical school. Yet most of medical practice is concerned with the treatment of incurable problems.

From a service perspective, demand for beds exceeds their availability, so it seems to make sense to screen out people for whom treatment outcome may be less assured, certainly if poor response means that their hospital stay becomes very prolonged. Unfortunately, treatability, which, in effect, has become a political and gatekeeping concept, seems to have been adopted by all services, including those where coercion and inpatient stay is not an issue, and applied especially to people with personality disorder. This, in turn, partly explains why development in the field of treatment for personality disorders has been so slow. Since the first edition of this book there has been a remarkable government attempt to address this problem by the provision of a few, notionally experimental services for people with personality disorder. The story of service for 'dangerous people with severe personality disorder' is taken up in chapter 16. Here, we simply emphasize the important Department of Health initiative that services for people with personality disorder need to be part of mainstream health provision – *Personality Disorder, No Longer a Diagnosis of Exclusion* (National Institute for Mental Health, 2003).

Many doctors remain reluctant to offer patients with personality disorders the same judicious mixture of informal and compulsory care that they are willing to offer patients with other mental disorders. While this may be related to the uncertainty about whether personality disorder really constitutes a medical condition – 'a disease' – with related questions about its moral eligibility for treatment, reluctance may equally follow from an understanding that one of the key characteristics of people within the cluster of personality disorders which includes borderline and antisocial personality disorder is established recidivism. Given the populist view that nothing predicts reoffending as well as previous offending, fear of the responsibilities entailed in attempting to help thus supervenes. It is a sad fact that if such a patient commits a serious offence after leaving psychiatric care, then it often seems that the psychiatrist and psychiatric services are as likely to be condemned in the national media as the offender him/herself. It is perhaps unsurprising that some psychiatrists will try to avoid 'guilt by association'.

Psychiatrists are not alone in this; however, psychologists have promulgated the more quasi-scientific approach of determining treatability by a PCL-R score. Originally used in this context as an aid to selection for treatment in prison programmes, we have concerns about the possibility that a prisoner may be deprived of access to prison-based cognitive treatment programmes solely on grounds of his (and it is here usually a man) PCL-R score. This is not least because in some systems, such as those in England and Wales, he must show that he has completed such programmes and changed to be eligible for release. The transfer of the principle to the very different context of a hospital setting without further detailed research, however, seems much more worrying. First it is important to establish whether high PCL-R scores do indicate a high risk of failure to engage in treatment, and second, if this is so, research is required into why it is.

The Psychiatrist and the Law

In his short story *Billy Budd, sailor,* Herman Melville (1924) asks:

> *Who in the rainbow can draw the line where the violet tint ends and the orange tint begins? Distinctly we see the difference of the colors, but where exactly does the one first blendingly enter into the other? So with sanity and insanity. In pronounced cases there is no question about them. But in some supposed cases, in various degrees supposedly less pronounced, to draw the exact line of demarcation few will undertake, though for a fee becoming considerate some professional experts will. There is nothing nameable, but that some men will, or undertake to, do it for pay.*

The detection of the shades of pathology, the boundaries between diseases, between normality and mental disease and the contribution of mental diseases to socially proscribed acts is part of the art of forensic psychiatry. In any country where forensic clinicians are more than trained court experts, they are getting paid for much more than trying to answer unanswerable legal questions. Nevertheless, we would all be wise to see the risk of becoming a hired hack within the expert role.

It is inevitable that large sections of this book cover matters which are specifically medico-legal. One or two points are thus worth emphasizing. It is extremely important, in spite of the evident overlap of interests, for psychiatrists to avoid playing amateur lawyers and *vice versa.* It is vital for psychiatrists to recognize and listen to sound legal advice. This is a central skill in forensic psychiatry. There is much legal advice, only a proportion of which is sound. How can the sound be distinguished from the unsound? Sound legal advice will usually come from someone who is well read or experienced in the field concerned. Lawyers, like doctors, specialize. Sound legal advice will usually follow a coherent pattern of argument and make sense in a broader context; it will only rarely be dogmatic and/or partisan. Unsound legal advice is more likely to come from enthusiasts and zealots; it will frequently be dogmatic and difficult to follow to a logical conclusion. Another key route to successful medico-legal relationships is that when doctors are asked to provide reports, they ensure that they have complete clarity about the questions their evidence must deal with and that they do not go beyond those questions.

A major factor in barriers to effective medico-legal practice lies in fundamental differences in thinking styles between clinicians and lawyers. Aubert's (1963a) six points are helpful here:

1. Law tends to favour simple dichotomies: guilty/not guilty, insane/not insane, while clinicians work with probabilities and with disease continua.
2. Thus, lawyers tend to apply only one or two simple concepts of probability, such as 'beyond reasonable doubt' or 'on the balance of probabilities', whereas clinicians generally see more variation.
3. Lawyers test the fit between an event or person and a formula with rather narrowly defined circumstances. In the event of fit, specified consequences follow. An example might be in relation to the diminished responsibility defence. In England and Wales, this is of interest in law exclusively in respect of a murder charge in which case the diminution refers specifically to the individual's cognitions and/or capacity for self-control; clinicians would reflect on a wider range of impairments and set them in their context, in practice applying the idea to a much wider range of behaviours.
4. Courts rely mainly on the past to decide on the future, imposing punishment according to the nature and context of the index offence, perhaps taking previous offending into account. Clinicians certainly do this, drawing on family history, personal psychiatric history including treatment responsiveness and evidence for previously harmful behaviour patterns, but they also consider the future in terms of what treatment and/or service framework will be available.
5. In common law countries, such as England and Wales, lawyers deal in specifics, including case precedents, in determining outcome for complex cases, while clinicians are more influenced by group research data.
6. The Court decides what happened in disputed incidents according to legal rules of causal relationships, which cannot be falsified, only overruled. Clinicians/scientists, at their best, are concerned only with scientifically demonstrable or falsifiable causes.

On the whole, British law is very supportive of good professional practice. The doctor who works well within the limits of medical ethics, who puts patients before personal interests, and who practises to the best of his/her ability and within recognized practice guidelines where available, will rarely, if ever, be in conflict with the law. The first prerequisite for lawful practice, therefore, is good medicine. The law intrudes into medical practice in only a limited number of ways. Specific laws dealing with medical problems are enacted by Parliament, and should always be available for reference. Some sections of the British mental health acts are appended to this book. Patients may sue doctors after a poor outcome to a course of treatment. Here the best defence lies in high professional standards, tested with an informed peer or peer group. In psychiatry, because of the psychiatrists' special powers of detention, there is a complex set of laws, regulations and institutions to deal with these powers. Knowledge of the local arrangements is as essential to the practice of psychiatry as is knowledge of the pharmacopoeia. Any psychiatrist should therefore see this knowledge, or access to it, as part of good professional practice.

Beyond a basic knowledge of the legal framework of psychiatry and good practice, the best way of avoiding legal

difficulties is to engage in frequent peer review. This may be done through informal consultations, formal one-to-one consultations, seminars and medical audit. One useful model is practised in the medium security hospital unit in Wales where one of us works. Each clinical team will call a peer review conference for each patient as a routine within the first year of admission, as discharge is being considered and on an *ad hoc* basis whenever else the team considers that it would be useful to do so. The peer review is regarded as quorate if there is at least one representative from each clinical discipline present at the meeting in addition to the presenting clinical team representatives. Observations from the clinicians from outside the patient's team are regarded as purely advisory, as the patient's team retains full responsibility for that patient, but the debate is often influential.

Court work

Court work may have a significant impact on the work of a psychiatrist, especially a forensic psychiatrist. Such work can be mystifying, intimidating, time-consuming and frustrating. Guidance is given in subsequent chapters about techniques for avoiding these negative factors. As a preliminary to those chapters, it is worth reiterating that court work should never, for the psychiatrist, become an end in itself. It should always be possible to explain easily and openly why a particular piece of court work is of benefit to a patient or to patients as a group. Court work should be strictly limited and, if the benefits are not obvious, avoided unless legal demands require it. Court work should always be justifiable in terms of efficiency, that is the time invested should be in proportion to the benefits obtained.

In court, no quarter should be given to the view that 'our side must win'. Doctors are likely, as we outlined, to have quite different considerations from the lawyers with whom they work. A doctor should take an objective view of the issues before him or her, and only be as partisan as medical ethics require. In law, the doctor, like any other expert, is supposed to have 'no other desire than to assist the court' (*Nowell*). That implies that everything, including all clinical duties, should be suspended for this high purpose. In practice, it can be taken to indicate that the doctor is expected to give a wholly truthful and balanced view, not dependent on which 'side' employed him or her, but professional judgments will have to be made in each case as to how far the court's desires should interfere with medical standards. In England this doctrine has been taken to the point where it seems perfectly proper for a doctor to provide the court with information which the employing solicitor would prefer to suppress (*Edgel*).

A book by Janet Malcolm (2011), *Iphigenia in Forest Hills,* describes a New York murder trial. It should be compulsory reading for all lawyers working in the adversarial system and it would be useful reading for anyone who attends such a court as an expert witness. It is the story of a young couple who disagreed about child rearing methods in respect of their only daughter. They separated pending divorce, but the husband was murdered by an unseen man at a routine custody handover meeting of the child to her mother. The mother was accused of hiring an assassin to kill her husband. The trial is described in considerable detail and is not comfortable reading. Even though it is possible for a British reader to say with a modicum of accuracy, 'Oh that's America, it's not like that here', the author lays bare the mechanisms of a criminal trial in the adversarial system and shows how easy it is for evidence to be distorted, misrepresented, and misunderstood. The author also points to the doubts that may arise in respect of 'factual' scientific evidence. She documents the huge influence, indeed power, that a single judge, with all his or her personal prejudices, may have on a trial. As the trial was in America the author was able to interview some of the jurors after the case was over and thus illustrate something that remains a mystery in the UK, the arguments which are used within the jury room to convict or otherwise. No one can read this book and feel comfortable that justice is bound to be done in our well-established system. The forensic psychiatrist who agonizes about the accuracy of risk assessments can take a crumb of comfort from realizing that other parts of the criminal justice system probably do not do any better. The judge in the case, Judge Robert Hanophy, of Caroline Beale fame,[1] saw himself as having a matter of fact approach; 'somebody's life was taken, somebody's arrested, they're indicted, they're tried and they're convicted. That's all this is'. Janet Malcolm, however, sets the trial in context by describing as much about the family involved as she can and showing, as any psychiatrist will know, that there is likely to be a great deal more to a story than emerges in court and that, here, the whole narrative was full of ambiguity.

Perhaps the most disturbing chapter in Malcolm's book is the last one, which should be read by all child psychiatrists and social workers. It describes the New York legal guardian system whereby a lawyer is appointed to protect the best interests of the child. Such lawyers may decide what they think is the child's best interests without reference to family opinions or to the child's opinion. They may not even meet the child who is presumably regarded as totally unable to think for him/herself on account of his/her legal infancy. The author may be going too far in

[1] Caroline Beale was a 30-year-old British woman who was arrested in September 1994 at JFK airport in New York with the body of her dead baby under her shirt. She was charged with murder, but after a great deal of legal wrangling and expert evidence both pathological and psychiatric she pleaded guilty to manslaughter and was released to an English probation service for psychiatric treatment. Caroline's father called the New York system of justice mediaeval. This infuriated Judge Hanophy who, in turn, was very critical of the English legal system citing the Irish miscarriages of justice (see Campbell, 1997).

inferring that the domestic homicidal tragedy described was triggered by an eccentric decision of the child's guardian in law to remove this little girl from her mother and give her to her father against the wishes of both parents and the child, but Malcolm does thus highlight the need for skilled multidisciplinary discussions before such a decision is taken, and the potential dangers of lawyers, inexpert in everything but the law, having complete control of such matters. Again it is easy to say that this could only happen in America but anyone who has experience of British family court matters knows that some individuals are much more powerful in the process than others and that full consultation is not invariably undertaken.

ACHIEVING THE KNOWLEDGE AND SKILLS

In the UK, the professions have generally been seen as responsible for developing, directing and scrutinizing their training, although the years since our first edition have seen some substantial changes. Regulation of training was changed, trainers and trainees had to accommodate to the European working directive and professional bodies reached out to other professions and service users to develop new approaches to training and new ways of working. A main effect of the European working directive, reducing weekly working hours to 48, meant that there had to be a rapid expansion of undergraduate training and of consultant posts, and postgraduate trainees and trainers alike have found it difficult, at times, to accommodate (Temple, 2010). Forensic psychiatric trainees and trainers have had to adjust, like everyone else, and the resultant competency-based curriculum was developed by the Royal College of Psychiatrists (2010b), with its specialist faculties working in conjunction with the curriculum committee, which included lay members. Competencies are organized within a framework of seven 'good medical practice domains', with acknowledgement that there is much overlap between them:

1. Medical expert.
2. Communicator.
3. Collaborator.
4. Manager.
5. Health advocate.
6. Scholar.
7. Professional.

The process is one of following basic medical training with postgraduate foundation training, then core psychiatry training, finally building to advanced training in forensic psychiatry. Clinical service providers work in conjunction with Deanery Schools of Psychiatry to support training and to complete workplace evaluations of emerging competencies. Successful progress through this system leads to specialist certification, whereupon the new specialist has a responsibility to establish him- or herself in a continuing professional development (CPD) cycle. This is supported by membership of a CPD peer group and annual reporting to the Royal College of Psychiatrists of continuing training achievements, which should follow from a specified job plan and peer agreed objectives.

Table 1.1 gives an indication of what competency-based training looks like, and how forensic psychiatry is built on to general adult psychiatry. It takes one core task (diagnostic formulation) within the good medical practice domain of being a medical expert, first in general terms and then for the specialist forensic psychiatrist. The table has to be read on the assumption that the basic skill, once gained is retained and developed and the specialist skills added. Even within this one skill, it can be seen that the specialist will be expected to be able to draw on a considerable range of the medical and non-medical knowledge and skills background which we have introduced.

The Ghent Group

Citizens of the European Union who have a medical qualification are entitled to practise their specialty in all countries of the Union provided that they have a completed certificate of training (CCT) in their specialty from their home country. Presumably this works easily for some specialties, maybe anaesthetics and pathology, but in psychiatry training differs between countries, and only three countries have specialist certification in forensic psychiatry – the UK, Germany, and Sweden. Furthermore psychiatry is a discipline that is dependent on highly sophisticated language skills; among the British, few are fluent in anything but English. This means that the freedom to practise in other countries is somewhat theoretical, nevertheless, it is important to prepare for working internationally within Europe.

In order to work towards the European objective of cross-border practice a few forensic psychiatrists from a number of European countries met together in Ghent in 2004 to discuss this matter (Gunn and Nedopil, 2005). An annual meeting of trained forensic psychiatrists and, whenever possible, trainee forensic psychiatrists has followed, each in a different European city. Differences in practice, in training, recruitment, national laws and their history, and specialist facilities have all been discussed, and fostered more detailed reflection on training within member countries (e.g. Goethals and van Lier, 2009). One important objective was to find an agreed framework and indeed definition for forensic psychiatry. This was achieved in Copenhagen in 2006, and was given near the opening of this chapter.

One innovation which has proved popular has been a training summer school held at Kloster Irsee in Bavaria, bringing together the Universities of Munich and Cardiff and strong support from the forensic psychiatry group in Denmark. This achieves the goal, not always attained with the more routine meetings, of linking young and

inexperienced practitioners with more experienced ones, and has been found to be a useful educational week for all, regardless of experience level or country.

The Ghent group welcomes new members and has a web site for interested readers.

FURTHER ENQUIRY

One of the main purposes of this book is to stimulate further enquiry. Knowledge has increased extensively since our first edition, so most of the text is completely fresh, and very little simply updated. Particular areas of growth have also meant that tantalizing possibilities have presented in the form of taking ever more sophisticated scientific medical evidence into court. Perhaps foremost in this area is neuroimaging. It may have a place in end-of-life decisions (Skene et al., 2009) and arguments have been advanced for its use in civil cases – perhaps as an aid to determining truth of a claim – and against its use in the criminal courts (Sinnoth-Armstrong et al., 2008). The legal evidential standard of 'beyond reasonable doubt' in UK courts is relevant here. Attempts have been made to rely on imaging as evidence of incapacity (USA, Appelbaum, 2009) or guilty mind (India, Giridharadas, 2010), but the weight of argument remains against using such evidence in this context (Reagu and Taylor, 2012). We are reassured that there is some evidence that jurors would be appropriately cautious with it (Schweitzer and Saks, 2011). Advice to exercise caution in expressing evidence which can so easily be made to appear unequivocally scientific by the injudicious expert is pervasive, extending from the Royal Statistical Society (2002; see also chapter 22, risk and chapter 26, ethics) to the diagnostic classification systems. ICD-10 notes that its standard version (WHO, 1992) is intended for general clinical, educational and service use, with a second version (WHO, 1993) for research, but makes no reference to its use in court; DSM-IV is explicit about the risks of its being misused or misunderstood if used for 'forensic purposes' and counsels against its use for legal purposes of establishing mental disorder, disability, disease or defect (American Psychiatric Association, 1994a).

The possibilities of obtaining information, and keeping up-to-date, have extended enormously since our first edition was published. Now, students and practitioners in the UK are able to access the vast wealth of material which is available on the Internet. Dependency on the local university library is no longer absolute, and in any event may be remotely accessed. Librarians are now helpful not only in assisting with acquiring references, but also in advising on search techniques and other technological advances. We expect readers to use this text as a starting point for further reading and research. Where we can, we have generally provided web references, which were accessible at 31 December 2011. We have found that relevant UK governmental websites are quite difficult to navigate, because when articles or research reports are archived, they are given a new electronic reference and inserting key words into their search engines often only produces tracts of irrelevant material. Nevertheless, they provide a wealth of information, some of it only available electronically, and most relevant documents may be downloaded without charge. Google is a good back up, and will often yield the elusive reference when other searches fail. We have not eschewed Wikipedia, although this website warns that its material should be checked. It should be, but we have found it to be very useful and a reliable starting point for further searching. This book itself and its internet references are available on-line to purchasers.

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Criminal and civil law for the psychiatrist in England and Wales

John Gunn,
with additional material from
Philip Joseph
RD Mackay
with a view from the bench by
Judge Rod Denyer QC
1st edition authors: Oliver Briscoe, David Carson, Don Grubin, John Gunn, Paul Mullen, Peter Noble, Stephen Stanley and Pamela J Taylor

Laws are not invented. They grow out of circumstances. (Azarias)

COMMON LAW AND CIVIL OR ROMAN LAW

Legal systems arise from diverse local customs, and become formalized as a society's development requires uniformity and predictability in the control of crime, the regulation of interpersonal relations, and the ordering of commercial transactions. The two most influential legal systems are civil law and systems derived from it, and English common law with its developments overseas. Countries in continental Europe have legal systems derived from Roman law, now called civil law. The lasting influence of the British Empire can be seen in the many of the countries of the Commonwealth, and in North America, which are common law countries. Of course there are other legal traditions which have influenced many countries, for example the soviet system of law, and sharia law in Moslem countries. The Christian canon law, developed both by the church and in the medieval universities, enriched the development of the English common law, particularly in the importance to be attached to the individual conscience in the determination of criminal responsibility and to the pledge in contracts. Mercantile law flowed into the common law in the seventeenth century with the growth of trade. The term civil law is confusing in Britain as part of British common law is called civil law to distinguish it from criminal law, and thus civil law in Britain has a different meaning.

Perhaps the most fundamental difference between civil (Roman) law and common law is in the way that common law developed by legal precedent and is established by the courts, whereas in civil law countries this is thought to be somewhat primitive, as all law in that tradition is formulated by the legislature and handed to the courts in the form of statutes and codes. It is very puzzling to someone brought up in a civil law country to learn that in England and Wales, for example, murder is a common law offence and has no statutory basis.

Some call the two main systems of criminal law procedure in the Western World the inquisitional system and the adversarial system. In essence the inquisitorial system conducts an enquiry into an alleged crime, a judge supervises that enquiry and s/he, alone or with others (judges or jury), make a finding. In the adversarial (or accusatorial) system the state prosecutes a case against an alleged criminal in front of a judge or jury and the accused answers the case as best as he or she can by refuting evidence, producing alibis and so forth. When both sides have fully aired their respective cases the court (judge or jury) decides who has the better argument according to agreed standards of proof such as 'beyond reasonable doubt' or 'on the balance of probabilities'. Inevitably this is an oversimplification and it should be noted that the two systems are influencing each other and drawing closer together. For example, the UK undertakes many enquiries which are inquisitorial in nature such as, for example, mental health review tribunals and Parole Board hearings. Continental European countries usually allow some degree of argument from prosecution and defence in court. In North America some jurisdictions that have been heavily influenced by French culture, e.g. Quebec in Canada and Louisiana in the USA, have retained some elements of

the Napoleonic Code (this is humorously exaggerated in the play *A Street Car Named Desire* by Tennessee Williams).

A strength of the common law is its roots in the country's history and social customs. It became an integral and growing part of society, adapted by the judges as they saw the need. This natural indigenous strength enabled it to withstand the otherwise probable introduction of civil law at the time of the Renaissance. Civil law has the attraction of a logically coherent system. The contrast was drawn by the celebrated American judge, Justice Holmes, who said, 'The life of the (common) law is experience and not logic.' Thus, the common law grew by adaptation and response to actual circumstances and situations, instead of starting with a general theoretical formulation of legal principles which would then be applied to particular cases as in civil law (see Pollock and Maitland, 1968 for further reading).

This chapter, indeed this book, is almost exclusively concerned with common law. It would be impossible to have it any other way for each country has its own legal system and generalizations of 'common law' and 'civil law' don't really give much guidance to the system that might be found in any particular country. For example the laws of France and those of Germany, two very large continental countries both claiming to practice civil law, are remarkably different from one another and together they are different from most other civil law countries. A useful and most informative book 'written for amateurs, not professionals' is by Merryman and Pérez-Perdomo (2007) and should be consulted by any British forensic psychiatrist abroad.

