

Handbook of Forensic Psychiatric Practice in Capital Cases

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Second Edition



In association with:

ForensicPsychiatryChambers

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Foreword

The execution of individuals with mental disorder (mental illness or intellectual disability) is clearly prohibited by international law. The presence of mental disorder and how it has been handled during the investigatory or trial process may render a conviction unsafe. In capital cases, where the consequences of any errors are potentially irreversible, norms of international law have developed to protect those with mental disorder. The United Nations (UN) Safeguards Guaranteeing Protection of the Rights of Those Facing the Death Penalty embody norms of customary international law that exclude individuals suffering from mental illness and intellectual disability from the death penalty, whether at the stage of sentence or execution. The UN Human Rights Commission has repeatedly called on states not to impose the death penalty on a person suffering from any form of mental disorder or to execute any such person. At the national level, the vast majority of states recognise, in principle, the exemption of mentally disordered persons from the death penalty, but the real difficulty lies in the implementation of the safeguard.

Legal provisions and safeguards are only as effective as the services available to implement them and, in practice, it is all too common to find prisoners with serious mental health issues on death row. For the rights of those with mental disorder to be upheld and enforced, individuals not only need to have access to adequate legal representation, but also – critically – to mental health services and the expertise of mental health professionals. The legal principles designed to protect those with mental disorder from the death penalty are not in dispute, but for them to be put into practice, mental health professionals must be equipped with medical expertise, in terms of making a diagnosis, as well as clinico-legal expertise in terms of presenting evidence to courts. There is also a clear need for judges and lawyers, whether acting for the defence or the prosecution, to understand key medical concepts and their relevance in the courtroom.

The first edition of this Handbook, published in 2013, was commissioned in response to an acknowledged resource gap in the capital jurisdictions where we operate and the knowledge that mental health issues were not being properly raised or adjudicated on by the courts. The first edition provided an authoritative, practical guide for legal and mental health professionals on all aspects of forensic psychiatric practice, and has been relied on by the courts in many jurisdictions and cited as an authoritative guide in a number of key judgments. The first edition was also complemented by our focussed training workshops, which have proven immensely valuable in supporting collaboration and encouraging discourse between legal and medical professionals involved in capital cases. We have already begun to see the rights of individuals suffering from mental disorder upheld as a result of improved understanding of principles of mental health law and their implementation in criminal proceedings. For example, there have been encouraging signs in Taiwan, where there has been an increase in the consideration of psychiatric evidence by the courts and, recently, a number of high-profile cases where the death penalty has not been imposed on individuals found to be suffering from mental disorder.

This second edition Handbook and the companion Casebook provide an up-to-date and enhanced resource for legal and medical professionals involved in capital cases. The Handbook, which has been updated to cover the latest legal developments, remains highly relevant to capital trials and appeals, but has been broadened to also include information relevant to all serious criminal cases. Readers will also benefit from the new Casebook, which complements the Handbook by using real case examples to put key legal principles, clinical standards and questions of ethics into context and provide a guide for

decision-making. Both publications can be used as stand-alone resources or in conjunction with training programmes offered by Forensic Psychiatry Chambers and The Death Penalty Project in a range of countries. The publications are designed to complement existing literature, including the *Oxford Specialist Handbook of Forensic Psychiatry*¹, which is similarly designed to assist clinicians and lawyers at the interface between medicine and law.

This second edition of the Handbook and its companion Casebook together create a comprehensive set of training material for future education, which will benefit a new generation of lawyers and medical professionals. By supporting those within the criminal justice system to fairly and accurately address mental health issues as they arise in capital trials, we hope to ensure that laws are properly applied and the protections afforded to those with mental disorder are realised.

Saul Lehrfreund and Parvais Jabbar

Co-executive directors

The Death Penalty Project

January 2018

¹ Eastman N, Adshead G, Fox S, Latham R, and Whyte S, *Oxford Specialist Handbook of Forensic Psychiatry*, Oxford University Press, Oxford, UK (2012).

Introduction

Forensic psychiatry comprises the psychiatry of mental disorder and offending behaviour – that is, *clinical forensic* psychiatry – plus law as it relates to all psychiatry, both civil and criminal law, usually referred to as *legal psychiatry*. The branch of law most obviously relevant to those with mental disorders is mental health law, although other branches of civil law will also potentially relate to them. However, mentally disordered offenders² – upon whom this Handbook is focused clinically, and who represent the substance of clinical forensic psychiatry – are unusually likely also to be the subject of criminal legal proceedings. They also tend, in practice, to be subject to the application of mental health law more often than others with mental disorder who do not offend, or are not considered at particular risk of doing so. Hence practitioners of clinical forensic psychiatry will inevitably have greater involvement with legal psychiatry than those practising within general psychiatry. Put another way, clinical forensic psychiatry often underpins not only the clinical assessment and treatment of mentally disordered offenders per se, but also the assessment of and reporting on them for legal purposes. Indeed, on many occasions, the sole purpose of clinical forensic assessment may be to report into the criminal legal process.

This Handbook is designed specifically to assist mental health professionals and lawyers engaged in serious criminal trials, sentencing hearings, appeals and mercy hearings where psychiatric or psychological issues may arise. However, it is ‘custom written’ in regard to serious crime within legal systems that retain the death penalty. This has been done so as both to address matters that are specific to capital trials and to demonstrate that similar medical and medico-legal principles apply to both capital and other serious criminal trials within any given jurisdiction. Medically, the Handbook draws upon ordinary principles of forensic psychiatric practice; whilst, legally, much of the text is relevant to a variety of common law jurisdictions. Finally, the Handbook is directed at legal systems within which forensic mental health services – including within prisons – are often not as highly developed as they are in the UK, and some other jurisdictions. And it follows that, in such jurisdictions, forensic psychiatry will often be practised not by specialists, but by general psychiatrists. Such generalists are necessarily thereby practising ‘forensic psychiatry’, and so must become closely acquainted with – and ‘expert’ in – the discipline. Hence, ‘forensic psychiatry’ is defined by the nature of the activity undertaken and not by the formal qualifications of the professional who is doing the undertaking.

The Handbook is designed for use with its companion volume, *Casebook of Forensic Psychiatric Evidence in Serious Criminal Trials*, and with The Death Penalty Project’s handbook on sentencing in capital cases³, the latter of which contains far more detail of authoritative law across a large number of jurisdictions than can be included within this volume. The intention is therefore that the two psychiatric texts will be used in parallel with one another; with the legal text being accessed when necessary. Inevitably, the psychiatric texts have frequently to refer to law; however, it can do so only in brief outline, as required. Also, we refer mostly to the law of England and Wales – not because it necessarily reflects law in the reader’s own jurisdiction, although it may do so, but so as to offer an example of law relevant to the topic at hand from a common law jurisdiction. And this can then serve as a comparator with the reader’s own jurisdiction.

² The term ‘mentally disordered offender’ is not restricted to individuals who are mentally disordered and been convicted of a criminal offence, but also includes those facing criminal legal process, as well as those deemed at risk of committing a serious criminal offence.

³ Fitzgerald E and Starmer K, *A Guide to Sentencing in Capital Cases*, The Death Penalty Project, London (2007) – new edition to be published in 2018

In order to make the Handbook ‘user friendly’ within the mental health and legal contexts for which it is written – where there may be little in the way of specialist forensic psychiatric training, knowledge or services – its scope and depth have been limited. Readers may therefore benefit from referring to a more comprehensive text of forensic psychiatric practice, albeit not oriented specifically towards capital cases or jurisdictions – *the Oxford Specialist Handbook of Forensic Psychiatry*⁴ – particularly since its approach to the practise of both branches of forensic psychiatry is directly reflected in this Handbook. The *Oxford Handbook* can therefore be seen as taking the reader further steps along the road they have begun to tread with the Handbook.

The abbreviated style of this Handbook does not allow for detailed referencing of sources, so it is important to make it clear that we have relied heavily on the work of a large number of other authors. We thank them all and acknowledge the copyright in their work. As for referencing law, we refer to statutes and cases of particular importance – mainly from English law – but must leave the reader to consult more detailed, and authoritative, legal texts from their own jurisdiction.

This is a stand-alone, single-volume, practitioners’ handbook, for use by psychiatrists and psychologists, solicitors, barristers, prosecuting authorities and judges, who are required to deal with homicide and other serious criminal cases, including where the death penalty can apply. It is intended to be relevant to all stages of the criminal justice process, from arrest and police interview, through fitness to plead and trial, to sentencing, appeal and mercy hearings (for capital sentences). So it deals not only with ‘mental condition defences’ at trial, but also with a wide range of psycholegal issues that can occur at all stages of capital and other serious criminal cases. Specifically with regard to sentencing, the Handbook should be read in conjunction with The Death Penalty Project’s guide to sentencing in capital cases⁵.

The Handbook deals with the interface between psychiatry and law in a similar way as does the *Oxford Handbook* – specifically, in terms of two ‘discourses’, each with its own constructs and methods of enquiry, derived from their very different social purposes and roles (see Chapters 1 and 2). It emphasises that the relationship between the two should be based on mutual understanding, while, at the same time, recognising the importance of the relationship being a clearly ‘boundaried’ one (Chapters 1 and 2).

The Handbook is written for use by mental health and legal practitioners, each approaching the ‘frontier’ between the two disciplines ‘from their own side’. However, to restrict its size, the explicit focus is often on helping mental health practitioners to navigate more effectively the frontier between their disciplines and law – although even text that is explicitly directed at such practitioners should also be of substantial use to legal practitioners in regard to that same frontier (since they also need fully to understand ‘clinico-legal practice’).⁶ Therefore, the roles of the forensic psychiatrist and clinical forensic psychologist, plus other clinical professionals, are explained in relation to each stage of the criminal justice process, including how the validity of expert evidence can be assured or challenged.

The Handbook also aims to give a statement of proper clinical practice within legal process, both in terms of clinical assessment and in relation to effectively presenting medical evidence into an adversarial legal arena. And this includes clear description of diagnostic principles and practice, with an emphasis upon

⁴ Eastman et al, *Oxford Specialist Handbook of Forensic Psychiatry*

⁵ Fitzgerald E and Starmer K, *A Guide to Sentencing in Capital Cases*, The Death Penalty Project, London (2007) – new edition to be published in 2018

⁶ Again, it is hoped that legal practitioners wishing to better understand psychiatric and psychological evidence will refer to the *Oxford Specialist Handbook of Forensic Psychiatry*

the use of accepted international classificatory systems of mental disorders. There is also description of how the problems of using expert medical evidence can vary greatly with the nature of the diagnosis, or mental state abnormality, as well as with the specific legal question(s) at hand.

A model structure for forensic psychiatric assessment and report writing is also described, including history taking and examination in the special context of the subject not being a 'patient', but solely a 'defendant' or 'appellant'. This includes dealing with validation of diagnosis and mental state description within a legal context, and – by inference – appropriate means of legally challenging any given diagnosis or mental state description. The Handbook also offers some 'ways of thinking about' core ethical issues that attend all forensic psychiatric practice, but which are particularly acutely present in relation to clinical assessment and reporting in capital cases (see Chapter 15).

Finally, the Handbook and accompanying Casebook are designed not only 'to be read in the practitioner's study', but also to be used within education and training programmes offered jointly to clinicians, lawyers and judges by members of Forensic Psychiatry Chambers and The Death Penalty Project. They, effectively, amount to 'resource books' for such education and training.

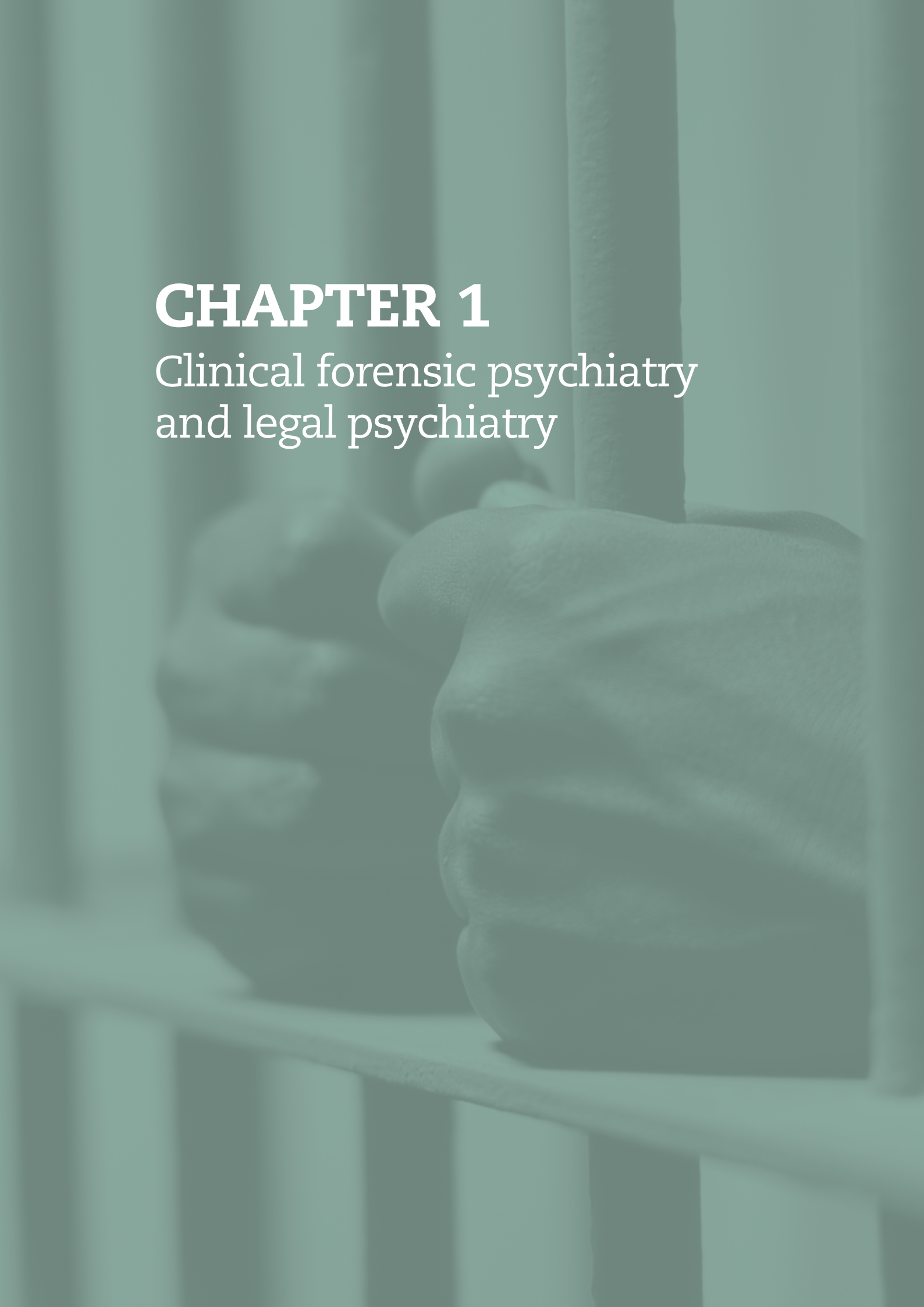
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CHAPTER 1

Clinical forensic psychiatry
and legal psychiatry



As described in the introduction, forensic psychiatry comprises both the psychiatry of mental disorder and offending behaviour – that is, *clinical forensic* psychiatry – and law as it relates to all psychiatry, that is, civil, mental health and criminal law, or *legal psychiatry*.

The Handbook concentrates on presenting aspects of clinical forensic psychiatry and its application to legal tests and process. And, in doing so, it often necessarily describes such tests and process⁷. The Handbook ‘refers across’ to legal tests, so as to offer an understanding of the ‘frontier’ between psychiatry and elements of law applicable to capital and other serious cases (see Chapter 2 generally). For example, within the various chapters that offer advice on assessment and report writing for pre-trial matters, trial matters – including psychiatric defences – sentencing hearings and mercy hearings, we describe relevant legal tests, so as to offer advice on how psychiatric assessment and report writing can best be conducted in a manner directly relevant to, and ‘mapped onto’ (see Chapter 2), those individual tests. In like manner, the Casebook that accompanies this Handbook distinguishes between aspects of each case it presents in terms of ‘clinical’, ‘legal’, and ‘clinico-legal’ (as well, also as ‘ethical’) aspects.

What the Handbook mainly offers is presentation of clinical information and method relevant, particularly, to stages of serious, including capital, legal cases. It does not, therefore, offer a comprehensive guide to clinical forensic psychiatric practice in a health setting, other than where such information is of particular relevance to legal process. It follows that, if the reader requires a comprehensive guide to assessing and treating mentally disordered offenders, be it under court-originating orders or under civil mental health legislation, they should consult a comprehensive forensic psychiatric text, such as the *Oxford Specialist Handbook of Forensic Psychiatry*.

This Handbook also cannot offer a fully comprehensive and general guide to ‘practising forensic psychiatry in the courts’. Rather, it offers a much-reduced version of what will be found within the *Oxford Handbook*, and is focused, particularly, on the application of psychiatry within capital jurisdictions. By way of illustration of this, Chapter 3 – which deals with the relationship between mental disorder and violence – is much reduced from what appears within the equivalent section of the *Oxford Handbook*. In this Handbook, all we can offer is skeletal information about such a topic, sufficient to give the reader ‘the bare bones’ of the topic and sufficient to give him⁸ an ‘understanding’ of the topic.

As further illustration of the ‘reduction’ we have applied, the reader will find only limited coverage of ‘risk assessment’, and coverage that is focused, particularly, upon the presentation of risk assessments into legal proceedings. There is also only limited, ‘first principle’ coverage of ‘ethical issues’ and ‘ethical decision-making’ within forensic psychiatry, with particular emphasis upon ethical issues for clinicians as they occur within capital cases.

In summary, clinical forensic psychiatry is concerned with the assessment and treatment of mental disorder where that disorder is associated – not necessarily causally – with offending behaviour, whether or not the individual has been charged or convicted. However, clinical forensic psychiatry is also closely engaged with law – and so with legal psychiatry – so that a clear understanding of law, and of legal process, is necessary in order to practise clinically. For example, it is not possible for a clinician to negotiate his patient out of the criminal justice system and into mental health care without knowledge of the relevant

⁷ But it usually does so briefly, and using English law as a comparator; so that, for detailed description of law relevant to capital and other serious criminal trials, sentencing, mercy hearings and to the carrying out of execution, in the reader’s own jurisdiction he must look towards local information.

⁸ Throughout the text we use the male term, but intend both male and female.

law and procedure. So clinical forensic psychiatry can be pursued effectively and ethically only if it is based upon substantial knowledge of the law and legal process, and its interface with psychiatric practice (see Chapter 2), while *legal psychiatry* comprises all law and process relating to mental disorder, and to the treatment and care of those suffering from mental disorder.

It follows, therefore, that the relationship between psychiatry and the law is bilateral, comprising both the giving of psychiatric evidence into a wide variety of civil and criminal legal contexts *and* the use of law for clinical purposes and for the regulation of clinical practise. This bilateral relationship is at the heart of forensic psychiatry, within which it is particularly strongly represented by comparison with other branches of psychiatry.

