Introduction

Mary Davoren and Harry Kennedy

It is a privilege to edit a textbook in the subject to which we devote our professional lives. We were both influenced by Derek Chiswick and Rosemary Cope's text that set out a list of essential topics. Part of the reward for the work of renewing this textbook has been to nudge new topics into the canon of forensic psychiatry.

Forensic psychiatry is the interface between psychiatry and the law. It is a complex and challenging discipline encompassing clinical care and treatment for a highly vulnerable patient group with some of the most complex presentations in psychiatry, legal knowledge and ability, as well as leadership and academic expertise. The forensic psychiatrist must be the experts' expert, a shrewd clinician with serious attention to detail. It is not for the faint-hearted. We hope this book will inspire the brightest and the best to undertake training in this discipline.

Forensic psychiatry is often thought of only in terms of violence risk, and clearly the assessment and management of violence is key to this discipline. 'Risk' is the name of a popular board game in which war and diplomacy are pitched against each other by rolling the dice. Clinical ability in the area of risk assessment is often seen as the defining skill and characteristic of the very best forensic psychiatrists, though actually the best forensic psychiatrists must excel in multiple areas. Forensic psychiatry can also be understood as an uneven distribution of risk in which professional expertise and practice generate means of either regulated redistribution of risk or unregulated accumulation. The risk of violence arising from mental illness, substance misuse and delinquency can only be partly quantified and even more imperfectly regulated. Unregulated, relapses and interactions in these three domains lead to disorder, damage and occasionally death. The risk accumulates non-randomly among the vulnerable – those with mental illnesses, substance misuse issues and personality disorders. The victims are also seldom random: parents, spouses and friends, others with the same vulnerabilities, and sometimes professionals. Most patients in forensic hospital settings are both victims and perpetrators of violence – when the consultant forensic psychiatrist can see only the victim or only the perpetrator, they are unlikely to succeed. A nuanced understanding of both sides is required for excellence in this complex area.

Forensic psychiatry services provide care and treatment to mentally disordered offenders for whom violence linked to mental disorder is also an unmet treatment need. The purpose of these services is to reduce both the probability of violence and the seriousness of violence if it occurs. This is accomplished first through a process of redistribution of risk – placing the high-risk patient in the most therapeutically safe and secure setting, while those who are at a lesser risk, or a less serious risk, can be placed in or moved to medium or lower levels of therapeutic security. Restrictive practices such as seclusion, restraint and

forced medication may be medically necessary to prevent imminent violence while treatments, both pharmacological and psychological, are implemented and take gradual effect. Reducing and eliminating the cycle of violence and providing a safe space for therapeutic engagement and the challenge inherent in good therapy are vital.

There are competing models for how such risks should be managed or regulated. A libertarian approach would hold the mentally disordered to be strictly liable for their acts and would use compulsion under almost no circumstances. Like any unregulated economy, great inequalities in the distribution of risk follow, with prisons becoming the main centres for coping with severe mental illnesses, comorbidities and disadvantages. A bygone era of moral regulation confined the mentally disordered away from civil society in asylums and 'colonies'. A more recent era of risk consciousness and risk aversion also confines but more selectively and with greater attention to selective triage, risk stratification and legally regulated recovery pathways. Modern specialist forensic psychiatry services should provide culturally sensitive services, women's services and specialist services for uniquely vulnerable groups such as children and adolescents and those with intellectual disability.

This second edition of *Seminars in Forensic Psychiatry* aims to find clinical relevance across services and across jurisdictions insofar as this is possible, since we believe that this will reflect the needs of a forensic psychiatry readership. We are confident that this will also benefit forensic psychiatry patients.