In England the post conquest Norman seignorial courts gradually gave way to the unifying effect of a common law administered by the royal judges riding out on circuit from Westminster to hold assizes in major towns and, by the end of the thirteenth century, the supremacy of the King's courts was established. To ease the burden upon the royal judges of administering the criminal law nationwide, the forerunners of present-day magistrates were appointed by 1328. The King's Bench was one of the principal central courts set up at that time. The exercise of the early common law depended upon a limited number of particular writs issued by the King's Chancery and only certain wrongs were recognized as capable of being redressed. The embryonic centralized or common law was developed by the royal judges adapting customs and such principles as they knew. They were held to be the repository of the law and would declare what it was when confronted by a particular set of circumstances. Thus, we can see the origins of the present concept of precedent where an established principle decided in a specific case is applicable in subsequent cases, although superior courts can overrule a precedent.

The early writs were not sufficiently flexible for a developing society, and pleas for justice, where no writ was available, began to be made to the King. The Court of Chancery was established as the pleas addressed to the King were passed to the Lord Chancellor who tended to decide according to what he thought was equitable instead of following strict common law principles hammered out by the King's judges. So the common law grew by the experience of innumerable cases, leavened by the individualistic remedies of the Chancery. As more cases were heard in the Chancery courts, it too began to develop rules and principles as precise as those of common law. That system came to be known as equity. For many years the common law and equity developed side by side, practised in different courts by different judges. In 1873 the Judicature Act fused these two systems so that courts today employ both blended together. A contemporary example would be the legal mortgage and the equitable mortgage, both capable of being held in respect of the same property, but subject to different rules (see Walker, 1980 for definitions).

In England the adversarial system of justice is employed. When a criminal case is heard in the Crown Court the parties to the case are the accused or defendant, and the Crown or prosecution. The legal representatives of both sides present their view of the facts, examine and cross examine witnesses, and make closing speeches to the jury. The judge sums up, and instructs the jury upon the law. The jury are the judges of fact, they consider the evidence, bring in a verdict, and the judge passes sentence. Only some cases are officially reported, but those that are add to the ever-growing body of reported decisions which influence the results in future cases on identical or similar relevant facts. There are many sets of printed reports. The *All England Law Reports* are an example. Databases, such as *Lexis,* are now recording all the decisions of the High Court and above.

The doctrine of precedent is very important to the practice of law in England. Judgments are said to be binding or persuasive. Thus a judgment in the Court of Appeal on a particular set of facts will bind judges in the Crown Court in a case on conceptually similar facts. A judgment in the Supreme Court will bind the Court of Appeal. A judgment in the Crown Court will be only of persuasive authority if a similar case is heard in the Crown Court.

In modern English law, statute (i.e. acts of Parliament) plays an increasingly important part. Sometimes statutes are used to codify parts of the law, where perhaps a myriad of individual case decisions have become what Cromwell called an 'ungodly jumble', and have made the law uncertain. The Theft Acts 1968 and 1978 are examples of codifying statutes. Sometimes, like the Mental Health Act 1983 (amended) statutes arise purely from Parliamentary concern and debate. Statutes are often framed in general terms, and precise definition may not be given. Thus the term mental disorder in the Mental Health Act 1983 (amended) is not defined. If a particular case required the term to be defined, this would be a question of law for a judge in the particular circumstances of the case. Another example might be the meaning of 'treatment' in a particular statute.

Thus the common law in its broadest sense is a cycle of accumulating case decisions which may require

clarification by statute, itself to be interpreted by further case law. How the cases concentrate and what statutes are required depend upon the issues in contemporary society, its philosophy, its politics, ethics, and its concept of rights. Since Britain joined the European Economic Community, the European Court has erected a further tier of binding authority above the Supreme Court. Common law is, obviously, an older system of law than modern statute law. It is gradually being codified by parliamentary statutes, but it should not be thought that in situations where little or no statute law has been enacted there is no law. Usually there is well-developed common law. A case in point is the law of battery. This is the infliction of unlawful personal violence by one person on another. Violence in this sense includes all degrees of personal contact (e.g. touching) without consent or other lawful authority. Clearly, this is of great importance in medicine, for much that is done by a doctor could be called battery unless it is with the consent of the patient. Hence the importance of the law of consent and an individual's capacity to give consent (see chapter 4). Many other circumstances are covered by the common law. It is not possible to deal extensively with the common law authorities or cases in this book. Professionals in doubt about the legal position in a particular case should consult legal textbooks and, on occasions, legal advisers. However, and this is most important, they should not allow ignorance of the law, or absence of advice, to prevent them from acting in the patient's best interests. If a matter is urgent, then good medical care should be offered without looking backwards to law. The commonest suit that patients bring against clinicians is one of negligence, but the law of negligence emphasizes both contemporary standards of professional practice and what level of competence was to be reasonably expected. Acting in good faith with proper professional skill on behalf of the patient is usually a sound defence when negligence is alleged, particularly in an emergency. Indeed, inaction may itself be unlawful in some situations because, if the law construed that someone has a duty to take a particular action, then failure to take that action may give rise to a criminal charge or to a civil liability.

EUROPEAN COURTS

In addition to national courts Europe has two influential international courts. The European Court of Justice (mentioned above) is in Luxembourg and deals with all matters relating to the laws and regulations of the European Union, disputes between member states and the European Union and matters of that kind. So far it has had little to say about psychiatric practice. However, the European Court of Human Rights in Strasbourg, established as part of the European Convention on Human Rights of 1950, has had a profound effect on both mental health law and prison law throughout Europe including the United Kingdom (see Council of Europe).

The *Convention for the Protection of Human Rights and Fundamental Freedoms* (usually known as the *European Convention on Human Rights*) is a remarkable achievement. It is a treaty between the 47 member states of the Council of Europe. The states maintain their sovereignty but commit themselves through conventions and co-operate on the basis of common values and common decisions. The Convention was adopted in 1950 and became operational in 1953. It created the European Court of Human Rights which sits in Strasbourg. The Court supervises compliance with the European Convention on Human Rights and thus functions as the highest European court for human rights. It is to this court that Europeans can bring cases if they believe that a member country has violated their rights. It has 59 articles and 13 protocols. It is the section on rights and freedoms, articles 2 to 18, especially article 5, which is of most interest to the forensic psychiatrist. An abbreviated version of the Convention is given in appendix 1.

The Human Rights Act 1998 brought the Convention rights into UK domestic legislation. The impact of the Convention and particularly article 5 is seen at its most marked in the various mental health acts of the UK and the Republic of Ireland.

COURT STRUCTURE, ENGLAND AND WALES

Figure 2.1 shows the overriding importance of the new Supreme Court and also the lines of appeal, but not all courts are included, e.g. coroners' courts are omitted and there is no mention of the Parole Board which functions as a court. Tribunals are included but they now are part of a separate tribunal service. For this text coroners' courts will be included in this chapter and mental health review tribunals in chapter 3.

CRIMINAL LAW IN ENGLAND AND WALES

It is a long-standing principle of English common law that to be guilty of a crime and subject to the full rigours of the appropriate punishment two elements should be proved (except in cases of strict liability, such as careless driving). First, it has to be shown that an illegal act or omission has occurred and been carried out by an identified person (*actus reus*). Further, it has to be shown that the act or omission caused the offending consequences. Second, it has to be shown that the person had the state of mind (*mens rea*) proscribed in relation to that crime. There is plenty of room for debate on both of these issues in many cases; resolution of these is one important function of criminal courts. The second or 'mental' element is the one with the greater potential for debate.

If this sounds somewhat arcane, a simple hypothetical example may illustrate both the importance and the difficulty of making decisions about these concepts. Let us suppose that two people are coming, side-by-side, down a long stone staircase. One of them falls, crashes to the bottom,

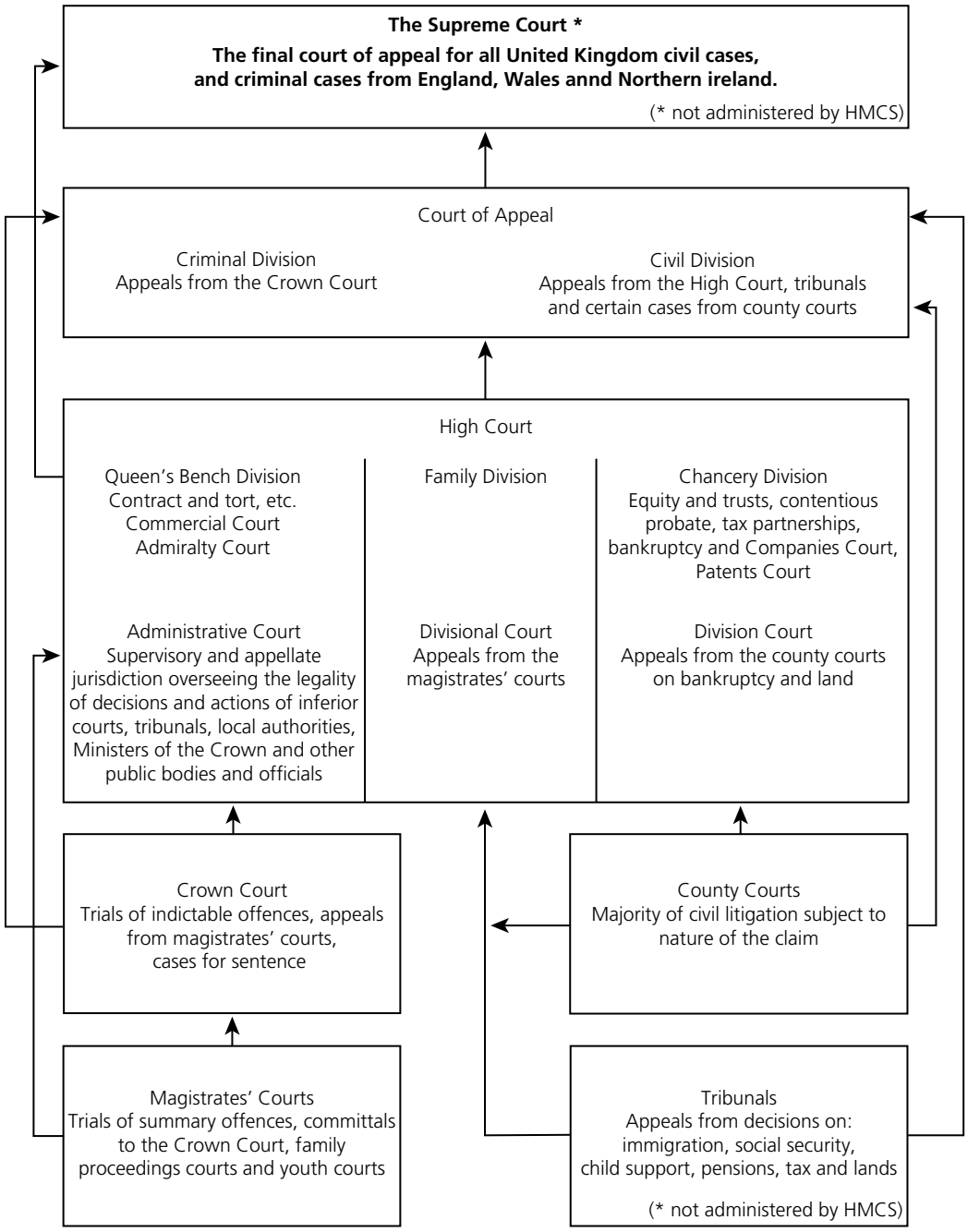

Figure 2.1 The court structure of Her Majesty's Courts Service (HMCS) in England and Wales. Reproduced from the HMCS website: www.hmcourts-service.gov.uk/aboutus/structure/index.htm

suffers a head injury and dies. Did the survivor touch the deceased? Was the touch a push or a trip? If it was a push or a trip was it deliberate or an accident? If it was deliberate what was the intention? The answers to these questions determine whether the incident was an accident or a crime, and if a crime, the seriousness of the crime.

In the real case of *White,* Mr. White put poison in his mother's drink in order to kill her; she drank some of the poison and died, but from a heart attack; thus no *actus reus* of murder took place and Mr. White was convicted of attempted murder instead.

In the law, *mens rea* means the mental state or quality of behaviour (such as 'recklessly') required for the offence under consideration, and it is expressly stated or implied in the definition of the particular offence. For example, in the Theft Act 1968, theft is defined in section 1 as dishonestly appropriating property belonging to another with the intention of permanently depriving the other of it. Thus the

mens rea for the offence of theft requires both dishonesty and an intention permanently to deprive the victim of the property. In other offences expressions such as 'knowingly' and 'maliciously' describe the required *mens rea.* Clearly 'mental state' is used here in a very restricted sense; it is concerned largely with the cognitive aspects of a person's mental state and not with the emotional aspects. *Mens rea* may include intentionality, recklessness, 'guilty knowledge' (i.e. knowing that one is doing wrong), competence and responsibility. Such concepts are abstract ideas, antedate psychiatry, and are *not* subservient to medical ideas.

The concept of responsibility, for example, is fundamental to our view of man as a free, intentional being. Every society, every culture uses it. It is the basis of every criminal code and system of punishment. We understand that some people (e.g. the young, the mentally abnormal) are less responsible than others, and we sometimes excuse people of responsibility altogether. Lawyers use a list of excuses which includes mistake, accident, provocation (to a charge of murder), duress and insanity (Hart, 1968). Psychiatrists are sometimes called upon to give evidence in support of these excuses. As we shall see below, they should, on the whole, resist the temptation except in very special circumstances or in the case of insanity. They should note too that they are called upon to give *evidence* rather than take the decision, even though courts press hard on occasions for medical opinions about these non-medical matters. The rules concerning expert testimony limit such witnesses to their expertise and psychiatrists should, in particular, avoid being drawn into discussions of moral or legal responsibility.

In considering the way a legal system handles these matters, it is as well to remember that 'the law' is neither logical nor consistent, nor does it satisfy everyone's notion of justice. It is human, pragmatic, and has developed by piecemeal legislation, by precedent and by tradition (see Ormerod, 2008 for a good account). In England, it is so pragmatic that it has produced the apparent paradox that all but a tiny handful of mentally abnormal people are found guilty of their antisocial/illegal acts even if they were clearly mentally abnormal at the time of the act, and matters of responsibility and culpability are dealt with as mitigation of sentence. This is probably true even in other legal systems which use the insanity defence more often.

For convenience, the criminal process including the court hearing will be divided into three phases: pretrial, trial, and sentence. These three phases can be detected in every criminal hearing even if they are very brief or amalgamated. Table 2.1 indicates the issues to be considered in each phase.

Table 2.1 Criminal hearing

Pretrial	Trial	Sentence
Prosecution	Automatism	Psychiatric mitigation
Fitness to plead	Insanity	
	Infanticide	
	Diminished responsibility	

Magistrates' Courts

No matter how grave, all crime has its first hearing in the magistrates courts, where basic issues are addressed, such as whether there is sufficient evidence against the accused to constitute a 'case to answer' in a higher court, and whether s/he should be granted bail.

Over 95% of cases are finalized in the magistrates' courts, almost 92,000 cases are sent or committed to the Crown Court for trial, and a further 20,000 cases committed to the Crown Court for sentence.

In magistrates' courts, approximately 7% of defendants plead not guilty; in the Crown Court, approximately 33% plead not guilty. Details of the history, composition and procedure of these courts may be found in various texts such as Walker (1985), White (1991) and Skyrme (1983). Such courts try offences occurring within their own catchment area or local criminal justice areas, of which there are some 254 in England and Wales. The maximum penalty which may be imposed is 6 months' imprisonment for a single offence (and 1 year for two offences), in addition to fines, the upper limit of which is £5,000 (2007). The magistrates' court may also order the defendant to pay compensation of up to £5,000. Apart from about 300 district judges and deputy district judges who are legally qualified, paid for the work, and who sit alone, the function of judge (in sentencing) and jury (in deciding issues of innocence and guilt) is performed by two or three justices of the peace, who are unpaid lay members of the public who have had some training. The linchpin in the magistrates' court is the legal advisor to the justices, who advises on points of law and procedure. The courts are of 'summary' jurisdiction, in which brevity is of the essence. Over 90% of cases are dealt with without a request for psychiatric opinion or intervention. Even so, magistrates' courts pass the bulk of the hospital orders which are made each year (these data are from the Crown Prosecution Service annual report 2006/7); more up to date data can be obtained from www.cps.gov.uk/Publications/reports/

Mental Health Courts

It is noticeable that mental health courts do not appear in figure 2.1. They are new, experimental and may not last. They are adjunctive to magistrates' courts.

Most authorities now recognize that large numbers of mentally disordered people are caught up with the criminal justice system. Since the 1990s Britain has developed criminal justice liaison and diversion services which operate as an interface between mental health services and criminal justice agencies to ensure that offenders with mental health problems are diverted into treatment. Rutherford (2010) estimates that there are

150 such schemes in England and Wales. The schemes however do not in any way meet the demand for such services. Rutherford lists some of the reasons why this might be so: for example there are no national guidelines; they are poorly funded; they rely on inadequately trained staff; they do not seek to influence the decision of the court; they do not have assertive interventions.

In the United States a different system also known as mental health courts has developed. Two mental health court pilot projects were established in England in 2009. They are not running parallel to the general court system (as in the USA) but are integrated into magistrates' courts. The two pilot schemes were established in Brighton and in Stratford (east London). These schemes also do not meet with universal approval. Bradley (2009) questioned the value of such courts in his report 'the majority (of benefits) could be met by effective liaison and delivery services which would eventually be available to all courts.' Such optimism is hardly justified by the results of the first 10+ years of the criminal justice liaison and diversion services. In reality if either type of service is to succeed, a great deal will depend on the level of both psychiatric interest and resources which support them, above all psychiatrists and psychiatric nurses will need to be specifically trained.

The existence of two slightly different services working towards the common goal of diverting mentally disordered people from the criminal justice system provides an ideal comparative research opportunity. Who is betting on that opportunity being taken?

Pretrial

For illustration let us take a mentally abnormal man who has been violent. The police are called and the criminal process begins. As soon as the facts are clear and a defendant is arrested, the police officer in charge of the case has decisions to make about *mens rea* and/or mitigation (although s/he does not call them that); s/he has to decide whether a prosecution should proceed at all. If the patient is already having psychiatric treatment, s/he may ask the doctor and/or hospital to deal with the matter as a medical one. S/he is told that 'provided sufficient evidence exists, the decision whether to charge must be guided by what is in the public interest. The existence of mental disorder should never be the only factor considered and the police must not feel inhibited from charging where other factors indicate prosecution is necessary in the public interest.' It is essential to take account of the circumstances and gravity of the offence and what is known of the person's previous contacts with the criminal justice system and psychiatric and social care services (Home Office Circular 1995, No. 12). If a hospital or doctor declines to take the patient or the police officer believes that to fail to prosecute would be against the public interest s/he will report the case to the Crown Prosecution Service. Once again, the question of going forward will be debated and here, too, it is possible for psychiatric advice to be sought and, if appropriate, for the case to be diverted from the penal system to the healthcare system.

Another option available to the police officer, if the arrest was made in a public place, is to move the offender directly into a mental hospital under the police powers (s.136) within the Mental Health Act 1983 (amended). This can be done irrespective of whether the offender is already a patient or not. If the offensive behaviour was in a public place and the police officer thinks that the individual is 'suffering from mental disorder and to be in immediate need of care or control' in the patient's own interests or for the protection of others, the constable should take the patient to 'a place of safety', which can be a hospital, to await a medical examination. The detention is for a maximum of 72 hours and the hospital has to agree to take the patient (it may refuse). The 'place of safety' may also be a police cell, but no one believes that this is an appropriate place to care for an acutely disturbed patient and the Code of Practice (Department of Health, 2008) sees it as a place of last resort. The Code emphasizes that:

> *The purpose of removing a person to a place of safety in these circumstances is only to enable the person to be examined by a doctor and interviewed by an AMHP (approved mental health professional), so that the necessary arrangements can be made for the person's care and treatment. It is not a substitute for an application for detention under the Act, even if it is thought that the person will need to be detained in hospital only for a short time. It is also not intended to substitute for or affect the use of other police powers (para. 10.14).*

Prosecution decisions are not necessarily affected by this process, although admission to hospital may make prosecution less likely and hospital rejection may make it more likely. Phillips and Brown (1998), in their study of 4,250 people detained at ten police stations in England and Wales, in 1993/4 found that, 'Those whom the police treated as mentally disordered were much less likely than average to be charged: this was the outcome in just 44% of cases.' Robertson et al. (1996) reported a similar pattern in their research: 'The below average charge rate for mentally disordered detainees partly reflects the fact that a third had been detained under the Mental Health Act and not for an offence. However, those arrested for offences were also less likely than average to be charged.'

If it is decided to prosecute the offender, then s/he will have to appear in a magistrates' court. Here s/he will be remanded on bail or in custody according to the rules of the Bail Act 1976. The bail decision will be influenced by medical opinion about suitability for treatment and availability of treatment facilities. The court may also wish to remand the offender to hospital, either as a voluntary patient, or under the powers of the Mental Health Act 1983 (amended). As the criminal process moves on, the magistrates' court will have to decide whether there is a case to

answer (the ancient grand jury function) and, if so, whether it should be tried in a lower court or moved up to the Crown Court. The rules which are applied are complicated but, briefly there are three categories of seriousness: the most serious or indictable which have to go to the higher court, the least serious or non-indictable which are always tried in a magistrates' court (summary trial), and a large middle group which is triable either way, and in which any of the parties – prosecution, defence, or court – can opt for trial by jury in the Crown Court.

Fitness to plead

If someone is so mentally disordered that it is thought unfair to proceed with his or her trial, then the trial can be postponed, often indefinitely. Magistrates may postpone or adjourn the case to await a more favourable time; if they adjourn the proceedings *sine die* (i.e. postpone the case without a date for a further hearing), this is tantamount to excusing the accused from a trial. The other options available to them are either to promote the case to the Crown Court, so that the question of fitness to plead can be properly tested, or to proceed with the trial in order to hear the facts against the accused and consider a hospital order without recording a conviction (see below). If a remanded prisoner is suffering from 'mental illness or severe mental impairment', it is also possible to transfer him or her to hospital under section 48 of the Mental Health Act 1983 (amended).

The concept of being unfit to plead emerged from the rituals of the medieval court of law where a trial had to begin with the taking of the plea. If an individual was mute and did not enter a plea, the court had to decide whether this was through malice or by visitation of God. By the nineteenth century, the court also made a further determination of whether the accused could conduct a 'defence with discretion' (*Dyson*). An individual who was unfit to plead was said to be insane on arraignment and, subsequent to the Lunatics Act 1800, held at Her Majesty's Pleasure, usually in an asylum.