As described in Chapter 2, there are natural tensions between law and psychiatry, which arise from the very different purposes of the two disciplines, and from the very different methods they apply in pursuing those differing purposes. That is, the constructs relating to ‘things mental’ that arise from the ‘human welfare’ objective of psychiatry are very different from those artifices of mental functioning and status that the law constructs in addressing its objective of the pursuit of ‘justice’.

The constructs in psychiatry are determined essentially by its pursuit of improving human welfare, including through understanding mental disorder in order to reverse it or its effects or to ameliorate its effects. By contrast, law pursues abstract justice, albeit this may sometimes involve balancing the welfare of different parties against one another, or of one party against societal welfare. While, even within one or other discipline, different domains can give rise to different approaches to determining constructs.

For example, as criminal law at trial is concerned with ‘responsibility’ or ‘culpability’, its definitions of mental disorder – and there are a number – are characteristically tight. By contrast, the constructs used in sentencing, sometimes relating to public protection, are often more loosely defined, although, again, without reference to the welfare of the individual concerned, except where sentencing occurs by way of mental health legislation.

Finally, the ‘values set’ of medicine is quite distinct from that of law and the justice system; and this presents a rich domain of ethical difficulty and challenge to clinicians where they are required to apply medical information and techniques in order to offer evidence into legal process. Specifically, the ethical underpinnings of medicine are not those of law, and so the clinician offering evidence into legal process does so, essentially, within an environment that is alien to him (see Chapter 15).

How forensic services are related⁹

Hospital and community-based mental health services

Services that relate to mentally disordered offenders (MDOs) are predominantly clinically directed – that is, directed at the needs of the offender patient and at public protection. However, they also provide a service to the court system, in regard to expert evidence and advice concerning any stage of a criminal trial involving an MDO. Some of these services may be set up specifically as specialist forensic mental health

⁹ Much of this description is taken from the *Oxford Handbook of Forensic Psychiatry* and reflects service in the UK. Its inclusion is intended to be as a ‘benchmark’ – albeit many services in small jurisdictions will not be able to provide close to such a benchmark.

services, directed solely at, or for, MDOs. However, many services will be psychiatrically ‘generic’, albeit still offering a service to the courts – and this will very likely be the case within small jurisdictions lacking large and highly developed, including specialised, mental health services. However, whether or not a jurisdiction boasts a ‘specialist forensic mental health service’, any practitioner who deals with MDOs – whether based in such a service or within a generic mental health service – is, inevitably, operating as a ‘forensic’ practitioner, and must both possess clinical forensic skills and be legally informed.

Consequently, clinical mental health services provided to offenders may be offered by general psychiatrists or rehabilitation psychiatrists, substance misuse services or those psychiatrists – sometimes forensic psychiatrists – working in secure settings. Although, for some time, the term ‘forensic’ was only applied to those services that managed offenders and/or ‘risky’ patients, it is now expected that many other services will also manage such patients.

Similarly, almost any professional group can offer forensic testimony, far beyond medical or psychological professionals; there are, for example, forensic entomologists and forensic accountants. Therefore, clinical psychologists and psychiatrists who give expert testimony are, by definition, acting as ‘forensic’ professionals when doing so, regardless of their usual clinical practice.

Secure psychiatric services

The ‘forensic’ professionals who work in secure mental health services in the UK include the same range of professionals expected in any mental health service. Thus, there will be psychiatrists, clinical psychologists, art psychotherapists, medical psychotherapists, nurses, health care assistants, occupational therapists, social workers and pharmacists. Confusingly, some secure services will also employ forensic psychologists (see below) because of their expertise in offender management programmes. Generally, however, the distinguishing feature of any ‘forensic’ mental health professional is that they have experience of working with very disordered men and women, usually with long and/or significant histories of violence, and often in long-stay residential therapeutic care.

Again, in less developed economies, such services may be absent as specialist services per se, with reliance being necessarily placed upon general services to provide forensic care.

Mental health services in prison

Since 2006 in the UK, the NHS has provided ‘in-reach’ health services to prisons. In regard to MDOs, this usually consists of community psychiatric nurses and some psychiatric/clinical psychological consultancy, usually with a dedicated healthcare (though not necessarily mental healthcare) centre. These personnel may be general adult practitioners or, sometimes, specialist forensic practitioners. In addition, the prison service retains its own psychology service, staffed by forensic psychologists who are not clinically trained, but who are skilled in administering offender management programmes, where the offending behaviour may not be related to any diagnosed mental disorder.

In less developed economies, or small jurisdictions, such services are often more patchy and less integrated.

Specific staff groups

Forensic psychiatrists are initially medically qualified and have then undergone postgraduate training in psychiatry, plus higher further training in the sub-specialty of forensic psychiatry.

Clinical psychologists working in forensic settings have undertaken general training in clinical psychology to doctorate level. They almost always work as members of a multidisciplinary team, but will often be especially responsible for the coordination and delivery of psychological assessment and interventions of a variety of types. Increasingly, they are forensic specialists within clinical psychology – as are forensic psychiatrists within psychiatry.

Forensic psychologists are, by training, quite distinct from clinical psychologists (see above), and typically hold a Master's degree in their subject. They usually address offending behaviour directly, as already described, often not in the context of mental disorder. They also often carry out risk assessments and oversee psycho-educational programmes for offenders, typically in prisons. They may or may not have any general, or forensic mental health experience.

Forensic psychotherapists are trained psychotherapists – whether also medically trained or not – who have specialised in working with mentally disordered offenders. They may work in specialist services or provide consultation and supervision for forensic multidisciplinary teams, and they may deliver individual or group interventions to MDOs.

Probation officers may be involved in the supervision of MDOs in the community, usually in collaboration with mental health professionals. Interventions offered by them may include measures aimed at risk reduction and rehabilitation. In the UK they also take on particular roles with sex offenders and, commonly, coordinate sex-offender interventions, sometimes with mental health service involvement. There may be communication between probation officers and forensic psychiatrists in the production of reports used for sentencing convicted offenders, sometimes resulting in 'joint working' thereafter.

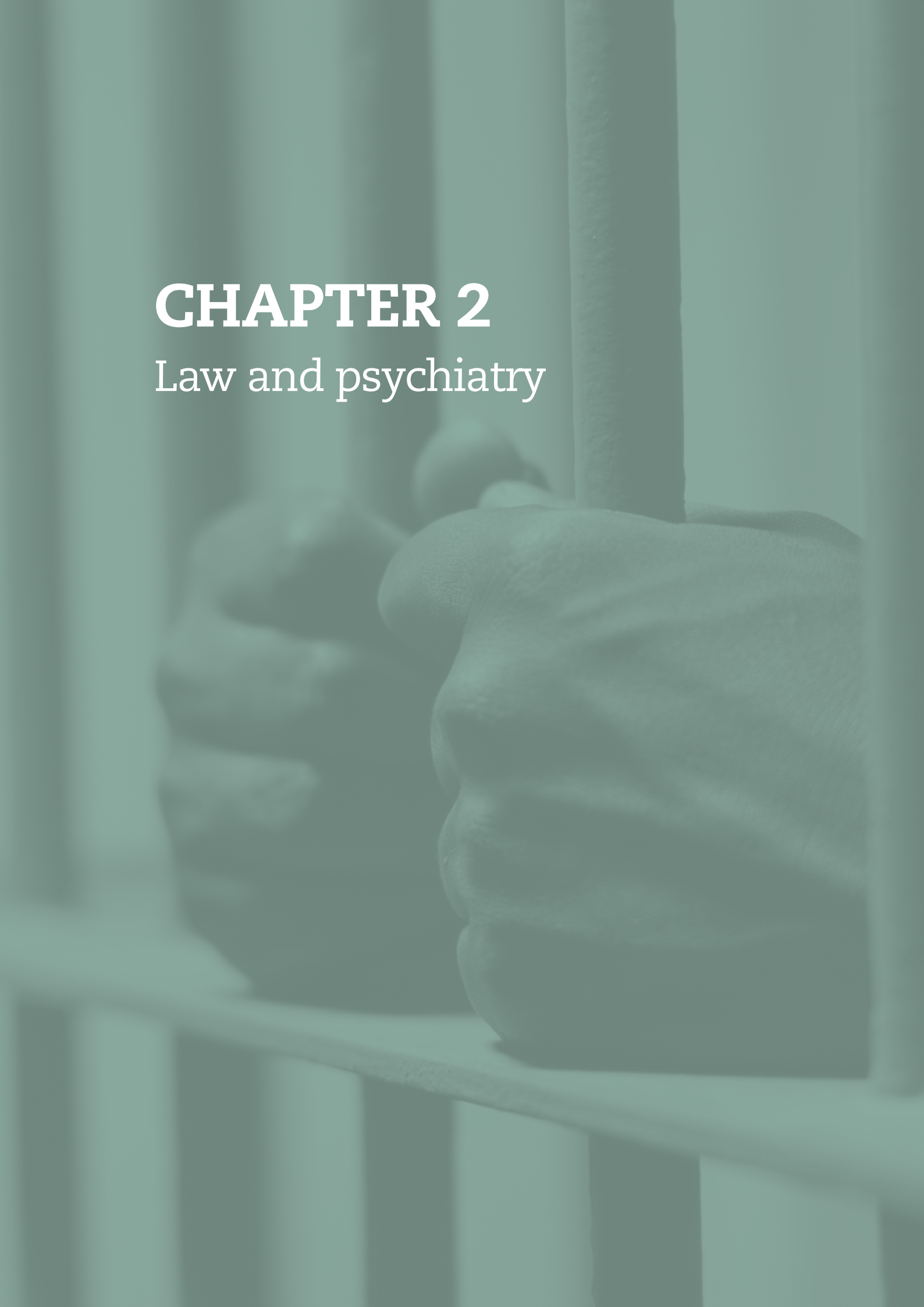
Criminologists study crime and criminals and, in the UK, do not have direct involvement in the care of MDOs. The impact of criminological research is, however, widespread, as many mentally disordered offenders are driven to offend not only by virtue of their mental disorder but also by criminogenic factors.

Clinical forensic services in less developed jurisdictions

Most health and related criminal justice services in less developed – and particularly small – jurisdictions cannot sustain the types of specialist forensic psychiatric services described above, such as are available in the UK. The challenge in these jurisdictions, therefore, is for generic services to be capable of dealing, on relatively infrequent occasions, with what can sometimes be complex forensic cases, including through liaison with the justice system. And the challenge can be the greater where the death penalty is in play. The purpose of this Handbook is, therefore, to enhance the training of such staff in order to assist the development and provision of this capacity.

CHAPTER 2

Law and psychiatry



Goals and aims of the psychiatric and legal systems

The relationship between psychiatry and law is at the heart of forensic psychiatry. As a result, whether practising clinical forensic psychiatry or providing psychiatric evidence to a court or tribunal, an understanding and knowledge of the goals of the legal system – and the way the law asks and answers questions in the service of those goals – is crucial.

Tensions between psychiatry and law

The core purpose of law is the dispensing of justice. By contrast, that of medicine is the pursuit of human welfare. This profound distinction between goals determines major problems where medical information is used to address legal questions.

Words or phrases within discourses

The purposes of a discipline and the interests of its practitioners determine both the *constructs* it uses and the *methods of inquiry* it adopts. Psychiatry as a branch of medicine adopts constructs such as ‘diagnosis’ and ‘mental state’ in order to define ‘conditions’ that are disadvantageous to those individuals in which they occur, or to others, and which might potentially be alleviated by way of therapeutic intervention.

In terms of medical ‘discourse’, words or phrases such as ‘schizophrenia’, ‘bipolar disorder’ and ‘dementia’ represent *diagnoses*, while ‘thought disorder’, ‘depressed mood’ and ‘depersonalisation’, for example, represent *mental state abnormalities*. Elements of these may occur in more than one *diagnosis*, and will probably represent the basis of any *disability* that the individual may suffer as a result of their ‘condition’ – and which, again, clinicians will wish to alleviate or compensate for, albeit such disabilities may, on occasions, be relevant legally (see below).

Similarly, psychology defines its own mental constructs, which may – and often do – differ from mental constructs originating within medicine and psychiatry (see below).

By contrast, words or phrases such as ‘abnormality of mind’, ‘insanity’, ‘disease of the mind’, ‘responsibility’, ‘fitness to plead’, ‘fitness to be sentenced to death’ and ‘fitness to be executed’ occur solely within law, so that each has a solely legal meaning – and they are *legal artifices* erected to serve the legal purpose of justice, in particular, individual legal circumstances.

Within law’s approach of creating legal artifices for specific legal purposes, it sometimes defines its own ‘mental concepts’, of which ‘intention’, ‘disease of the mind’ or ‘insanity’ are examples.

However, some words or phrases are ambiguous in their ‘ownership’ between medicine and law, or occur in both discourses. Consider, for example, words or phrases such as ‘mental illness’, ‘mental disorder’, ‘psychopathy’ or ‘psychopathic disorder’, ‘treatment’, or ‘treatment for mental disorder’.

So law is suffused with myriad legal constructs of mental functioning, or malfunctioning, which may appear to be ‘mental terms’, and to which mental functioning – defined medically – may be evidentially relevant. However, they remain legal words with, ultimately, solely legal meaning.

It follows that, when the reader is confronted with – or addresses – an apparently ‘mental’ word or phrase, he should explicitly consider ‘does it come from medicine or psychology, or from law?’ Knowledge of the origin and nature of the term used is crucial to effective functioning as a medical expert within a legal context.

Finally, where there is an explicitly ‘moral’ element to a term, it will have its origins in law – unless it originates within ethics or philosophy – as law is inherently normative or moral in its essence, although there is subjectivity within medicine that can lay it open to its constructs having a covert moral component to them.

Methods of inquiry

Psychiatry – also psychology – and law differ in their methods of inquiry, too. All medicine is *investigative* in its approach, taking a judgement based on all of the information available, albeit weighing some information more heavily than other. By contrast, law is *adversarial* in its method and *restrictive* of the information that it allows into that adversarial process – that is, whatever information is allowed in as ‘evidence’ is restricted for reasons of ‘fairness’. Consequently, the psychiatrist will weigh all available data in an investigative ‘hypothesis testing’ manner, whereas law assumes that ‘the truth’ – or at least ‘a truth’ – will emerge by setting up opposing restricted data sets and arguments against one another, and ‘judging’ which of the two sides’ positions is the stronger.

It follows that, in coming to his opinion, a psychiatrist may wish to use data that is legally inadmissible – and this must confront him with a profound ethical dilemma, by way of there being a head-on clash of paradigms. Specifically, if he limits the clinically relevant data he considers in coming to a diagnosis or formulation to that which is legally admissible, the opinion reached will be ‘clinically artificial’ and, potentially, ‘wrong’. The alternative course, however, is to refuse to give any opinion at all, and to withdraw from the case, such that injustice may be done to a defendant or to society.

The practical effect of discipline incongruence

As a result of all of these disparities between psychiatry and law, psychiatrists and psychologists appearing in court are likely to feel uncomfortable, as they will be asked questions within an adversarial mode, yet wish to answer within an investigative one – and be stopped from doing so. They may wish to rely on particular data, but be told they may not do so.

Recognising the context is crucial

What is crucial, especially where a word or phrase appears within both medicine, or psychiatry, and law – or where, for example, law adopts ‘mental constructs’ of its own – is that both clinician and lawyer

recognise ‘within which discourse’ the term is being used. That is, whether it is being used within medicine and is, therefore, ‘positive’ – referring to something in being – or within law and ‘normative’, that is, being an artifice and/or evaluative in nature. If both sides fail to recognise the ‘provenance’ or ‘dual provenance’ of the term that is being used, there is room for misapplication of the term within the ‘wrong discourse’, and/or misunderstanding of its meaning as it is intended to be in any particular discipline.

Medicine and psychiatry versus psychology

Even within mental health disciplines, there are disparities in the meaning of words, and in the method of inquiry (see further above, and below). Therefore, in broad terms, psychiatry – as a branch of medicine – adopts ‘categorical’ constructs, whereas clinical psychology adopts ‘dimensional’ ones.

The differences between the constructs and methods of inquiry of psychiatry and psychology also determine different incongruities between each and the law, and legal process. So that, in broad terms, psychiatry is ‘less incongruous’ with law than psychology; because the more categorical and ‘binary’ approach it adopts is less incongruous with the often ‘binary’ approach adopted within law (a doctor may be prepared to answer the question put to him in the witness box, ‘Well, doctor, was he ill or not?’, whereas a clinical psychologist may wish to revert to statistical description against a normal population).¹⁰

Ultimate disparity

Ultimately, the purposes of all mental health sciences are focused on the welfare of the individual, who should expect to receive some health benefit from treatment, albeit sometimes with additional gain accruing to others – for example, potential third-party victims. By contrast, law is concerned with justice for all, including concern for the rights of both the defendant and victims, and society. Therefore, the manner of striking the balance between the pursuit of patient welfare and public protection is almost bound to be different between mental health care professionals and legal agencies, since psychiatry and law potentially address related concerns by applying different values. Hence negotiating the interface between the two is not only legally, but also ethically both difficult and crucially important.

Autopoesis versus reflexivity

Since the law is more or less binary and categorical in its approach within different legal contexts, the degree of incongruity between it and either psychiatry or psychology may, again, vary. For example, since criminal law at trial is concerned with the presence or absence of *responsibility*, or its degree, its definitions of mental disorder (and there are a number) are characteristically tight – and, of course, they address justice¹¹ and not human welfare. By contrast, the constructs utilised in *sentencing* – sometimes relating to public protection – are often more loosely defined, although, again, generally without reference to the welfare of the individual concerned (except where sentencing occurs by way of mental health legislation).

¹⁰ From here on, even though the constructs of medicine, or psychiatry, and psychology are distinct in their nature and derivation, they have sufficient in common at least to be distinguished from mental constructs that occur in law, such that the reader should interpret ‘medicine, or ‘psychiatry’, to infer the inclusion of psychology, unless we specify a distinction.

¹¹ Justice can mean, from the perspective of the individual, *proportionality*, or ‘*just deserts*’. There are other meanings attributed to the concept also.

Certainly, within all criminal domains, the constructs derived are wholly different from the biological or psychological constructs adopted within medicine, psychiatry and clinical psychology, which are concerned chiefly with aetiology and/or with treatment.

Related to the foregoing, the terms ‘autopoiesis’ and ‘reflexivity’ refer to law’s openness, or otherwise, to adopting the constructs used in other disciplines.

Family law, for example, is relatively reflexive, in that it adopts quite loose concepts and process. It can accommodate a wide range of types of expert evidence and constructs generally without apparent conflict or distortion of such evidence – albeit at the cost of apparent imprecision and some risk of different courts faced with the similar facts reaching different decisions.

Criminal law, however, is highly autopoietic – that is, non-reflexive, so it tends towards creating solely from within itself. Hence, it employs only its own strictly defined constructs, within a strictly observed discourse, rules of evidence and process, greatly inhibiting adoption of the constructs or methods of other disciplines, which, in turn, can seriously distort the meaning of constructs given in evidence. This is because criminal law is preoccupied with ensuring that its procedures are scrupulously fair to both defendants and prosecution.