Chapters commence with two approaches to the psychiatry of violence in mental disorder (Chapters 1 and 2). Next (Chapter 3) is a chapter on the history of how modern forensic psychiatry services have evolved in Britain, through inquiries and reports that shaped policy. A chapter on psychiatry in prisons follows (Chapter 4). A review of legal issues (Chapter 5) may represent a watershed between psychiatry in the courts and legislation as a gateway or pathway into treatment. A later chapter also addresses questions of medical negligence (Chapter 16). Chapters then deal with structured professional judgement and risk as ways of understanding expertise in forensic psychiatry (Chapter 6); models of care in forensic psychiatry (Chapter 7); the pharmacology of aggression and violence (Chapter 8); the clinical management of in-patient violence (Chapter 9); and community forensic psychiatry (Chapter 10). There are then four chapters covering special subjects such as personality disorder, stalking, sex offenders and terrorism (Chapters 11, 12, 13 and 14, respectively), followed by chapters on psychotherapies and psychological treatments (Chapter 15); forensic child and adolescent psychiatry (Chapter 17); forensic psychiatry and women (Chapter 18); intellectual disability (Chapter 19); cultural psychiatry (Chapter 20); ethnic inequality (Chapter 21); and academic forensic psychiatry (Chapter 22). The book concludes with some no-nonsense guides (Chapter 23) that we hope will be useful prompts and supports as readers set out on their forensic careers.

Forensic psychiatry is much more than medico-legal psychiatry. Dr Katherine Warburton says we must be advocates and educators, as well as treatment providers. An essential aspect of being a consultant forensic psychiatrist is working to attract the very best psychiatry trainees into our discipline; this is what is required to reach the top of this challenging field, and it is what our patients, with their very high levels of vulnerability and complexity, deserve.

Chapter 1

Violence and Mental Disorder
The Evidence

Jeremy W. Coid

The assessment of violent behaviour and its association with mental disorder is at the core of clinical practice in forensic psychiatry. It is the main clinical skill that a forensic psychiatrist needs to develop. This chapter will concentrate on the evidence for the association between psychotic illness and violence. Most persons referred for assessment of violence to a forensic psychiatrist in the UK present with psychotic illness, mainly schizophrenia, and to a lesser extent personality disorders and sexual deviation. However, this does not reflect violence in the UK general population but a system of referral and gatekeeping of patients and clients assessed in what is a relatively small tertiary care service. Although forensic psychiatrists should be experts in the assessment of violence among people with mental disorder, it is essential to develop expertise with those who have no evidence of mental disorder. Paradoxically, these cases are often the most challenging to understand and evaluate.

Training in UK forensic psychiatry is based primarily on an 'apprenticeship' model and does not require passing additional examinations after becoming a specialist in psychiatry. This means that it is essential to obtain further specialist training in assessment techniques and to have some understanding of criminology. It is also important to have as much experience as possible of the different healthcare and prison facilities for violent individuals and at different levels of security. For many psychiatrists, Broadmoor, Ashworth and Rampton high-secure hospitals represent the most severe level of risk for violence, but in fact there are a group of individuals contained in special prison units who represent an ongoing level of risk for violence that cannot be contained within a high-secure hospital, some with severe mental illness.

Assessment of violence will sometimes require courage and the ability to monitor one's personal safety based on observation, experience and training. It also requires an ability to remain objective and detached from the personal feelings that can interfere with giving a sound and helpful opinion. With experience, one's own personal response to a potentially violent individual can be highly important in an assessment. What is it that makes one uncomfortable around or even afraid of the patient? Why is it that the patient appears to have a good relationship with one member of the clinical team but no-one else? This means learning to be aware of and overcoming the strongly negative feelings held by most persons when encountering violence and violent individuals. It helps if a forensic psychiatrist has a natural interest in violence. If not, it will be necessary to develop one.

This chapter is intended for trainees in forensic psychiatry but may be of help to more experienced practitioners because it is based on personal clinical experience, as well as involvement in research into violence. The aims are, first, to help trainees refine forensic assessments of offender patients so they can give advice to courts in determining an offender's legal responsibility for a criminal act. Second, the chapter aims to help increase

understanding of the motivation for violent offending and the pathways to violence. This is not only necessary for giving expert evidence in courts but is also essential in choosing the treatment that should be offered to a patient and the level of security required in which to deliver treatment, and in some cases it may be relevant to the likelihood of a successful response to the treatment. Third, the chapter shows that associations between criminal behaviour and mental disorder may be highly important in the assessment of risk for future reoffending, although this chapter does not deal with risk assessment as currently operationalised in many North American and European forensic services. Finally, and most importantly, the chapter emphasises that a good forensic assessment should concentrate on the future management and prevention of further violence.