The criteria by which an individual is determined to be unfit to plead evolved through nineteenth-century case law, mainly in relation to cases of deaf mutes who were unable to communicate; the most important case was that of *Pritchard*. In essence, an individual is unfit to plead if s/he is not able to make a proper defence. Fitness has been interpreted as:

> *being able to plead with understanding to the indictment; being able to comprehend the details of evidence; being able to follow court proceedings; knowing that a juror can be challenged; being able to instruct legal advisers.*

Clearly, these criteria are concerned with intellectual performance. This is one illustration of the difference between the legal category of insanity and the medical concept of mental illness, showing how much weight is put on understanding or cognition in the former. Although the Criminal Procedure (Insanity) Act 1964 codified the process whereby a person is found unfit to plead (known in it as 'disability in bar of trial') and integrated it into modern legal practice, it remained silent on the factors that actually render an accused unfit to plead. The criteria, therefore, remain those relating to nineteenth-century legal concepts of insanity.

The question of fitness to plead can be raised by the defence, the prosecution or the judge. Although the judge can delay consideration of the question until after the prosecution has presented its case to ensure that there is, in fact, a case to answer, in practice, the issue is usually raised and decided pretrial. Since the passing of the Domestic Violence, Crime and Victims Act 2004 the issue of fitness to plead is decided by the court without a jury. This involves evidence and testimony by a psychiatrist directed towards the criteria listed above, as the 1964 Act was amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 to ensure that a finding of unfitness to plead cannot be made except on the evidence of two registered medical practitioners, at least one of whom is duly approved by the Secretary of State under the Mental Health Act.

The number of individuals found unfit to plead had been declining steadily since the late 1940s (Walker, 1968). Between 1980 and 1992 there were on average about 20 cases a year in England and Wales (Grubin, 1991a). Individuals who were then found unfit to plead, including those who are mentally impaired or deaf, were sent to 'such hospital as may be specified by the Secretary of State'. The bed had to be made available within 2 months. Little was known about the fate of those who had been found unfit to plead before 1976, but the course of all individuals found unfit to plead between 1976 and 1988 has been documented (Grubin, 1991a,b,c). Most had been sent to local, catchment area hospitals, although about 30% had been sent to high security special hospitals. Once in hospital, the patient was treated as though detained on a hospital order with restrictions on discharge, and came under the jurisdiction of the Mental Health Act 1983, amended 2007. Thus, it was possible for an individual found unfit to plead to be held in hospital for the remainder of his or her life without ever having been tried. Because of this risk of unlimited detention, it was often said that the issue of fitness to plead was only raised in cases where the charges were serious. In fact, however, only about one-quarter of cases between 1976 and 1988 involved charges of a severe nature; about one-third were related to cases of only mild severity, the most infamous of which involved Glen Pearson, accused of stealing £5 and three light bulbs from a neighbour's house (the case is described by Emmins, 1986).

Thus the arrangements for this group of mentally disordered people were very unsatisfactory. Only a few cases found unfit to plead were returned for their day in court after their mental health had improved. However, for those subject to restrictions, the Secretary of State could also discharge the patient from restrictions instead of remitting him or her for trial. In addition, because the patient was

detained under the Mental Health Act (amended), discharge via a mental health review tribunal was also possible. Patients who did not recover were subject to long-term compulsory hospitalization. Of those found unfit to plead between 1976 and 1988, almost a quarter remained in hospital in 1990. Most were, in fact, quite unwell and needed to be in hospital in view of their mental health. However, because they were held on the grounds of being unfit to plead, some of them were cases who would not otherwise have attracted a restriction order.

Following repeated criticism the law relating to both fitness to plead and insanity was amended in the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991. This law made two important reforms. In the case against an individual likely to be found unfit to plead, it requires a trial of the facts to be held to determine whether s/he has committed the act or omission in question. In effect this means that the prosecution must prove that the accused has committed the *actus reus* which forms the basis of the charge. If they cannot do so the accused will be acquitted. So it is only in those cases where the prosecution can satisfy a jury as to this requirement that the accused will be the subject of any further disposal by the court. Further, although the House of Lords in the case of *Antoine* confirmed that the trial of the facts does not include proof of the *mens rea* but only the *actus reus*, nevertheless the accused in such proceedings may be able to use certain defences. For example, if the accused is charged with assault but there is clear evidence that s/he was acting in self-defence then s/he ought to be able to use such a defence.

The 1991 Act also introduced flexible disposals for findings of unfitness to plead and verdicts of not guilty by reason of insanity, removing the inevitability of a hospital order with indefinite restrictions on discharge. This meant that a range of disposal options became available to the court. Subsequently, the Domestic Violence, Crime and Victims Act 2004 refined the disposal options. There are three available disposals. As before an individual may be admitted to hospital with or without restrictions, but any hospital order must now comply with all the required conditions for the making of such an order under the Mental Health Act 1983 (amended), and the court will determine which hospital the patient will go to. This important change was in order to protect those who are unfit to plead but not mentally disordered, such as the deaf mute, from possible hospitalization. A second option is for the court to use a community disposal, e.g. a supervision order under the 2004 Act which specifically includes those who are physically as well as mentally disordered; a medical treatment requirement can be added if appropriate. The court may also order an absolute discharge. In the light of this disposal flexibility the number of findings of unfitness to plead has risen (see Mackay et al., 2007a).

One way of avoiding or illuminating these weighty matters in the case of an individual who meets the required criteria is for the court to remand the patient to hospital under s.36 Mental Health Act 1983 (amended). If the patient improves quickly, then the trial may proceed, if not, then there is more information available. Another way (see below) is to make a hospital order without recording a conviction.

Amnesia

From time to time, a good deal of attention has been given to the question of memory and fitness to plead. It is sometimes argued that if someone has a loss of memory for the time during which s/he is alleged to have committed an offence, then s/he cannot properly defend him- or herself and so should be regarded as unfit to plead. All common law jurisdictions have ruled that amnesia does not affect fitness to plead. They could hardly rule otherwise if the courts are to continue to function. The most notable case concerning this issue was that of *Podola*.

Mr Podola was charged with the murder of a policeman by shooting. He submitted that he was unfit to plead because of amnesia for the events. He was found fit to plead and subsequently convicted. On appeal, the principle that the defence should only have to prove the unfitness on the balance of probabilities was clearly enunciated, and the jury's verdict that the hysterical amnesia from which Mr Podola was alleged to have suffered was insufficient to amount to a disability in relation to the trial was confirmed. His counsel had submitted that he could not 'comprehend' the details of the evidence. The Appeal Court judges ruled that, nevertheless, he was of sufficient intellect to comprehend the course of the trial proceedings and that was what mattered. Further, a previous Scottish case had ruled that loss of memory on the part of a defendant did not render his trial unfair because he could tell the jury that he had no recollection of events. The Court of Appeal concurred and agreed that the jury should take the loss of memory into account, but of itself this should not render an accused unfit to plead.

Between one-half and one-third (O'Connell, 1960; Taylor and Kopelman, 1984; Kopelman, 1987) of people charged with serious offences, especially homicide, have some degree of amnesia for their offence and cannot adequately recall what happened at the time. Few questions about this issue will be asked of the psychiatrist in the pretrial phase in England.

The clinical aspects of amnesia are dealt with in chapter 12.

The Trial

The three main issues for psychiatrists in the trial are automatism, insanity, and diminished responsibility. It is only in homicide that English law allows degrees of responsibility according to degrees of mental health. In all other cases a defendant is found responsible or not responsible

and findings of non-responsibility on psychiatric grounds are extremely unusual. The special verdict, like all serious convictions until the nineteenth century, carries a mandatory sentence, (meaning no judicial discretion), if the jury believes there is malice aforethought. In other words it is a common law offence which has survived into the twenty-first century with a minimum of codification by statute. The reasons for this are political and historical. Until the abolition of the death penalty in Britain in 1965 the mandatory sentence was execution. Execution is always popular with the tabloid press and it was a struggle for abolitionist MPs to get the sentence repealed. They did so, in part, by agreeing to keep the verdict of murder different from all other verdicts by giving it the mandatory sentence of life imprisonment. The reality is however that homicide, like all other serious offences, comes in different shades of intent and malice. The calculated killing of someone for their money is different from a drunken fight in which someone dies and different again from a mercy killing. During the time of capital punishment all three such cases would probably have been sentenced to death although mitigation was often exercised by the Secretary of State. The Homicide Act 1957 was introduced to circumvent this nonsensical position to some extent by allowing special mitigation for mental disorder and for provocation. This did not solve the problem entirely and several attempts have been made to persuade various governments to remove the mandatory sentence for murder as allowing judicial discretion which would enable the judge to give a sentence appropriate to all the circumstances of the case. Politicians however are adamant that murder must remain different.

Automatism

Automatism is difficult enough to define in medical terms. It is even harder in legal terms. A good discussion of the legal principles involved is to be found in Ashworth (2006). Automatic behaviour is involuntary behaviour and most likely unconscious behaviour. English courts have divided automatism into non-insane (sane) automatism and insane automatism. A successful defence of automatism will always lead to a finding of not guilty, however the distinction between sane automatism and insane automatism means that the latter is subject to the McNaughton[1] Rules (see below) and thus disposals available to the court are as for insanity. The basis for the distinction is whether or not the automatism was caused by 'a disease of the mind'. As Ormerod (2008) reminds us 'whether a cause is a disease of the mind is a question of law' i.e. not medicine or psychiatry. Any 'internal factor', mental or physical, is, in law, a disease of the mind, so automatism caused by cerebral tumour or arteriosclerosis, epilepsy (see below), or diabetes arises from a disease of the mind. Convulsions, muscle spasms, acts following concussion, anaesthesia, medication or hypnosis are external causes and if successfully proved lead to a verdict of not guilty. As time has passed courts have tended to put more types of automatic and/or unconscious behaviour into the insane category, largely on the pragmatic ground that behaviour which is otherwise criminal and is likely to recur is better regarded as insanity. For example, sleepwalking at one time could be said to lead to sane automatism but since 1991 (*Burgess*) it has been regarded as insane automatism.

Two matters of medical importance concern self-induced intoxication which cannot *per se* give rise to a defence of automatism, but is complicated and dealt with under insanity below. The second matter is epilepsy which illustrates how legal thinking in this area has developed. At one time epileptic automatism was a fairly certain non-insane excuse. Bratty killed a girl by strangulation with one of her stockings. He said that a 'blackness' came over him and that he did not know what he was doing. He was said to suffer from psychomotor epilepsy. At the trial, the defences of insanity and automatism were both raised, but the trial judge refused to allow the defence of automatism. The jury found Bratty guilty of murder. On appeal, the conviction and the refusal to allow the defence of automatism were upheld in the House of Lords. Lord Denning said:

> *It seems to me that any mental disorder which has manifested itself in violence and is prone to recur is a disease of the mind. At any rate, it is the sort of disease for which a person should be detained in hospital rather than be given an unqualified acquittal.*

Thus was the concept of insanity enlarged and that of sane automatism diminished. A further step on the road was the case *of Sullivan,* also finally decided in the House of Lords. Mr. Sullivan was described as a man of 'blameless reputation' who suffered from epilepsy and had been treated for several years as an outpatient. When he was visiting a neighbour, he probably had a seizure and attacked an elderly man who was talking to him. The elderly man had to be treated in hospital, and Mr. Sullivan was charged with causing grievous bodily harm. His defence was automatism and evidence was given that he was almost certainly in an epileptic state at the time of the assault. Nevertheless, the judge ruled that the defence was really one of not guilty by reason of insanity. The defendant changed his plea to guilty and was given 3 years on probation with a condition of treatment. Lord Diplock dismissed an appeal against conviction on the grounds that epilepsy is properly described as a 'disease of the mind'. This meant that epilepsy is to be regarded as insanity in the legal sense. It has also been decided that hyperglycaemia may be regarded as a disease of the mind (*Hennessy*) if caused by failure to take insulin for diabetes. (The position in respect of hypoglycaemia is less clear; see for example *Watmore.*)

The Sullivan case sparked off letters to the medical journals and a symposium to discuss it all (see Fenwick and Fenwick, 1985). What had happened was the pragmatic

[1] Also spelt M'Naughten.

reaffirmation that people who do violent things will be subject to legal controls whatever semantic contortions have to be endured. Mr. Sullivan was found guilty, and the mitigating factors in his case were taken into account at the sentencing stage. He received a sensible disposal and was not punished for his automatic behaviour. The effect of all this on the patient has been described:

> *PS, like Rogozhin (Dostoevsky's character in* The Idiot*), never contradicted his clever counsel, although he clearly found his eloquence beyond his comprehension….We told him that the judge was prepared to consider him not guilty by reason of insanity 'But I'm not insane,' said PS. We advised him, because of the consequences of this, to plead guilty. 'But I'm not guilty,' said PS. Even the eloquent counsel paused, then PS spoke again: 'But you're three intelligent, educated people – I'll do whatever you say' (Taylor, 1985).*

Things improved with the passage of the Domestic Violence, Crime and Victims Act 2004. Now unless the accused is suffering from a 'mental disorder' within the meaning of the Mental Health Act 1983 (amended) which warrants treatment in a psychiatric hospital s/he cannot be sent to hospital. This means that if the only reason for the automatism (as in the Sullivan case) is found to be epilepsy, then only a non-custodial disposal would be available. No longer then would Mr. Sullivan be 'forced' to change his plea to one of guilty. However he would still carry the stigma of being labelled 'insane' which is a disincentive to using such a plea (see MacKay and Reuben [2007] for a discussion).

As the door closed on epilepsy and sleep-walking being non-insane automata in England and Wales, it is still left open for concussion and drug-induced states of altered consciousness. Two mental hospital nurses were charged with causing actual bodily harm to a patient by assaulting him. One of them had diabetes and he said that, before the assault, he had taken his insulin, but had eaten too little and had no recollection of the incident. His medical evidence supported hypoglycaemia at the material time. The trial judge (J Bridge) ruled that the proper defence would be insanity, whereupon the defendant pleaded guilty. His appeal was, however, allowed on grounds that a disease of the mind within the meaning of the McNaughton Rules is a malfunction caused by disease as opposed to a transitory external agent (such as insulin). The Court concluded:

> *In our judgment the fundamental concept is of a malfunctioning of the mind caused by disease. A malfunctioning of the mind of transitory effect caused by the application to the body of some external factor such as violence, drugs, including antibiotics, alcohol, and hypnotic influences, cannot fairly be said to be due to disease. Such malfunctioning, unlike that caused by a defect of reason from disease of the mind, will not always relieve an accused from criminal responsibility. A self-induced incapacity will not excuse, see* Lipman*, nor will one which could I have been reasonably foreseen as a result of either doing, or omitting to do something, as, for example, taking alcohol against medical advice after using prescribed drugs, or failing to have regular meals while taking insulin (Quick).*

Although the very rare problem of violence associated with epilepsy has been firmly put in the insanity category, this case opens the possibility (no more than that) that an epileptic seizure caused by an external agent, for example a flickering light, could still successfully plead sane automatism (see Mackay and Reuben, 2007).

Insanity

A prominent myth concerning forensic psychiatry is that questions of insanity in the trial are an important part of the job. In reality, very few cases of insanity come to the courts each year in England and Wales and the average forensic psychiatrist can expect to deal with only one or two in a professional lifetime.

Hospital orders without a conviction

There is a special mechanism in the lower or magistrates' court for dealing with mentally disordered offenders. Quite simply, the magistrates press on with the case if it is within their jurisdiction, hearing the evidence for and against conviction. If they are persuaded that the accused carried out the act as charged, they can then take psychiatric evidence about him or her. If a recommendation is forthcoming that the defendant should go to hospital rather than prison, and hospital order papers are signed, they can then accept that option and simultaneously decide, under section 37(3) of the MHA 1983 (amended) not to record a conviction. This neat device ensures a proper hearing, but allows a psychiatric disposal without the stigma of what would be a criminal conviction in the tradition that the mentally ill should be excused the behavioural consequences of their illness (insanity). The disposal is not used very often; most such offenders are convicted and then given a psychiatric disposal. Perhaps it should be used more often. It should always be considered as a possibility by the examining psychiatrist and discussed with the patient's lawyer when the patient is to be recommended for a hospital order in the lower court. It is also helpful in cases where the accused is charged with a relatively trivial offence, but seems unfit to plead.

The special verdict

In England and Wales, legal insanity is a valid defence to any charge which can be tried in the Crown Court.[2] The Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, as with unfitness to plead, brought in flexible disposal following an insanity verdict, giving the court a range of disposal options. The tests of insanity used in the trial

[2] It is also available in a magistrates' court where there is no special verdict so may in an appropriate case give rise to an unqualified acquittal, see *Singh*.

focused on knowing and understanding. The tests are the 1843 McNaughton Rules (see West and Walk, 1977). The Rules state:

> *Every man is presumed to be sane, until the contrary be proved, and that to establish a defence on the ground of insanity it must be clearly proved that at the time of committing the act the accused party 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 that what he was doing was wrong.*

In essence this has two limbs. The first, which is the 'nature and quality' limb, has been interpreted to require that the accused because of a disease of the mind 'did not know what he was doing' (*Sullivan*). The second, the 'wrongness limb', is limited to those who, again because of a disease of the mind, did not know that what they were doing was legally wrong (Johnson, 2007; EWCA Crim, 1978). Both limbs are so narrow and limited in their application that they will rarely be applicable to those who are mentally ill, irrespective of the severity of the illness.

A lesser-known rule says:

> *If the accused labours under a partial delusion only, and is not in other respects insane, he should be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real.*

This latter rule relates to the defence of mistake, and is difficult for psychiatrists to understand because of the difficulty of knowing what is meant here by a partial delusion and, in practice, is rarely employed. A partial delusion is probably not simply an overvalued idea, but is more likely a monosymptomatic delusion. The rule seems to be saying that if, for example, the man accused held a single delusional belief that his ear surgeon had implanted a transmitting device in his head and the device was interfering with his brain or giving out messages, then an assault (let us say on the surgeon) should be judged by the jury as if that were really true.

Clearly, the McNaughton Rules are strict rules. However, much as with unfitness to plead, the introduction of flexibility of disposal has resulted in an increase in the use of the insanity defence (see Mackay et al., 2007b).

Most jurisdictions using these rules have found them unsatisfactory and tried various devices to circumvent them. For example in the USA there is the Durham Rule, the American Law Institute Rule, and there is even a verdict of guilty but mentally ill in some states. This last piece of legislation has been highly contentious because it is argued that an insane person cannot be guilty (see Blunt and Stock, 1985, and Weiner, 1985, for discussions). However, very few mentally abnormal offenders in any jurisdiction are protected against conviction by their mental status at the time of the offence. The special verdict was of much greater importance in Britain when the mandatory sentence for murder was capital punishment and there was no diminished responsibility law. Arguments about the McNaughton Rules became arguments about life and death.

Diminished responsibility

Infanticide

Special legislation concerning women who kill their children originated in an 'Act to Prevent the Murthering of Bastard Children' of 1624, which decreed that if an unmarried woman concealed a birth and the child was subsequently found dead, she was presumed to have killed it unless she could prove that the child was born dead. The Act was aimed as much at discouraging immorality as against the killing of children, and the penalty was death. In the seventeenth and eighteenth centuries most infanticide charges were under this statute; three-quarters of the accused were spinsters (Beattie, 1986). By the mid-eighteenth century attitudes began to change and both judges and juries became reluctant to convict. An Act of 1803 changed the onus of proof, and infanticides were then treated like other kinds of murder. Concealment of birth became a separate offence in 1828 (Smith, 1981). The last woman executed for killing her child was Rebecca Smith in 1849; she had used poison (suggesting premeditation) and was suspected of poisoning several other children (Walker, 1968). Since the mid-nineteenth century the death penalty has invariably been commuted, and by 1864–65, when the first Royal Commission on Capital Punishment heard evidence, most witnesses were in favour of exculpatory legislation on infanticide. After a series of unsuccessful bills the first Infanticide Act was passed in 1922. It was restricted to the killing of 'newly-born' children, but uncertainties of interpretation led to the enactment of the Infanticide Act 1938 which extended the age limit to 12 months.

The Act provides that if a woman kills her child under the age of 12 months in circumstances which would otherwise amount to murder, but at the time 'the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child', she will be convicted of infanticide, an offence punishable as if she had been guilty of manslaughter. In practice, it is dealt with leniently and the defence is falling into disuse. In 1971 there were 18 cases; between 1997/8 and 2007/8 there were 20 cases, 5 in 2000/1 but only 3 between 2001/2 and 2007/8. This gives an annual average of 6.8 women convicted of infanticide in the last third of the twentieth century and one in the first 8 years of the twenty-first century. Although the majority since 1997 were put on probation three were sentenced to terms of imprisonment of 4 years or under (Povey et al., 2009).

About half the women convicted of infanticide kill newborn children in the context of unwanted, concealed pregnancies, and about half are battering mothers. Social and psychological stresses are more relevant than mental illness (d'Orban, 1979), although puerperal psychosis must not be forgotten as a potentially lethal illness (see chapter 20).

Infanticide can be charged in the first instance, but often the initial charge is murder, and infanticide is either replaced as the charge or is pleaded as a defence to the murder charge. Once evidence has been adduced to raise the defence, the burden of disproving it rests on the Crown; in this respect it differs from the defences of insanity or diminished responsibility, where the burden of proof is on the defence using the balance of probabilities standard. Further differences are that infanticide does not require proof that the killing resulted from the abnormal mental state, merely that, at the time, the mother's 'balance of mind' was disturbed. The jury does not have to weigh the question of responsibility. The degree of abnormality implied by the disturbance of 'balance of mind' is, in practice, much less than that required to substantiate 'abnormality of mind' in the diminished responsibility defence (d'Orban, 1979).

Despite some anomalies, the Infanticide Act 1938 continues to serve a useful purpose. One anomaly is that it only applies to the killing of the last born child although the mother's other children may also become victims. Another anomaly, the lack of provision for an offence of attempted infanticide, has been remedied by the Criminal Attempts Act 1981, so that a woman whose baby victim survives can now be charged with attempted infanticide rather than attempted murder (Wilkins, 1985). Third, the Court of Appeal has decided in *Gore* that infanticide is not restricted to cases where the offence would only have amounted to murder in the sense that it must be proved that the accused intended to kill or cause grievous bodily harm at the time of the killing. Rather, infanticide is wider and may be used where the accused is charged with manslaughter. This makes infanticide a wider offence/defence than was originally thought and will protect those women who, whilst mentally disturbed as a result of childbirth, kill their children under the age of 12 months but do so by neglect rather than intentionally. In short, such women will not be required to acknowledge that they murdered their children before they can benefit from a charge of infanticide.