However, criminal law operating in a sentencing mode is less binary and less rigid in its approach, aside from where there is a mandatory sentence for a given offence. Therefore, in this mode of operation, law is more accommodating of information admitted from experts in psychiatry and psychology; and accommodating with less risk of distortion in the process of communication between the discourses. So, for example, in administering the *discretionary death penalty*, although a court will be subject to *sentencing guidelines*, it will inevitably be more open to – and flexible in – consideration of expert psychiatric or psychological evidence than it will be when hearing such evidence in the context of a trial and the determination of whether the defence of *insanity* or the partial defence of *diminished responsibility* is satisfied, or whether the defendant is *fit to plead*. Indeed, the second of the accepted sentencing criteria for imposition of the discretionary death penalty – that of ‘beyond reformation’ (see p126) – is clearly easily open to consideration of a range of types of expert psychiatric and psychological evidence. This could be, for example, in respect of ‘treatability’ and/or ‘risk management’.

Attempted translation between discourses

As described in both the Preface and preceding chapter, the relationship between psychiatry (also other mental health disciplines) and law can be seen in terms of being between two different ‘discourses’, each with their own constructs and methods of enquiry, derived from their very different social purposes and roles. Therefore, there must be an attempt at ‘translation’ between, or across, discourses.

Put another way, law and psychiatry are like two neighbouring countries, each with its own purposes and languages, and each with its own districts and regions, expressed in the various branches of the law and in different psychiatric diagnostic categories and mental state descriptions. Hence travelling from one country to the other involves translating the language of one into that of the other, and this creates many opportunities for confusion and distortion of meaning.

It follows that there is the potential for both a *lack of coherence* between constructs and, even where that is not the case, simple *misunderstanding* on either or both sides.

Therefore, the route to proper, and just, use of psychiatric and psychological evidence within the criminal justice process – as well as to minimise misunderstanding – must be one of ‘each understanding the discourse of the other’, while ‘never adopting the discourse of the other’. That is, the relationship should be based upon mutual recognition but always be clearly ‘boundaried’.

Further, an understanding on both sides of there being different manifestations of the relationship between psychiatry and law in different legal circumstances is crucial to the effective, and just, use of expert evidence.

Minimising errors in attempted translation

Although a perfect translation may be impossible (see ‘mapping’ below), the effects of the inherent mismatch between concepts can be minimised where:

- Lawyers ask psychiatrists clear legal questions, especially when giving *instructions*; for example, ‘Please explain how the defendant’s diagnosis might or might not amount to a *defect of reason*’, as opposed to ‘Please give a report on the defendant’s mental condition’
- Psychiatrists understand how the law will wish to use the answers they give to questions – that is, to determine justice and not to achieve what is in the interests of the defendant (who may, coincidentally, be a patient under treatment)
- Psychiatrists recognise the limits of their professional expertise and role, and do not, for example, attempt to *address the ultimate issue*

‘Psycholegal mapping’

One way to think of the application of psychiatric or psychological constructs and evidence to a specific legal definition that may be helpful is in terms of ‘mapping’ of a construct from psychiatry, or psychology, onto that legal definition. That is, mapping from one construct field onto another, since this reflects the fact that there is ‘inherent disparity’ between legal and clinical constructs, thereby recognising that there *cannot* be ‘translation’.

As already described, there are inevitable incongruities and ambiguities inherent in the use of mental disorders as the basis for determining whether legally defined criminal defences are satisfied. These arise primarily because medicine derives its constructs from its pursuit of the welfare of ‘patients’, whereas law derives its constructs from its pursuit of justice in relation to ‘defendants’. As such, difference of purpose determines the potential for incongruous ‘mapping’ of real medical constructs – for example, diagnoses or mental states – onto abstract legal constructs – for example, mental condition defences. And this must be so unless the law were simply to adopt or incorporate within itself medical constructs directly as the basis for excuse, or partial excuse, without any reference to constructs such as ‘responsibility’ (see, for an example of such law, Section 44 of the Norwegian Criminal Code, where *insanity* it automatically ‘proved’ if the medical diagnosis of *psychosis* is satisfied). Also, an aspect of ambiguity is added where the

legal defence at hand is defined ‘loosely’ (that is, the definition is not tight and restrictive). In summary, therefore, ‘mapping’ of medical constructs onto legal defences (or other criminal legal constructs) can be – indeed, almost invariably is – inherently incongruous, while such incongruous mapping may variously be ‘focused’ (if mapped onto a tight legal definition), or ‘blurred’ (where the legal definition is loosely defined).¹²

Therefore, the greater the ‘congruence’ is between the two constructs, the greater room there is for ‘clinically valid’ admission of psychiatric or psychological constructs as evidence probative of a given legal definition. And the ‘looser’ the legal definition at hand is, the more room is there for discretion in the proof of a legal defence based upon psychiatric or psychological evidence. So, for example, ‘insanity’ represents a defence expressing ‘a double whammy’, in that the definition is both incongruous with medicine and tightly defined, including with a high threshold. ‘Diminished responsibility’, however, is still defined in most common law jurisdictions as incongruent with psychiatry, but loosely – so as to allow variability and discretion in its application.¹³

Psychiatry as forensically special

The problems in the relationship between psychiatry and law are very different from those between (say) forensic pathology and law, where the law is interested only in matters of fact (for example, the nature of a wound and therefore how it was probably inflicted). By contrast, psychiatry deals with constructs apparently – but only apparently – similar to some of those of law, for example, *volition* in psychiatry and *intention* in law. Although these two are distinct constructs, they are apparently sufficiently close for the essential difference between them often not to be apparent to psychiatrists and lawyers. And this can lead to mutual misunderstanding, miscommunication and, for the psychiatrist, *ethical tension*.

Some detail of ‘constructs from purposes’

Compare and contrast *psychosis* within psychiatry and *insanity* within law, each of which involves a loss of reality testing, and/or of the ability to recognise the true nature of actions. Similarly, *abnormality of mind* within *diminished responsibility*, which still persists in most or all of the jurisdictions for which this Handbook is written, although appearing almost medical, is not.¹⁴ Hence the seminal case in England and Wales on ‘What is abnormality of mind?’ *R v Byrne* [1960] offers the definition: ‘A state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal.’ Therefore, although there must be expert medical evidence upon which a jury can rely in determining the presence

¹² Eastman N and Grubin D, Insanity, Diminished Responsibility and Personality Disorder in England and Wales, in A. R. Felthous and H. Sass (eds), *International Handbook on Psychopathic Disorders and the Law*, Volume II (Law and Policies), Wiley and Sons (in press).

¹³ Notably, S52 of the Coroners and Justice Act 2009, amending S2 of the Homicide Act 1957 in England and Wales has enhanced the congruence of diminished responsibility with psychiatry, while also making the definition tighter (see Eastman N, Adshead G, Fox S, Latham R, Whyte S (2012) *Oxford Specialist Handbook of Forensic Psychiatry*, Oxford University Press, at pages 494–496).

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of ‘abnormality of mind’ (*R v Dix* [1982]), the construct is, by definition, ‘lay’, and distinct from anything medical.

Psychiatry defines psychosis by its symptoms and aetiology, so that it can be reliably identified by different doctors and classified within distinct *diagnoses*, both to determine prognosis and facilitate appropriate treatment – not to determine whether the psychotic defendant should be found *unfit to plead*, or *unfit for execution*.

Underlying the distinction between psychosis and either insanity or diminished responsibility is the fact that, whereas medicine objectively defines ‘things in being’, law is inherently ‘moral’, so in determining reduction or abolition of responsibility, there has to be a step beyond medical diagnosis into a moral domain. Hence, common law jurisdictions do not typically equate loss or diminution of responsibility with a particular medical diagnosis (there are no examples of ‘insanity by reason of schizophrenia’ in common law jurisdictions). To do so would neglect any reference to a ‘moral step’ in determining responsibility.¹⁵

The consequence of a finding of insanity is to remove responsibility entirely, whereas that of diminished responsibility is merely to reduce it, so the law adopts different definitions that – to a doctor – look entirely inconsistent with one another, but which are legally coherent in their difference, given their different justice functions.

Similarly, criminal law defines various ‘fitness’ tests, not as identical with any medical diagnosis but according to some notion somewhat akin – although not equivalent to – a ‘capacity’. Therefore, it defines *unfitness to plead* in terms of whether a fair trial is possible;¹⁶ and it defines *fitness for execution* in similar terms of ‘whether it would be fair to execute’, based notions related to the ability to appreciate the moral and legal basis of such punishment.

What, of course, a doctor must not do is to give effect to any ‘disagreement’ with the law’s established construct of a given ‘legal capacity’ he may hold, and to give an opinion on the matter on what amounts to his or her own ‘made up’ legal definition. He must, by contrast, ‘accept’ the law’s definition and simply give medical evidence that is deemed relevant to whether the legal test is satisfied or not, whatever his or her own views about how the definition in law should be drawn.

Use of information: ‘history’ versus ‘evidence’

Psychiatry and law also regard information in quite different ways.

To a court, any piece of information is *evidence*, to be admitted or excluded (according to the *rules of evidence*), and then deemed true or false, and given greater or lesser weight (based upon rules concerning the *burden* and *standard of proof*).

¹⁵ Of note, Section 44 of the Norwegian Criminal Code does equate ‘insanity’ with ‘psychosis’, such that all that is at issue in determining the legal question is whether, at the time of the offence, the defendant was suffering from medically defined ‘psychosis’.

¹⁶ The definition of ‘unfitness to plead’ is not, in fact, defined strictly in terms of a ‘capacity’ test (for example, ‘the capacity for effective participation in a trial’, as the Law Commission for England and Wales has recommended should be the case).

To a psychiatrist, however, the same piece of information may form part of the patient's *history*, or observation of their *mental state*, to be taken into consideration diagnostically or therapeutically. And there is much less concern to consider – according to an established *standard of proof* – whether individually each particular piece of information in itself is 'true' (although some assessment of the reliability of the source will still be made). Rather, what is looked at is the total pattern of information (for example, of symptoms) and whether, overall, this is sufficient to make a particular *diagnosis* or *formulation* – within which it is to be expected that some known symptoms of the condition will be absent or there may be some symptoms inconsistent with the diagnosis.

By analogy, what is addressed is whether, taken together, there are sufficient pieces of the diagnostic jigsaw puzzle, and sufficient absence of contradictory pieces, as to be confident that the diagnosis can be made. It follows also that such an approach allows that the combination of pieces of evidence can be mutually reinforcing in terms of the weight to be attached to each piece. Therefore, although sometimes law does apply 'corroboration' probatively within its own method, validation in medicine is very different from truth-finding in law.

These two very different approaches – not only to what information is to be considered, but also to the manner in which they are to be considered – essentially reflects the disparity between the *adversarial* and *investigative* methods of inquiry of law and medicine, respectively – but with the added factor that, within the investigative method of medicine (by comparison with the investigative approach sometimes adopted in some legal domains), what is at its core is 'pattern recognition', within a strictly medical paradigm.

Methods of selecting and gathering information

Methods of selecting and gathering information also differ between law and psychiatry. A court will only consider evidence that is put before it by the parties, and which is deemed 'admissible'; and it will then test each piece of information adversarially. By contrast, a forensic psychiatrist will actively seek out any information that could be relevant to diagnosis, or determining the mental state of an defendant at some specified time, set it alongside information given by others – including from past medical records and from witness statements – and then come to a view taking into account all such information, with nothing excluded that could be relevant.

Implications for forensic psychiatrists

The foregoing differences have several consequences for forensic psychiatric practice.

Clinical data collected by the psychiatrist, and contained within a court report, can have not only medical but also legal relevance – including to guilt or innocence – so information collected under the 'cloak' of medical assessment may become part of the substantive legal case. Alternatively, some of the information collected by a psychiatrist for diagnostic purposes may be ruled out of consideration, for example, because it is covered by 'legal privilege', and so cannot be referred to by the doctor. Similarly, other information collected legally as 'evidence' may be diagnostically relevant yet inadmissible – so, again, the doctor cannot refer to it or has to pretend that he does not know it.

Further, in order for the court to test the likely validity of a piece of information collected medically, so as to ascertain what weight should be given to it if it is disputed, the court will wish to know the expert's status (for example, consultant or trainee), post, relevant qualifications and experience. That is, to the court the likely validity of any information collected clinically will depend upon who collected it.

For the same reason, any other sources of information used by a psychiatrist should be made clear (for example, from the subject, an informant, or records) so that the court can apply its own approach to what it holds likely to be true.

Since there may be disparity between the information that a psychiatrist would use in determining a diagnosis, mental state or formulation, and that which is admissible within the relevant legal proceedings (see above), this can cause ethical tension for an expert in court (for example, where he is told that certain information cannot be considered by the court). There may be information that he is aware is *inadmissible* as evidence but which may be diagnostically or otherwise clinically highly relevant. Therefore, a report should make clear how conclusions have been derived and from which information, making clear the information that has been legally excluded but is deemed clinically relevant.

Where information contained within the court proceedings – for example, witness statements – are used as data by the forensic psychiatrist (by analogy, with informant information in ordinary clinical practice), and where such evidence is contradictory, the expert will then have to make conditional statements ('if the court believes A then the diagnosis of X is reinforced, if B then it is undermined'). Crucially, the expert should never take a view on which evidence is correct (or they will effectively become 'a thirteenth jury person').

Information received from the criminal justice system should be given great weight if it has been considered and accepted by a court, given that it will have been tested within the rules of evidence and been subjected to attempts by one or more parties to disprove it (so that convictions should weigh more heavily, for example, in a *risk assessment* than allegations for example – see Chapter 7). Hence, although the expert must maintain his hold on 'investigative method and consideration of pieces of the diagnostic jigsaw together', so as to allow the pieces to be potentially mutually reinforcing, any individual jigsaw piece that the legal system has determined to be true must be placed within the picture as 'definitely part of the overall picture'.

Finally, any diagnostic, mental state or formulation conclusions should be explicitly subjected by the expert, within the report to the court, to consideration of its likely 'validity' – including addressing alternative interpretations of all the data. This will serve both to make explicit to the court what are the likely 'validity issues' and to ensure that the author of the report has himself rigorously tested the opinion arrived at. This will, in turn, ensure that the expert, in giving oral evidence, will be well prepared for robust cross-examination (see Chapter 9).

Psychiatry and law as a two-way relationship

The relationship between psychiatry and law is bilateral.

Psychiatry is used by law to assist in answering the law's questions, as when psychiatrists *testify* as to whether a defendant was capable of forming the requisite *intent* for a particular crime, or whether he

satisfies the legal criteria for the partial defence to murder of *diminished responsibility*, or whether he comes within one of the two criteria for the imposition of the discretionary death penalty – that is, being *beyond reformation* (see Chapter 12).

However, psychiatry itself also uses legal processes to therapeutic ends, such as when a psychiatrist decides to recommend detention for treatment under mental health legislation, including sometimes as part of their *risk management plan* directed at public protection.

Keeping boundaries via mutual understanding

A psychiatrist pursuing knowledge and understanding of the legal system does not run an enhanced risk of being used improperly by it. Rather, knowledge and understanding is likely to encourage the maintenance of a bounded relationship, accompanied by mutual respect, and the enjoyment of difference. Doctors and lawyers do not need to become fully acquainted with each other's professions and epistemologies. However, each does need to have sufficient understanding of the discipline and method of the other so as to operate effectively at the discipline interface, and without transgressing the medical/legal boundary.

Cooperation not contamination

As crucial as mutual understanding and *cooperation* between psychiatry and law is the avoidance of mutual *contamination*. The proper role of a doctor acting as expert is to aid the *effecting* of justice, through cooperation with the law, and not to aim to *affect* justice, via contamination of his limited expert medical role.

However, the inherent bias of psychiatry towards welfare rather than justice can result in a psychiatrist inadvertently – or even deliberately – tailoring his opinion to achieve a result that he perceives as in the defendant's best interests, despite the law (because he perceives the subject not as a 'defendant' but as a 'patient'). Some may even give evidence tailored towards their own view of what would be the 'just' outcome. All such practices are ethically and legally indefensible.

More difficult to address than such 'explicit' or 'conscious' justice-affecting behaviour is the problem of 'unconscious bias' (see Chapter 15).

The risk of convergence between psychiatry and the criminal justice system

Early in the development of forensic psychiatry, the discipline approached public protection essentially as an adjunct to, or knock-on effect of, the treatment of patients. This amounted to the 'rescue' approach to forensic psychiatry; that is, achieving diversion from the justice system into mental health care services (sometimes with discontinuance of the justice process) of those with severe mental disorders.

Increasingly, however, society has demanded to be kept safe from the people it fears, and has therefore increasingly expected forensic psychiatrists to manage and contain the risks posed by mentally disordered

offenders, whether or not they can offer benefit to the individual – as ‘patient’ – through treatment. These forces have tended to cause forensic psychiatry to converge on law’s public protection functions – as distinct from law and psychiatry converging with the common purpose of welfare-based ‘rescue’.

Manifestations of convergence include:

- A developing shift in the clinical balance adopted between the goals of treatment of the patient and protection of the public
- A widening of definitions within mental health legislation so as to allow the detention of those who may not benefit from treatment
- The increasing involvement of forensic psychiatrists in the administration of risk-based sentencing (see Chapter 12)
- Convergence also implies the potential for movement away from the core objectives and values of medicine – albeit, these are properly modified when a doctor acts as expert to a court.