Evaluating Research, Risk Assessment and Considering Causation

This chapter covers a wide-ranging area of research and clinical observation and should be considered as an overview. When considering research, it is important to evaluate the current literature on mental disorder and violence, what it means for the practice of forensic psychiatry and why some is highly limited and even unhelpful. The chapter also aims to give some indication of future directions for research into violence for forensic psychiatrists.

This chapter will not consider risk assessment for violence, which is covered in Chapter 6 and by means of specific training. However, the assessment of violence for planning a treatment intervention or giving evidence to court should not be confused with an assessment of future risk for violence. For example, many current research limitations derive from an overemphasis on research methods used to develop instruments which aim to predict violence. Some disciplines have even come to confuse assessment of violence with assessment of risk. There is no reason not to carry out both forms of assessment. From the perspective of the assessment of violence, a numerical score of future risk can be helpful in a limited sense by categorising individuals based on their previous behaviour and demography. However, these predictions stand a good chance of being wrong in the narrow sense of estimating future likelihood of violence.

There is no current high-grade research evidence which demonstrates that a structured clinical risk assessment instrument or an actuarial risk instrument can prevent an act of violence following discharge from hospital or release from prison. The only randomised controlled trial to date which tested a structured professional judgement instrument against management as usual failed to show a significant reduction in violence following hospital discharge [1]. There are two randomised controlled trials which demonstrate a significantly reduced count of violent acts among patients in hospital who were assessed for short-term risk by nurses [2, 3]. However, closer examination reveals these risk assessments were tied to the requirement by clinical teams in the intervention arm of these studies to select, then carry out, active interventions based on a score of risk.

These findings indicate that it was very likely that the clinical preventative intervention was the active and effective component resulting in reduction of violence and not the risk assessment. Clinical experience with violent patients soon reveals a range of different chance events and circumstances that can interfere with one's predictions of future behaviour. The most important clinical use of risk assessments should therefore be to determine the necessary treatment and management options to prevent future violence rather than categorising patients according to risk scores, or speculative notions of future risk based

on a training session in structured clinical judgement. No risk instrument can consider all possibilities and the increasing proliferation of these instruments for different forms of violence emphasises these clinical limitations. No new statistical development or advance in machine learning can substitute for professional experience. However, they can help as an important aide-memoire and ensure that key areas are not forgotten in an assessment.

Multiple limitations of violence research are shown when attaching too much importance at the individual level to results from surveys and, most importantly, to case register studies – no matter how large the sample size and despite claims the sample represents the entire population of a country. It is important to question whether the published research has any bearing on forensic clinical practice. The forensic psychiatrist should have multiple sources of information before conducting an assessment, and experience soon shows that most epidemiological studies are remarkably short of the key variables that determine violence. These studies are important in suggesting avenues for future research and creating new hypotheses. However, interpretations such as violence being substantially determined by genetic factors, while a possibility, cannot be relied upon in studies that use data that was never intended for the purpose of genetic study and that depend entirely on sparse data on siblings and criminal records to determine genetic association.

Forensic psychiatrists should have a healthy scepticism of studies where the statistics are so dense and complex that they are incomprehensible to the average clinician. There have been a series of studies of violence using the Scandinavian case registers where patients – sometimes all patients in a country captured by the register with a psychiatric diagnosis who have had contact with hospital and out-patient/community services – are linked with police records. Apart from the fact that neither register was designed for the study of either complex criminal acts or mental illness and that both are merely administrative registers to record the performance of services, criminal records are a poor indication of violence in a population and convictions and arrest records represent the last stage along the criminal pathway in which mentally ill persons are disadvantaged at each stage. Most Western countries now rely on self-report surveys of victims of crime to get a picture of crime trends and do not rely on official police statistics alone. But more importantly, the presence of a categorical diagnosis in a register does not mean that symptoms of mental illness or intoxication from drugs or alcohol were actually present at the time the violence occurred.