Scotland, like some civil law countries, has used diminished responsibility since the nineteenth century (Walker, 1968). England embraced the concept for the same reason that it had embraced infanticide: growing abhorrence of the death penalty. Both these concepts allow a killer to be convicted of a serious offence, one carrying life imprisonment if appropriate, but they give discretion to the judge and avoid any mandatory sentence death until 1969 (1965 in effect) and now life imprisonment. There is considerable confusion about the future of this concept in England with the enactment of the Coroners and Justice Act 2009 in November 2009 (see below). It abolishes the provocation defence and significantly changes the diminished responsibility legislation. It is worth noting something of the existing diminished responsibility legislation and its history to set this change in context.

Section 2 of the Homicide Act 1957 stated:

S.2 Persons suffering from diminished responsibility

1. *Where a person kills or is a party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing.*

2. *On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section not liable to be convicted of murder.*

3. *A person who but for this section would be liable, whether as principal or as accessory, to be convicted of murder shall be liable instead to be convicted of manslaughter.*

4. *The fact that one party to a killing is by virtue of this section not liable to be convicted of murder shall not affect the question whether the killing amounted to murder in the case of any other party to it.*

Provocation

Where on a charge of murder there is evidence on which the jury can find that the person charged was provoked (whether by things done or by things said or by both together) to lose his self-control, the question whether the provocation was enough to make a reasonable man do as he did shall be left to be determined by the jury; and in determining that question the jury shall take into account everything both done and said according to the effect which, in their opinion, it would have on a reasonable man.

It was not long before this curious Parliamentary wording was subject to a deal of legal wrangling. In *Byrne* a judge's direction was overturned by the Court of Appeal and Lord Chief Justice Parker ensured that, from 1960 onwards, the concept of abnormality of mind used in the statute could be interpreted very widely. He ruled:

Abnormality of mind... means a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal. It appears to us to be wide enough to cover the mind's activities in all its aspects, not only the perception of physical acts and matters and the ability to form a rational judgment whether an act is right or wrong, but also the ability to

exercise willpower to control physical acts in accordance with that rational judgment.

This remarkable judgment made legal history. It introduced the long-disputed concept of the irresistible impulse into the law on homicide and allowed all forms of mental disorder – handicap, neurosis, personality disorder – to be considered for the verdict. Byrne himself was an unintelligent, personality-disordered individual.

Presumably the intention was to allow the most disordered people to be excused as insane, other middle ground cases to be liable to conviction of manslaughter, leaving only the mentally normal to the full rigours of a conviction for murder. Presumably too, the Lord Chief Justice would have expected the proportion of people excused from murder on psychiatric grounds to increase, but this did not happen.

The defence can only raise the question of diminished responsibility on medical grounds, and it has to be demonstrated on the balance of probabilities. Sometimes, the prosecution and defence agree that there is such a probability. If so, they can then put their agreement to the trial judge; if s/he accepts the position and the facts are clear, there is no trial, the accused is convicted of manslaughter and the sentencing can begin. If either the prosecution or the judge disputes the defence submission, then the matter is argued out in the usual way in front of a jury who make the final decision.

Griew (1988) and others have argued that the wording of the Homicide Act is extremely odd and makes for legal difficulties. As a result:

Psychiatrists, rather more than lawyers, have agonized over the statutory expression, have looked unavailingly to the lawyers for enlightenment, and have contributed to the inconsistency in the use of the section by the differences in their own reading of it... There can be little doubt that the fate of some people charged with murder since 1957 has turned on the qualities of robustness and sophistication shown by those professionally involved in their cases.

Yet something more fundamental than this is happening. When Griew was writing in 1988 approximately 16 or 17% of murder charges were being reduced to manslaughter by reason of diminished responsibility. Since that time the picture has completely changed and at the beginning of the twenty-first century the rate of such decisions has dropped to 2 or 3% (figures calculated from Povey et al., 2009). This must be due to changing social pressures and illustrates that legal decisions are subject to those pressures just like all other behaviour. It is difficult to know what factors have brought about this fairly dramatic change, but impressions from the courtroom would suggest that prosecution policies have changed so that many fewer 'diminished' cases are dealt with by agreements between the prosecution and the defence and many more are subject to trial and the opinion of the jury. Standing in the court room, it often seems that juries are reluctant to grant any mitigation from mental disorder; indeed they sometimes seem to regard mental disorder as an aggravating factor. In addition to these legal issues it seems also that psychiatrists are less and less willing to acknowledge the role which mental disorder plays in many serious crimes. This may be due in part to swimming with the tide of increasing toughness and incarceration for interpersonal offences and it may also be affected by resource issues. A diminished responsibility verdict may imply to the judge, for example, that hospital admission would be more appropriate than imprisonment and, as the stock of long-term security beds falls, such admissions are less and less palatable to psychiatrists.

These trends are much longer term than they appear on superficial examination and they are almost certainly rooted in British government policy, in spite of frequent declarations that diversion of the mentally disordered to prison is a government objective. Dell (1984) showed that, between 1964 and 1979, in spite of an increasing number of homicides in England and Wales, and in spite of the fact that at that time the proportion of men who had their conviction reduced to manslaughter by reason of diminished responsibility remained fairly constant at 20%. The number of such convicted men going to hospital had not changed (about 24 per annum) but the number of such men going to prison increased sharply (12 men in 1964, 48 in 1979). Dell suggested possible reasons for this increasing proportion being sent to prison and concluded that the main factor was a decreasing readiness of psychiatrists and prison doctors to recommend hospital places. In turn, this reluctance was based on a tightening up of the criteria for admission to special hospitals. The Department of Health had tightened the criteria for admission to high security hospitals with the hope that regional health authorities would provide a bed instead. In practice, reporting doctors increasingly failed to recommend this option and more and more men went to prison.

The myth that high security hospitals are not really needed and that they can be supplanted (largely if not completely) by a scattering of medium security units across the country is driven by a fine idealism, but omits to take into account important and practical considerations such as the extra cost of managing long-term patients this way, the hostility to serious offenders which exists within many mental health trusts, and the important domestic needs of long-term patients which are often not adequately met in medium security units. The idealism is driven by the notion that most if not all psychiatric care can be managed 'in the community'. Serious offenders who have significant mental disorders cannot be admitted to the community; they require long-term hospital care. Caution has been urged about the consequences of running down the high security hospital population (see for example Abbott, 2002; Coid and Kahtan, 2000; and Gunn and Maden, 1998) but it has largely

fallen on deaf political ears. The special or high security hospital population in England peaked at 2,522 patients in 1956 and has been falling steadily since that time; by 1987 it was 1,724 and 10 years after the turn of the century it is approximately 400. It is no wonder that the trend towards imprisoning mentally disordered serious offenders has continued and now is virtually changing the law with the marked reduction in the proportion of homicide offenders who are able to take advantage of the Homicide Act 1957. Of course this should not occur; each case should be considered on its merits and the consequences of doing that should put pressure on the government to change its policies and services. Reality is different however, and although the actors in the pageant are not aware of colluding with a paradoxical government policy, that is what they do.

It is generally agreed that homicide legislation in England and Wales is unsatisfactory. The Law Commission (2006) produced a proposal to modify the common law offence, as has been done in many of the United States, so that homicide could be prosecuted in different degrees thus producing first-degree murder and second-degree murder with only first-degree murder continuing to carry the mandatory sentence. They said:

> *The law governing homicide in England and Wales is a rickety structure set upon shaky foundations. Some of its rules have remained unaltered since the seventeenth century, even though it has long been acknowledged that they are in dire need of reform. This state of affairs should not continue. The sentencing guidelines that Parliament has recently issued for murder cases presuppose that murder has a rational structure that properly reflects degrees of fault and provides appropriate defences. Unfortunately, the law does not have, and never has had, such a structure… We will recommend that, for the first time, the general law of homicide be rationalized through legislation. Offences and defences specific to murder must take their place within a readily comprehensible and fair legal structure. This structure must be set out with clarity, in a way that will promote certainty and in a way that non-lawyers can understand and accept.*

However, the Law Commission shied away from shooting the elephant in the room. The mandatory sentence bedevils all legal discussion about murder because it removes all discretion about punishment and disposal from the court. The Homicide Act 1957 is an attempt to acknowledge the varying degrees of culpability of homicide. This Act and its successor would not be necessary if the mandatory sentence were removed. The judge who tried the case could impose the penalty appropriate to the facts of the crime. The mystical significance of the mandatory sentence is lost on most people who have grown up in Europe in which capital punishment is outlawed by protocol 13 of the Council of Europe. To shrink the elephant somewhat the Law Commission recommended that England and Wales should follow the American system of having two degrees of murder in addition to manslaughter.

HM government responded to the 'Murder Report' as they called it with a consultation document (Ministry of Justice, Home Office 2007) which was issued during the summer holiday season of 2007. The document made it clear that the crime of murder was not to be considered. They said:

> *The Murder Report recommends wholesale reform of the law in this area and, specifically: a new offence structure for homicide, including new offences of first degree and second degree murder, as well as manslaughter; reforms to the partial defences of provocation and diminished responsibility; reforms to the law on duress and complicity in relation to homicide; and improved procedures for dealing with infanticide… In taking forward this (report), the Government is proceeding on a step-by-step basis, looking first at the recommendations which relate to: the partial defences of provocation and diminished responsibility; complicity in relation to homicide; and infanticide. The Law Commission's recommendations in these areas are predicated on their proposed new offence structure, but this paper considers them in the context of the existing structure (italics added). The wider recommendations in the Law Commission's report may be considered at a later stage of the review.*

This is perverse, as the partial defence proposals have to be seen in the context of the new proposals for murder.

HM government went on to set out their own proposals:

> *To abolish the existing partial defence of provocation and replace it with two new partial defences of:*
>
> - *killing in response to a fear of serious violence;* and
> - (to apply only in exceptional circumstances) *killing in response to words and conduct which caused the defendant to have a justifiable sense of being seriously wronged.*

There were 73 responses representing the 54 million people of England and Wales. The end result is the Coroners and Justice Act 2009. For diminished responsibility the Act has produced the following amendments to section 2. The first clause has now been divided into three subclauses with their own subdivisions. The reader should be warned that our consultation with lawyers who study this particular field has produced no simple answers as to the meaning of the new wording which will obviously give rise to many courtroom disputes and Court of Appeal judgments. The only advice that can be given in a textbook is to watch out for the date of implementation, take the best legal advice available to you after that date and follow the judgments which will arise. The other clauses of section 2 remain the same. However, and this may be the real meat of the changes, section 3, the defence of provocation has been abolished.

S.2 Persons suffering from diminished responsibility

1. A person ('D') who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which – (a) arose from a recognized medical condition; (b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A); and (c) provides an explanation for D's acts and omissions in doing or being a party to the killing.

1A. Those things are – (a) to understand the nature of D's conduct; (b) to form a rational judgment; (c) to exercise self-control.

1B. For the purposes of subsection (1c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct.'

Will this improve the situation? It is impossible to say especially as the new wording for diminished responsibility in the 2009 act is difficult to understand but in the face of the continuing mandatory sentence it is unlikely. Some further thoughts on the use of the new law in court are given on p.168.

Disputed facts and mental disorder

A small but important point to note about a murder trial is the peculiar difficulty in which a defendant finds him- or herself if s/he both disputes the facts of the alleged killing and is also mentally disordered. In the case of any other charge up to and including attempted murder, the matter is straightforward; the defendant simply pleads not guilty using whatever evidence is available to him or her (e.g. an alibi). If that defence does not succeed, then at the sentencing stage psychiatric evidence can be adduced in mitigation. If, however, the victim dies and the charge is murder, the same defendant would be in a much more difficult situation. There is no mitigation possible against the life sentence for murder. Any psychiatric evidence would have to be adduced in the trial to either insanity or diminished responsibility, and this would have to be done at the same time as trying to convince the jury that the wrong person had been charged anyway. A difficult task indeed – the psychiatric case is almost bound to reduce the credibility of the factual one and the jury may become muddled as to their task.

Alcohol and drugs

Intoxicating substances require a special section because they raise legal and philosophical issues which are quite different from other issues dealt with in the trial.

Self-induced intoxication is generally no defence to a criminal charge. Traditionally, it has been regarded as an aggravating factor rather than an excuse. Thus Aristotle (BC 330) in book 3 of the Nichomachean Ethics stated that penalties were doubled if the offender was drunk. He also formulated the modern concept of recklessness: the drunken man is punished even if he did not know what he was doing because he is responsible for getting himself drunk. Coke in the seventeenth century, and Blackstone, in the eighteenth, both regarded drunkenness as an exacerbating the offence (Whitlock, 1963; Walker, 1968). However, during the nineteenth century these rigid views were modified to allow for the partial exculpation of the intoxicated offender in the case of serious crimes which would otherwise attract harsh penalties (Fingarette and Hasse, 1979). There are now two circumstances in which drugs or alcohol may be relevant to criminal responsibility: first, if intoxication is of such a degree that the accused does not have the necessary intent to commit the offence; second, if it gives rise to a mental disorder. In some cases either of these arguments could, at least in theory, lead to a defence under the McNaughton Rules.

Intoxication and intent

The difficulty is that intoxication is a temporary form of brain damage which is, for the most part, self-induced. The basic principle is that anyone who intoxicates him- or herself should understand and take responsibility for all the consequences. Intoxication should not be available as an excuse; it is easy to see that if intoxication could be a defence against serious crime anyone planning such a crime with care could take the precaution of being drunk while committing it. On the other hand courts have found it difficult to rule out intoxication as a defence in all cases. A system to cope with this complexity has been developed in England and Wales which is confusing (note also that this does not necessarily apply to other common law countries). The psychiatrist does not need to know all this esoteric law and should lean heavily on experienced legal opinion. Ormerod (2008) gives a good account and what follows is a sketchy version of that authority.

A distinction has been developed between crimes that require a mental element of 'specific intent' and those that require only 'basic intent'. The objective is to allow some intoxicated offenders to be convicted of offences that carry less serious penalties. Crimes of specific intent are those in which the intention (*mens rea*) can be negated by intoxication; examples are murder, wounding with intent to cause grievous bodily harm, robbery, theft, handling stolen goods, burglary and criminal damage. Other crimes such as manslaughter, rape, sexual assault, malicious wounding and grievous bodily harm require only 'basic intent' which cannot be negated by intoxication. The point of this artificial distinction is that intoxication may be a defence to crimes of 'specific intent' if it can be shown that the accused was so intoxicated that s/he could not form the intent required for the offence. The accused may still be convicted of a lesser offence for which only 'basic intent' is required. For example, a killer may have been too drunk to form the intent

to commit murder, but that would not matter if s/he was reckless, because recklessness is sufficient to constitute the *mens rea* of manslaughter.

This doctrine was formulated by Lord Birkenhead in the case of *Beard*, who had suffocated a girl while raping her. Things however have become complicated, particularly by *Majewski* which went to the House of Lords, which could not decide unanimously the basis for the distinction between crimes of specific intent and basic intent. Further complications were added by *Heard* but the listing approach to the two forms of intent remains a reasonable starting point. Even so the law does seem confusing and illogical, for example it is possible for a drunken shoplifter to be acquitted of theft but to be convicted of assaulting the arresting store detective. The Butler Committee (Home Office, DHSS, 1975) suggested the creation of a new offence of 'dangerous intoxication' to deal with this problem, but this idea has never been taken up.

Although the law originally developed in relation to alcohol intoxication, drugs are treated in a similar fashion. Lipman killed a girl while under the influence of LSD; he thought he was struggling with snakes and asphyxiated her by stuffing a sheet down her throat. He was acquitted of murder, as he lacked the required specific intent, but was convicted of manslaughter as he was deemed to have been reckless and thus had basic intent or *mens rea.*

Alcohol, drugs and mental disorder

1. **The insanity defence (special verdict).** If alcohol or drugs give rise to psychotic illness (for example delirium tremens or amphetamine psychosis) the McNaughton Rules, in theory, may be applicable, although, in practice, the insanity defence is now rarely used. In *Davies,* a man was charged with wounding with intent to murder during an attack of delirium tremens. Stephen J drew a clear distinction between simple intoxication and disease caused by alcohol:

   Drunkenness is one thing and the diseases to which drunkenness lead are different things: and if a man by drunkenness brings on a state of disease which causes such a degree of madness, even for a time, which would have relieved him of responsibility if it had been caused in any other way, then he would not be criminally responsible.

2. **Diminished responsibility.** Under section 2 of the Homicide Act 1957, an 'abnormality of mind' must arise from one of the causes specified in the Act; those of possible relevance to drugs and alcohol are disease, injury or inherent causes. An abnormality of mind arising from intoxication is no defence (*Fenton*).

It is doubtful whether alcohol or drug dependence alone without any psychiatric complications or additional factors would qualify as a disease causing 'abnormality of mind'. The essence of the legal disease concept of dependence is the assumption that the conduct of the addict is involuntary, and this cannot be accepted as a general proposition (Fingarette and Hasse, 1979). In *Tandy,* it was explicitly stated that the very first drink of the day would have to be completely involuntary – a tough test indeed.

The question of alcohol dependence as an 'inherent cause' was discussed in *Fenton* where the defence argued that:

> *Part of the appellant's mental make up is.... an inability to resist the temptation to drink, and accordingly when he succumbs to this temptation he must be regarded as succumbing to an abnormality of mind due to inherent causes.*

Dismissing the appeal, the court nevertheless left the door open, stating that:

> *A case may arise where the defendant proves such a craving for drink or drugs as to produce in itself an abnormality of mind within the meaning of section 2 (of the Homicide Act).*

In *Di Duca* the defendant who was convicted of murder in the furtherance of theft had pleaded an abnormality of mind arising from injury by alcohol, as he had been drinking beforehand. Dismissing the appeal, the Court found that whether or not alcohol caused 'injury', in Di Duca's case, there was no evidence that it had led to 'abnormality of mind'. This leaves open the possibility that demonstrable evidence of 'injury' by alcohol, if sufficiently severe, could substantiate diminished responsibility. Cortical atrophy on a CT scan combined with psychological deficits (Ron, 1977, 1983) would seem consistent with the concept of injury from the toxic effects of alcohol.

'Pathological intoxication' was once considered to be a specific disease and therefore available as a defence within section 2 of the Homicide Act 1957. In a review Coid (1979) argued that pathological intoxication is an ill-defined diagnostic category and that 'pathological drunkenness' should be omitted from the International Classification of Diseases. It should not be used as a defence. States of supposed pathological intoxication may be attributable to alcohol-induced hypoglycaemia or organic brain damage.

Alcoholic amnesia is a common clinical problem, but the issue of diminished responsibility is unlikely to arise unless there is some abnormality additional to intoxication and subsequent amnesia. If the amnesia is accepted as genuine, the problem is to decide whether the accused was able to form intent at the material time (Glatt, 1982). The same consideration applies to other drugs which may cause amnesia, particularly benzodiazepines (Subhan, 1984).

In most cases where diminished responsibility becomes an issue, drugs or alcohol interact with other factors such as depression, personality disorder or organic brain damage. Although it is an artificial exercise, for legal purposes the effects of intoxication have to be discounted. In order

to establish diminished responsibility the associated condition (such as depression) must in itself be of sufficient severity to constitute an 'abnormality of mind'. Thus in *Fenton,* five psychiatrists agreed that the accused had a personality disorder, that he suffered from reactive depression and that he was disinhibited and possibly confused by drink. The jury were directed to convict him of murder if they were satisfied that the combined effect of the factors other than alcohol was insufficient to substantially impair responsibility, and this direction was upheld on appeal. The ruling was confirmed by *Gittens*. A man suffering from depression who took drink and prescribed drugs was taunted by his wife about the paternity of their sons; he clubbed her to death and then raped and strangled his stepdaughter. Three doctors said he had diminished responsibility due to depression, while a fourth said his abnormality of mind was brought on by drink and drugs and was not due to illness. The jury were invited to decide the substantial cause of his behaviour, and they convicted him of murder. On appeal it was held that the judge's direction was improper: the jury must be instructed to disregard the effects of drugs or alcohol and then to consider whether the other matters which fall within section 2 amounted to an abnormality of mind which would substantially impair his responsibility; a verdict of manslaughter was substituted.

The decision in *Gittens* was upheld in *Hendry* and also approved by the House of Lords in *Deitschmann* where Lord Hutton remarked: '*a brain damaged person who is intoxicated and who commits a killing is not in the same position as a person who is intoxicated, but not brain-damaged, and who commits a killing*.'

The defence of involuntary intoxication is applicable both to cases where a person's drink is laced without his knowledge, and to intoxication by drugs prescribed in the course of medical treatment. If successful, the defence of involuntary intoxication results in acquittal but, in practice, it is extremely rare. d'Orban (1989) reported the case of a man who developed a severe psychotic illness from dexamethasone administered for a maxillary operation. Suffering from messianic delusions, he attacked his fiancée believing that he had to kill her to save the world. He was charged with her attempted murder, but was acquitted on the grounds of involuntary intoxication. The Court made no distinction in this case between drug intoxication and a drug-induced mental illness.

Since then, courts have distinguished unforeseen intoxication or unexpected side-effects produced by 'therapeutic drugs' from intoxication caused by alcohol or 'dangerous drugs' (*Bailey; Hardie*). In the case of therapeutic drugs, the defendant may be considered reckless if he appreciates that the drug 'may lead to aggressive, unpredictable, and uncontrollable conduct, yet deliberately runs the risk or otherwise disregards it' (*Bailey*). Therapeutic drugs do not necessarily refer to those prescribed for the patient; they may include, for example, diazepam taken in good faith from another person's medicine cabinet (*Hardie*). The distinction between the two classes of drug is not entirely clear, but dangerous drugs seem, in law, to be those that are commonly known to cause aggressive or unpredictable behaviour (*Bailey*).

Law in this area is long overdue for reform. In 2009 the Law Commission produced a report suggesting reform with this press statement:

> *The present rules governing the extent to which the offender's intoxicated state may be relied on to avoid liability are inadequate. Our recommendations would remove the unsatisfactory distinction between basic intent and specific intent and provide a definitive list of states of mind to which self-induced intoxication is relevant.*

In 2012 the Lord Chancellor told Parliament that 'The Government is not minded to implement the Commission's recommendations' (Ministry of Justice 2012, para. 50).