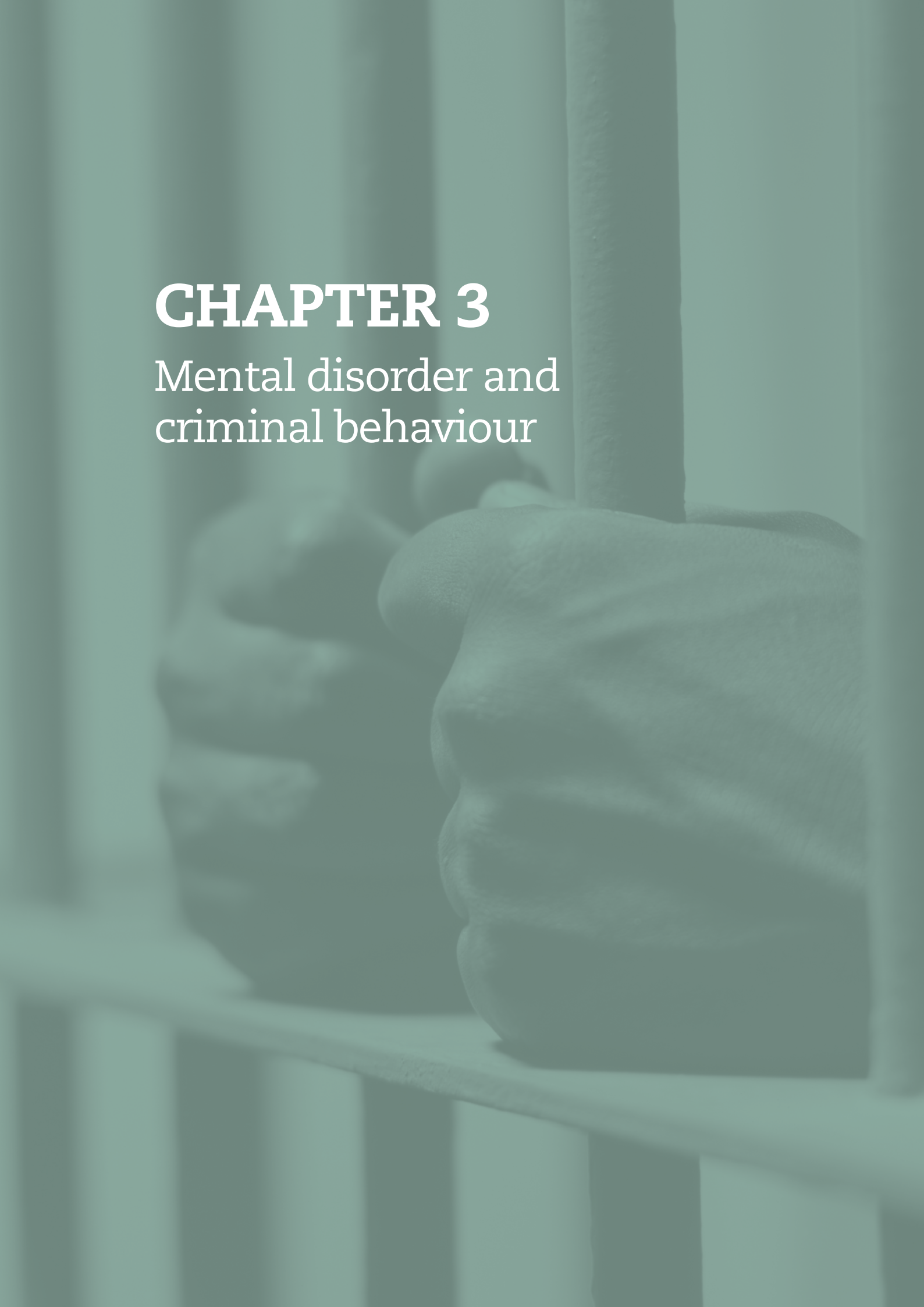
Conclusion

An effective and proper relationship between psychiatrists acting as experts and lawyers and courts can be protected only by both sides understanding the role and methods of the other and respecting their mutual difference. Failure to achieve this must result in ethical danger.

In order for there to be constructive dialogue between psychiatrists and lawyers, each must be prepared to understand – and work with the constructs – of the other, translating between the two, or mapping the one onto the other, as best can be achieved. Although a perfect translation is almost invariably impossible, because a medical construct is being ‘mapped onto’ a legal one, ‘least unacceptable’ translation, or clearest ‘mapping’, will be achieved where: lawyers ask psychiatrists clear legal questions; psychiatrists understand how the law will want to use the answers they give; and psychiatrists recognise the limits of their professional expertise and do not use psychiatric constructs directly to address any ultimate legal issue.

CHAPTER 3

Mental disorder and
criminal behaviour



This handbook is not a textbook of psychiatry, and it is assumed that the reader will have access to a general psychiatry text.¹⁷ Rather, in addition to offering summaries of different mental disorders, sufficient for lawyer readers to understand the gist of each, the focus of this chapter is upon description of ways in which each disorder can enhance the risk of, or explain, criminal offending. And, even here, it is not an exhaustive exploration of the field; again, the reader is referred to the *Oxford Handbook of Forensic Psychiatry* for more ‘in-depth’ consideration of the relationship between individual disorders and offending. Also, it is important to emphasise that ‘background’, or epidemiological, knowledge of association between a disorder and offending in the aggregate is just that – ‘background’ – so that factors in the individual must be considered in every assessment.

The relationship between specific diagnoses and criminal behaviour is susceptible to epidemiological investigation and, in respect of this, the reader is referred to Chapter 7, which deals with risk assessment based on population statistics. However, in general, there is little robust evidence of a clear statistically significant association between many types of mental disorder, or specific mental symptoms, and violence in particular. Rather, *in some individuals* with particular types of mental disorder, particular symptoms can be observed to have been associated with violent behaviour in the past, and to be relevant therefore to the genesis of *their* violence, in terms of their own particular ‘biography of violence’. What follows, therefore, is a description of known associations between disorder and offending as they *can* occur in individuals. Where there is epidemiological evidence of association, an attempt has been made to make this clear.

Functional psychosis, including paranoid schizophrenia

Psychotic disorders are associated with a somewhat higher risk of violent offending at a population level. However, much of this enhanced risk is mediated through concurrent drug abuse. Therefore, it is the *combination* of psychosis and drug ingestion that appears to enhance the risk, in populations, of violence. Also, there is good evidence that ordinary criminogenic factors (for example, upbringing and early offending) present in an individual with psychosis are more important in determining violence than are symptoms of psychosis – even though, intuitively, it might be thought that certain symptoms might ‘obviously’ give rise to violence (for example, auditory hallucinations instructing towards violence, or delusions of paranoia about another individual).

Also, specifically, cannabinoids – although not themselves enhancing of the risk of violence – are recognised as capable of precipitating psychosis, probably in some individuals who are genetically, or otherwise predisposed to psychosis.

Psychotic symptoms in an individual that are probably particularly capable of enhancing risk include:

- Altered perception of external reality, including false perceptions of threat (within what is called ‘threat/control-override symptoms’)
- Delusional misinterpretation of other people’s identities, and of any threat they might pose
- Delusions of jealousy
- Delusions of love, and subsequent experience or perception of rejection

¹⁷ We recommend Semple D and Smyth R (2009) *Oxford Handbook of Psychiatry*, Oxford University Press, Oxford, UK as being particularly useful, in that it is the ‘sister’ handbook to the *Oxford Specialist Handbook of Forensic Psychiatry* and is written in a similar ‘handbook’, rather than ‘textbook’, style.

- Distorted cognitions of a wide range of types
- Disordered mood
- High levels of fear and anxiety secondary to psychosis
- Reduction in inhibition, arising from intrinsic mental illness or drug or alcohol ingestion, or within personality disorder

However, to emphasise, the best ‘predictor’ of violence arises within the individual biography of violence of a person – that is, what matters is not, for example, experiencing ‘command hallucinations to be violent’ per se, but whether, in the past, an individual has been violent in the context of experiencing such hallucinations.

Alcohol and drug misuse and dependence

Drug and/or alcohol misuse is commonly seen in violent offenders, whether or not they have any other mental disorder, and is predictive of violence in the aggregate. Indeed, of all mental disorders, this group is most strongly linked to offending and violence. Also, those who exhibit drug or alcohol dependence, and who are therefore highly likely often to be intoxicated, are at risk of offending – although some aspects of dependence may ‘disable’ the person in respect of offending, particularly certain types of offending. Finally, the association of substance misuse and criminogenic factors enhances the risk of violence to others.

- Mechanisms of enhanced risk of violence in the individual in respect of alcohol or drugs include
- Disinhibition associated with intoxication
- Disorganised behaviour associated with intoxication
- Withdrawal states
- Paranoia induced by drugs
- Agitation and anxiety
- Neuropsychiatric effects of long-term use

Acquisitive crime in particular is associated with compulsion to obtain substances in those who are dependent.

Personality disorder

Personality disorder amounts to a developmental disorder, essentially, of ‘who the person is’, going beyond ‘ordinary variance’. As a group, those with personality disorder are diverse, and it is largely ‘cluster B’ (within DSM-5) personality disorders that are seen in the context of serious crime (that is ‘antisocial’, ‘borderline’ and ‘narcissistic’). The defining characteristics of these disorders include impulsivity, disordered relationships, rule-breaking and criminal behaviour per se (so that some features of the disorder are ‘identical’ with violence).

At a population level, ‘antisocial personality disorder’ is strongly associated with offending, including violent offending, and epidemiological studies of prison populations show between 50 and 70 per cent of inmates satisfy diagnostic criteria for the disorder. However, the smaller subset who exhibit ‘psychopathy’

(in terms of the definition by Hare, operationalised through the PCL-R assessment tool – see Chapter 5) are the more likely to exhibit serious violence. And it is particularly those exhibiting ‘callous unemotional traits’, within ‘factor 1’ of the PCL-R, that are particularly at risk of violence to others – this factor representing not violent behaviour per se (as described in ‘factor 2’) but highly disordered psychology, which tends to give rise to violent behaviour.

The following mechanisms can be routes to violence in those with Cluster B personality disorders:

- Transient psychosis (as above); often associated with stress or drug use
- Paranoid cognitions and heightened perception of threat
- Impaired regulation of mood states, including anger
- High levels of anxiety and agitation
- Impaired empathy and emotion recognition
- Disregard for the feelings of others
- Impulsivity and lack of a normal capacity for reflection
- Need for risk-taking or excitement
- Grandiosity and contempt for others
- Substance misuse secondary to the disorder

Mania

Individuals with mania (for example, within ‘bipolar disorder’) may be predisposed to violence and other offending because of the symptoms they experience; but any observed empirical association in the aggregate is weak.

Potential mechanisms include:

- Elation
- High levels of anxiety and agitation
- Impaired judgement
- Impulsivity
- Hyper-sexuality
- Psychosis, where present (see above)

Depression

Depression is not associated with violence statistically, other than to self, but can be relevant in understanding an individual’s perpetration of a violent act in terms of:

- Hopelessness impacting upon judgment
- Enhanced perception of criticism or threat, in the context of feeling ‘worthless’
- Reduced threshold to loss of control, usually against self but sometimes against another
- Psychosis where present (see above)

Post-traumatic stress disorder (PTSD)

There is no definitive link between PTSD and violent behaviour at a population level; but studies of Vietnam veterans suffering from the condition, consequent upon engagement in battle, have demonstrated enhanced irritability, aggression and substance misuse, leading to enhanced violent offending.

For the individual, symptoms of PTSD relevant to a violent act can be:

- High levels of anxiety and arousal
- High levels of irritability, impulsivity and anger
- Hyper-vigilance or preparedness; being 'on the lookout' and highly sensitive to threat•
- Misperception or overperception of an objective threat
- Triggering from flashbacks
- Mental dissociation
- Nightmares, resulting in violent actions on waking from sleep¹⁸

Asperger's syndrome and other autistic spectrum disorders

There is no clear link between autistic spectrum disorder and violent offending at a population level; but the following aspects can be relevant in individuals:

- Lack of concern for social norms
- Lack of awareness of the consequences of actions for other people
- Lack of empathy
- Lack of understanding of other people's behaviours and actions
- A tendency to interpret others' words in a concrete manner
- Lack of understanding of what is wrong in moral and social terms

Learning disability

Learning disability does not increase the risk of serious violence, but people with learning disability are over-represented in prison populations. This may be because they are more readily apprehended when they offend.

Aspects of their learning disability can contribute to offending as follows:

Inability to manipulate abstract concepts

- Inability to foresee consequences of offending
- Difficulties in appreciating the emotions of their victims
- Lack of alternative strategies to cope with feelings of anger and high arousal
- Poor problem-solving skills

¹⁸This must be distinguished from violence during an episode of brain-determined 'sleep disorder', usually in deep sleep in the absence of detailed dreaming.

Acquired brain injury

The severity and location of any brain injury will be relevant to any association between the mental abnormality and offending there may be in an individual, but could incorporate the following:

Frontal lobe damage leading to dysexecutive syndrome and ...

- Impaired planning ability and organisation of behaviour
- Disinhibition
- Impulsive behaviour
- Increased aggression
- Cognitive impairment altering understanding of legal boundaries

(See also Chapter 5 dealing with neuropsychological assessment for legal purposes, and Chapter 7 dealing with risk assessment).

Epilepsy

Although rarely associated with serious violence epilepsy can sometimes be so, and so can be raised in relation to defences at trial (usually automatism and insanity).

The following can arise:

- Ictal (during a seizure) violence within complex partial seizures (of the temporal lobes)
- Post-ictal or inter-ictal violence associated with confusion, disorientation or psychosis

Sleep disorders

There is no epidemiological association between sleep disorder and violent or sexual offending. And only very rarely are sleep disorders associated with violence or sexual behaviour in an individual. However, such behaviour is not unknown, in association usually with 'deep sleep' (stage 4) or in the context of abnormal sleep arising after brain damage (which can include being during REM sleep). Crucial is whether there is an established history of a sleep disorder per se, almost always going back to childhood, unless the disorder has apparently arisen secondary to acquired brain damage.

Determining the likelihood of offending having occurred during sleep is complex and controversial, and requires assessment by a specialist sleep clinic.

Comorbidity

Aside from the fact that there can be overlap of symptoms of, and criteria for diagnosis of some psychiatric conditions (for example, for more than one type of personality disorder), there can, of course, be comorbidity of mental conditions, plus of mental and physical conditions. And this can potentially

impact upon patterns of offending behaviour. So, for example, a defendant might exhibit some type(s) of personality disorder plus psychosis of some sort, or an affective condition, or brain damage, or substance misuse disorder. Indeed, specifically, comorbidity of personality disorder with some other condition is common in forensic psychiatric practice. As a result, it is necessary to take account both of the possible contribution of each condition to offending and of the interaction of the two – usually in terms of the contribution of the whole of their mental disorder being greater than the sum of its parts. That is, a psychotic person who also exhibits personality disorder may be more at risk of offending than might be represented by their psychosis alone. And, although comorbidity particularly involving personality disorder is the most common occurrence in forensic psychiatric practice,^{19,20} clearly, any combination of comorbid conditions is possible.

Conclusion

Even where there is a known association at a population level between a given mental disorder and offending, in an individual case this can be only of background relevance. What is crucial, in particular in preparing reports for courts, is description of how, in the defendant, his disorder is likely to have led to offending – including in terms of both an apparent association in the past, in him, between given symptoms and offending within his own ‘biography of offending’, and in the ‘formulation’ of his current offending (see Chapter 7).

¹⁹ Notably, in the UK, epidemiological studies demonstrate up to 75 per cent prevalence of antisocial, or dissocial personality disorder in prison populations, albeit the prevalence of ‘psychopathy’, requiring not just patterns of antisocial behaviour but also ‘psychopathic’ psychology, is much lower.

²⁰ Comorbidity involving personality disorder can be an important complicating factor in consideration of the operation of mental condition defences, even where there was psychosis, for example, present at the time of the offence.



CHAPTER 4

Forensic psychiatric assessment²¹

²¹ For a doctor, some of the text of this chapter may seem 'unnecessary' to read. However, it is offered bearing in mind that some readers will be legal and not medical in professional background. Also, we have attempted to place medical process into the particular legal context within which it must occur. And some of the text may also serve as 'medical revision'.

Overview

There are essential features of any psychiatric assessment. However, aspects of the form and detail of any assessment must depend, in some measure, upon the context of the assessment and upon the purposes for which it is intended. For example, the approach taken when seeing a patient who presents himself to hospital suffering with psychosis asking for treatment will be somewhat – but not wholly – different from the interview techniques and assessment process used when seeing a defendant facing serious criminal charges in prison, for the purpose of preparing a court report. Each psychiatric interview is, therefore, somewhat specific to its circumstance and, in forensic psychiatry, is driven by either the legal or clinical question that needs to be addressed.

The ethical issues that pertain will also be dependent upon the context and purpose of the assessment, in that assessing a *patient* for treatment differs in its ethical implications markedly from assessing a *defendant* for trial – for example, in relation to a possible mental condition defence (see Chapter 11). Since the relationship between assessor and assessee is different, as are the potential implications of the assessment for the assessee.

There are, however, general principles that apply to all psychiatric assessments, including forensic assessments, since assessing a defendant for court requires application of the same core clinical techniques as does assessment of a patient, even though the context may somewhat alter the process and the result may be applied to legal rather than medical questions. Put more strongly, the essentials of clinical method must not be distorted by virtue of the legal context. The reader should, therefore, consult a general psychiatry text for detailed advice about assessment.

The central aim of any psychiatric interview is to elicit any symptoms of mental disorder there may be; to understand those symptoms in terms of both diagnosis and the implications for behaviour; and to conduct a mental state examination. However, in addition, a forensic assessment requires, clinically, particular focus upon antisocial behaviour – and the attempt to ascertain its relationship, if any, with mental symptoms experienced or with disabilities inherent in the individual's condition, including in terms of 'formulation' (see Chapter 6).

Therefore, there should be detailed 'dissection' of symptoms and of their relationship with behaviour, in order to try to establish a detailed understanding of that relationship beyond what might be pursued in ordinary clinical practice – given that the genesis of behaviour may be subject to scrutiny within a legal paradigm and not just a medical one, and may also be relevant to the safety of others. For example, if in a murder case there is a possibility of the defence raising the partial defence of 'diminished responsibility', or the full defence of 'insanity', then assessment of 'the causes of behaviour' will have to be both detailed and conducted in light of the legal definitions that apply in relation to each of those defences.

What is also added to a forensic assessment is the utilisation of more, and different, information. It commonly requires collection of much more 'collateral' information, plus often detailed information of history back to childhood, as well as consideration of information contained within legal papers that may be relevant to diagnosis, or mental state at a particular time (for example, evidence in witness statements of abnormal behaviour in the defendant close to the time of the alleged offence).

In addition, specialist investigations may need to be taken further than would normally be indicated in a solely clinical context, particularly where the civil liberty effect of a finding of guilt in the absence of mental disorder is high, through lengthy imprisonment or execution – such that the principle of ‘leaving no stone unturned’ applies. For example, any suggestion of the possibility of brain damage must result in a full neuropsychological examination and brain scanning, and possibly electrical encephalographic (EEG) investigation, even where the index of suspicion would not be high enough to warrant such investigation in an ordinary clinical situation. A further core reason for ‘leaving no stone unturned’ is that – unlike in ordinary clinical practice, where it may be acceptable, even preferable, to await further development of the patient’s condition in order to address diagnosis without carrying out brain investigation at present – a court case will not await clinical outcome; rather, all investigations that could elucidate diagnosis must be carried out now.

Within the clinical assessment itself, attention must also be paid explicitly to the possibility of feigning, or exaggeration, of symptoms beyond what might routinely be pursued in an ordinary clinical assessment.

What is special about the context?

The effect of difference of purpose

The purposes of any forensic psychiatric assessment for court will usually also include providing advice to the subject’s legal advisors, or to the prosecution – albeit still within the requirement of maintaining ‘independence’ (unless the psychiatrist is engaged only to offer ‘advice to counsel’ based solely upon papers, without clinical assessment of the defendant; for example, advising on the likely validity, or the weaknesses, of an expert opinion proffered by ‘the other side’). Further, in many cases there is likely to be no direct effect upon the individual’s clinical care arising from the assessment, except where one purpose of the assessment is to advise the court on the appropriateness of detention in hospital rather than prison – whereby a forensic psychiatric assessment can *lead to* therapy and treatment. This, again, marks the assessment out clearly from a general adult psychiatric assessment.