This key data is simply not available in the Scandinavian case registers. Closer examination shows that this is an unsubstantiated assumption on which to base conclusions such as that depression causes violence, drugs and alcohol cause violence among persons with schizophrenia (but not their schizophrenic illness), a substantial proportion of all violence in a population is genetically determined and so on. If the data does not include the social circumstances and other potential social determinants of violence and whether symptoms of mental illness were present at the material time, together with observational effects of those symptoms on the violence, it cannot be determined whether any of these factors had any impact or whether unknown confounders not included in the register were the key drivers.

Epidemiology of Violence

Violence, according to the World Health Organization [4], is 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation'. Although violence is a criminal

behaviour, before it is formally deemed a crime the violence must have been observed and reported to the police, the individual must be arrested, a decision must be made to prosecute, and the offender must appear at trial in court before a final conviction. The verdict may be 'not guilty'. It is therefore important to remember that the overwhelming proportion of violence in all countries is not reported to or detected by any official agency. Criminologists refer to the 'dark figure' of crime: that which is not reported in official criminal statistics, which only represent the 'tip of the iceberg' of actual crime in a population. This means that when evaluating epidemiological research evidence, it is essential to be fully aware of the limitations of the measures of violence in the research study.

Psychiatric studies of violence are bedevilled by poor measures of violence. If a study relies entirely on criminal convictions, this means the majority of violent events in the population have been missed and cannot be included in the study. It is estimated that 95% or more of all violent events will not be reported to the police. Although it is argued that if more serious crimes such as homicide are studied, then more violence will be included, it still has to be remembered that even in Western countries with resources to conduct careful investigations, a proportion of offenders will never be arrested or convicted. In countries with exceptionally high homicide rates, such as in Central and South America, nearly half of offenders may never be arrested. Most importantly, persons with mental illness are more likely to be detected, arrested and convicted than other offenders. Furthermore, for those who are violent in hospital, the violence may not be reported to the police unless serious injuries occur. In the UK, however, this is changing as staff become less able to respond to and less willing to accept violence from patients, particularly in community-based services.

Homicide and Mental Disorder

It is important to place violence in the UK in an international context. The most extensive information for comparison purposes is recorded for homicide. Rates vary greatly between world regions [5]. Homicide is considered the best comparator for international purposes because it is seen as the most serious violent offence and more time, effort and financial expenditure is invested in its investigation. However, not all deaths are accurately identified as homicides or the perpetrators identified. Overall, less than 1% of all global deaths are due to homicide, but in some countries this is as high as 10% and a leading cause of death. Rates are highest in Central and South America and South Africa and lowest in certain East Asian countries and western Europe (see Figure 1.1).

Figure 1.2 shows the number of deaths internationally by cause for all ages. Homicides are not the leading cause of death. However, if the histogram includes younger persons aged 15–49 years, it rises to the ninth most common cause. If the data is applied to Venezuela in 2017, homicide was the third, in Honduras the fifth and in Guatemala the sixth most common cause of death. Looking at younger adults aged 15–49 years in Latin American countries, homicide is the highest-rated cause of death.

Homicide rates appear to have fallen in all regions over the last quarter century. But because the global homicide rate is calculated as a proportion of the population, it has declined only because the global population has risen. The overall number of people killed worldwide in homicides actually increased from 1990 to 2017. During this same period, homicides due to criminal activity caused as many deaths as armed conflicts and terrorism combined. Women and girls account for a far smaller share of victims of homicide in general than men. The majority of all homicides involve young men, both as perpetrators