Other 'mental' excuses

So far in the trial phase we have been concerned with automatism, insanity (which may be used for any charge), infanticide and diminished responsibility (which are specific to a murder charge). What about lesser degrees of mental abnormality that do not amount to insanity in respect of other charges? We have noted the way in which magistrates either disregard such questions altogether and simply convict an otherwise acknowledged offender or send him or her to hospital without conviction. In the Crown Court the second option does not apply and mentally ill offenders, not charged with murder, are simply found guilty, even if their illness is severe.

Theoretically, there is no reason to prevent psychiatric evidence being called to support the other 'excuses' (as Hart [1968] calls them) i.e. mistake, accident, provocation, and duress. For example, it could be argued in the case of a man who stabs his wife that he was not McNaughton insane but, nevertheless, was so depressed and as a result so absent-minded that, during an argument with his victim, he did not realize he was wielding a knife and hence the stabbing was accidental. Such a defence is highly unlikely to succeed and in the Crown Court the judge is likely to rule that all psychiatric matters should be dealt with under the McNaughton Rules, i.e. as insanity *v* sanity, and so these defences are rare in English courts and seem to be confined to property offences such as shoplifting (theft). In *Clarke*, the defendant pleaded not guilty to stealing from a shop on the grounds that she was absent-minded as a result of a depressive illness. The assistant recorder directed that her defence was actually the insanity defence and the McNaughton Rules applied, so she changed her plea to guilty. However, the Court of Appeal said the judge was wrong in his interpretation and the conviction was quashed; absent-mindedness did not amount to insanity.

So, psychiatric evidence in the trial is virtually limited to insanity, infanticide or diminished responsibility, or automatism; *Chard* indicates why. Peter Chard was convicted of murder; he had been examined by a prison doctor who pronounced 'mental illness, substantially diminished responsibility, the McNaughton Rules, subnormality and psychopathic disorder, do not appear to me to be relevant to the issue,' but the doctor went on to add, 'what does seem clear to me in the light of this man's personality was there was no intent or *mens rea* on his part to commit murder at any time that evening.' Defence counsel believed that opinion should have been admitted at the trial, even although he could find no precedent for so doing. Roskill LJ was not surprised that no precedent could be found:

> *It seems to this Court that his submission, if accepted, would involve the Court admitting medical evidence in other cases not where there was an issue, for example, of insanity or diminished responsibility, but where the sole issue which the jury had to consider, as happens in scores of different kinds of cases, was the question of intent.*

Concurring, Lane LJ said:

> *One purpose of jury trials is to bring into the jury box a body of men and women who are able to judge ordinary day-to-day questions by their own standards. … where, as in the present case, they are dealing with someone who by concession was on the medical evidence entirely normal, it seems to this Court abundantly plain... that it is not permissible to call a witness, whatever his personal experience, merely to tell the jury how he thinks an accused man's mind – assumedly a normal mind – operated at the time of the alleged crime with reference to the crucial question of what the man's intention was (Chard).*

The Sentence

The length and complexity of the discussion of the role of psychiatry in the trial phase of a hearing does not signify especial importance. It is more a reflection of the detailed complexity which legal philosophy leads to and which can be so disconcerting to the medical practitioner. In practice, it is in the sentencing phase where the psychiatrist is most needed, can do most good, and is most comfortable, for the philosophical issues are simpler, the legal jargon is minimal, the adversarial process is over and a genuine clinical discussion can be held. One word of warning at the outset may, nevertheless, be appropriate. At the sentencing stage, a great deal of power and authority is, on occasions, loaned to the psychiatrist who should realize that this may be happening. It is not part of a doctor's function to recommend that people are punished, e.g. recommendations for imprisonment, or for particular lengths of imprisonment should always be eschewed. Punishments may be inevitable, but those recommendations will come from elsewhere and the doctor's role is the provision of a realistic and practical disposal. Realistic mitigation means the provision of explanation and meaning to the crime being considered; it means sensible offers of treatment and disposal. Both rejection and/or condemnation on the one hand and wildly overoptimistic proposals on the other are bad practice, as is any encouragement of the belief that the offender will get adequate treatment in prison.

Sentencing theory

Before the question of psychiatric disposal is examined, it is as well to note briefly some of the principles of sentencing to which the judge will attend. Textbooks of sentencing theory and practice have emerged in Britain (see for example Thomas, 2008; Easton and Piper, 2008). The psychiatrist does not need to be an expert in this field, but it is important for him or her to understand what is happening in this crucial phase of the hearing, as it is the phase in which psychiatry and the law have the greatest impact on each other.

Thomas (1979) reminds us that in legal terms discretionary sentencing practice is a modern development beginning in the latter half of the nineteenth century. Originally, the common law allowed the sentencer no discretion in cases of felony other than recommendations of royal clemency and/or transportation to the colonies for the many capital offences then extant. By 1840, however, the number of capital offences was considerably reduced and, later, transportation gave way to penal servitude. In the twentieth century Parliament began to give to courts powers to deal with offenders as individuals. Perhaps the most notable milestone in this respect is the Probation of Offenders Act 1907 which gave courts the power to make probation orders in any case they chose except where the penalty was fixed by law. In Thomas's view the effect of the British legal history of sentencing has been to create two distinct systems of sentencing, reflecting different penal objectives and governed by different principles. The sentencer may choose either a sentence to reflect culpability, or may subject the offender to an appropriate measure of supervision, treatment or confinement.

Underlying the first type of sentencing, which is usually done in the name of general deterrence, is the tariff. This 'represents a complex of penal theories – general deterrence, denunciation, occasionally expiation,' with an overriding principle of proportionality between the offence and the sentence (Thomas, 1979). This means that the sentence is chosen more by reference to the offence than to the offender.

Individualization, on the other hand, looks primarily to the offender; however the offence is always taken into account. Individualizing measures are more likely for five grades of offenders: those under 21, those in need of psychiatric treatment, recidivists who have reached a critical point in their life, persistent recidivists, and offenders who are thought to be a continuing danger to the public. The court will generally rely heavily on psychiatric advice in respect

of those requiring psychiatric treatment provided such people are clearly identified, the nature of their problem is explained comprehensively, and a practical plan of management is outlined which is compatible with the judge's view of public safety.

Sentencing was however completely changed by the Criminal Justice Act 2003. It is probably best to let the Act speak for itself through its explanatory notes:

> *The Act aims to provide a sentencing framework which is clearer and more flexible than the current one. The purposes of sentencing of adults are identified in statute for the first time, as punishment, crime reduction, reform and rehabilitation, public protection and reparation. The principles of sentencing are set out, including that any previous convictions, where they are recent and relevant, should be regarded as an aggravating factor which will increase the severity of the sentence. A new Sentencing Guidelines Council will be established. Sentences will be reformed, so that the various kinds of community order for adults will be replaced by a single community order with a range of possible requirements; custodial sentences of less than 12 months will be replaced by a new sentence (described in the Halliday report: Home Office, 2001, as 'custody plus'), which will always involve a period of at least 26 weeks post-release supervision in the community; and sentences over 12 months will be served in full, half in custody, half in the community, with supervision extended to the end of the sentence rather than the ¾ point as now. Serious violent and sexual offenders will be given new sentences which will ensure that they are kept in prison or under supervision for longer periods than currently. At the other end of the custodial scale, several 'intermediate' sanctions will be introduced. These include intermittent custody and a reformed suspended sentence in which offenders have to complete a range of requirements imposed by the court. The intention is for the court to be able to provide each offender with a sentence that best meets the need of the particular case, at any level of seriousness, and for sentences to be more effectively managed by the correctional services who will need to work together closely in delivering the new sentences.*

This appears to be a mixture of legislative directives and hoped for greater individualization. It is also part of the Labour government 'risk' agenda, as discussed in chapter 3, and puts a heavy emphasis on 'dangerousness'. The Court of Appeal was the authority on sentencing guidelines until the Sentencing Guidelines Council was set up by this Act.

However, it didn't last long. The aim of the Sentencing Guidelines Council had been to issue *sentencing guidelines* to courts to improve consistency in sentencing. The Council was an independent body which took over responsibility for developing sentencing guidelines from the Court of Appeal and the Magistrates' Association. It was chaired by the Lord Chief Justice. It received advice from the Sentencing Advisory Panel, which produced draft guidelines which were published for consultation. All the publications of the Council and the Panel can be accessed at www.sentencing-guidelines.gov.uk

All this has been overtaken by the Coroners and Justice Act 2009. Following recommendations from the Gage Committee (Sentencing Commission Working Group, 2008) the Act amalgamated the Sentencing Guidelines Council with the Sentencing Advisory Panel to form the Sentencing Council for England and Wales. The new Council has four main areas of responsibility: (a) devising sentencing guidelines, and monitoring their use and impact; (b) assessing the impact of sentencing practice and non-sentencing related factors; (c) when requested, assessing the impact of policy and legislation proposals; and (d) promoting awareness of sentencing matters. Functions (b) and (c) are additional to the functions given to the old Sentencing Guidelines Council. The Council is expected to produce and maintain a 'robust' set of guidelines for the criminal courts dealing with criminal cases. When deciding a sentence courts 'must' follow the guidelines 'unless it would be contrary to the interests of justice to do so.' Although the Council undertakes widespread consultation, the final decision on the content of a guideline is that of the Council which is an independent body.

The Council has 14 members. Its President is the Lord Chief Justice who is entitled to attend meetings. There are eight other judicial members, one of these chairs the Council and there are six non-judicial members.

There are four types of sentence available to the courts in respect of adults: discharges, fines, community punishments, and imprisonment. All offences have a maximum penalty set out in law and a limited number of crimes have a minimum sentence. These, for adults, are:

- Life imprisonment for murder.
- Indefinite imprisonment for public protection for a second serious sexual or violent offence (there is a list of qualifying offences), (this replaces the old automatic life sentence). (This has been repealed; see below.)
- 7 years imprisonment for third-time trafficking in class A drugs.
- 3 years imprisonment for third-time domestic burglary.
- 5 years imprisonment for possession or distribution of prohibited weapons or ammunition.

Discharges

A court can make an order to discharge an offender who has been found guilty. There are two types of discharge: (1) absolute discharge in which no further action is taken, since either the offence was very minor, or the court considers that the experience has been enough of a deterrent. (2) conditional discharge in which the offender is released and no further action is taken unless they commit a further offence within a period decided by the court (no more than

3 years). Discharges, conditional or absolute, can be used, on the recommendation of a mental health professional, when a mentally disordered individual needs the opportunity to undertake psychiatric treatment, either inpatient or outpatient, is willing to have such treatment but, in the circumstances of the case, a community order with a condition of medical treatment would be inappropriate (perhaps too severe). An example in this category is the first-time shoplifter who is depressed. The discharge is usually a conditional discharge which is made on condition that the offender does not reoffend within a specified period of time, usually 1 year.

Community orders

Previous community sentences for adults have been replaced by a single generic community order with a range of possible requirements. Judges are able to choose different elements to make up a bespoke community order. The elements which may be included are: compulsory (unpaid) work; participation in any specified activities; programmes aimed at changing offending behaviour; prohibition from certain activities; curfew; exclusion from certain areas; residence requirement; mental health treatment (with consent of the offender); drug treatment and testing (with consent of the offender); alcohol treatment (with consent of the offender); supervision; attendance. Some of these are useful for psychiatric patients.

Supervision

The offender may be required to attend appointments with an offender manager from the Probation Service. The subject of the supervision and the frequency of contact will be specified in the sentence plan. The offender manager can also delegate supervision to another person.

Programme requirement

A court can impose a programme requirement for the offender to attend a group or individual programme. These are usually accredited programmes run by the probation service designed to address the offender's criminal behaviour in the five categories of general offending, violence, sex offending, substance misuse and domestic violence.

Residence requirement

The court can instruct the offender to reside at a place specified, an approved hostel, and a private address or in the case of a mental health treatment order (below) a hospital or a care home.

Mental health treatment requirement (MHTR)

With the offender's consent, the court may direct the offender during a period or periods specified in the order, to treatment by or under the direction of a registered medical practitioner (usually a psychiatrist) or a chartered psychologist (or both). When deciding upon this requirement, the judge must be satisfied that:

- on the evidence of a registered medical practitioner, the mental condition of the offender is such that it requires treatment, but does not need the intervention of a hospital or guardianship order;
- arrangements can be made for the treatment needed; and
- the requirement is suitable for the offender.
- the treatment may be as an outpatient or as an inpatient in an independent hospital or care home within the meaning of the Care Standards Act 2000 or a hospital within the meaning of the Mental Health Act 1983 (amended), but not a high security hospital. The nature of the treatment is not to be otherwise specified in the order.

The offender has to remember that serious challenges to the authority of the supervisors may be dealt with as a breach of the order and lead the offender back to court. Leaving hospital against medical advice, or failing to attend an outpatient clinic, are examples of matters which may be regarded as a breach of the order. As far as treatment is concerned, however, no breach may be implied simply on the ground that the probationer has refused to undergo any particular treatment. The provisions of the Mental Health Act 1983 (amended) would be needed to enforce any particular treatment.

The Centre for Mental Health found that at least 40% of offenders on community orders are thought to have a diagnosable mental health problem (Khanom et al., 2009), but there has been very little uptake of the MHTR since its introduction in 2005. Only 686 orders commenced in the year to the 30 June 2008, and a total of 221,700 other requirements issued with community orders. This compares with 12,347 requirements for drug rehabilitation and 3,846 for alcohol treatment. The CMH team found that probation officers, defence solicitors, and psychiatrists were not fully familiar with the use of the MHTR, some were not aware of it at all, many felt that the court should not get involved in mental health issues! Many others felt that the MHTR was not suitable for people with personality disorder, depression, or anxiety. The research team found that the biggest barrier to the creation of an MHTR was the need for a psychiatric report and some of these, when obtained, did not deal with the possibility of treatment from local mental health services. Court diversion and liaison teams rarely played an active role in the operation of the MHTR. Courts seemed happier with the drug rehabilitation requirement because they were more familiar with it and because the process of making and managing such a requirement is clearer. The team recommended that primary care trusts should commission services to enable the courts to issue MHTRS and the National Offender Management Service should provide detailed information for probation officers. Liaison between courts, probation and health services is obviously important if services are to be implemented.

Drug rehabilitation requirement

A drug rehabilitation requirement provides fast access to a drug treatment programme. Offenders agree their treatment plan with the probation and treatment services. The plan will set out the level of treatment and testing and what is required at each stage of the order. This type of sentence is for problem drug users aged over 16 who commit crime to fund their drug habit and show a willingness to co-operate with treatment. The requirement lasts for between 6 months and 3 years. Treatment is carried out either as an inpatient or outpatient and includes regular drug testing and court reviews. Failure to stick to the treatment plan will mean a return to court for breach of the order.

Alcohol treatment requirement

As with other drugs the alcohol treatment requirement provides access to a tailored treatment programme with the aim of reducing drink dependency. Again the requirement can last between 6 months and 3 years.

Hospital orders

Hospital orders are available to both the Crown Court and magistrates' courts (including youth courts) for individuals who have been convicted of an offence for which they could suffer imprisonment, provided two doctors (one of whom is approved under s.I2 of the Mental Health Act 1983 [amended]) are prepared to sign forms stating that the offender suffers from mental disorder.

This gives very wide powers to commit offenders to hospital, including offenders with personality disorders and mental impairment, provided (and it is a very big proviso) that a hospital is willing to accept them. The practical effect is to hand the offender over to medical care which is almost identical to the care provided for civilly committed people under s.3 of the Mental Health Act 1983 (amended). However, unlike patients on treatment orders, those on hospital orders cannot apply to the Mental Health Tribunal for discharge within the first 6 months, and relatives never gain any powers of discharge. The powers given to magistrates to impose a hospital order without recording a conviction have already been mentioned (p.28).

The issue of finding a bed is crucial, especially as available NHS resources decline. If, after an order is made, the hospital changes its mind, then the order lapses 28 days after it was imposed. This does not prevent a new order being made. If the patient is not transferred within 21 days, the Ministry of Justice may try to bring pressure on the hospital concerned. The **interim hospital order** (under s.38) is an arrangement whereby, if the court is in a position to make a hospital order, it can arrange for a trial period first. The arrangement is for 12 weeks in the first instance, renewable for further periods of 4 weeks (28 days) by the court (on the advice of the responsible clinician) up to a maximum of 12 months. Some of the conditions are slightly different to a full hospital order. One of the doctors signing the forms has to work at the receiving hospital. The patient is not entirely handed over to the hospital; his/her final sentence is yet to be determined so if, during the period of the order, s/he runs away, s/he can be brought back to court. The grounds for making the interim order are slightly less rigorous in that the doctors only have to state that there is 'reason to suppose' that a hospital order is appropriate rather than it 'is' appropriate. An important difference between interim and full hospital orders is that patients on interim orders do not have the right to apply to the hospital managers or to the Mental Health Tribunal at all. Magistrates' courts do not have the power to impose an interim hospital order without recording a conviction. The point of all this is that if there is any doubt about the suitability of a particular patient for a hospital order, then a trial period can be undertaken before (or instead of) a full commitment. It was perhaps primarily intended to test the treatability of those with mental impairment or psychopathic disorder (Mental Health Act 1983), but it is little used in this way.

Another way of carrying out a trial period of treatment before the hospital order decision is finally made is for the Crown Court to remand the offender to hospital (under s.36 MHA 1983 (amended)) for treatment. Magistrates' courts cannot make an order under s.36; it can only be done for patients suffering from mental illness or severe mental impairment, and is only possible for periods of 28 days at a time and 12 weeks in all.

Restriction orders

The effect of a restriction order is to give the powers of leave, transfer and discharge, which are normally held by the responsible clinician, to the Justice Secretary. Such orders are made after a hospital order has been made (they are not available for civilly committed cases) or in respect of transferred prisoners. They are made under s.41 of the Mental Health Act 1983 (amended) only when – *it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm.*

One of the reporting (form filling) doctors in respect of the hospital order has to give oral evidence in court before the order can be made, and the order can only be made in the Crown Court. If magistrates believe that a restriction order might be appropriate, they have to promote the case to the Crown Court.

In his/her oral evidence, the doctor will be asked for his/her views on the appropriateness of a restriction order. They will have to think about questions of dangerousness bearing in mind that the restriction order provides, compulsory aftercare with both medical and social work supervision. Whatever the doctor thinks, however, the judge has the last word (once the hospital order is in place) and will impose a restriction order if s/he believes that the criteria have been fulfilled and the public need to be protected.

It should be noted that a restriction order may be imposed when the current offence, perhaps a burglary or a petty theft, would not seem to warrant it, because other factors such as the antecedents of the offender and the content of any medical reports are taken into account. All patients with a restriction order have an opportunity to appeal to the Mental Health Tribunal chaired by a judge.

Guardianship orders

A court may impose a guardianship order instead of a hospital order in suitable cases. Such orders are, however, rare. The usual effect of such an order is to hand over the care of the offender to the local authority, thus giving a social worker limited powers over the patient. It is also possible for someone else to become the guardian. The patients who are most likely to benefit are those who are mentally handicapped or socially impaired. Like a community order, there may be a stipulation about where the patient is to reside; unlike a community order, however, the patient's consent is not required before the order is imposed. One problem with the order is that little can be done if the patient refuses to co-operate, but some patients respond to the knowledge that there is a formal order imposed upon them. Other patients co-operate completely and are relieved to have a social worker advise them on most of the important decisions in their life. The conditions of the order give to the guardian (1) the power to decide where the patient is to reside; (2) the power to require the patient to attend for medical treatment, occupation, education, or training; (3) the power to require access to the patient by a doctor, social worker, or other specified person. Such guardianship orders are underused, partly because local authorities are reluctant to supervise them, and partly because psychiatrists do not have much experience with them.

Prison sentences

For the most serious offences a court may impose a prison sentence. The length of sentence imposed by the court will be limited by the maximum penalty for that crime. Such a custodial sentence can only be imposed if: (a) the offence is so serious that neither a fine alone nor a community sentence can be justified for the offence; or (b) the offender refuses to comply with the requirements of a community order; or (c) the offender is convicted of a specified sexual or violent offence and the court finds that the offender poses a risk of harm to the public.

The sentence imposed by the court represents the maximum amount of time that the offender will remain in custody. Prisoners serving sentences of less than 4 years are released at the halfway point of their sentence. Those who receive a sentence of 4 years or more may apply to the Parole Board for release at the half-way point of the sentence. If the Parole Board does not recommend release, then the offender will be automatically released at the two-thirds point of the sentence.

For those offenders assessed as 'dangerous' and serving indeterminate sentences for public protection release arrangements are different. These sentences ensure that dangerous sexual and violent offenders are subject to assessment by the Parole Board and are not released from prison until and unless their level of risk to the public is assessed by the Parole Board as manageable in the community. If the risk is not reduced to a safe level, they may never be released.

Fixed-term sentences

Many mentally abnormal people are sentenced to fixed-term imprisonment. This may be because their disorder has not been recognized, or it has been ignored, or because no one offered the court a sensible alternative disposal. When a psychiatrist has no offer to make, s/he can sometimes assist a patient by indicating any damage which could occur to the individual if sent to prison. A patient with severe epilepsy, for example, lived on a knife-edge of fit control; previous prison sentences had produced either paranoid psychotic states or status epilepticus, or both. He persisted in being a lorry thief. The court was told of the dangers to his health of imprisonment, but no suitable hospital accommodation could be found, and he was sentenced to 3 years' imprisonment. He died in prison in unrecognized status epilepticus.

A potential trap for the unwary psychiatrist lies in making statements about the length of treatment required in prison should an offender receive it. Some judges will base a sentencing decision on such statements. Psychiatric resources are very scarce in prison and courts have no control over activities within a prison. They have, for example, no power to send a man to a particular prison, such as Grendon. A court can make recommendations about these matters, but that is all. Further, it is no part of the medical role to recommend punishment. Sometimes, the use of custody has to be advised to hold a patient until treatment can be arranged, but this is different from recommending imprisonment itself.

Under the Legal Aid, Sentencing and Punishment of Offenders Act 2012, the judge may decide to extend a fixed-term sentence beyond the need for punishment in order to provide some extra public protection. S/he can do this if the offender is convicted of two specified offences (see below), life imprisonment or custody for life is either not available or not justified, the judge considers that the offender is dangerous and the offence requires a custodial sentence of at least 4 years.