Additional stages in capital cases

Whether in regard to a capital case or other serious criminal case, any forensic assessment can be in respect of pre-trial, trial or sentencing issues. However, one clear difference about sentencing reports in capital cases is that they will usually be directed towards a legal criterion, usually that of ‘beyond reformation’, which is utilised in determining whether the discretionary death penalty should be imposed (unless, of course, the death penalty is mandatory in the jurisdiction concerned). There *may* also be relevance of psychiatric factors to the other legal test for imposition of the discretionary death penalty, of the case being ‘the worst of the worst’. Here, the court may sometimes address not only the nature of the killing per se but also individual ‘characteristics’ of the defendant, as they may relate to the nature of the killing (see generally Chapter 12 dealing with assessment for sentencing, and Chapter 7 concerning risk assessment and treatability in relation to ‘reformability’). Reports can also be requested in capital cases in relation to ‘mercy hearings’, wherein ‘softer’ mental condition data and opinion may be relevant than is allowed within a trial or sentencing hearing (for example, a defence of ‘diminished responsibility’ may fail at trial, yet the same data and expert opinion may be relevant within a mercy hearing in regard to some lower level of ‘diminution of responsibility’). Finally, a report may be requested in relation to whether a convicted prisoner awaiting execution is ‘fit for execution’ (again see Chapter 12).

More generally, as with any forensic assessment, an important aspect will be the need to assess an individual's mental state, not only currently, but also as it was at some time in the past.

Difference of relationship with the assessee

The relationship between doctor and assessee is different in a forensic context from in general psychiatry, crucially captured by the distinction between assessment of a 'patient' and of a 'defendant'. That is, the particular situation and role of the assessee determines an entirely different relationship with the assessor than applies within a general psychiatric assessment.

In terms of the implications of this unusual relationship, typically, when seen by a doctor, the patient can withdraw their consent, if necessary, by leaving the interview room. Defendants in forensic assessments – including, and perhaps especially, those facing the possibility of the death penalty – are far less autonomous. They might not wish to be assessed at all, or may not wish to discuss particular aspects of their history, yet there will likely be pressure upon them to do so – both 'externally' from lawyers and 'internally' from knowledge of the potential consequences of not taking part in an assessment, in not having access, for example, to a potential mental condition defence or to mitigation factors in sentencing. Therefore, the process is far less consensual, and collaborative.

The doctor conducting a forensic assessment must therefore walk a difficult and narrow ethical line, using clinical techniques – for example, empathy – to put the defendant at his/her ease and to elicit a truthful and honest account, yet being mindful that his primary duty is to the court, and not the defendant.

There is also a risk of 'doing harm' to a defendant assessed, for example, where data is elicited which infers not mitigation but aggravation of culpability, as it will be perceived by the court – thereby contradicting one of the main principles of medical ethics of 'non-maleficence' (see Chapter 15).

Some forensic psychiatrists perceive no ethical difficulty in assessing a defendant for legal purposes, even where it is clear that the effect may well be 'to do harm'. They do so by resorting to their duty in 'justice' (a medical, and general, principle which can be in competition with that of 'beneficence' or 'non-maleficence'); and by way of describing assessment for legal purposes as being not 'medical practice' at all but, rather, as 'being a forensicist', akin to a forensic scientist. However, although this is a 'nice distinction' in theory, in practice it is spurious. Even if, quite properly, the doctor makes plain to the defendant at the outset his purported non-medical – that is, 'forensicist' – role, he will necessarily immediately adopt and apply medical techniques, and this includes techniques of empathy and others that are clearly medical and which aim to extract valid information from the defendant. So, he is quite clearly 'being a doctor' and, even if he thinks he is not, the defendant will soon forget the initial warning about the assessor's role and quickly 'experience' the alleged 'forensicist' as 'doctor'.

The lack of any real escape from 'being a doctor' in carrying out assessments for court most acutely focuses the medical mind ethically in capital cases where the doctor is asked to assess by the prosecution. Some doctors find this to be 'a potential harm too far', and will only accept instruction in capital cases from the defence – although this position emphasises the importance of both being aware of the potential impact upon assessment and reporting of one's own 'values set', in terms of the potential for bias, and of aiming to act 'honestly' (see Chapter 15).

Even where a doctor is instructed by the defence, which gives control of use of the report to that side, if he is not adequately competent to conduct the assessment, he can clearly ‘do harm’ in any event – for example, by way of not eliciting medical information that would likely assist the defendant legally.

Before accepting instructions

If approached to conduct a forensic assessment, the first question to ask yourself is whether the proposed assessment is within your fields of expertise, or whether – even if it ‘just is’ – it would be more within the expertise of a different doctor. Alternatively, whether, in addition to your own assessment, that of another expert is also required (for example, where there is the possibility of brain damage, it may be necessary that a neuropsychiatrist, and/or neuropsychologist, be instructed alongside a forensic psychiatrist).

To reach a view on these matters, a detailed letter of instruction is required; albeit, even before this, there is often much to be gained from an informal discussion with a defendant’s legal advisors, or the prosecution (depending on by whom you have been approached) encompassing clinical information as it can best be gained at that stage, plus what legal questions the lawyer wishes addressed by expert evidence. Also, do not accept instructions without confirming that you are able to prepare the report within the timescale required.

In jurisdictions with limited available specialist forensic psychiatric expertise, any psychiatrist approached should still pose for himself the following questions:

- Have I undertaken the necessary training, not just in psychiatry, but also in the application of psychiatry to legal process?
- Do I have enough experience, including of giving evidence in court?
- Do I know enough to be able to assess the patient and answer the questions posed?

It is better to decline a case at the outset than to do so after having seen the defendant, incurring costs and wasting time for all concerned; even worse, to find yourself in court being asked questions to which the answer is not just ‘I don’t know’ but ‘I couldn’t know’.

Consultants in forensic psychiatry who have completed specialist training are likely to feel competent to answer most standard questions that are asked in legal contexts, not only concerning what treatment is indicated, but also concerning the effects of mental disorder upon mental functioning and behaviour – for example, describing the implications of acute psychosis for a patient’s ability to control their actions, or to make rational decisions. However, some defendants will require clinical assessment from doctors having particular expertise beyond that even of the specialist forensic psychiatrist – for example, describing the effects of a lesion in the temporal lobe upon a patient’s perception of their behaviour. And, since most such highly specialised psychiatrists are almost always not also forensic psychiatrists, it is often necessary that two experts be instructed, operating in tandem; one who has the necessary highly specialised clinical and scientific knowledge required, plus a forensic psychiatrist, who can carry out a forensic psychiatric assessment and both incorporate the implications of the highly specialised findings of the neuropsychiatrist within a forensic formulation and apply all of the relevant clinical information to the legal questions at issue.

Any doctor asked to take instructions in a particular case should also consider whether doing so could lead to any conflict of interest. This might include providing an independent report on a patient already under your care, where the fact of a therapeutic relationship is likely to give rise to the risk of bias or at least the perception by others, including the court, of bias (see Chapter 15).

Finally, once instructions have been accepted in a case, it is crucially important to clarify the instructions, including any relevant legal constructs or terminology.

Instructions

Legal questions potentially asked in serious criminal – including capital – cases may include:

- A range of legal ‘capacities’ relevant to trial including, for example: the capacity to have understood the police caution at the time of being interviewed; and the capacity to have waived rights to appeal
- Reliability of confessions; unreliability arising, for example, from ‘compliance’ and/or ‘suggestibility’
- Fitness to plead and stand trial
- Mental disorder at time of an alleged offence in relation to a mental condition defence: for example, ‘diminished responsibility’, ‘insanity’, ‘automatism’, ‘the capacity to have formed the requisite intention’
- Mental factors potentially relevant to sentencing: for example, assessment of the risk of future violence; reformability; mitigation by way of mental disorder
- Assessment in relation to the capacity to appeal against conviction and/or sentence
- Mental factors relevant to mitigation within a mercy hearing
- Mental factors in relation to the legal capacity to be executed

Before the interview

Time spent preparing for assessment is generally time well spent. Hence, before leaving your base to conduct an assessment, ensure you have the contact details of the lawyer who is coordinating the assessment. Also, check:

- What identification will be needed if you are visiting a prison or hospital?
- Is a letter of introduction required and, if so, from whom?
- What forms of identification are needed?
- Is proof of being a doctor needed?
- Are the facilities to be provided within the prison or hospital adequate for the assessment required?
- Is there agreement from the prison, or hospital, that the assessment will be in private and not, for example, within the hearing of prison officers?

Sources of information

Ideally, case papers will have been provided to you well in advance of the assessment. However, the amount of documents offered can vary widely. So consider whether you have received all that you need, recognising that what will be required will vary depending upon whether the assessment is for trial or appeal, and the questions to which the assessment will be directed.

A bare minimum, for trial, in respect of legal papers is likely to be a case summary and prosecution witness statements, plus police interviews with the defendant. Medical notes will also need to be seen but are sometimes difficult for legal representatives to locate, and often arrive late in the assessment process. And, in advance of clinically assessing the subject, it is sometimes impossible to know how important these are likely to be; for example, if the subject reports a long psychiatric history, detailed medical records are likely to be crucial. It is always good practice, however, to obtain all records, since defendants may not inform you of significant medical events. For example, if the medical records describe contact with psychiatric services, or a brain injury, then questioning and examining the subject in relation to this is likely to be important. So, while it is sometimes unavoidable that the subject's interview takes place without the medical notes to hand, it is certainly far from desirable.

Thought should be given to what opportunities there will be to gather further information; for example, will it be possible to speak to doctors who are, or have been, involved in the subject's care? Can additional medical notes be viewed, perhaps by visiting a local hospital? If so, what form of authorisation will be needed?

It is also often relevant to gain school records, particularly if there is a possible diagnosis of personality disorder.

Similarly, any social services records will be needed if there is a possibility of childhood disturbance and/or family disruption.

If travelling to conduct the assessment, think about how much documentation you should actually take with you, since the total volume may be large.

Assessment

The environment

The psychiatric interview is a key opportunity to gather information, and the environment in which it takes place needs to be 'safe' in several senses.

As regards interviewer physical safety, very often the psychiatrist will face the prospect of interviewing a subject not known to him. And an anxious interviewer will be distracted and inefficient. Therefore, sensible precautions should be taken to manage any risk; for example, by ensuring that staff, whether prison officers or nurses, know where you are and roughly how long you will be. The interviewer should also make sure that there is an unimpeded route from their chair to the exit; often sitting closest to the door of the room is best. And, in any event, many doctors would consider placing themselves squarely behind a desk to be overly formal, and as likely to run the risk of further intimidating the defendant,

who is likely to be anxious. An alternative is to sit at a diagonal, keeping some distance from the subject but allowing a more relaxed interaction. Some rooms will have alarms, and the position of these should be noted. It is also useful to know in advance what to expect if they are pushed (it can be a source of particular embarrassment to press a button hoping that someone will simply open the door, then to find that it triggers a full scale response from the prison security team).

To facilitate the subject feeling psychologically safe, or as safe as is possible, the interview should be conducted in a quiet room where the defendant cannot be overheard, especially as they are likely to be disclosing information that is highly personal and sensitive. Prison officers, particularly those guarding 'death row' inmates, are often reluctant to leave the room while an interview is conducted, and this can lead to awkward situations if the arrangements for the interview have not been agreed in advance. Hence, negotiation in advance is required to ensure privacy, with the provision of a letter agreeing to this from the governor of the prison. However, any expectation of ideal conditions is likely to be disappointed, and some compromises will need to be made, albeit there must be a limit to such compromise.

Finally, facilities to examine a subject physically – and particularly neurologically – are likely to be very limited or absent, and this can pose a challenge and, ultimately, a problem.

Consent

The interview should start by the doctor describing who he is; who has asked for the assessment; what is its the purpose; how long it will last; what it will cover; and who will see the report that is eventually produced, and in what circumstances (a defence commissioned report will be seen by the court and prosecution only if it is disclosed; a prosecution commissioned report will automatically be disclosed both to the defence and court).

Explaining the absence of confidentiality is particularly necessary; it is crucial that the defendant is made aware that anything he says can 'get to the court'. Patients typically meet doctors with the proper expectation of privacy and secrecy. However, in this and others ways, a forensic assessment is different from consultations in other forms of medicine, and this must be made clear at the outset. An attempt should then be made to record the subject's acceptance of the terms of the interview, at least by way of making a note of it (some experts use a 'consent form').²²

If the defendant lacks the capacity to decide whether to be assessed or not, you will have to take a decision based upon their 'best interest', after discussion with their lawyer if you are instructed by the defence, or via informing the prosecution, who can then contact the defence, if you are instructed by the state.

The interview

Unless the diagnosis, or the lack of any disorder, is crudely obvious, psychiatric assessment involves lengthy interviewing. So it is unusual to be able to complete an adequate assessment of someone facing a serious criminal charge in less than three or four hours (this excludes time considering past medical records and the legal papers in the case or time gaining data from informants).

²² See Rix K (2011) *Expert Psychiatric Evidence*. Gaskell, London.

In clinical forensic psychiatric practice, patients or subjects are usually seen on their own, as in most other medical practice. And this is likely to be advisable also in serious criminal or capital cases, since the presence of someone else can distort or inhibit clinical interaction. However, occasionally, it is worth at least considering whether the presence of a lay advocate or interpreter is advisable, especially in interpreting cultural nuances of communication and behaviour where the doctor originates from a different country or culture. As to whether it can ever be advisable to have the subject's lawyer present, it can sometimes be necessary where clinical interviewing has given rise to information or matters that may have direct legal, rather than solely clinical, relevance; and where the subject should be given the opportunity to be advised by his lawyer about any further interaction on the subject at hand with the doctor.

In contrast to most general adult patients, forensic assesseees may have a motive to conceal and/or distort information they offer, in that a favourable evaluation might, for example, lead to freedom, or the avoidance of the death penalty. Hence, there can be no assumption of honesty. Consideration should therefore be given to adopting techniques specifically designed to determine whether there is feigning or exaggeration of symptoms (see also Chapter 5). And, related to this, any diagnostic, or other opinion expressed in the report subsequently offered to the court should be accompanied by explicit consideration of likely validity (see Chapter 8). Open questions should always precede closed ones, and direct questions can, for example, include asking about symptoms that one would not expect to be experienced in any of the diagnoses that you have under active consideration. Also, the manner in which symptoms arise in clinical interaction with the subject may suggest whether they are likely to be validly experienced, and the nature of – or changes in – the subject's mental state concurrent with describing symptoms may assist. (Techniques relevant to validation of interview material are described in more detail in Chapter 5.)

A sense of detachment between interviewer and patient is required, but so is empathy – and this combination can be difficult to achieve. Yet, such 'finessing' of both clinical empathy (essential to clinical process) *and* detachment from taking any interest in the outcome of the assessment and case (given your role solely in the aiding of effecting justice) is essential, and lies at the heart of good court-related forensic psychiatric practice.

Essentially, the forensic psychiatrist assessing for court must manage to hold in place 'being a doctor' – for example, using all the usual observational and response skills of medicine, including responding to any emotional problems presented by the subject – while, at the same time, maintaining 'disinterest' in the outcome of the assessment, since to do otherwise will likely bias his assessment and hinder the court in achieving justice.

While some testing of emotional response – for example, by challenging statements made by the subject – is arguably an integral part of any psychiatric assessment, and can be particularly relevant in a court related assessment, deliberately aggravating a subject is clearly both wrong and likely to be counterproductive to achieving valid assessment.

A particular common difficulty is the limited amount of time made available to the clinician by prison authorities. So often the interviewer needs to control the assessment more than would usually apply in ordinary clinical practice.

Virtually all interviews will cover the basic building blocks of a psychiatric history and a mental state examination, but each assessment is 'different', being influenced by the defendant, the setting and the

legal context. Constructing an interview plan in advance – even if just mentally – can help, particularly in complex cases (which death penalty assessments, for example, often are); where time will be short; or where the interviewer is more anxious than normal, due to high stakes of the assessment or the need to discuss an offence that is particularly abhorrent.

The key is to be systematic but flexible. Starting with general questions about background is usually best, well before addressing questions relevant to the alleged or index offence, since this is most likely to put the subject most at his/her ease, and since ordinary diagnostic issues are most likely to be addressed validly without the ‘contamination’ of discussion of emotive issues relating to the offence or trial. Also, by the time the assessor gets around to addressing the offence, he will likely thereby have already gained initial hypotheses, or even conclusions about diagnosis and/or formulation (albeit not yet formulation of the offence, or patterns of offence behaviour).

The ultimate focus of any serious – including capital case – assessment will be the alleged (if the report is ‘for trial’) or index (if ‘for appeal’) offence. However, there may be strong and understandable reasons why the defendant, or appellant, is reluctant to talk about this, including fear of incriminating himself if the assessment is pre-conviction, or worry about jeopardising the chances of a successful appeal in that legal context – especially so if the appeal is against imposition of the death penalty. The assessor needs to be accepting of this.

The foregoing said, the good interviewer will allow the subject at times to talk freely. He will then check his understanding of what has been said. In general terms, the interview process should be fluid, with the information that is gathered used to generate, and then test, hypotheses in an active and advancing process of exploration, while taking care that – though allowing flexibility – no significant areas are left unexplored. The proficient interviewer, mindful of potential diagnoses, will want to explore for related symptoms, and for evidence both ‘for’ and ‘against’ potential disorders, in terms of accepted diagnostic criteria, whether made by reference to ICD10 or DSM-5.

Beyond comprehensive clinical and diagnostic assessment per se, it is essential to ensure that you have asked any necessary questions that lie at the interface between such clinical – including retrospective mental state – assessment *and* the legal questions to which you know the information must be applied. That is, to address the ‘psycholegal mapping’ that is required (see Chapter 2).

Clearly, some interviews are more difficult to conduct than others; some require a high level of clinical skill, emphasised by the complications of the forensic context. So, for example, disturbed subjects often benefit from being given time, space and reassurance about the interviewer’s interest in them. However, ultimately it is important not to be afraid to terminate an interview; if a defendant is aroused, it is unlikely they will be able to provide a worthwhile history, and further attempts to elicit information might simply escalate the risk, either to him/her or you.

At the conclusion of an interview, it should be explained to the defendant what is likely to happen next, with approximate timescales for the production of a report, if possible. However, it is never appropriate to tell the defendant your conclusions. Aside from taking time properly to read all available information and to think, your opinion and its implications will have to be set in the context of all of the evidence in the case, as a whole, and of legal opinion concerning the totality of the evidence, of which yours is only one

part. Therefore, information to the defendant about your opinion should come from his lawyer, whether you have been instructed by the defence or by the prosecution.

Interpreters

Some interviews, especially in cases assessed by doctors not from the culture of the defendant, will need to be conducted with the help of an interpreter – if not in terms of language per se, then in terms of culture. Clinical history taking via an interpreter is not easy, and requires skill on the part of both the interpreter and the doctor. If possible to achieve, the best results come from setting up the room and exchange in such a way that the subject is still ‘talking to the doctor’, even though ‘through’ the interpreter. And, clearly, the choice of interpreter is important but practically that might be limited. What is crucially important is that the interpreter relates exactly what the subject has said, without any ‘interpretation’ or ‘embellishment’, since the words used may be not only clinically, but also legally, relevant, and sometimes crucially so.

Although it might be thought expedient in certain situations, there are clear difficulties with using family members in this role – not least in regard to confidentiality and the difficulty for defendants speaking about unpleasant events that have happened in the family, or the shame that a defendant might feel in reporting symptoms of mental illness or discussing the details of an offence in front of a family member.