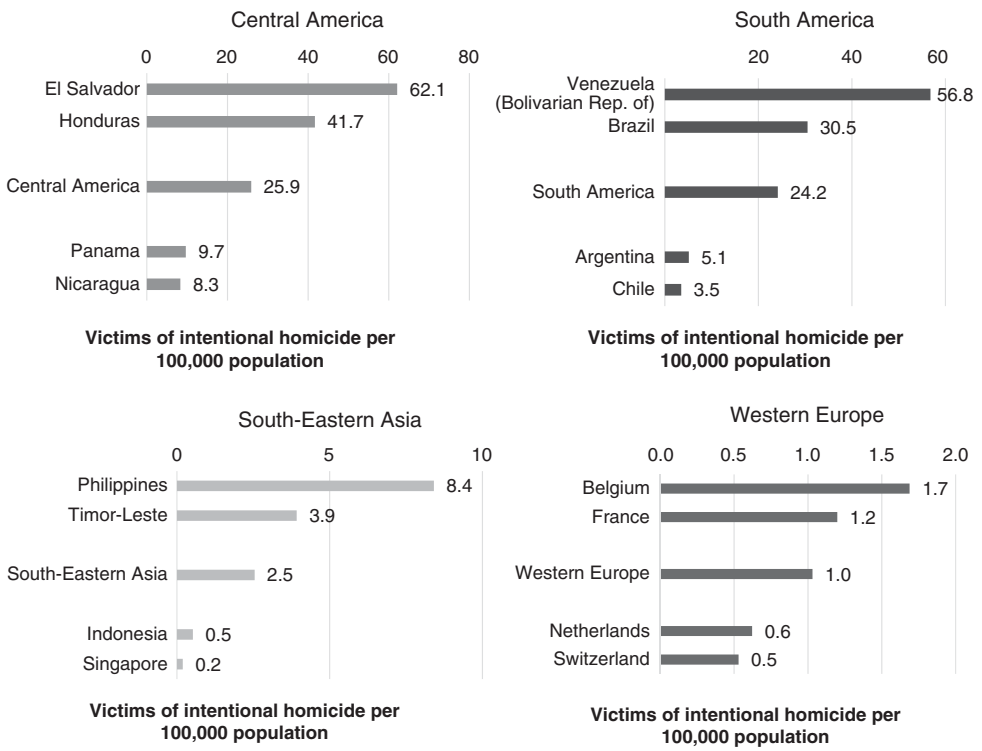

Figure 1.1 Countries with the highest and lowest homicide rates in selected subregions, 2017. United Nations Office on Drugs and Crime homicide statistics. From *Global Study on Homicide* by the United Nations Office on Drugs and Crime. © (2019) United Nations. Reprinted with permission of the United Nations.

and victims. However, women bear by far the greatest burden of family-related and intimate partner homicide as victims.

Rises and falls in homicide rates in most countries are largely explained by changes in rates among young adult males with no mental illness. Pinker has argued that there has been a dramatic fall in homicide since the Middle Ages, measured largely in Europe and more recently North America, and that humans are becoming less violent and more altruistic [6]. However, not all academics agree in that violence changes in its form and fluctuates over time. For forensic psychiatrists, a key issue is whether violence has fluctuated over time among the severely mentally ill. However, there is little evidence to indicate change over time using homicide statistics, which may be the best data available but are dependent on processing through the criminal justice system; also, different jurisdictions differ in how they deal with mentally disordered offenders. If this data can be relied upon in England and Wales, homicide rates for the mentally ill appear to have remained the same, while those for other offenders have changed over time [7].

To understand violence in a single country, it is necessary to observe fluctuations in rates rather than relying on cross-sectional surveys and case register studies, which take measures over short time periods – although these often represent the only detailed data available. Changes in exposure to risk factors affecting this subgroup of the population include the