Indeterminate sentences

Indeterminate sentences available to the Crown Court include, for adults: *life sentences*, both *mandatory* and

discretionary, and *indeterminate sentences for public protection between 2005 and 2012*. Indeterminate sentences for public protection (IPPs) replaced the automatic life sentence for persistent violent offenders and extended sentence to protect people from dangerous offenders. IPP sentences were imposed where the offender would be required to serve at least 2 years in custody or (in the cases of offenders under the age of 18) where the offender has a previous conviction for one of a specified list of very serious offences. Imprisonment for life is the maximum sentence for those over 21 convicted of some serious offences, e.g. manslaughter, attempted murder, rape, armed robbery, arson etc.

Young people who commit very serious offences are dealt with under sections 90/91 of the Powers of Criminal Courts (Sentencing) Act 2000. If the conviction is for murder, the young person is sentenced under s.90 to **Detention during Her Majesty's pleasure**, which is a mandatory sentence for a child who was aged 10 or over but under 18 at the time of the offence. As with life imprisonment the court will set a minimum term (the tariff) to be spent in custody, after which the young person can apply to the Parole Board for release. Once released, the young person will be subject to a supervisory licence for the rest of their life. **Custody for life** is the mandatory sentence for a person aged 18 or over but under 21 at the time of the offence who is convicted of murder and sentenced while under 21, this sentence may also be imposed where a person aged 18 or over but under 21 at the time of the offence is convicted of any other offence for which a discretionary life sentence may be passed on an adult. **Detention for life** is the maximum sentence for a child aged 10 or over but under 18, who is convicted of offences other than murder for which a discretionary life sentence may be passed on a person over 21. Youth court sentences for less serious offences by young people are dealt with below.

The terminology makes it clear that unlike a determinate sentence a release date cannot be calculated for a prisoner with an indefinite or indeterminate sentence, indeed the prisoner has no right to release and a few will remain in prison all the rest of their life. Each prisoner must serve a minimum period in prison custody to meet the needs of retribution and deterrence. This punitive period is decided by the trial judge and is known as the 'tariff'. After serving the tariff period an indeterminate sentence prisoner will be reviewed by the Parole Board, which needs to be satisfied that the prisoner now poses a risk of harm to the public which is acceptable. The release of indeterminate sentence prisoners is entirely a matter for the Parole Board (see below).

The **indeterminate sentence of imprisonment for public protection (IPP)** original statute produced a surge in the prison population but was modified by section 47 and schedule 8 of the Criminal Justice and Immigration Act 2008 so that IPP sentences were only imposed where the offender would otherwise be required to serve at least 2 years in custody.

All indeterminate sentence prisoners are released on a licence and are supervised by the Probation Service. The release licence contains a number of standard conditions that the released prisoner must adhere to. On the recommendation of the Parole Board the licence may also contain additional conditions that are specific to the individual prisoner such as the requirement to undertake further offending behaviour work in the community or conditions to exclude the individual from certain places in order to protect the victim or victim's family.

Two differences from lifer prisoners exist for IPP prisoners after release. The licence for a lifer remains in force until they die and they may be recalled to prison at any time if it is considered necessary to protect the public. Released IPP prisoners, however, can apply to the Parole Board to have their licence cancelled after 10 years (and if unsuccessful at yearly intervals thereafter). At the time of sentencing someone convicted of murder may be given a whole life tariff by the sentencing judge; this cannot be done in respect of other indeterminate prisoners. Although a whole life order applies only in mandatory lifer cases, it is open to a trial judge in non-murder cases to decline to set a minimum period of imprisonment which has the same effect. In either case the prisoner can appeal. It is also possible, in theory at least, for a prisoner serving an IPP sentence to remain in custody for the rest of his or her natural life because the Parole Board does not find the risk the prisoner poses to the public to be acceptable in the community.

The new regime of sentencing dangerous offenders and the IPP in particular have brought very significant changes to the way in which a group of offenders, who are of particular interest to forensic psychiatrists, are managed. The new regime has brought problems for the judiciary, for the prisons, for psychiatry and for the offenders themselves. The sharp rise in the prison population as a consequence, coupled with the totally inadequate provision for the management of the new indeterminate sentences brought embarrassment to the government that introduced the measures, hence the revision in the Criminal Justice and Immigration Act 2008 and the Legal Aid and Punishment of Offenders Act 2012. The new provisions about dangerous offenders do not change the rules governing the making of hospital orders and restriction orders pursuant to sections 37 and 41 of the Mental Health Act 1983 (amended).

Rutherford and his colleagues (2008) discovered that by July 2008 there were 4,619 prisoners serving IPP sentences but just 31 had been released. They found that nearly one in five had previously received psychiatric treatment, and one in ten continued to receive treatment in prison and one in five was still on psychotropic medication. One in twenty of them had previously been a

patient in a secure hospital unit. Using the standard NOMS Offender Assessment System (OASyS) the IPP prisoners were shown to be needier people than either lifer prisoners or fixed term prisoners, needier for such basic requirements as accommodation and employment as well as medical treatment, they were prone to alcohol abuse and had poor emotional well being. Further nearly seven in ten of the IPP prisoners were assessed as requiring a clinical assessment for personality disorder compared to four in ten of lifer prisoners and three in ten of the general prison population.

IPP prisoners find it difficult to live alongside prisoners on determinate sentences who know when they are getting out of prison. The IPP prisoners complained that the indeterminacy was removing their sense of hope and it was damaging their relationships with families and friends. It was particularly demoralizing for them when they reached their tariff date, and they expected to be released, only to be told by the Parole Board that they had more psychological work to complete, work that often they could not complete, either because it was not available to them or because of their mental health problems.

The Rutherford report suggested that mental health legislation should be used in preference to criminal justice legislation for these dangerous prisoners. This of course implies that NHS commissioners should pay more attention to the provision of specialist services for dangerous people. It also means that most released IPP prisoners should be referred automatically to a community mental health team and secure hospitals should be prepared to receive more transfers of IPP prisoners.

The new measures are extremely unpopular with the judiciary, mainly because of the prescriptive nature of the legislation which removes, in their view, a great deal of judicial discretion. To address this important question, which of course interacts with the health issues identified by Rutherford et al. (2008), a judicial view has been included in this chapter.

Additional controls for sex offenders

The Sex Offenders Act 1997 introduced a system of notification to the police for convicted sex offenders. This was reinforced by the provisions of the Criminal Justice and Courts Services Act 2000 which introduced other child protection measures and the matter was consolidated by the Sexual Offences Act 2003.

Under the 2003 Act a convicted sex offender has to notify the police of his or her whereabouts; any changes of address and travel have to be notified. This system which enables the police to monitor the activities and movements of some sex offenders (the ones they are most worried about) is often called a sex offenders' register, but the onus of notification is on the offender with criminal penalties for failure to do so. The notification periods vary according to the seriousness of the sexual offence as measured by the severity of the sentence given. Anyone who is given a sentence of 2½ years or more, or an indefinite sentence, or is admitted to hospital under a restriction order for a sexual offence is subject to an indefinite notification period. If the period of imprisonment is between 6 and 30 months, the notification period is 10 years. For sentences of less than 6 months or admission to hospital without a restriction order, the notification period is 7 years. Other lesser sentences attract notification periods of 2 or 5 years. Finite notification periods are halved if the person is under 18 when convicted or cautioned.

Parole Board

The Parole Board of England and Wales functions as a court and is an essential part of the judicial system. It is of increasing importance as the number of indeterminate prisoners gets larger, as it, and it alone, determines the length of time an indeterminate prisoner spends in prison. Technically it is an executive non-departmental public body (NDPB) appointed by the Justice Secretary, but its position in the court system is under discussion; it is likely to become part of the tribunal service and have a few more powers. It has powers to discharge prisoners who have reached a certain point in their sentence (see below), and to advise the Justice Secretary about prisoners suitable for open conditions. It was originally established by the Criminal Justice Act 1967 and has been significantly modified by the Criminal Justice Acts of 1996, and 2003 and the Criminal Justice and Immigration Act 2008. This history means that it sometimes seen as a part of the civil service, but those days are in the past. The Board has a brief to protect the public and to contribute to the rehabilitation of prisoners. Although the Board is funded by the Ministry of Justice it is not an agent of the Crown and it has unfettered power of discharge, and the Secretary of State cannot discharge prisoners who have been refused release by the Board.

Members of the Board, including its chairman and its chief executive, are appointed by the Justice Secretary using the Commissioner for Public Appointments. Members are judges, both serving and retired, psychiatrists, psychologists, probation officers, criminologists, and other 'independent' members who represent the laity. The chairman and the vice-chairman are senior lawyers (although this is not a fixed requirement); the chief executive and three other members of the Board are full-time, all the rest being part-time except serving judges who are expected to fit 15 days parole work per year into their judicial workload. The expectations for psychiatrists and psychologists are 20 to 35 days a year. Following the increased workload created by the Criminal Justice Act 2003, the Board is increasing its membership to about 200 people. There is also a secretariat of between 50 and 60 people, divided into five teams.

The Board mainly deals with two classes of prisoners who have committed a violent or sexual assault:

1. *Those serving indeterminate sentences* Indeterminate sentences include life sentences (mandatory life, discretionary life and automatic life sentence prisoners and Her Majesty's Pleasure detainees) and indeterminate sentences for public protection (IPPs). The Parole Board considers whether prisoners are safe to release into the community once they have completed their tariff (the minimum time they must spend in prison) and also whether the Secretary of State was justified in recalling them to prison for a breach of their life licence conditions and, separately, whether they are safe to re-release following recall.
2. *Those serving determinate sentences of two kinds*
   a) Discretionary conditional release prisoners serving more than 4 years whose offence was committed before 4 April 2005.
   b) Prisoners given extended sentences for public protection for offences committed on or after 4 April 2005.

   As with indeterminate prisoners the Board considers whether these prisoners are safe to release into the community once they have completed their tariff and review those recalled for a breach of their parole licence conditions.

The details of the law and practice of the Board are given in Arnott and Creighton (2010) which also includes the rules as agreed by the Secretary of State in Parliament. In essence oral hearings involve a three person panel, chaired by a judge or a specially trained independent member of the Board. The hearings use a relatively informal inquisitorial approach, the matter being enquired into is the risk which the prisoner poses to other people if s/he is released.

The risk to be assessed is the likelihood of the prisoner 'committing serious offences'. This has been the clarified and somewhat narrowed by the Court of Appeal as a test of the risk of harm to the life or limb of another person (see *Bradley*). It is attempted by using a thorough but straightforward technique. The first step is to identify all the factors associated with the violent or sexual behaviour in the prisoner's convictions. The list is often quite long and may include alcohol, other drugs, impulsiveness, deviant sexual drives, aggressiveness and anger, distorted thinking, jealousy, mental disorder and social isolation. Many other factors turn up in individual cases and the list tends to grow as the prisoner is better understood and is observed by prison staff. The second step is to seek evidence of change in all the factors that have been listed. The evidence presented to the Board is a mixture of staff reports, particularly key staff such as the offender supervisor and the offender manager (probation officer), specialized reports from, for example, a forensic psychologist, and very occasionally a clinical psychologist or a forensic psychiatrist, and reports from courses that the offender may have undertaken such as Enhanced Thinking Skills, a sex offender treatment programme, CALM (Controlling Anger and Learning to Manage), RAPT (Rehabilitation of Addicted Prisoners Trust), Cognitive Self Change and many others (see chapter 25). Psychologists may have used risk assessment instruments such as the Offender Group Reconviction Scale (OGRS) (see Howard et al., 2009) and/or HCR 20 (Webster et al., 1997; see also chapter 22). Oral evidence is taken from the prisoner and from staff who know him/her well and who are responsible for his/her welfare and progress. The final step is to evaluate all this information on an individualized basis. The starting point is the so-called 'static risk', i.e. the number and severity of the previous convictions, together with static risk scales such as OGRS. This may be quite influential in the final decision but the skill is in judging the amount of change that has taken place during the prisoner's sentence. This may include motivation, time spent on offender work, external evidence, such as success or otherwise in work activities, especially work external to the prison, and success or otherwise on town visits and home leaves. As this suggests, testing out is an important part of the assessment and in most cases the release decision is staged by recommending transfer to open conditions where the prisoner takes a lot of responsibility for him/herself and can demonstrate, or otherwise, trustworthiness.

There are two major difficulties with this system, the first is that the final release decision is all or nothing. The prisoner is handed over to the probation service. If things go wrong and/or the risk assessment of the releasing panel of the Board was incorrect, the offender manager can recall the prisoner, but this is heavy handed and in many ways a counterproductive procedure, quite unlike the flexibility which is available for moving patients between an outpatient clinic and an inpatient service in the NHS.

Inevitably the procedures and practice of the Board owe something to its history, which is set out in Arnott and Creighton, especially in Sir Duncan Nichol's foreword to the first edition of that book (Arnott and Creighton, 2006). Nichol explains that the oral hearings only began in 1992 and the concept of fairness which that brought was enhanced by the increasingly transparent approach from that time. A good deal of academic debate about the pros and cons of the Parole Board, its practice, decisions, and effectiveness has been generated. An excellent starting point for this literature is Padfield (2007). In that volume Thornton gives an overview of the functions of the Board, and particularly the impact of the European Court of Human Rights on its decisions. The complex Parole Board rules can be found on its website www.paroleboard.gov.uk.

When an oral hearing is due the prison holding the potential parolee will prepare a dossier of reports, some dating back to the trial, others concerned with coursework the prisoner has undertaken, perhaps a psychology report,

reports from the offender supervisor in prison, the personal officer, the offender manager (probation officer) and other relevant people. This is sent to the Parole Board and an experienced member who has undertaken special training will review the dossier, check that the appropriate documents for the hearing are present, identify witnesses who should attend the hearing, note whether a psychiatrist or psychologist should be on the panel, and estimate the time that the hearing will take. This is the intensive case management which has significantly reduced the number of deferred hearings.

The oral hearing takes the form of an informal tribunal or court. The prisoner attends and usually has a legal representative (solicitor or counsel); the Secretary of State may send a written opinion on the case, or if it is considered to be of special importance a public protection advocate or even a barrister who will argue the Secretary of State's position (which is usually for the prisoner to remain in custody). Questioning of witnesses is formalized to the extent that each witness is heard separately and questioned by each side and by the panel. The prisoner is usually a key witness in his or her own case. Decisions are usually unanimous, but occasionally are taken on a majority basis. The chairman drafts a letter to the prisoner, the so-called 'reasons' letter, according to a template setting out the decision of the panel, the evidence considered by the panel, an analysis of the prisoner's offending, a description of the factors which are thought to increase and decrease the prisoner's risk of re-offending and causing harm, evidence of change during the sentence, the panel's assessment of current risks, the risk management plan which was presented by the offender manager, the conclusion and if release is being directed the licence conditions which must apply. This draft is then agreed by the panel before being sent out to the prisoner and all the relevant parties by the secretariat.

A prisoner's case should be reviewed by the Board at least every 2 years. A prisoner can request a hearing to be deferred, and some do, to complete a course or to get more evidence.

In 2008–09 28,596 cases were considered. As in previous years 15% of prisoners receiving an oral hearing were released. A total of 89 prisoners on life licence were recalled during the year; this is 5.4% of the 1,646 prisoners with life licences under active supervision in the community. If the recall is for a serious offence, perhaps a quarter of that number, then the case would be referred to the Board's review committee to analyse the case, and write to the original panel in confidence telling them the outcome of that analysis. The review committee includes experienced criminal justice personnel who are not on the Parole Board.

The frustration for a mental health professional in this process is the limited powers of the Board. The Board is told that suggestions about moves within the prison estate other than to open conditions and suggestions about the sentence plan are not welcome. However it is plain common sense that a detailed analysis of a case in the presence of three parole experts, one or more of whom may have expertise in psychiatry or psychology, may produce useful ideas to assist with the prisoner's progress and as such should not be kept under wraps. Prison officials are not obliged to take any notice of Parole Board suggestions, however, many prison staff say that they're very grateful for the outside views which the Board may bring.

The Justice Secretary can overrule the recommendation for open conditions; some ministers do this more often than others. Many of the prisoners require psychiatric help, often this is not recognized either by the prisoner or by the prison and probation staff. Even if it is, getting a psychiatric assessment is difficult, and treatment next to impossible. Resources and attitudes have improved in recent years, but there is still a shortage of resources and considerable antipathy to offender patients, especially ones who have committed terrible crimes. 'Untreatable personality disorder' is code for 'don't expect me to help this person', or maybe 'I have no psychotherapeutic skills and don't know how to treat him/her', or occasionally 'I would take him/her if I had a bed, but I don't.' It would help individual prisoners and also the process of getting more resources if professionals were more candid in acknowledging mental disorder and the real reasons for failing to assist.

A Parole Board hearing thus gives an opportunity to review a case in the presence of relevant people, so that discussions about diagnosis and treatment options can take place. The reasons letter can draw attention to medical issues and problems which might otherwise be overlooked. Parole Board membership should be seen as an important post for a forensic psychiatrist at some stage in his or her career. The educational aspects of the work are particularly important both for the psychiatrist member and for the rest of the Board; the role, function and skills of psychiatry are still widely misunderstood. It is still too easy for non-psychiatrists to believe that psychiatry is both stigmatizing and ineffective and thus best avoided!

Young Offenders

Young offenders, in law, are people under the age of 18 years. A child under the age of 10 years in England, Wales and Northern Ireland is deemed not to have criminal responsibility. The age of criminal responsibility varies widely between countries, from 6 years in some states of the USA to 18 years in Belgium. The European average is about 12 years.

The Youth Justice Board for England and Wales (YJB) is an executive non-departmental public body. It was set up under the Crime and Disorder Act 1998 to monitor the performance and operation of the entire youth justice system. Its statutory duties include commissioning and purchasing places in the juvenile secure estate (young offender institutions, secure training centres and local

authority secure children's homes) for young people sentenced or remanded to custody. Young people from the age of 10–18 years who commit offences are the responsibility of the Youth Justice Board. The primary aim of the Board is to prevent offending by children and young people. This is an enormous task as the peak age of offending is 14 years. (See also chapter 19.)

Youth Offending Teams (YOTs) were set up by the Crime and Disorder Act 1998. There is a YOT in every local authority in England and Wales. They are made up of representatives from the police, probation service, social services, health, education, drugs and alcohol misuse and housing officers. Each YOT is managed by a YOT manager who is responsible for co-ordinating the work of the youth justice services. YOTs supervise young people who have been ordered by the court to serve sentences in the community or in the secure estate. They also arrange for appropriate adults to advise young people, who have been arrested, at the police station. Education and supervision are key functions of a YOT; they may employ, for example, educational psychologists. As with adults mental health issues are prominent in young offenders, but psychiatric input into their work is the exception rather than the rule (see chapter 19 and Harrington and Bailey, 2005).

Sentences for young offenders

A wide range of sentences are available to the youth justice system, and custody is a last resort. When young people first get into trouble for committing minor offences or for antisocial behaviour, they can be dealt with outside the courts. For antisocial behaviour, the police and local authority can use precourt orders such as antisocial behaviour orders (ASBOs) or child safety orders. For first or second time minor offences the police can use reprimands and final warnings. When a young person is charged with an offence they will appear before a youth court (the Crown Court in very serious cases). The young offender may receive the following sentences:

- Discharge, absolute or conditional.
- Referral order, given to all young offenders (aged 10–17) pleading guilty to a first offence unless it is very serious or very trivial, the offender is referred to a youth offender panel of two local volunteers who consider the best course of action.
- A fine.
- Compensation order, paid to the victim (may be combined with another sentence).
- Reparation order, for example repairing damage caused to property.
- Action plan order, for up to 3 months for supervision, counselling, training, etc.
- Curfew order, requiring the offender to remain in a specified place for set periods of time (2 and12 hours a day) for up to 6 months for those 16 years of age and above (3 months if under 16 years of age), may use tagging, (may be combined with another sentence).
- Attendance centre order, supervision by police on Saturdays.
- Supervision order for 6 months to 3 years, details tailored to offender by YOT and court, may include residence and or curfew or an ISSP.
- Intensive supervision and surveillance package (ISSP) for up to 6 months as an alternative to custody, the first 3 months may require up to 25 hours supervision per week.
- Community rehabilitation order, for 16 to 17 year olds, this is like a supervision order for older adolescents and is supervised by a YOT or by probation and can include an ISSP.
- Community punishment order, for 16 to 17 year olds, this is usually unpaid work under supervision.
- Community punishment and rehabilitation order for, 16 to 17 year olds, a combination order.
- Drug treatment and testing order.
- Detention and training order for 12 to 17 year olds with a history of previous offending, if the offence would be punishable with imprisonment for an adult; it lasts between 4 months and 2 years, the first half of the sentence is served in custody and the second half in the community under the supervision of a YOT when it may include an ISSP.
- The Crown Court dealing with the most serious offences uses section 90/91 of the Powers of Criminal Courts (Sentencing) Act 2000; if the conviction is for murder, the young person is sentenced to 'Her Majesty's Pleasure' under s.90, if the conviction is for an offence for which an adult could receive at least 14 years in custody, the young person may be sentenced for any length of custody up to the adult maximum for the same offence, which may be life. The young person will be released automatically at the halfway point of the sentence and selected cases could be released up to a maximum of 135 days early on the home detention curfew scheme. Once released, the young person will be subject to a supervisory licence until their sentence expires, if the sentence is 12 months or more; or a notice of supervision for a minimum of 3 months, if the sentence is less than 12 months.

Secure accommodation

There are three types of secure accommodation in which a young person can be placed.

Secure Training Centres (STCs)

STCs are purpose-built centres for young offenders up to the age of 17. They are run by private operators under Home Office contracts. There are four STCs in England. They have a minimum of three staff members to eight trainees.

The regimes in STCs are education-focused. Trainees are provided with formal education 25 hours a week, 50 weeks of the year and all services are provided on-site, including all education and training, primary health care, dentistry, social work and mental health services.

Local Authority Secure Children's Homes

Local Authority Secure Children's Homes are run by local authority social services departments, overseen by the Department of Health and the Department for Education and Skills. They provide secure accommodation for children and adolescents who have been through the criminal justice system. They should have a high staff ratio and are generally small facilities, ranging from six to 40 beds and are usually used to accommodate offenders aged 12 to 14 years, although some who are assessed as vulnerable can stay until they are 16.