A professional interpreter who has some experience of psychiatric interviews is preferred. They should not be known to the defendant and, preferably, should belong to an organisation that offers training to its staff or associates – and, of course, it is especially important that the interpreter is prepared and able to maintain confidentiality. However, in practice these quite basic requirements are sometimes hard to meet.

Note-taking

Clinicians will have their own ways of taking notes, plus their own idiosyncratic notations and abbreviations. That accepted, however pursued, note-taking should not interrupt the flow of what ideally will appear to the subject as a natural conversation.

It is important, too, to remember that the clinical notes of an interview will also become a matter of legal record, and may even be scrutinised by experts or lawyers ‘for the other side’. So they need to be understandable, accurate, and full enough for you later to be able to prepare a report by reference to them.

Should you record the precise questions asked and the precise responses?

This has merits. A very full account of the interview is then available to the court, particularly of how symptoms of mental disorder emerged during the interview. However, the process can be laborious and can interrupt the flow of the interview, and report of it. Hence, in practice it is probably best to write notes in summary form, and in the third person, but also to ensure that topics that may be legally crucial are recorded verbatim, with answers written in the first person, as they were spoken by the defendant. It is also important to distinguish in your notes between things said spontaneously by the subject and things said in response to ‘direct questions’.

Should the defendant be seen more than once?

Seeing a defendant twice allows the information elicited at the first interview to be checked; any contradictions or discrepancies that arise from having checked the defendant's account with other material can also be put to him or her. In addition, the mental state of the defendant can be observed on two separate occasions, allowing noting of any changes or inconsistencies between the two interviews. This is likely to be especially important in cases of suspected personality disorder.

After the clinical interview(s)

After the assessment per se has been completed, it will be necessary to review all current and past medical records from whatever source they may arise, including the prison. In some circumstances, it may also be necessary to read educational records in order to gain information about childhood development. The importance of all such records is at least twofold.

First, the assessing doctor himself can only take directly a medical 'snapshot' of the defendant. The past records provide a 'cine film' view. This is important diagnostically per se, but is also of importance in determining the extent to which any disorder persists, or did persist over some period of time in the past.

Second, assessment by a psychiatrist for trial often occurs after a substantial period of time has elapsed since the date of the alleged offence. Therefore, assessment is necessarily 'retrospective'. It is unhelpful for a doctor to argue, however, that he cannot give an opinion, for example, as to whether the defendant had been suffering from an 'abnormality of mental functioning' within a defence of 'new diminished responsibility' because he had not assessed the defendant at the time that he committed the offence. Retrospective reconstruction is the norm for the forensic psychiatrist, and records are important in such reconstruction.

Mental state examination

Having taken a history, the doctor conducts a 'mental state examination'. This amounts to describing and classifying evident mental state phenomena, including augmenting observation of the defendant during interview with specific 'bedside' tests of mental functioning, aimed at ruling out, or identifying, any organic abnormality of the brain (these are not a substitute for comprehensive organic assessment, but often represent a relatively crude 'screening' process).

Further collateral information

An important aspect of any psychiatric assessment, be it for ordinary clinical purposes or for legal purposes, is the gaining of data from 'other informants'. This is because – unlike in most (non-psychiatric) medical illnesses – the person's perception of their 'usual functioning', or functioning when possibly ill, may be profoundly distorted by mental disorder. Since variation of the person from their own usual functioning is, in general terms, often an important contributor to the conclusion that the person is indeed currently mentally ill, or was at the time of the offence, the availability of such information is important. Of course,

given that such availability is dependent upon circumstance and is not under the control of the doctor, its absence may have to be coped with.

A variety of potential sources of ‘collateral information’ (as the courts term it) may be available. Some will be present within the case papers, for example in witness statements. Friends or family members can be interviewed – although often this is not possible. As well as case papers and medical records, other potentially helpful written sources of information may include school and social services records (see above); and all should be matched against the subject’s account.

Such a process of ‘triangulation’ will allow the clinician to express an opinion with a greater degree of confidence than would otherwise be the case, presuming that the information obtained is consistent across sources. However, gathering information from others may be subject to special rules if they are also prosecution witnesses, requiring consent from the prosecution lawyers (there is usually no difficulty in questioning defence witnesses, if you are instructed by that side).

Physical examination and investigations

Mental disorders can have organic causes. If such a cause is established, not only can this have significant clinical significance, it can also have important legal consequences – ultimately, albeit rarely, even in terms of determining a legal automatism (see Chapter 11). Notwithstanding its importance, it can be difficult practically to conduct a physical examination, particularly in a prison, where there may be a relative lack of both privacy and equipment (see above). The examiner may also thereby place himself in close contact with the defendant, and in some cases could possibly expose himself to an enhanced risk of violence. However, such examination may be necessary.

Specialist investigations such as electroencephalogram (EEG), magnetic resonance imaging (MRI) brain and computed tomography (CT or CAT) head scans are now commonplace in clinical practice in Western Europe and the USA. However, there is far less – and often no – access to such technologies in practice for those detained in prison in parts of Africa; and such investigations are also often difficult to access for prisoners in the Caribbean.

The assessing clinician needs to come to a view as to how necessary these investigations are. If it is thought that they are crucial then representations, probably made by the defendant’s solicitor, supported by a letter from you as the assessing psychiatrist setting out the clinical indication for further investigations, need to be made to the prison authorities. Arrangements for the investigations to take place should be made with a hospital that is local to the prison, if at all possible.

Beyond this, however, it can reasonably be argued that where the death penalty may be imposed ‘no stone should be left unturned’ in terms of medical investigation, even if there is only a low level of suspicion of brain disorder and such investigation would not be conducted – at least not at this time – in ordinary clinical practice. This approach relates directly to international legal provisions concerning ‘minimum standards’, whereby not only are there minimum standards that must apply legally to capital cases but also minimum medical standards, based upon equivalence with what would be available in a developed country.

Psychological testing

A detailed description of psychological testing is offered in Chapter 5. However, in terms of the relevance and use of such testing in conjunction with psychiatric or medical assessment, the following may assist understanding of their value and use from a medical perspective.

From the perspective of a psychiatrist assessing a case, psychometric tests that may assist fall essentially into two categories.

First, tests that are directed at brain function and which typically assess cognition. Most commonly, these tests are of global intelligence. They are used, for example, to demonstrate learning disability – although their use goes well beyond this particular diagnosis, and it is also common to use them, augmented by other more specific tests, to demonstrate the acquired presence of either global or focal brain damage or deterioration (or its absence where clinically it had been suspected). Such tests can demonstrate or confirm the presence of brain damage, by showing that the person cannot use their brain in a normal way. Indeed, ‘neuropsychometric tests’ can be more sensitive in detecting brain damage even than brain imaging through CAT or MRI scans.

Neuropsychometric testing can also be important in order to complement scanning in assessing whether there is brain damage, resultant from head injuries or sustained alcohol abuse for example. Its can also be used to help confirm or refute a clinical ‘impression’ that the defendant’s intelligence is low, including amounting to learning disability, even in the absence of identifiable brain damage.

Further, neuropsychometric tests are often of particular assistance in assessments carried out for legal proceedings, because they can frequently demonstrate specific abnormality in the way in which the person functions mentally in a fashion that can then be applied directly to particular ‘abilities’ that are important in relation to particular legal tests.

Second, psychologists administer tests that demonstrate (broadly) aspects of ‘personality’. Such tests, as with the first category of tests (above), have been validated on large populations of patients/subjects and are, therefore, scientifically (and, therefore, forensically) robust. They can be tests of personality type or disorder per se, which may be of relevance to a case of diminished responsibility, for example, which rests upon an assertion medically of ‘personality disorder’ (indeed, the seminal case in English law defining ‘abnormality of mind’ within ‘old diminished responsibility’ involved a personality disordered defendant, and allowed into law the notion of ‘irresistible impulse’ arising from such disorder (*R v Byrne* [1960])).

Additionally, psychological tests might be of ‘suggestibility’, ‘compliance’ or ‘acquiescence’, relevant usually to the reliability of police interviews.

As in all medicine, the combination of clinical assessment and the administration of a range of tests of varying sorts of brain, mind and body, contribute together to the conclusion that a person suffers (or does not) from a particular condition. That is, there may be cross-validation. Although diagnosis may be possible simply on clinical assessment, without other informants or the availability of ‘tests’, in many cases confidence in a diagnosis requires, or can be aided by, ‘triangulation’ – that is, the use of more than one source and type of information that offer different ‘perspectives’, and which thereby lend confidence to a diagnostic conclusion.

Even where a 'negative' conclusion has been reached, it is equally important that the conclusion is a confident one, since the implication is that no interventions will be offered. However, in a forensic context, the importance of high quality, cross-validated evidence for the presence of a condition is further emphasised, given the possibility of 'faking'. It is also equally important that any conclusion that no abnormality is present is held with maximum confidence. A 'false negative' finding for abnormality can result in initial lack of justice, and a subsequent attempt at appeal, after a more robust assessment has suggested the presence of disorder.

Psychiatrists engaged in preparing a report are likely to want to approach the defendant's legal representatives seeking to arrange a psychological assessment in cases where there is an indication of impaired cognitive functioning or possible personality disorder. Testing might also be of value where serious psychosexual pathology is suspected. Additionally, assessment for the traits of 'suggestibility' or 'compliance' requires specific psychological testing.

Personality assessment

There are particular issues and difficulties accompanying the assessment of personality, including towards a possible diagnosis of personality disorder. Such diagnosis is quite distinct from 'mental illness', 'brain disorder' or 'learning disability', in that personality disorder is a developmental disorder essentially of 'who the person is', with consequent mental dysfunction and disability, and also behavioural disorder, measured against a normal population. By contrast, mental illness and brain disorder are expressed in terms of change away from some previously normal state in the individual (unless the brain damage is congenital).

There is complexity in defining personality, with varying weighting attached to individual capacities, affective traits, psychological defences, cognitive abnormalities and social aspects. It is defined in psychiatric manuals in terms of requiring the condition to be enduring, developing or manifesting in early life and reaching such severity as to have a significant impact on functioning.

The clinical interview is important in the assessment of personality but should always be combined with other information from a wide range of sources. In addition, usually it will be necessary for there to be psychological testing, by way of personality psychometrics – thereby describing personality structure in a valid and reliable fashion. It is important to note, however, that 'personality disorder' is defined in psychometric terms simply by way of sufficient deviation statistically from 'normal', and without the requirement of the 'effect upon domains of daily function' that is required by the two accepted international classificatory systems used psychiatrically for diagnosis (see immediately above). This said, the advantages of psychometric assessment are in terms of both 'validity by way of comparison with a normal population' and 'triangulation' with other, clinical, methods of assessment.

Specifically, 'psychopathy' should only be commented upon if assessed using the Psychopathy Checklist Revised (PCL-R). Careless use of the term 'psychopathic' should be avoided, given its emotive and lay connotations.

Beyond possible diagnosis of personality disorder per se, assessment of personality in terms of 'type' rather than 'disorder' is important; personality can influence the expression of mental illness, or even of brain disorder, so some attention should always be paid to this.

Finally, given that personality disorder is defined in terms of ‘variation from the normal’ rather than ‘variation from the subject’s own previous normality’, it is more inclusive of ‘judgement’ than mental illness or brain disorder. Indeed, there is much research evidence demonstrating significantly lower ‘inter-rater reliability’ in the diagnosis of personality disorder compared with mental illness. And this, in turn, determines that there is an enhanced risk of ‘values incursion’, and ‘bias, into clinical assessment (see Chapter 15), with an attendant ethical need for particular ‘insight’ and ‘self monitoring’ in regard to the exercise of judgement.

Learning disability

Diagnosis of learning disability, like that of personality disorder, is dependent upon comparison with normal, and so is open somewhat to judgement. However, it is less so than is personality disorder because intelligence can be quantified validly and reliably psychometrically. That said, diagnosis rests not solely upon psychometrics, but also on variation from normal performance in aspects of living, so detailed information about this must be collected too.

Cognitively, crossing the threshold to ‘learning disability’ rests upon demonstration of a WAIS-R (see Chapter 5) of ‘less than 70’. However, measurement has an ‘error factor’ attached to it, and this can give rise to confusion when the numbers are discussed in a legal context. Such confusion becomes acutely focused where imposition of the death penalty is at stake, given international jurisprudence determining that it is unlawful to impose that penalty on a defendant exhibiting ‘learning disability’ or ‘mental retardation’.

Ultimately, the diagnosis requires judgement across several sources of information.

Validity

The validity of any diagnosis made can be seen somewhat in terms of a ‘jigsaw puzzle picture’. That is, diagnosis is dependent upon the *presence* of sufficient pieces, arising from various sources, to suggest with confidence the presence of the picture, plus the *absence* of pieces that are inconsistent with the picture, and diagnosis. Adopting this approach makes it clear that diagnosis does not, therefore, equate with simply accepting what the defendant told the doctor – although, as in all branches of medicine, the ‘history’ taken from the ‘patient’, and evaluation of that history, are important factors.

As regards establishing the presence of symptoms within the clinical interview, this should not be approached with naivety but with recognition that someone engaged in legal proceedings might seek to fabricate or exaggerate symptoms. However, first, the way in which symptoms ‘come out’ at interview will either be characteristic, or not, of how such symptoms are characteristically described by patients (that is, not defendants). Second, whether the ‘pattern’ of symptoms as a whole suggests a given diagnosis, or not, will assist. Third, the absence of description of symptoms inconsistent with a given diagnosis will offer further validity support. Fourth, consistency of expression of symptoms over several interviews, or with other reports on the defendant, will suggest validity, so that the reporting of highly unusual or unheard of symptoms, or of symptoms likely to be what defendants would expect to be symptoms of disorder will cast doubt upon validity. Similarly, the over-reporting of symptoms will cast doubt (few patients present with a ‘full house’ of symptoms of a condition). Fifth, consistency between reported symptoms

and symptoms recorded in past medical records, especially close to the time of the alleged offence will suggest validity.

Beyond the foregoing, if there is significant concern about the veracity of symptoms reported, psychological testing can be undertaken to assist in establishing whether malingering or fabrication of symptoms is occurring (see Chapter 5).

Ultimately, however, fabrication is both difficult to achieve effectively and relatively unusual. And, as already suggested, what is looked for, as in all medicine, is whether there are enough ‘pieces of the jigsaw picture’ to be convincing that ‘the picture is there’. This means that the presence of one or more pieces of a particular type can reinforce the likely validity of others. Notably, this goes beyond the legal analogy of ‘corroborating evidence’, in that there is mutual reinforcement of the likely validity of pieces ‘across the picture’, while the presence of pieces that ‘do not fit’ will tend to cast doubt on the picture that is observed.

Medical assessment in capital cases

Given how high the stakes are, clinicians who undertake assessments in capital cases need to demonstrate a higher standard of professional practice than those engaged in general forensic psychiatric work.

Clearly, psychiatrists carrying out such work need to be experienced not only in clinical forensic practice, but also in preparing medicolegal reports, given that there is substantial ‘expertise in being a medicolegal expert’, which goes beyond merely being a good clinician. Indeed, in the UK, where there is no death penalty, the General Medical Council reprimanded an experienced consultant in general psychiatry for undertaking a murder report, and doing it poorly, when he had never undertaken such a report before. And in jurisdictions retaining the death penalty, the stakes are far higher, given that there is no ability to set errors right at a later stage.

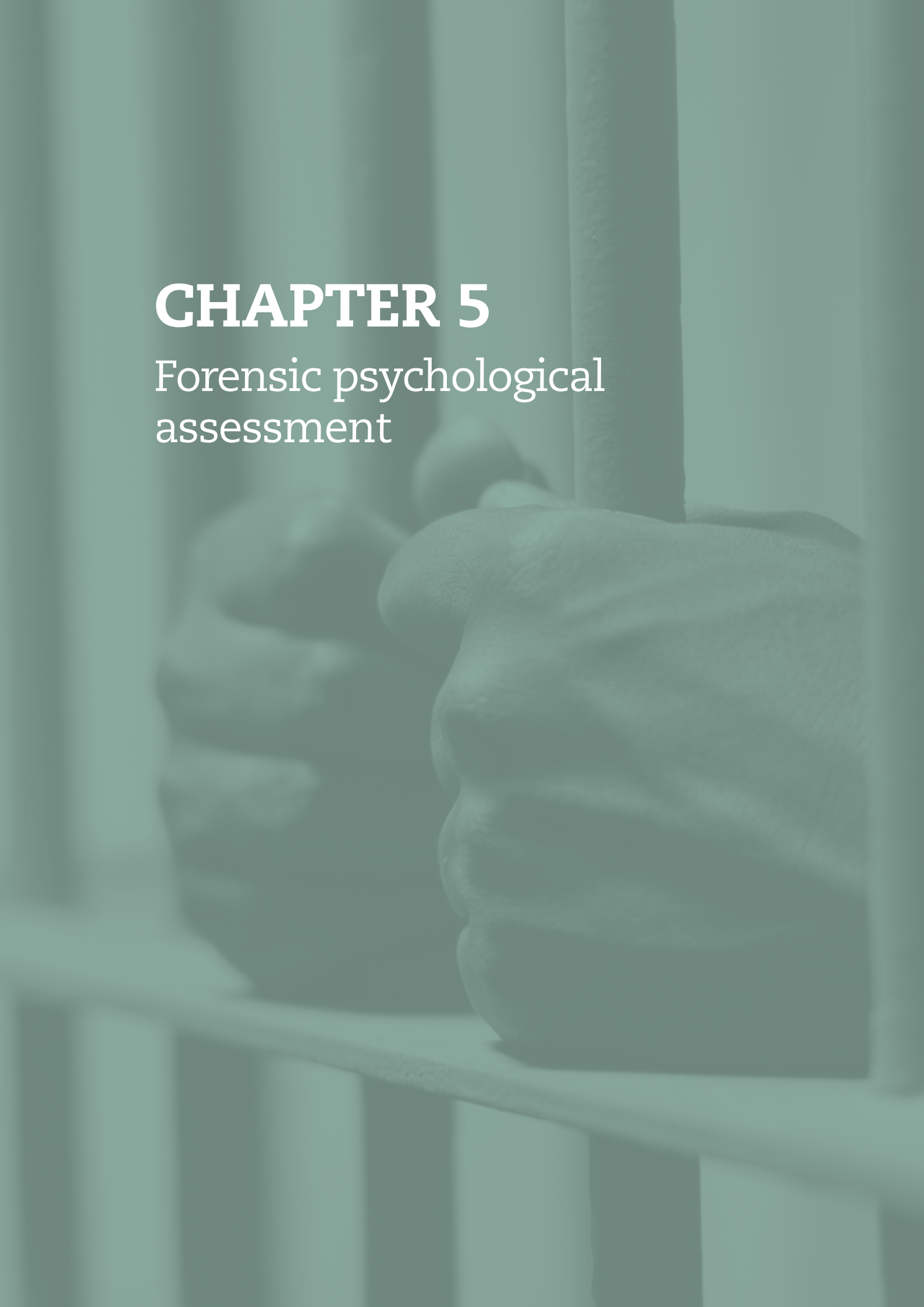
Experts undertaking such work also need to be able to work in potentially very difficult environments. And assessments conducted in capital cases can – indeed, perhaps should – provoke anxiety in clinicians, in that much is potentially at stake and those involved need to be accepting of, and comfortable in, the knowledge that one potential outcome of their assessment can be the execution of the defendant.