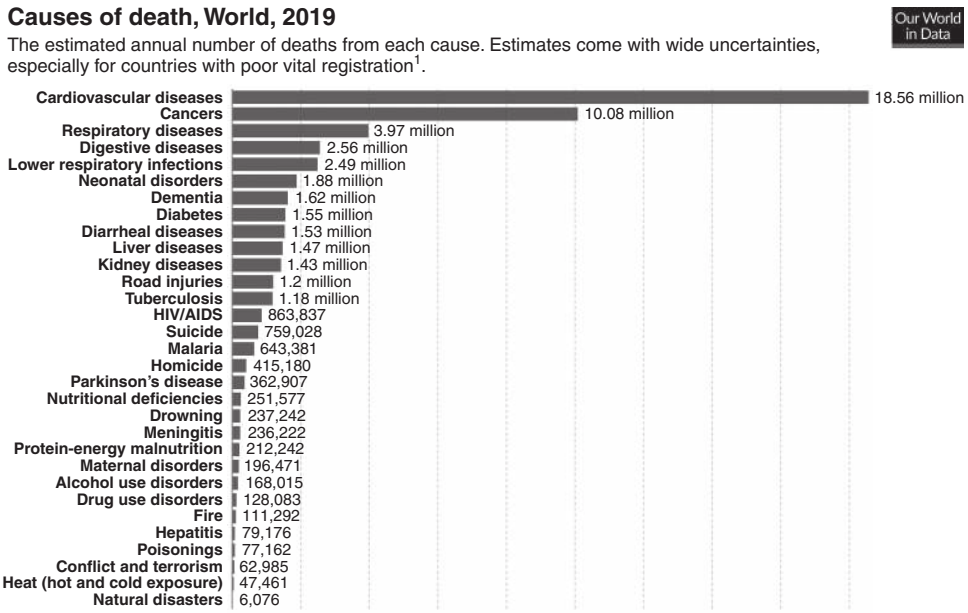

Figure 1.2 Causes of death. Source: Institute for Health Metrics and Evaluation, *Global Burden of Diseases* (2019) (https://ourworldindata.org/causes-of-death, https://ourworldindata.org/grapher/share-of-deaths-from-major-causes?time=1990).

availability of firearms, gang involvement, changing involvement in criminal activity (particularly drug trafficking and sales) and the consumption of alcohol. The impact of these social and environmental factors means that the public health problem of violence has to be considered. Forensic psychiatrists should be aware of local, population-based factors in their catchment-area populations and when giving opinions on cases in other jurisdictions. Changes in homicide rates involving women rarely make an impact on fluctuations or changes in national homicide rates. For example, the homicide rate for Scotland became the highest in western Europe by the 1990s, but then fluctuated. Further rises and subsequent falls in homicide rates in Scotland between 2000 and 2014 were entirely accounted for by men. Meanwhile, women showed a small, progressive *decline* over the same period.

There is also no current evidence that *changing* rates of homicides are explained by persons with mental illness. Although it may make complete sense to a forensic psychiatrist that the closure of the mental hospitals and shift of patients into the community should have led to an increase of recorded violence by mentally ill persons, this has not been convincingly established and study findings remain controversial. In 1939, English mathematician, geneticist and psychiatrist Lionel Penrose hypothesised that the numbers of psychiatric hospital beds and sizes of prison populations were inversely related. The hypothesis fell out of favour in the 1980s, by which time bed closures had become a more accepted aspect of ongoing changes in psychiatric provision in most of Europe and North America. The

hypothesis was revived by the work of Mundt and colleagues more recently in South America, showing that the prison populations in 17 Latin American countries had substantially increased and that they had increased more where more psychiatric beds were removed [8]. These findings held up when introducing per-capita income and income inequality as co-variates. However, it remains unclear and controversial whether serious violence by persons with severe mental illness has increased as a result of bed closures.

An earlier study in England and Wales [9] observed the overall rise in homicide rates in England and Wales but demonstrated that court adjudications, resulting in successful diminished responsibility and insanity defences, had remained remarkably stable over a 30-year period, during which the overall rises had occurred. Subsequently, it was claimed there had been a rise and then a fall in homicides attributed to mental disorder over a 50-year period, the fall coinciding with a fall in the overall homicide rate [10]. However, these observations were dependent on small numbers of cases each year and, most importantly, processing through the criminal justice system to identify the mental disorder. The change was more likely due to a change in the willingness of psychiatrists giving evidence in courts to recommend defendants for a defence of diminished responsibility and offer a hospital bed, particularly for those with personality disorder, rather than a true rise and fall in homicides involving mental disorder. It is worth reflecting that in Western countries, particularly in Europe, where there are few homicides, a larger proportion (but not rate) with mental disorder will make it appear that there is a large problem of violence by the mentally ill. In countries with very high rates of homicide, homicides by the mentally ill may appear to be negligible. Paradoxically, stigmas involving the mentally ill are often similar in both locations.