At the time of writing there were 15 such homes providing 509 beds covering most of England and Wales, however provision is inadequate, for example London has only one such home (Orchard Lodge in Croydon).

Young Offender Institutions (YOIs)

Young offender institutions (YOIs) are prisons for young people and are run by the Prison Service. They accommodate 15 to 21 year olds. The Youth Justice Board is only responsible for those under 18 years of age. The male YOIs can house up to 360 youngsters in wings of 30–60 and should have 3–6 prison officers on each wing. Some are stand alone prisons; others are simply a separate wing in an adult establishment.

Sentencing Dangerous Offenders: A View from the Bench

There are a number of offences which carry a potential maximum sentence of life imprisonment. Obvious examples are attempted murder, wounding with intent to do grievous bodily harm, rape and robbery. All have in common a generally accepted view that they could properly be described as grave offences. However, a life sentence as opposed to a lengthy determinate sentence was only to be imposed if the offence itself was a serious example of the crime in question and there were good reasons for believing that the offender might remain a serious danger to the public for a period which could not reliably be estimated at the time of sentencing. The reasons which might found such a belief often, but not necessarily, related to the mental condition of the offender as well as the facts of the particular offence. As a general proposition, life sentences were not to be passed where a lengthy determinate sentence could properly be regarded as providing sufficient protection for the public. Subject to these criteria, a judge had a genuine discretion as to whether to impose a life sentence and, generally, such sentences were only imposed in bad cases.

The first significant attempt to fetter judicial discretion in this area came with section 109 of the Powers of Criminal Courts (Sentencing) Act 2000. Unless there were exceptional circumstances that section *required* a judge to pass a life sentence where the defendant was convicted of a serious offence such as robbery whilst in possession of a firearm and that defendant had a previous conviction for a serious offence such as for example wounding with intent to do grievous bodily harm.

The Criminal Justice Act 2003 introduced an even more prescriptive regime in respect of offences committed after 4 April 2005.

Specified offences

The first concept that has to be grappled with is that of the 'specified offence'. These offences fall into two categories, namely specified violent offences and specified sexual offences. By section 224(3) of the Act, a specified violent offence means an offence specified in part 1 of schedule 15 and a specified sexual offence means an offence specified in part 2 of schedule 15. Part 1 sets out some 65 specified violent offences. Apart from obvious crimes such as manslaughter and wounding with intent the schedule also includes matters such as unlawful wounding, affray, death by dangerous driving and harassment. Part 2 sets out some 88 specified sexual offences. Again they range from obviously serious matters such as rape and assault by penetration to behaviours such as exposure and voyeurism and sex with an adult relative who consents to penetration.

Specified serious offences

Having mastered the concept of the specified offence, we next have to consider the specified 'serious' offence. By section 224(2) a specified serious offence is one which is capable of being punishable in respect of persons aged 18 or over with imprisonment for life (regardless of the new provisions) or a determinate sentence of 10 years or more. In other words, any specified violent or sexual offence which carries a potential maximum of life imprisonment or a prison sentence of 10 years or more is a specified serious offence.

Sentencing régime for those over the age of 18 years[3]

Section 225 of the Criminal Justice Act 2003 applies when any person aged 18 years or more is convicted of a serious offence and 'the court is of the opinion that there is a significant risk to members of the public of serious harm occasioned by the commission by him of further specified offences.' We shall consider the 'significant risk' provision later. By section 225(2), where the offence is one which is capable of attracting a life sentence (apart from the provisions that we are considering) and 'the court considers that the seriousness of the offence, or the offence and one or more offences associated with it, is such as to justify the imposition of a sentence of imprisonment for life' the court must impose a sentence of life imprisonment. By section 225(3), where the case does not fall within subsection (2) the court must impose a sentence of imprisonment for public protection. By section 225(4), a sentence of imprisonment for public protection is a sentence of imprisonment for an indeterminate period. The crucial point to note is that a life sentence can only be imposed where the

[3] This was written before IPP sentences were abolished.

seriousness of the offence/associated offences justifies life. In all other cases, it is imprisonment for public protection whether or not the particular offence carries with it a theoretical maximum of life imprisonment. The practical differences between life imprisonment on the one hand and imprisonment for public protection on the other are not great. The only difference is that pursuant to section 31A of the Crime (Sentences) Act 1997, the Parole Board may order the Secretary of State, 10 years after the prisoner's release from custody, to say that the prisoner shall no longer be on licence. If no such direction is given a person released from such a sentence remains on licence for life.

When should it be life?

It would seem that even now a life sentence should only be imposed where such a sentence would have been passed under the pre-2003 regime – see *Lang* at paragraph 8, *Samuel* at paragraph 21 and *Folkes* at paragraph 14. Unless those pre-2003 criteria are satisfied, it should be public protection not life.

The extended sentence

Schedule 15 of the Criminal Justice Act 2003 sets out a large number of offences many of which carry a maximum sentence of less than 10 years imprisonment. Obvious examples are unlawful wounding, assault occasioning actual bodily harm and affray. These are catered for in the new regime by the extended sentence. By section 227, when the relevant significant risk is present in respect of an individual convicted of a specified but not serious offence, 'the court must impose on the offender an extended sentence of imprisonment.' This is a sentence of imprisonment the total length of which is equal to (a) the appropriate custodial term and (b) a further period (called the 'extension period') for which the offender is to be subject to a licence which is of such length as the court considers necessary for the purpose of public protection. The section further provides that the 'appropriate custodial term' must be at least 12 months' imprisonment and that the extension period must not exceed 5 years in the case of a violent offence or 8 years in the case of a sexual offence. Section 247 of the Act also deals with extended sentences. By subsection (2), as soon as the prisoner has served one half of the appropriate custodial term and the Parole Board has directed his/her release under this section, it is the duty of the Secretary of State to release him/her on licence. By subsection (3) the Parole Board may not direct the prisoner's release 'unless it is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined.' However, once the custodial term has been served in full, the prisoner must be released – see section 247(4).

Assume therefore a custodial term of 2 years and an extension period of 4 years. If the Parole Board has not directed his release, the prisoner serves 2 years in prison. He is then on licence for a period of 4 years. If he commits a further offence or otherwise acts in breach of his licence conditions, he is liable to be recalled to prison and may be kept there until the expiry of the licence period.

In *S*, the Court of Appeal came to the tentative conclusion that in the case of a prisoner released part way through the custodial period of his sentence there could effectively be two licence periods, namely the ordinary period to which all prisoners are subject that is until the end of the custodial period, and then the extension period which only started at the end of the notional custodial period. In our example therefore, if the prisoner were released after 12 months, he would be on normal licence for the remaining 12 months of the custodial term, then the extended licence of 4 years would kick in.

Dangerousness

Whether it be life, public protection or an extended sentence, the dangerousness criterion has to be considered. It will be remembered that before imposing any of these sentences, the court has to be 'of the opinion that there is a significant risk to members of the public of serious harm occasioned by the commission by him of further specified offences.' Accordingly, there are two matters that have to be considered, namely (1) is there a risk of the defendant committing further specified offences and (2) would such further offending cause a significant risk of serious harm to members of the public? It might be thought that an assessment of these matters could properly be left to the discretion of the sentencing judge. However, section 229 introduced a highly prescriptive regime particularly in the case of those with previous convictions for a specified offence.

Section 229(1) provides as follows:

1. This section applies where:
   a) a person has been convicted of a specified offence and
   b) it falls to a court to assess … whether there is a significant risk to members of the public of serious harm occasioned by the commission by him of further such offences.

Section 229(2) deals with those who have not previously been convicted of a specified offence. Its provisions are somewhat anodyne. In making the assessment the court must (a) take into account all such information that is available to it about the nature and circumstances of the offence, (b) may take into account any information which is before it about any pattern of behaviour of which the offence forms a part, and (c) may take into account any information about the offender which is before it. I observe in passing that it might be thought that any sentencing exercise would involve considerations like this!

The more interesting and difficult provision is that arising under section 229(3). This applies to those who have been previously convicted of a specified offence. In such a case 'the court must assume that there is such a risk' unless 'the court considers that it would be unreasonable to conclude that there is such a risk.' In making the judgment that it would be unreasonable to conclude that there is such a risk, the court must take into account (a) all such information as is available to it about the nature and circumstances of each of the offences; (b) where appropriate, any information which is before it about any pattern of behaviour of which any of the offences form part; and (c) any information about the offender which is before it.

As a matter of commonsense, if a defendant has previous convictions for violence or sexual offending there is clearly a risk that s/he will commit further such specified offences and indeed that such future offences might be serious specified offences. In other words, the first of the risk factors namely further offending can relatively easily be satisfied. It is the second limb which causes the difficulty namely predicting that such further offending 'poses a significant risk to members of the public of serious harm.'

Section 224(3) provides that 'serious harm' means 'death or serious personal injury whether physical or psychological.'

In *Lang*, which is the leading case on the whole subject, Rose LJ said at paragraph 17(i) that 'the risk identified must be significant. This is a higher threshold than mere possibility of occurrence and in our view can be taken to mean (as in the concise Oxford dictionary) noteworthy, of considerable amount … or importance.' So, some risk is not enough: It has to be significant. The serious harm that might ensue has to be serious within the meaning of 224(3).

Accepting that reported cases on sentencing are very much dependent upon their own facts, it is illustrative to look at how robbery offences have been dealt with under the new provisions. In *Lang* itself, Rose LJ said at paragraph 17(iii) 'if the foreseen specified offence is serious, there will clearly be some cases, though by no means all, in which there may be significant risk of serious harm. For example, robbery is a serious offence. But, it can be committed in a wide variety of ways many of which do not give rise to a significant risk of serious harm. Sentencers must therefore guard against assuming there is a significant risk of serious harm merely because the foreseen specified offence is serious.' In *Lang*, the appellant had several previous convictions for robbery: The current robbery involved threatening the victim with a knife. The court held that a sentence of imprisonment for public protection (though not a life sentence) was appropriate.

In *McGrady*, the offence was robbery of the bag snatch type albeit that there had been a bit of a struggle. The appellant had previous convictions for specified violent offences. The Court of Appeal took the view that although there was clearly a risk of future offending, those offences did not carry with them the risk of serious harm. Accordingly an indeterminate sentence was not justified. This should be compared with *Bryan and Bryan*. In that case, two brothers carried out a betting shop robbery involving the use of actual violence. Both defendants had previous convictions for specified offences including robbery. The Court of Appeal had no difficulty in upholding a sentence of imprisonment for public protection. There was a clear risk of serious harm if anyone resisted their threats of violence – they were obviously prepared to use violence. Reference should also be made to *Sharrock* and *Thomas*. Lastly, it was said in *Johnson and Others* that 'it did not automatically follow from the absence of actual harm caused by the offender to date, that the risk that he would cause serious harm in the future was negligible.' It might be that serious harm had been avoided to date simply because the victim or victims had not chosen to resist. If the hypothetical future victim did resist was there a risk that the offender would use violence and cause serious harm?

I have already set out the matters that the court must consider pursuant to 229(3) in deciding whether there was significant future risk or whether it would be unreasonable to make that assumption. In practical terms, as was said in *Lang* at paragraph 17(iii), 'a presentence report should usually be obtained before any sentence is passed which is based on significant risk of serious harm. In a small number of cases where the circumstances of the current offence or the history of the offender suggest mental abnormality on his part, a medical report may be necessary before risk can properly be assessed.' But, it should be remembered, as the Court of Appeal said in *Betteridge*, that a trial judge is entitled to form his or her own view about future risk without hearing expert evidence on the point and is not bound to accept the assessment made in the pre-sentence report.

Young offenders

For legal purposes, a young offender is a person under the age of 18 years at the date of conviction (not sentence) – see *Robson*. Sections 226 and 228 are applicable here. Section 226 provides a regime for detention for life or detention for public protection for such offenders. There is one important difference between the regime for the under 18s compared with the 18+ group. By section 226(2) if the court decides that it is not a case requiring detention for life, it should only impose a sentence for public protection if 'the court considers that an extended sentence under section 228 would not be adequate for the purpose of protecting the public.' In other words, once detention for life is ruled out, the court should only consider detention for public protection after it has considered (and rejected) the extended sentence regime. Whichever option is being considered, the assessment of 'dangerousness' pursuant to section 229 is less prescriptive than in the case of an 18+ even where he has a previous conviction for a specified offence. The court is not bound to make the rebuttable presumption of dangerousness which it has to in the case of those aged 18 years or more when section 229(3) bites. Even in the context of the extended sentence, it is worth remembering what Rose LJ said in *Lang* at paragraph 17(vi) namely 'it is still necessary, when sentencing young offenders, to bear in mind that, within a shorter time than adults, they may change and develop. This and their level of maturity may be highly pertinent when assessing what their future conduct may be and whether it may give rise to significant risk of serious harm.'

Tariff

We turn now to a provision which mystifies the public and the press. Section 82A of the Powers of Criminal Courts (Sentencing) Act 2000 applies to most discretionary life sentences and to all sentences of imprisonment for public protection. When passing such a sentence, the judge has to specify the minimum term that must be served before the prisoner is eligible to apply for parole (note – 'eligible to apply' not 'entitled to be given'). In specifying the minimum term the court is obliged to give credit for the period of time that the prisoner has served on remand – see section 240 of the Criminal Justice Act 2003. In addition, the sentencer has to consider Section 244 of that Act. That provides that in respect of a fixed term prisoner, the Secretary of State must release him on licence once he has served half his sentence. If a person is sentenced to a determinate term of 12 years, he is automatically released after 6 years. Now it is necessary to factor in section 144 of the Act. The sentencer must take into account, if it be the case, that the defendant has pleaded guilty. By section 172, the sentencer has to take account of guidelines issued by the Sentencing Guidelines Council and they have indicated that a person who indicates an intention to plead guilty at the earliest available opportunity is entitled to a discount of one-third from his sentence. Accordingly, we end up with a sentencing process as follows:

a) the allegation is rape of a young child
b) the sentence is one of imprisonment for public protection but

c) the judge has to spell out the appropriate custodial term which means –
   i. deciding what the term would have been had the defendant pleaded not guilty but had been convicted by a jury, say 18 years but
   ii. the defendant has pleaded guilty at the first available opportunity therefore one reduces the sentence to 12 years but
   iii. if it were a determinate 12-year sentence the defendant would automatically be released after 6 years plus any time spent on remand so
   iv. the appropriate custodial term before the defendant is eligible to apply for parole is 6 years less the time spent on remand.

As to eligibility for parole, this is governed by sections 28 and 34 of the Crime (Sentences) Act 1997. By section 34 'life prisoner' and 'life sentence' include those subject to imprisonment for public protection pursuant to section 225 of the 2003 Act. Section 28 provides that as soon as a life prisoner has served the relevant part of his sentence, he must be released by the Secretary of State when the Parole Board is satisfied 'that it is no longer necessary for the protection of the public that the prisoner should be confined.' In other words release is in the hands of the parole board.

AGENCIES OF THE LAW

The police

The police take the first policy decisions in administering the criminal law, and exercise considerable discretion in investigating and initiating the prosecution process in criminal cases. The police are responsible for the decision to charge a suspect in simple and straightforward cases. In all other cases, the decision to charge lies with the Crown Prosecution Service, and the police must obtain advice on the appropriate charges before the suspect is charged. The police are so closely connected with forensic psychiatry services that they feature in more than one chapter (see chapter 25). Here we are concerned with their diversion activities to avoid offenders, especially mentally disordered ones (where appropriate), having unnecessary court appearances and imprisonment.

Police have a range of measures they can use instead of the courts to deal with low-level crimes. For adults, these include simple cautions, conditional cautions, cannabis warnings, penalty notices for disorder and fixed penalty notices for driving offences. For youths aged 10 to 17, there are no cautions but reprimands and final warnings instead; penalty notices for disorder can be given to those aged 16–17 as well.

The conditional caution was introduced by the Criminal Justice Act 2003 as a disposal available for adults who are willing to admit their guilt and want to prevent the offence recurring. The authority of the Crown Prosecution Service is required before a conditional caution can be given. A prosecution may occur if any of the conditions attached to the caution are breached. Conditions must be rehabilitative or reparative. Rehabilitative conditions could include attendance at drug or alcohol misuse programme, or other services aimed at interventions tackling other problems, such as gambling or debt management. Reparative conditions could include apologies, physical repairs and financial recompense to an individual or to a charity.

The police may decide to divert a mentally disordered offender from the criminal justice system altogether by taking the person to a place of safety, under section 136 Mental Health Act 1983 (amended), so that the person can be assessed and receive appropriate treatment. Too little is known about police activity in relation to the mentally disordered in their caring capacity. Most of the studies carried out refer to London in the twentieth century (Fahy and Dunn, 1987; Fahy et al., 1987; Pipe et al., 1991; Turner et al., 1992; Simmons and Hoar, 2001; see also chapter 25). Clearly, in an era of deinstitutionalisation and community care for psychiatric patients, the role of the police is important.

The Royal College of Psychiatrists report (2011) on the use of s.136 recommends that police stations should only be used as the place of safety on an exceptional basis. This point has been endorsed by the Code of Practice to the MHA 1983 (amended) (Department of Health, 2008). The report acknowledges that this will mean there should be sufficient places of safety in psychiatric facilities to meet local needs, and these should have dedicated staffing on a 24-hour basis to ensure continuous patient care and allow the police to leave promptly after a handover even when the patient is agitated. Once an individual has been taken to a 'place of safety', s/he must be assessed by an approved clinician and by an approved mental health practitioner (AMHP). A new arrangement brought by the 2007 Mental Health Act is that a patient may be taken from one place of safety to another within the 72-hour period of the order. In spite of these admonitions most patients are still taken to police stations (11,000 in 2008; Bather et al., 2008)

When the police decide to take no action, the possibility of prosecution ends forthwith unless the victim decides to bring a private prosecution. However, Community Legal Service Funding is unlikely to be available to finance a private prosecution, which makes a private prosecution expensive as well as legally complex. The police have considerable discretion in investigating criminal offences and initiating the prosecution process; chief constables, for example, have discretion in how their force should in general be allocated to fulfil the various functions of the police; in individual cases, in the face of undoubted evidence, there is discretion as to whether a prosecution should be brought. The widespread use of cautioning has led to a lot of criticism. On 11 June 2007, the BBC News website reported that 'Almost 8,000 sex offenders have been cautioned across England in the past five years, rather than being charged.' This apparently included 230 cases of rape. The Association of Chief

Police Officers answered in some detail pointing out that such sex offenders can be put on the sex offenders register, victims' views are taken into account, and rape includes statutory rape amongst youngsters.

Multi-Agency Public Protection Arrangements

Multi-agency public protection arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. They were introduced in 2001 and bring together the police, probation and prison services into the MAPPA responsible authority. Other agencies are under a duty to co-operate with the responsible authority, including social care, health, housing and education services.

Just to confuse the uninitiated there are three categories of offenders dealt with by the multi-agency arrangements at three levels which do not correspond to the categories. The offenders are categorized as: (1) registered sex offenders (around 30,000 offenders in 2004/05); (2) violent or other sex offenders (around 12,600 offenders in 2004/05); and (3) other offenders (around 3,000 offenders in 2004/05). The offenders are managed at three different levels determined by seriousness and the perceived management requirements which are orthogonal to the categories.

Level One: involves normal single agency management. Offenders managed at this level will have been assessed as presenting a low or medium risk of serious harm to others. In 2004/05 just more than 71% of MAPPA offenders were managed at this level.

Level Two: local inter-risk agency management e.g. police and probation; most offenders assessed as high or very high risk of harm are managed at this level, about 25% of MAPPA offenders in 2004/05.

Level Three: known as multi-agency public protection panels (or MAPPPs); these are appropriate for those offenders who pose the highest risk of causing serious harm, or whose management is so problematic that multi-agency co-operation and oversight at a senior level is required. MAPPPs have the authority to commit exceptional resources in some cases. Problematic management may be about risk to the offender for example from vigilantes, or door stepping by the press. In 2004/05 just more than 3% of MAPPA offenders were managed at this level.

(The data quoted here are from the MoJ website: http://www.justice.gov.uk/statistics/prisons-and-probation/mappa/)

Sharing of information is highlighted by the MoJ website as follows: 'MAPPA promotes information sharing between all the agencies, resulting in more effective supervision and better public protection.' For example, police will share information with offender managers that they have gathered about an offender's behaviour from surveillance or intelligence gathering and local authorities will help find offenders suitable accommodation where they can be effectively managed. It is very important that victims' needs are represented in MAPPA, with the result that additional measures can be put into place to manage the risks posed to known victims. It is for these reasons that the Faculty of Forensic Psychiatrists in the Royal College of Psychiatrists has strongly recommended that the health representative sitting on a MAPPA panel should be a consultant psychiatrist, preferably a consultant forensic psychiatrist; other individuals may not have the ethical background or the authority to examine in detail the ethical issues which are posed by this policy. (See chapters 25 and 26 for more commentary on confidentiality.)

National Policing Improvement Agency

The National Policing Improvement Agency (NPIA) is a UK wide police resource for the storing and rapid transfer of information. It embraces automatic car number plate recognition, a fingerprint database, a list of those who have applied for firearms certificates, the Police National Computer and a dangerous persons database (Violence and Sexual Offenders Register (ViSOR), see below).

ViSOR

To quote the NPIA website:

> *ViSOR is designed to facilitate the work of the multi-agency public protection arrangements (MAPPA) by assisting co-operative working between the three responsible authorities (police, probation and prison services) in their joint management of individuals posing a risk of serious harm. The system is very secure – rated at CONFIDENTIAL level in the Government Protective Marking Scheme – to ensure that details of both offenders and those contributing intelligence to the system are kept safe. It is used by specially-trained and security-cleared public protection professionals.*

The register includes those required to notify the police under the Sexual Offences Act 2003 (see above), those jailed for more than 12 months for violent offences, and unconvicted people thought to be at risk of offending.

The Crown Prosecution Service

The Crown Prosecution Service is the principal prosecuting authority for England and Wales. It was established under the Prosecution of Offences Act 1985 in order to prosecute cases investigated by the police. It deploys the power of the State to put people on trial, acting on behalf of the Crown.

The Crown Prosecution Service is headed by the Director of Public Prosecutions, England and Wales are divided into areas, each headed by a Chief Crown Prosecutor. All members of the Service are civil servants. In all but simple and

straightforward cases, Crown Prosecutors are responsible for deciding whether a person should be charged with a criminal offence, and if so, what that offence should be. These decisions are made in accordance with the Code for Crown Prosecutors (February 2010) and the Director's Guidance on Charging (September 2008).