Even clinicians who are experienced in other areas of forensic psychiatry are likely to be unfamiliar with the case law relating to capital cases. This is not to say that a medical expert needs to be a ‘mini-lawyer’, but he does need to understand the interface between medicine and law, so as to be able to offer expert evidence effectively in terms of ‘psycholegal mapping’ (see Chapter 2). And advice on relevant law, including legal tests, should be sought and fully understood, if not already known to the doctor. Also, if he lacks experience of working in a country that retains the death penalty, and/or in a less developed country where services are limited, these may present challenges that will need to be overcome.

Perhaps the greatest challenge, both technically and ethically, arises from the fact that the future risk of violence is likely to be an important consideration in sentencing in almost all jurisdictions that maintain the death penalty on a discretionary basis. And ‘clinical risk assessment’ is fraught with both technical and ethical problems (see Chapter 7).

CHAPTER 5

Forensic psychological assessment



Peer review is central to good forensic psychiatric practice. Usually this applies ‘ex post’, having written any report and/or having given oral evidence. However, even soon after an assessment is concluded, it can often be valuable to discuss the findings with an experienced colleague, in an anonymised fashion. This will allow an opportunity for reflection from a position of some distance, and for tentative conclusions to be challenged and, if necessary, revised. Such advice is particularly relevant to a doctor who has little experience of assessment of defendants in capital cases – albeit no doctor should be too proud to seek discussion with a colleague. This said, clearly the opinion expressed in a report must be that of the expert, and not an ‘opinion by committee’. And, if there has been discussion with a colleague, this should be made plain in the report.

This chapter provides a practical guide to best practice concerning a range of matters that clinical psychologists are routinely asked to comment on in relation to criminal trials. In addition, Appendix 1 offers an ‘at a glance’ guide to conducting clinical psychology assessments, while a brief description of each of the measures referred to in the chapter is presented in Appendix 2. These two appendices may be used as quick reference guides to appropriate practice.

Expert psychological evidence can, and often does, stand alone, of course, since clinical psychologists are independent practitioners who express within their own discipline. However, psychiatrists commonly need to understand the opinions of clinical psychologists and their foundations, and to be able to set those opinions within a range of sources of information contributing to an expression of their own opinions, so it is hoped that this chapter also serves as a ‘medical consumer’s guide’ to clinical psychological evidence.

Clinical psychology assessment process

Clinical psychology assessment involves evaluation of behavioural, emotional, personality and cognitive functioning, through the use of clinical interviews, administration of various standardised test batteries, and reviewing of the defendant’s available records. Clinical psychologists also then use psychological theories and knowledge in order to develop an understanding of the nature and aetiology of the individual’s psychological abnormality, and to offer a ‘formulation’ of their offending behaviour (see Chapter 6 on the relationship between ‘diagnosis’ and ‘formulation’). And, in so doing, they consider both evidence from ‘tests’ and ‘clinical’ assessment, looking for cross-validation – or its absence – in regard to likely validity.

Use of psychometric tests

Psychometric techniques represent science concerned with the knowledge and techniques of measuring psychological attributes, such as cognitive abilities, emotions, attitudes and personality features. Psychometric investigation is focused on the study of differences between people, usually comparing an individual with a ‘normal’ population. This is usually pursued by way of a questionnaire, or questions being presented to the examinee. Their responses are then compared to relevant ‘norm’ groups, in order to establish their level of functioning in the attributes measured against those norm groups.

Psychometric tests are only useful and appropriate to use if they possess good psychometric properties – that is, they are ‘reliable’ (free of measurement error) and ‘valid’ (measure what they supposed to measure). Notably, many psychological tests, particularly neuropsychological tests, are culturally biased, and such

tests are only valid if norms upon which they have been developed apply to the examinee. Therefore, a test needs to be culturally appropriate, and the normative sample that the test was developed upon needs to match the individual to be tested.

Hence, clinical psychologists are required to familiarise themselves with a test's appropriate application, and its limitations, before deciding whether it is appropriate to administer it to the individual being assessed. This is particularly important in 'high stakes' cases, where test results can have large implications for both justice and the defendant's life.

Assessment of personality and of clinical syndromes

Personality assessment

Personality traits are defined as 'enduring patterns of perceiving, relating to and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts'. When personality traits overall become maladaptive, and result in subjective distress and/or functional impairment, they are conceptualised medically as personality disorder(s). So, in terms of DSM-5 and ICD10, *personality disorder* is defined as 'ingrained, maladaptive patterns of cognition and behaviour, recognisable in adolescence or earlier continuing throughout most of adult life, although becoming less obvious in middle or old age'. And there are 'types' of personality disorder, in terms of which traits predominate. Within psychology, however, 'disorder' can also be defined more narrowly, in terms of 'the degree of variance' of an individual from the norm (see below).

There is a high prevalence of particular personality disorders among offenders. So clinical psychologists are often asked to assess a defendant's personality functioning, and to comment upon the presence – or absence – of a personality disorder, or problematic personality traits, and upon whether they relate to their offending.

Self-report personality measures

Self-report personality questionnaires offer a good starting point for assessing an individual's personality 'style', and whether they are 'disordered'. They extrapolate the individual's personality traits, and their possible psychological problems, from their responses, and then compare these with 'healthy' cohorts, in order then to determine whether they meet the criteria for a personality disorder.

The following self-report tests are among those most frequently used by clinical psychologists to assess personality functioning:

- Millon Clinical Multiaxial Inventory (MCMI-IV)
- Minnesota Multiphasic Personality Inventory (MMPI-2)
- Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF)
- Personality Assessment Inventory (PAI)

These tests are useful screening tools. However, all self-report measures can be affected by factors such as malingering, lack of insight and literacy problems, as well as inappropriate cultural norms. Therefore, it is not advisable to use them as 'stand-alone' assessment tools for diagnosing personality disorders –

although many of the instruments can, by the answers given, or by reference to other (for example, cognitive) tests administered, suggest either ‘validity’, or its absence.

Semi-structured interviews

Semi-structured interviews are considered to be the ‘gold standard’ in assessing personality. They include specific questions related to each diagnostic criterion, and therefore tend to be more thorough and objective than self-report questionnaires. However, the relative disadvantage of semi-structured interviews compared with self-report questionnaires is that the interview process, and scoring procedures, are time-consuming. And their use requires specialist training; although, of course, interpretation of self-report questionnaires also requires specialised knowledge.

The *International Personality Disorder Examination (IPDE)* is the most widely used and validated interview-based protocol for assessing personality disorders. It is a semi-structured diagnostic clinical interview designed to evaluate personality disorders according to the DSM-5 and the ICD10 classification systems. The interview contains questions relating to various personality disorder criteria, covering six aspects of functioning: work; self care; interpersonal relationships; affects; reality testing; and impulse control. It then provides dimensional scores: ‘negative’; ‘probable’; and ‘definite’ personality disorder.

The *Structured Clinical Interview for DSM-5 (SCID-5)* is another semi-structured diagnostic interview that provides categorical (present or absent) diagnosis, as well as dimensional information regarding the level of personality functioning.

The *Psychopathy Checklist – revised (PCL-R)* is widely used by clinical psychologists and psychiatrists to assess the presence of ‘psychopathy’, which shares many features with ‘antisocial personality disorders’ (ASPD) but which goes beyond the latter (whereby those exhibiting ‘psychopathy’ largely represent a relatively small subset of those with ASPD). It is also used as a risk assessment tool, since high scores are associated with higher levels of risk of reoffending. The PCL-R utilises a semi-structured interview plus a review of the individual’s history and available records. It assesses behavioural, affective and interpersonal features of psychopathy. The scores can be used both to define the presence, and degree, of disorder and to predict the individual’s level of risk of reoffending, plus the probability of successful rehabilitation.

Best practice in conducting personality assessment is to administer self-report questionnaires with inbuilt response style indices; conduct a semi-structured interview; and review all of the available records. Meanwhile it is important to keep in mind the cultural and ethnic background of the person being assessed, as factors arising from these can influence the individual’s beliefs about, for example, discipline, aggression and appropriate behaviour.

Assessment of affective disorders

Psychological evaluations should always include assessment of mood, since, aside from assessing for affective disorders per se, affective abnormalities – such as depression and anxiety – can interfere with the individual’s capacity to engage in the assessment process, affecting their performance on psychometric tests. Additionally, assessment of mood can assist in understanding some of the individual’s behaviour, including at the time of an alleged offence and during subsequent police interviews and court hearings.

The *Beck Anxiety Inventory (BAI)*, *Beck Depression Inventory (BDI-II)* and the *Hospital Anxiety Scale* are the most widely used and helpful instruments for detecting depression and anxiety around the time of the assessment. Additionally, personality assessment instruments such as *MCMI-IV*, *PAI*, and *MMPI-2-RF* all contain clinical subscales that measure affect.

Assessment of post-traumatic stress disorder (PTSD)

A large percentage of offenders have experienced either physical or psychological trauma, or both, in their histories; and in some individuals traumatised during childhood, there is a close relationship between the impact of their traumatic experiences and criminal behaviour. In addition, being traumatised – even for the first time – in adulthood can be associated with subsequent offending. Hence, some of the defendants referred for psychological and psychiatric evaluations may likely present with PTSD symptomatology.

Clinical psychologists employ various psychological tests, in combination with structured and semi-structured interviews, to ascertain the presence of PTSD. The *Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)* is considered to be the gold standard in PTSD assessment. It is a 30-item structured interview that is used to make a current, or lifetime, diagnosis of PTSD, and to assess PTSD symptoms experienced over the past week. The CAPS-5 assesses 20 PTSD symptoms, evaluating: the onset and duration of symptoms; subjective distress; the impact of symptoms upon social and occupational functioning; overall response validity; overall PTSD severity; and specifications for the dissociative subtype ('depersonalisation' and 'derealisation').

As regards 'making the diagnosis', however, the individual must, of course, come within the required diagnostic criteria of DSM-5 and/or ICD10.

Neuropsychological assessment

Neuropsychology is concerned with the relationship between behaviour, cognitive functioning and emotion, *and* the brain. It employs a range of standardised, scientifically validated assessment tools designed to measure various aspects of mainly cognitive functioning, and to determine the presence, and severity, of any dysfunction.

A comprehensive neuropsychological assessment covers various aspects of cognitive functioning, including intellectual functioning, memory, language abilities, visuospatial skills and executive functioning.

Assessment of premorbid intellectual functioning

Clinical psychologists are often asked to comment upon whether there has been deterioration of a defendant's cognitive functioning; that is, whether his/her current functioning is lower than it was prior to the onset of mental illness or acquired brain damage, arising, for example, from a head injury. This is difficult to extrapolate based upon the individual's current abilities. Therefore, premorbid functioning tests typically involve assessing the ability to read irregular words, a skill that is acquired early in an individual's development and that is minimally affected by brain injury or degeneration, or indeed by mental illness.

The *Test of Premorbid Functioning (TOPF)* is based upon a reading task that contains such irregular words. And the result for the individual can then be directly compared with a normative sample, as well as to the individual's measures of current cognitive functioning, in order to ascertain whether there has likely been any decline.

Assessment of current intellectual functioning

The *Wechsler Adult Intelligence Scale 4th edition (WAIS-IV)* is a stand-alone test battery specifically designed to assess an individual's current intellectual functioning. It offers a 'full-scale' IQ score relative to the normative sample. The WAIS-IV consists of 15 subtests (ten core and five supplemental) that measure different intellectual abilities. The test thereby provides four index scales: 'verbal comprehension'; 'perceptual reasoning'; 'working memory'; and 'processing speed'. And, although all of these contribute to the 'full scale' score, often it is the subtest scores that are of particular importance, including in a forensic context.

Clinical psychologists are frequently asked to assess a defendant's level of understanding of matters relevant to their legal situation, or to a given legal test definition, and to establish specifically whether s/he meets the criteria for 'learning disability'. The diagnosis of learning disability requires the individual to have low intellectual abilities (IQ score <70, where the average IQ = 100 for the population). However, they also have to demonstrate social and/or adaptive dysfunction, and an early onset of the difficulties, which have to be clearly evidenced; the condition is not diagnosed simply based upon an IQ score. In any event, given that there is an 'error range' attached to a given score (as to most psychometric tests), where the test results for an individual are close to the cut-off point of an IQ of 70, it has to be accepted that the likely valid score can, in fact, be anywhere between 66 and 74, in probability terms.

Memory assessment

Memory is one of the most fundamental cognitive functions, and many psychiatric and neurological disorders – such as schizophrenia, dementia, epilepsy and traumatic brain injury – are associated with memory disabilities. Additionally, some decline of memory functioning is a normal aspect of aging, so a formal memory assessment is often required in order to differentiate between pathological and normal age-related memory loss.

Apparent absence of memory for past events (amnesia) is a common focus of assessment for clinical psychologists, both in relation to court cases and in routine clinical work. There are robust psychometric tools for the measurement of memory functioning, as well as psychological 'models of mind' that can offer suggestions about the likely cause of apparent memory disability, or of amnesia claimed for a given period (through organic brain deficit or psychological factors).

The question of 'why' an apparent period of amnesia, or ongoing memory disability, is present is often an important question for the court. Clinical psychologists are often asked to determine both whether a claimed, or observed, memory loss is likely to be 'genuine' and whether it is organic or functional (psychogenic) in its origin.

The *Wechsler Memory Scale – Fourth Edition (WMS-IV)* is the most widely used memory assessment instrument that measures the individual's ability to learn and remember information presented both

verbally and visually. (See also below in regard to ‘feigning’ or ‘malingering’ of mental symptoms, including amnesia and memory disability.)

Executive functioning assessment

Executive functioning is an umbrella term that refers to higher order cognitive abilities such as planning, problem solving, working memory, inhibition, and mental flexibility. It is often referred to as ‘frontal lobe’ functioning, because these functions are largely sub-served by neuronal networks involving frontal lobe regions of the brain.

Executive functioning deficits – sometimes referred as ‘dysexecutive syndrome’ – are observed in a number of types of disorder, including diffuse traumatic brain injury, depression, bipolar disorder, paranoid schizophrenia and (non-organic) personality disorder.²³ Deficits in this domain of functioning can be associated with violence and other offending, as they reduce the ability to inhibit anger, and to utilise socially acceptable and adaptive coping mechanisms in response to internal or external stimuli.

A number of robust psychometric measures have been developed to assess different aspects of executive functioning. The most widely used tests are:

- Hayling and Brixton Tests
- Behavioural Assessment of Dysexecutive Syndrome (BADS)
- Stroop Neuropsychological Screening Test
- Reitan Trail Making Test

Malingering, feigning and deception

Malingering is defined as the intentional faking or exaggeration of symptoms for personal gain. *Feigning* refers to exaggerating or fabricating psychological symptoms, without any assumptions being made about its goals, if such are present.

Psychological and psychiatric assessments often rely upon self-report, which can easily be subject to distortion, and the forensic setting provides a variety of incentives for malingering and deception in respect of psychological problems. It is estimated that between five and 20 per cent of criminal defendants malingering or feign their reported symptoms. Therefore, clinical psychology and neuropsychology assessments should always include a formal assessment of malingering, and endeavour to ensure the validity of the defendant’s testimony.

Malingering and deception detection strategies

It has been proposed that feigning should be established first, and motivation for feigning, and the probability of malingering, second.

²³ Features of personality disorder are commonly caused by psychological factors; but change in personality, including resulting in disorder, can also be caused by acquired brain damage.

A number of tests, such as the *Structured Interview of Reported Symptoms-2 (SIRS-2)* and *Structured Inventory of Malingered Symptomatology (SIMS)* have been specifically designed to detect feigning of mental illness. The *Paulhus Deception Scale (PDS)* assesses two forms of socially desirable responding, namely *Self-Deceptive Enhancement (SDE)* and *Impression Management (IM)*. Additionally, personality assessment questionnaires, such as the *Minnesota Multiphasic Personality Inventory (MMPI-2)*, the *Millon Clinical Multiaxial Inventory (MCMI-IV)*, and the *Personality Assessment Inventory (PAI)*, all have built-in validity scales that detect feigning and ‘faking good’ profiles. However, it is important to note that, although extremely useful, none of the measures is 100 per cent valid. Also, although they provide information about possible feigning, they cannot be used to infer whether the process is intentional or unintentional and, therefore, amounts to malingering.

An expert opinion that an individual is likely malingering can have major consequences in legal settings. Therefore, malingering assessments should never rely solely upon a single measure or method but, rather, should incorporate data from clinical interviews, psychological tests and collateral sources, in order to give an opinion on the likely validity of the defendant’s presentation. Further, if the defendant has been assessed by more than one clinician (say, by a psychologist and a psychiatrist) then all of the data available should be used by each expert.

Malingering cognitive deficits and poor effort

Cognitive malingering refers to feigning a deficit, and doing so with insight towards an objective – such as pretending to be less intelligent or otherwise less cognitively able than one actually is. For example, a defendant might attempt to present with a learning disability or dementia by putting little effort into their responses, or by deliberately providing wrong answers. Therefore, neuropsychological assessments should always include a test of ‘effort’ in order to address the likely validity of the results obtained.

There are a number of ‘forced-choice’ symptom validity tests (having to choose one of two possible answers), such as the *Test Of Memory Malingering (ToMM)*, that are designed to assess whether the individual is putting in ‘optimal effort’ and whether the observed result is likely to be a true representation of their abilities. If the individual performs below the chance level (worse than you would obtain by flipping a coin), it is likely that he knew the correct answers and purposely provided incorrect answers.

Slick et al (1999) have proposed the following criteria for malingered neurocognitive dysfunction (MND): (a) presence of a substantial external incentive; (b) evidence from neuropsychological tests; (c) evidence from self-report; and (d) behaviours meeting necessary criteria from (b) or (c) that are not fully accounted for by likely valid psychiatric, neurological, or developmental factors. The diagnosis of ‘definite MND’ is made if there is evidence of a definite negative response bias, such as below-chance performance on one or more forced-choice symptom validity tests.

Other features suggestive of symptom exaggeration and malingering within a neuropsychological assessment are:

- Inconsistencies between neuropsychological domains (for example, impaired attention but normal memory)

- Inconsistencies between neuropsychological test scores and the suspected aetiology of any brain dysfunction (for example, normal IQ and memory scores in the context of alleged hypoxic brain injury)
- Inconsistencies between the neuropsychological test scores and the medical evidence regarding severity of injury (for example, low test scores more commonly associated with coma rather than with there having been no loss of consciousness)
- Inconsistencies between the neuropsychological test scores and behavioural presentation (for example, being able to offer autobiographical information while failing tests of recent and remote memory)

Interrogative suggestibility and compliance

Suggestibility

Police investigations regularly involve interviewing suspects, victims and witnesses; and the interview process is critical to the judicial process, including even rendering such evidence inadmissible if there is any irregularity in the manner of the interviews and/or abnormal vulnerability in the subject of the interviews that was not somehow sufficiently ameliorated in its impact.