A key unresolved question is whether rates of homicide by mentally ill persons are the same or differ between different countries. An early study showed that they were apparently very similar, but this was based on countries with low overall homicide rates [7]. A later study criticised this argument and suggested that if countries with higher overall rates were included, then the rate among the mentally ill would correspond to the overall rate [11]. This would imply that in countries with high overall rates, with specific risk factors influencing these high rates such as firearm availability, persons with mental illness would be proportionately influenced by these same risk factors – in the same way that persons without illness are affected. In a country such as the USA, with ready availability of firearms, rates should therefore be higher for persons with severe mental illness than in the UK. However, this possibility ultimately remains unresolved due to a lack of data from countries with high homicide rates. Countries with the highest homicide rates tend to have low clear-up rates or do not routinely screen for mental disorder. In countries with multiple unsolved murders, drug cartels and readily available firearms, mental illness is simply not considered a likely or relevant factor in the overwhelming majority of cases. This is an important consideration in countries with low homicide rates. If media attention and public opinion does not keep these issues in perspective, concern can arise that homicide by the mentally ill is a major problem when it is in fact exceptionally uncommon. It is therefore essential not to confuse percentages of the total number of homicides with age-standardised population rates.

A key epidemiological finding with regard to psychotic illness and homicide is that, for schizophrenia, it is the prodrome and during a first episode of psychosis (often the period of greatest symptomatic disturbance over the lifespan) that is most strongly associated with homicide – a relatively short timespan over the entire life course. In a meta-analysis, approximately 30% of homicides in a range of countries were found to have occurred

prior to ever receiving treatment. The risk during this period was 12 times that during the rest of the lifespan following a diagnosis of schizophrenia [11]. As the first episode of psychosis is relatively short compared to the total duration of the illness, the risk of homicide during a first episode is therefore considerably greater than the annual risk among individuals with treated psychosis. This confirms that a first episode is a medical emergency and suggests that reducing the duration of untreated psychosis might save lives. However, because many individuals committing homicide during a first episode will not be known to mental health services, this may be difficult to achieve. Furthermore, the illness may only be identified as a result of the homicidal behaviour.

In a national nested case–control study of previously admitted male patients diagnosed with schizophrenia in England and Wales, those who were convicted of homicide were statistically more likely to be non-adherent to their treatment plan; had lost contact with services prior to the offence; had a history of violent criminality, comorbid personality disorder or drug use disorder; had been admitted to hospital multiple times; and belonged to a black and minority ethnic group. Homicide perpetrators were less likely to have had recent routine contact with services and to have been recently discharged from hospital [12]. It was subsequently argued that these findings showed that much of the risk of serious violence in schizophrenia is related to comorbidity with alcohol or drug misuse, corresponding to previous research, with similar conclusions to the national Scandinavian case registers study and a related meta-analysis [13, 14]. However, none of these studies had information on whether psychotic offenders were actually intoxicated or had even taken any drugs or alcohol at the time of the violence to confirm this assumption and rates for schizophrenia in England and Wales were not standardised to be able to tell if there had really been a trend over time. They did, however, show that 90% of homicide offenders with schizophrenia had psychotic symptoms at the time of the killing, meaning that intoxicated or not, psychotic symptoms may have driven the homicide in a proportion of cases. Substances may have interacted with the acute psychotic process at the time, but no data was available to confirm this.

This is an important study with important epidemiological findings, but methodological limitations make it difficult to interpret the implications of substance misuse for homicide by persons with schizophrenia. The uncertainties of these study findings directly impact on clinical forensic practice because it is the role of a forensic psychiatrist to be absolutely sure when giving an opinion to the court whether psychotic symptoms were a causal factor at the material time of the homicide, and to give a precise opinion on the role of substance misuse. Such opinions cannot rely on a comorbid diagnosis of substance misuse at some undefined time in the past. Furthermore, when giving opinions on treatment and management, ensuring compliance with treatment and follow-up is highly important in preventing future violence in persons treated for schizophrenia. Patients who abuse substances are more likely to be non-compliant with medication and follow-up and thereby are at greater risk of relapse.

Non-lethal Violence

Homicide is an unusual violent crime with particular characteristics. The overall level of violence in a population can be obtained from non-lethal violent crimes which are recorded by the police, but many countries also record self-reported violence using surveys carried out at regular time intervals. These can give a different picture. For example, an earlier study of crime rates in the USA and England and Wales covering 1981–96, comparing New York and London, showed a considerably higher homicide rate in New York, whereas common