Non-Crown prosecutions constitute one-fifth to one-quarter of all cases coming before the criminal courts, mostly involving relatively minor matters, the vast majority in the magistrates' courts (Samuels, 1986). About one-quarter of crime is thus prosecuted 'privately'. The agencies bringing these prosecutions are diverse and include, for example, local authorities (food and drugs, or false trade descriptions) and the Royal Society for the Prevention of Cruelty to Animals. They retain the power to conduct the prosecution in court, but they vary widely in practice. Some, for example, appear to be quick to prosecute (e.g. the Department of Social Security in social security fraud); yet others see prosecution as a very last resort (e.g. the Health and Safety at Work Inspectorate). Such a diversity of practice raises important questions of public interest and social justice. For example, tax frauds are often not prosecuted; thefts from shops frequently are. In the overwhelming majority of tax contraventions, prosecution is seen as the ultimate sanction and used infrequently (Samuels, 1986).

CIVIL LAW

Non-criminal or civil law disputes in England and Wales

Civil law is the term used here for the law dealing with disputes between individuals or organizations (as opposed to criminal law in which the dispute is between an individual and the state, i.e. the Queen (*Regina*) in the UK and some parts of the British Commonwealth); it relies heavily upon common law. The civil law system used in most parts of the world is quite different.

Non-criminal disputes may concern a contract, a will, or property for example. The civil law equivalent of a crime is a tort. A tort is a civil wrong or breach of a duty to another person which creates a liability if a fault can be demonstrated. Much of the work of the civil court is concerned with providing compensation for personal injury and property damage caused by negligence. Personal injury nowadays does include psychiatric injury.

Civil courts are different from criminal courts. They still use an adversarial system of collecting evidence but they usually do not use a jury, the decision-making being undertaken by a lone judge. The standard of proof is different in a civil court. Whereas in a criminal court guilt has to be the proved by the prosecution 'beyond a reasonable doubt,' liability in a civil court simply has to be proved 'on the balance of probabilities.'

Compensation

There are three ways in which compensation can be awarded by the legal system for wrongs done to an individual.

1. The first is within the criminal system. An English criminal court may, after a finding of guilt, make a *compensation order* to direct the offender to pay monies to his or her victim and this will be in addition to any other penalties imposed. This can be compensation for personal injury or loss, but it cannot be for losses associated with motor vehicles nor for losses arising from the death of a victim. The offender's means have to be taken into account. If damages are awarded in a civil action, the level given has to take into account the sum already awarded under a compensation order.
2. A Criminal Injuries Compensation Board was set up in 1964. It has subsequently been substantially modified and superseded by the *Criminal Injuries Compensation Authority* which covers the whole of the United Kingdom and is based in Glasgow. A *Criminal Injuries Compensation Scheme* was established in 2008 (http://www.justice.gov.uk/downloads/victims-and-witnesses/cic-a/how-to-apply/cica-guide.pdf) under the Criminal Injuries Compensation Act 2005. The scheme is mainly (although not exclusively) concerned with violent injury and claims may be made for both physical and psychiatric injury. The rules which cover awards reflect the common-law precedents which have been set in the civil courts and are discussed below. The claimant does not have to show that an offender has been convicted of a crime which injured them. No awards are given for injuries from motor accidents unless the vehicle was used as a weapon. Awards of up to £500,000 may be given according to the Authority's tariff. Although this scheme technically relates to the criminal justice system its standards of proof and evidence are those used in the civil system.
3. Lawsuits for damages to compensate financially for both physical and psychiatric injury may be pursued in the civil court.

Psychiatric injury ('nervous shock')

In the nineteenth century there was no question of compensation for psychiatric injury. 'In February 1888, the Judicial Committee of the Privy Council, in the case of *Victorian Railways* decided that the plaintiff was not entitled to recover damages for nervous shock caused by the defendant's negligence, in the absence of proof of actual impact, even though serious physical injuries resulted from the shock.' The House of Lords said 'damages arising from mere sudden terror unaccompanied by actual physical injury, but occasioning a nervous or mental shock, cannot ... be considered a consequence which ... would flow from... negligence' (*Victorian Railways*).

Readers interested in the depressing history of the psychiatric consequences of frequent rail accidents in the nineteenth century (*railway spine*) should read Cohen and Quinter (1996).

The first chink in this heavy armour defending against psychological matters came at the very beginning of the twentieth century. In *Dulieu* in 1901 Ms. Dulieu, a pregnant barmaid, suffered shock followed by the premature birth of her child when runaway horses and a cart crashed into the pub where she was working. There was no impact causing physical injury, but she was in fear of her own safety and it was on this basis that her claim succeeded.

Since 1974 in the USA (*Prince*) and 1982 in the UK (*McLoughlin*) it has been possible for someone suffering psychological injury following trauma to receive compensation even when they were not directly threatened with death or injury themselves. In the USA, following the Buffalo Creek disaster, it was held that:

> *all survivors – even those who were outside the valley at the time of disaster – could collect for mental injury if we could convince the jury that the coal company's conduct was reckless (i.e. more than merely negligent), and that this reckless conduct caused the survivors' mental suffering.* (Stern, 1976)

Psychic impairment was the American term coined for these injuries. In the UK we stick with the quaint old-fashioned term of *nervous shock* which whilst being picturesque does not really do justice to the medical conditions involved.

Nervous shock was defined in *McLoughlin* by Lord Bridge.

> *The common law gives no damages for the emotional distress which any normal person experiences when someone he loves is killed or injured. Anxiety and depression are normal human emotions. Yet an anxiety neurosis or a reactive depression may be recognizable psychiatric illnesses, with or without psychosomatic symptoms. So the first hurdle which a plaintiff claiming damages of the kind in question must surmount is to establish that he is suffering, not merely grief, distress, or other normal emotion, but a positive psychiatric illness.*

Lord Bridge said that there are three criteria for nervous shock in English law:

1. *The plaintiff must be suffering from a 'positive psychiatric illness.'*
2. *A chain of causation between the negligent act and the psychiatric illness must be clearly established.*
3. *The chain of causation was 'reasonably foreseeable' by the reasonable man.*

The term 'positive psychiatric illness' embraces the whole range of morbid emotional responses as well as the neurotic and psychotic disorders in the standard diagnostic classifications. The important and difficult matter is to say whether the emotional response is 'normal' or 'abnormal', e.g. grief or depression. An important clinical point is that almost any mental illness may be caused by trauma. A great deal of attention is usually given to the anxiety state which is defined as being caused by trauma, post-traumatic stress disorder (PTSD), but it should always be remembered that other illnesses can occur alongside PTSD or instead of it (see Law Commission, 1998 for a discussion). Illnesses such as depression, alcoholism, personality change and sometimes psychosis (Morrison et al., 2003) can all occur (interestingly, like many medical observers the Law Commission does not mention psychosis in its discussion).

A further major medico-legal difficulty is the language of the law which can be at variance with the vernacular or other technical uses of language such as medical uses. A case in point here is 'cause'. A useful discussion of the use of this word and its derivatives such as 'causation' can be found in the Wikipedia encyclopaedia under the headings of 'proximate cause' and 'causation in English law'. To quote this website:

> *In the law, a proximate cause is an event sufficiently related to a legally recognizable injury to be held the cause of that injury. There are two types of causation in the law, cause-in-fact and proximate (or legal) cause. Cause-in-fact is determined by the 'but-for' test: but for the action, the result would not have happened. For example, but for running the red light, the collision would not have occurred. For an act to cause a harm both tests must be met; proximate cause is a legal limitation on cause-in-fact.*

And:

> *The basic test for establishing causation is the 'but-for' test in which the defendant will be liable only if the claimant's damage would not have occurred 'but for' his negligence. Alternatively, the defendant will not be liable if the damage would, or could on the balance of probabilities, have occurred anyway, regardless of his or her negligence (see* South Australia*).*

See also Elliot and Quinn (2005). J Devlin in *Lamb* said that:

> *duty, remoteness and causation – are all devices by which the courts limit the range of liability for negligence… All these devices are useful in their way. But ultimately it is a question of policy for the judges to decide.*

This seems to indicate that the court's main task is to do justice as between the parties which requires a weighing evaluative process, rather than a clear-cut rule of law, a view which seems to be held very strongly by the judiciary and which may be the basis on which Parliament refused to endorse the recommendations of the Law Commission for statutory changes in this area (see below).

In *Meah* the claimant suffered head injuries and brain damage as a result of the defendant's negligent driving, which led to a personality disorder. Four years later, he sexually assaulted and raped three women and was sentenced

to life imprisonment. The illegal nature of his conduct was not raised at the civil trial, and the claimant was held entitled to damages of £61,000 to compensate him for being imprisoned following his conviction. In separate proceedings, the three women assaulted obtained a judgment for compensation from the imprisoned rapist, so he sought indemnification from the negligent driver and his insurers for the amounts he had been ordered to pay. This was not a claim for his own personal injuries nor direct financial loss, but indirect loss. The three women could not have sued the driver directly because they were not foreseeable victims and so no duty of care was owed to them. The question was whether a person convicted of a crime was entitled to be indemnified against the consequences of that crime. J Woolf dismissed the action on two grounds. First, the damages were too remote to be recoverable and, if such actions were to be allowed, it would leave insurers open to indefinite liability for an indefinite duration. Second, as a matter of policy, claimants should not have a right to be indemnified against the consequences of their crimes.

In *Clunis* the claimant had been discharged from hospital where he had been detained under s.3 Mental Health Act 1983. He was to receive aftercare services in the community under s.117 Mental Health Act 1983, but his mental condition deteriorated and, two months later, he fatally stabbed a stranger at a London Underground station. He pleaded guilty to manslaughter on the ground of diminished responsibility and was ordered to be detained in a secure hospital. Subsequently, he brought an action against his local health authority for negligence. The health authority applied to strike out the claim as disclosing no cause of action on two grounds. First, that the claim arose out of the health authority's statutory obligations under s.117 Mental Health Act 1983 and those obligations did not give rise to a common law duty of care. Second, that the claim was based on the plaintiff's own criminal act. In the Court of Appeal, the health authority's appeal was allowed on both grounds.

As the psychological consequences of trauma become increasingly recognized and understood so the law, which finds scientific concepts difficult to embrace, ties itself in knots trying to dispense justice without reference to the science involved. Major accidents, such as the Zeebrugge disaster already mentioned, tend to set the scene. In March 1987, moments after leaving the Belgian port of Zeebrugge, the passenger ferry *Herald of Free Enterprise* carrying 459 passengers capsized killing 193 people. Many of the survivors suffered injuries and 70 were referred to the Maudsley Hospital seeking help with post-traumatic stress disorder and asking for help in recovering damages for nervous shock. In all over 400 compensation claims were made for survivors and relatives. Later the same year in the King's Cross station fire, 31 people died and more than 60 received injuries ranging from severe burns to smoke inhalation; many of these also sought help with PTSD and claims for nervous shock. The following year 35 people were killed in the Clapham Junction rail disaster and 500 people were injured; this too produced many psychological injuries and legal claims. Just two years later in August 1989 the *Marchioness* Thames pleasure boat, carrying 131 people at a birthday party, sank after being run down by the dredger *Bowbelle;* 51 drowned and again many, both survivors and relatives, sought psychiatric or psychological help. Immediately preceding the river Thames disaster in April 1989 came the notorious Hillsborough disaster in which 96 Liverpool football fans were crushed to death when the police allowed far too many spectators into a particular fenced enclosure. The police were severely criticized in the subsequent Taylor reports (Taylor, 1989, 1990).

The clustering of these major incidents in so few years gave rise to a good deal of legal interest and activity in respect of the compensation claims which were made in the context of a more psychologically sophisticated society.

It was the aftermath of the Hillsborough disaster which developed the law dealing with claims for psychiatric injury ('nervous shock'). There are several good sources which can be consulted, for example Elliott and Quinn (2005) and Slapper and Kelly (2006). The Law Commission (1998) report *Liability for Psychiatric Illness* also gives a very clear account of the problems posed by the Hillsborough disaster and gives a very thorough analysis of the legal decisions. As an aside it should be noted that, apart from omitting hysteria and psychosis as responses to trauma, the report gives a textbook analysis of the psychiatry of 'nervous shock'.

It also noted that:

> *While most of the officers were held entitled to recover damages, nearly all of the relatives of the dead and injured failed in their claims. The apparent injustice of this position has been acknowledged by judges, newspapers, MPs and legal commentators.*[4]

What happened was that the Chief Constable admitted liability towards those physically harmed. Sixteen relatives and friends, some of whom saw the event on television also made claims; 10 of them succeeded initially. The Chief Constable appealed in a test case (*Alcock*) and all 16 cases were rejected. The House of Lords decided that while it was clear that deaths and injuries in traumatic accidents commonly cause suffering that went well beyond the immediate victims, it was generally the policy of the common law not to compensate third parties (Elliott and Quinn 2005).

It was ruled, among other things, that parents and others who watched the Hillsborough disaster on television could not claim because television pictures are not normally equated with actual sight or hearing at an event or its aftermath. Clearly, this is a way of limiting claims against commercial organizations and their insurers. According to Elliott and Quinn (2005) *Alcock* confirmed that the claimants must

[4] Much is being done to remedy this following the publication of the report of the Hillsborough Independent Panel in 2012.

prove that their psychiatric damage amounts to a recognized psychiatric illness and that the psychiatric damage must have been caused by the claimants suffering a 'sudden and unexpected shock' caused by a 'horrifying event'. This rules out chronic stress and bereavement. *Alcock* further makes it clear that relatives are the people most likely to succeed in an action for psychiatric damage as a secondary victim, but the dividing line between those who are close enough to be considered for damages and disinterested observers is not easy to draw. For example does a recent boy/girl relationship count, or will the couple need to be engaged to be able to claim damages for nervous shock if one of them dies or is injured?

The public outrage about this particularly mean decision came when police officers on duty during the tragedy, suing their employer, were awarded damages (*Frost*) as a result of carrying out their professional duties at the scene.

It was in this climate that the Law Commission undertook a widespread consultation exercise and published its Report 249 in March 1998.

The Report concluded:

> *that in some respects, and most notably in the decision of the House of Lords in* Alcock v Chief Constable of South Yorkshire Police*, 5 the common law has taken a wrong turn. Legislation can cure the defects in the common law at a stroke and with certainty.*

It recommended:

> *there should be legislation laying down that a plaintiff, who suffers a reasonably foreseeable recognisable psychiatric illness as a result of the death, injury or imperilment of a person with whom he or she has a close tie of love and affection, should be entitled to recover damages from the negligent defendant in respect of that illness, regardless of the plaintiff's closeness (in time and space) to the accident or its aftermath or the means by which the plaintiff learns of it.*

See http://lawcommission.justice.gov.uk/docs/lc249_liability_for_psychiatric_illness.pdf

In any event Parliament rejected the idea of a new bill preferring to leave the whole matter to the common law and thus to the Court of Appeal and the House of Lords.

The Law Commission report was followed, however, by a further test case, again initiated by the Chief Constable against the decisions which had been made against him in *Frost*. The police officers concerned had been dealing with dead and injured fans. They claimed that they were not secondary victims and therefore not subject to the *Alcock* restrictions. Their claims succeeded on appeal but only to the extent that it is those who are in danger of physical injury, or thought themselves to be so, who could be viewed as primary victims. Rescuers were not to be considered as a special category of secondary victims either, which ruled out those officers who were simply rescuers and who had no pre-existing close relationships with the primary victims.

As this is the common law, the position continues to change, e.g. in 2002 in *North Glamorgan* it was decided, on appeal, that a 'horrifying event' need not be a single event or sudden. A mother had to watch her baby son die over a period of 36 hours when his acute hepatitis was not diagnosed and irreparable brain damage followed so that a life support machine had to be switched off. The Court of Appeal ruled that the plaintiff was not the primary victim, but could nevertheless succeed in her claim for damages for psychiatric injury as in this case the single shock could be considered to be composed of a number of shocks experienced over a period of time. In the same year a claim by secondary victims (husband and son) succeeded following a negligent mastectomy (*Froggatt*). Mrs Froggatt was wrongly diagnosed as suffering from invasive carcinoma of the breast and underwent a mastectomy. Shortly afterwards she was told that there had been a mistake and the lump had been benign. She was awarded damages for her physical injury and psychiatric injury. Her husband said that he had sustained a sudden shock when he saw her undressed for the first time after the mastectomy and as a result had developed an adjustment disorder. Her son overheard a telephone conversation in which Mrs Froggatt had discussed the fact that she had cancer and was likely to die. The son developed post-traumatic stress disorder. All the claims were allowed as they were thought to lie within the criteria set down for secondary victims in *Alcock* (http://www.psychiatryforlawyers.com). It is therefore important that legal opinion on recent developments is always sought at an early stage.

A clinical point to remember is that procedural considerations are important in compensation cases because cases that go to court can become protracted, wearisome, highly expensive and traumatic. Rehearsal of the traumatic events, especially under cross-examination, can produce flashbacks and an exacerbation of the underlying illness. Out of court settlements are ideal if the parties are willing to enter negotiations. A simple measure which can ease negotiations and be therapeutic in its own right is a straightforward and fulsome apology. Some of the victims of the *Herald of Free Enterprise* disaster said that an apology was all they wanted. They didn't get one in spite of their successful claims for damages, so the inner rage, especially concerning the accusations in the hearing that they were exaggerating their difficulties, continued its destructive course.

THE CORONER'S COURT

The office of the Coroner dates from the Norman invasion of Britain. By the twelfth century each county in England and Wales had appointed a coroner to protect the rights of the Crown. All violent and unexplained deaths were investigated, and where a guilty individual was identified, revenue was collected through fines and confiscation of goods.

Although the power of the coroner's court has waned in modern times, it continues to conduct its proceedings on an inquisitorial rather than adversarial basis, reflecting its Norman origins. For detailed information on coroners' courts, readers are directed to the following textbooks (Matthews, 2004; Christian et al., 2002).

The modern system of the Coroner's court stems from the recommendations of the Brodrick Report (Home Office, 1971) and is supposed to be a failsafe procedure, which provides that the registration of every death shall be subject to scrutiny and investigation for possible unlawful involvement. Since 1837 the law has required the registration of the death of every person, and registration cannot be effected without two stringent conditions being fulfilled. First there must be a valid certificate giving the cause of death and, second, the cause of death must be 'natural'. If the death is shown to be violent or 'unnatural', the coroner is required by law to conduct an inquest. In England and Wales there are approximately 550,000 deaths per year, 70% result in cremation and 30% result in burial. 200,000 deaths are reported to the coroner each year, 120,000 require a post-mortem and 20,000 require inquests.

An inquest is an impartial inquiry, conducted by a coroner on behalf of the Crown, for the purpose of establishing the truth concerning the events leading to and the ultimate cause of the death of an individual. Certain particulars are required by law to be registered concerning the death, namely the identification of the deceased person, the date and place where death occurred and how it occurred. There are no opposing parties, no provision of legal aid except in exceptional circumstances, and no enforceable judgment or order can be made.

At the inquest a coroner always has the discretion to summon a jury but has a statutory duty to summon one in prescribed situations, for example where a death occurred in custody or on a railway. Whilst not a statutory requirement following deaths in other institutions, for example, psychiatric hospital, a coroner may conclude that a jury is required in the public interest. Every inquest must be opened, adjourned and closed in a formal manner. Sometimes the coroner has a statutory duty to adjourn where, for example, a person may be involved in criminal proceedings connected with the death, and this will take precedence.

The procedure at an inquest is under the control of the coroner. The coroner must examine on oath any person having relevant evidence to give concerning a death. Any person who has a 'proper interest' in the circumstances in which an unnatural death has occurred is entitled to attend in person or be represented at the inquest and question witnesses. Interested parties can ask questions of the witnesses with the permission of the coroner, but may not address the court on the facts.

In announcing his or her verdict the coroner is strictly limited by the coroner's rules. S/he does not produce any legally enforceable judgment or order, and no finding of negligence, blame, culpability or guilt will be recorded. S/he no longer has a duty to commit for trial persons to be charged with murder, manslaughter or infanticide but must instead adjourn the case and send particulars to the Crown Prosecution Service. The verdict at the inquest is not subject to appeal but it may be questioned in the Divisional Court by way of judicial review on grounds such as fraud, error of law, bias, excessive jurisdiction or insufficiency of evidence. Whilst the standard of proof in a coroner's court is on a balance of probabilities, in those cases where the verdict is 'suicide', it has been established in the High Court that this verdict should only be made on the clearest and most unequivocal evidence, and that the stricter standard of 'beyond reasonable doubt' should be applied.

Following a number of major inquiries, the whole coroner's system has been overhauled. Disquiet was first publicly expressed at the Brodrick Committee (Home Office, 1971) that homicide might pass undetected through the existing certification system. This view had been put forward by Dr John Havard, later Secretary of the British Medical Association, who had expressed his concerns in his book *The Detection of Secret Homicide* (Havard, 1960). However the Brodrick Committee concluded that the risk of secret homicide had been much exaggerated. The systems of death and cremation certification remained virtually unchanged, and an opportunity to overhaul the system was lost.

The status quo could not be preserved, however, following the conviction of Dr Harold Shipman at Preston Crown Court on 31 January 2000 of the murder of 15 of his patients. The following day it was announced that an inquiry would be held to establish what changes to current systems should take place in order to safeguard patients in the future. It was held publicly and chaired by Dame Janet Smith (2002–5). Six reports were subsequently published between July 2002 and January 2005. She concluded that Dr Shipman killed 215 patients, and that the present systems of death and cremation certification had failed to detect any of those unlawful killings.

In her third report 'Death Certification and the Investigation of Deaths by Coroners' published 14 July 2003, Dame Janet Smith proposed radical changes to the current system. Her inquiry overlapped with a review chaired by Mr Tom Luce (Home Office, 2003b). The Luce review drew conclusions broadly in line with those of the Shipman Inquiry with the result that the momentum for change became irresistible and the Government had to respond. Dame Janet Smith urged the Secretary of State for Home Affairs not to allow the work of the Shipman Inquiry to meet the same fate as the Brodrick Report, and subsequently a Home Office position paper entitled 'Reforming the Coroner and Death Certification Service' was published in March 2004 and presented to Parliament (Home Office, 2004c).

The paper argued that certifying death should involve more rigorous procedures. A new two-stage death