It is estimated that between 15 and 20 per cent of people interviewed by the police are psychologically vulnerable, and that they are usually likely to be missed by any typical police screening process. This can result in unreliable testimonies and false, or at least rebutted, confessions.

Notably, there is a clear distinction to be made between ‘false confession’ and ‘rebutted confession’. A confession may later be rebutted by a defendant, and there may be clinical evidence that they are more likely than an ordinary person to be ‘suggestible’ (or ‘compliant’, see below) in the context of the confession having been made during police interviewing – but it cannot be said, of course, whether the original confession was ‘false’ or not.

Clinical psychologists are often asked to assess vulnerable adults and to comment upon their level of suggestibility. This can be of particular value in cases where an apparently vulnerable defendant was interviewed without the presence of ‘an appropriate adult’.²⁴

The *Gudjonsson Suggestibility Scale (GSS)* is the gold standard measure for assessing ‘interrogative suggestibility’, which is defined as ‘the extent to which, within a closed social interaction, people come to accept messages communicated during formal questioning, as the result of which their subsequent behavioural response is affected’. The scale has been validated cross-culturally and is widely used in forensic settings across the globe. It assesses two important factors within suggestibility: (1) the extent to which an individual can be misled by suggestive questions (‘yield’); and (2) how the individual responds to interrogative pressure (‘shift’). Although the scale was originally developed to identify people who

²⁴The term ‘appropriate adult’ is adopted in the context of English law, and the presence of such is required where the police had reasonable grounds to suspect, or ought to have suspected, that the interviewee was mentally vulnerable.

²⁵Clearly, an individual may express ‘suggestibility’ in more than one context, or in one context but not another. However, the GSS was developed to measure specifically ‘interrogative suggestibility’. The author of the research that underlay development of the GSS, though, has also indicated that other forms of suggestibility arising through interaction with others – for example, within a close relationship – may likely be ‘correlated’ with interrogative suggestibility (Source: personal communication with Nigel Eastman).

are susceptible to erroneous testimony within the interrogation scenario of police interviews, there are implications for their vulnerability to suggestion in other contexts.²⁵

Children and adults with intellectual disabilities tend to perform worse on the GSS, as they are likely to be more susceptible to trying to ‘make up for’ their disabilities (‘yield’) and to altering their answers under pressure (‘shift’). There is a large body of research evidence linking enhanced suggestibility to a range of mental conditions.

Compliance

Whereas a suggestible individual will exhibit an unreliable statement within interrogation by way of coming to believe the information that has been given to them covertly during an interview, compliance infers no such ‘false belief’. Rather, the individual is aware of ‘the truth’, or what s/he wishes to say, but gives into pressure to produce a statement that is against his own knowledge or belief. Therefore, compliance is the tendency to go along uncritically with requests made by others, largely in order to please others or to avoid conflict and confrontation – even though, privately, they might disagree with the others. It must be distinguished from ‘acquiescence’, which is compliance expressed in always responding ‘yes’.

The *Gudjonsson Compliance Scale (GCS)* is a self-report scale that identifies individuals who are susceptible to making a false confession under interrogative pressure. Relatedly, they may also be susceptible to being pressured into crime by peers and others.

The test is often used in combination with the GSS to identify whether or not an individual is vulnerable in more ways than one.

Giving opinions beyond suggestibility and/or compliance

It is important to emphasise that giving an opinion on whether a defendant exhibits ‘suggestibility’ or ‘compliance’ does not amount to offering an opinion that such a tendency ‘operated’ within a given interview (and, of course, even if it did, the confession given might still have not been false). Rather, in order to give an opinion on the latter question, it is necessary, in addition, to view either or both the transcript or video record of the actual interviews conducted, or to listen to a tape record of them, in order to see whether there is evidence that such ‘operation’ of suggestibility or compliance occurred. And this determines the need for both very detailed consideration of the interviews and then offering an opinion based upon both ‘formulation’ of the defendant’s likely functioning within such interrogation and detailed interpretation of the questions and answers.

Psychology and legal issues

There are multiple legal contexts within which one or more of the areas of psychological functioning that have been described in this chapter can be relevant to legal tests and process. Therefore, psychological evidence relevant to specific legal issues and tests is considered within the relevant sections of the Handbook dealing with these (see Chapters 10–14).



CHAPTER 6

Diagnosis and formulation^{26, 27}

²⁶ Much of this chapter is written with lawyers in mind, who may benefit from description of the basics of mental disorder diagnosis, although some doctors may find it helpful as 'revision', in particular in taking clinical assessment beyond diagnosis into formulation.

²⁷ Much of the text is taken from Eastman N (2010) *Psychiatric Assessment of Defendants in Murder Trials: Background Paper*, for Judicial Studies Board for England and Wales.

The purposes of *diagnosis* are several, including predicting prognosis, guiding therapy, assisting communication between professionals and, perhaps at its best, offering ‘pathological causation’ of the condition. It, therefore, allows for the ‘categorisation’ of mental disorders in terms of internationally recognised criteria, based upon identification of patterns of signs and symptoms observed in populations of individuals, but then applied to individuals. *Formulation* goes beyond diagnosis, through offering an ‘understanding’ of an individual’s mental functioning and behaviour, in terms of not only the mental state signs and symptoms that are recognised within his/her diagnosis, but also in terms of ‘psychological mechanisms’ and ‘mental patterns’ operating in him/her. Diagnosis will usually be the starting point from which much that is important clinically and legally will flow, including in terms of some likely relevance to legal questions at issue. However, formulation will offer a ‘narrative’ of mental functioning that can be applied within any legal narrative of offending that may be suggested.

Many psychiatric diagnoses are based upon the presence of signs and symptoms and do not rest upon establishing aetiology or pathology. In other words, they are perhaps best viewed as ‘syndromes’ rather than ‘diseases’. Therefore, whereas dementia, for example, has a clear and observable pathological cause, in terms of the structure and function of the brain, many conditions presenting with mental signs and symptoms have (as yet) no known organic cause. This does not mean that they are not valid ‘diagnoses’, in that the functional impairment that can accompany an observed syndrome may be profound; but it does mean that diagnosis depends upon pattern recognition – that is, recognition of patterns of mental signs and symptoms, and consequent impairments of functioning.

It is important, in the foregoing context, to note that by no means all aetiology of mental disorder amounts – or might amount potentially – to abnormality of brain function, or body function affecting the brain. Rather, there is a valid concept of ‘psychopathology’; that is, disorder of mental functioning arising from psychological factors (for example, childhood upbringing or experiences).

The fact that many psychiatric diagnoses amount to syndromes of signs and symptoms – rather as in the form of ‘Venn circles’, with the possibility of overlapping circles and dual, or even multiple, diagnosis – can give rise to ‘easy legal criticism’ and claims of ‘invalidity’. However, a serious mental condition that lacks a known organic pathological cause can be as, or more, disabling than a minor degree of brain dysfunction, arising either from brain abnormality per se or from the impact upon brain functioning of a bodily condition.

Legal questioning of the validity of some psychiatric diagnoses can go hand in hand with questioning based upon the criticism that making a diagnosis is based solely upon what the patient has told the doctor.

We deal with these latter issues in some detail below.

Diagnostic groups²⁸

There is insufficient space here to describe in any detail what is a very large number of diagnostic categories, all presenting with ‘mental signs and/or symptoms’. However, in summary terms, diagnoses can be grouped as follows.

²⁸ Much of the text is taken from Eastman N (2010) *Psychiatric Assessment of Defendants in Murder Trials: Background Paper*, for Judicial Studies Board for England and Wales.

Psychiatry is, of course, part of medicine. It is also closely allied specifically to neurology in relation to some of the disorders with which it deals. This is illustrated by the primary distinction between mental disorders that are clearly ‘organic’ in origin and those that are (what is known as) ‘functional’. The two types of disorder are both ‘psychiatric’ by virtue of their presentation with symptoms and signs that are mental in nature, and this emphasises that there can be uncertainty sometimes over whether symptoms and evident signs arise from an organic or functional cause. Hence, sometimes the ‘differential diagnosis’ of a case may range across both organic and functional conditions. A simple example is the experiencing of ‘hallucinations’ (sensory perception in the absence of a causally relevant external stimulus). This can arise either from abnormal electrical activity of a particular part of the brain, as an epileptic phenomenon, or from a functional psychotic illness (such as schizophrenia). The importance of emphasising the ‘crossover’ between the two types of condition in the particular context of assessment for criminal legal purposes is that it is always necessary to have available the full range of assessment techniques and investigations that apply to both organic and functional conditions.

Organic conditions causing mental symptoms and signs include congenital brain abnormality, plus brain disease, damage or degeneration; or brain malfunction arising from bodily abnormality, such as biochemical abnormality.

Functional mental disorders are themselves divided into ‘*psychotic disorders*’ (where the sufferer experiences delusions and/or hallucinations, and fails to ‘reality test’ his/her beliefs and perceptions against available evidence, and/or where there may be disconnection of emotion from thought, and ‘*neurotic disorders*’ (where the distortion of thinking and/or emotion is qualitatively less distant from normal experiences, but can still be very significant – both clinically and potentially legally – and, indeed, may be more severe in its impact upon functioning than some psychotic conditions).

Psychotic and neurotic conditions can be termed as being within the broad category ‘*mental illness*’. An additional category is that of ‘*personality disorder*’. This is a ‘developmental’ disorder that can be traced back at least to late childhood or very early adulthood, and which is distinguished from mental illness by virtue of the abnormality being defined against a population of ‘normal’ people, rather than (in the case of illness) against their own previous normality (even though the illness may then become permanent). Assessment of personality disorders, and their interpretation within a legal context or their application to criminal legal questions, is inherently more problematic than is the case with mental illness. It requires both particular skills (sometimes including assessment by both a psychiatrist and a clinical psychologist) and experience in dealing with the particular complexities and ambiguities of legal interpretation in relation to criminal ‘responsibility’ that occur with such disorders.

Finally, ‘*learning disability*’ (previously termed ‘mental handicap’, or sometimes ‘mental retardation’²⁹) amounts to genetic, congenital or developmental disorder that involves significant or profound disability of intellectual, social and sometimes emotional functioning. Again, this is not an ‘illness’, because the person is/has been permanently as they are. As with personality disorder, this is how they are – indeed, who they are.

²⁹The term ‘mental retardation’ is still commonly used in international jurisprudence, even some national law, in the context, for example, of prohibition of imposition of the death penalty upon defendants thus diagnosed.

Diagnostic classification

Diagnosis should be based upon one of the two recognised classification systems: The World Health Organisation's *International Classification of Diseases, 10th Edition (ICD10)* or the American Psychiatric Association's *Diagnostic and Statistical Manual, 5th Edition (DSM-5)*. Both of these manuals are periodically revised and a new ICD edition, ICD11, is expected soon.

Diagnostic manuals serve to enhance both inter-rater reliability and communication between clinicians. However, they are not to be used in place of clinical judgment and are not '*the Bibles of psychiatrists*' as is sometimes suggested, or thought by lawyers. Indeed, the DSM-5 itself cautions that it should not be used 'as a cook book', reflecting concern that, because of its 'criteria checklist' approach, it is at risk of this – particularly in a legal context, where its form lends itself to lay analysis and unpicking. Therefore, it is crucial that the legal process does not drag a doctor into apparent over-reliance on the classification systems at the expense of clinical judgment. That said, if a diagnosis is made, despite not sufficient criteria being satisfied in strict DSM terms, or in the more descriptive terms of ICD, then it should still be expressed in terms of one of those classificatory systems, being explicit about which system is being used.

Validity and classification

Concern about the validity of given diagnoses *per se* (as opposed to the validity of diagnosis in an individual, as discussed above, and in Chapter 4) in different cultures is mitigated to some extent by the international consensus methods used in agreeing criteria in ICD10. There may, however, be issues relating to the validity of specific instruments (if used diagnostically) in different cultures. If instruments are translated, then the *content* should be relevant to that culture. Similarly the words if translated should have the same meaning. And, if tools are used that require self-rating based upon reading, then rates of literacy in different cultures should be borne in mind. There is also a need to consider whether a tool will be interpreted similarly in different languages and cultures, and whether it measures the same construct (see also Chapter 5 concerning psychological testing).

Most clinicians do not have a diagnostic manual in front of them when considering the diagnosis of a patient they have assessed. They use their clinical experience and interviewing skills in order to establish the nature, duration and severity of symptoms, and then make the diagnosis based upon this. Some structured interviewing tools exist for making diagnoses that are predominantly research tools, but they are sometimes used in clinical and medicolegal settings (for example, *SCAN* or *SCID-II*). Training is required if these tools are to be used. Also, of course, doctors should not comment upon the tools applied and interpreted by other experts, unless they have been trained to administer those instruments themselves (it is not unknown for a medical expert to purport to interpret the results of psychometric tests administered and reported by a clinical psychologist, yet not to have either the general training in clinical psychology, or the specific training in the instruments concerned).

The following is a very brief summary of some significant difference between the two classification systems:

ICD10 (Chapter V)	DSM-5
Classification system	Diagnostic nomenclature
Prose description	Specific numbers of criteria required
Designed for collection of data, and includes diagnoses of questionable validity	Only contains categories with diagnostic validity
Diagnosis almost exclusively based upon symptoms	Almost all diagnoses include an impairment in functioning criterion

Communication of diagnostic information within reports should include:

The diagnosis that is made

- The manual that has been used in reaching the diagnosis
- The symptoms that are present, and the evidence for these symptoms
- Consideration of alternative diagnoses, and why these have been rejected

Consideration of the likely validity of the diagnosis made, including by reference to the possibility of feigning or malingering of symptoms and why this is not considered to be likely (if this is the case)

Where DSM-5 is used, it is helpful to list in the report those criteria satisfied, and those not satisfied (both for clarity in expression to the court and since it is easier, when giving oral evidence, to be able to rehearse your consideration of diagnostic criteria without ‘having to look at the book’ while in the witness box). However, as already described, it should be made plain that both manuals offer an ‘aid to clinical diagnosis’ but are not a substitute for it.

Diagnosis, behaviour and offence

There should be careful separation of diagnosis from behaviour, or criminal offending. Therefore, even where a term is used both in description of a mental condition and a type of offence, it is clearly not the case, for example, that someone who has been convicted of paedophilia is ‘a paedophile’ medically. So, again for example, child sex-offender might fulfill diagnostic criteria for paedophilia but neither the behaviour nor the conviction makes the diagnosis, and the two should not be confused. Similarly, arson is not a clinical diagnosis. In summary, there is no diagnosis that is directly equivalent to any legal finding, and it is improper to convert an offence into a condition. Yet again, for example, someone who has committed arson may, legally, be ‘an arsonist’, but they do not exhibit a mental condition called ‘arsonism’.

The same applies to legal defences. So, for example, psychosis might lead to consideration, and a finding, of insanity; but psychosis does not automatically indicate that insanity will apply. This represents the problem of ‘translation’ between psychiatry and law, or ‘mapping of a mental state description onto a legal test’, described in Chapter 2 – wherein law defines some ‘moral’ notion, to which medicine’s offering

of a 'positive' description of a defendant's functioning may be relevant, but which is not 'identical' to it. Only very rarely does the law 'incorporate' a medical notion into itself as a legal test or criterion³⁰, with, in common law jurisdictions, the diagnosis of 'learning disability' (in law, 'mental retardation') coming close to directly determining illegality, by way of 'mental retardation' rendering illegal the imposition of the death penalty, or execution *per se*.

Rather, what is usually crucial in regard to the relationship between 'diagnosis' and 'offence' is causation. And, even here, it is not diagnosis *per se* that will suggest causation but, rather, the detailed abnormalities of the defendant's mental state coincidental with commission of the *actus*, albeit arising from, or within, the diagnosis (see further below).

Diagnosing intellectual or learning disability in capital cases

Intellectual disability is synonymous with learning disability or mental retardation and can be a classification of great importance in capital cases (see Chapter 12).

In terms of the relationship of medical and legal terms, learning disability is unusual, in that establishing the diagnosis can be 'equivalent' to ultimate legal determination since, for example, classification of someone as 'mentally retarded' should automatically excuse them from imposition of a capital sentence (see footnote above). However, a clinical diagnosis will not always be legally accepted. Notably, in the United States, legal definitions of mental retardation differ between states.

Since the diagnosis is of significant importance, it should be approached carefully. In DSM-5 there are three broad criteria that need to be satisfied: (1) sub-average general intelligence; (2) limitations in adaptive functioning; and (3) onset before the age of 18 years. General intelligence is measured in different ways and expressed in the form of an intelligence quotient (IQ) (see Chapter 5).

The testing of IQ should take into account the individual's background, their language, their education and any specific impairments (again, see Chapter 5). Any assessment of IQ incorporates some possibility of error, so while an IQ score of 70 is the conventional cut-off for intellectual disability, this cannot be said to be absolutely precise. There is an advantage in criteria being precise, as in giving IQ scores, with respect to reliability – but there is a danger that the precise IQ may be over-emphasised in its significance. For example, a defendant with an IQ of 71 but with significant impairment in adaptive functioning might still fulfill the criteria for intellectual disability; and, with this example, in any event an IQ score is subject, statistically, to potential inaccuracy of 4 points in either direction.

Adaptive functioning is a complex notion, and for most prisoners the expectations of their functioning are limited. It is considered in different domains: communication; self-care; home living; social/interpersonal skills; use of community resources; self-direction; functional academic skills; work; leisure; health and safety. And assessment of some of these can be difficult to establish in prison, and it may be particularly important to gain collateral information about function in the community.

³⁰ Section 44 of the Norwegian Criminal Code offers an example, in that it provides that 'psychosis' and 'insanity' are one and the same thing, such that there is no separation of the clinical notion from the moral one.

Formulation

Diagnosis is almost inevitably followed by formulation, both in clinical practice and medicolegal practice. Diagnosis provides a reliable and succinct way to communicate the category within which a person falls, in terms of the nature of their disorder, but it may be limited when it comes to inferring an understanding of the individual, or of their offending. By contrast, formulation is more hypothetical and incorporates the underlying causes, precipitants and maintaining factors associated with a person's mental disorder and behaviour; and, essentially, it amounts to offering an 'understanding' of the individual's mental functioning and of its relationship with his offending (see also Chapter 7 in respect of using formulation in the context of risk assessment).

In many types of serious criminal case, including capital cases, it is likely that the formulation will represent a 'causal bridge' between the diagnosis of the disorder *and* the offending behaviour. Therefore, even where, for example, a defendant was experiencing 'command hallucinations' to harm the victim, within a diagnosis of schizophrenia, at the time of an assault, there may well be a fuller 'narrative' of the assault available than the simple assumption of direct and sole causation. Indeed, the notion of 'causation' within explanation of an offence is not 'scientific' causation but causation implied by narrative – often based upon historical information about the defendant's mental state when he has offended and when not (see Chapter 7, and below, concerning 'risk assessment', which represents 'the mirror image' of causation of actual offending).

The focus might be on developing a formulation in relation to episodes of mental ill health, risky or dangerous behaviour, or another specific aspect of a person's life. And, as just suggested, such formulation of a case can be applied not only to elucidate how past offences came to be committed but also to offer a foundation for risk assessment and risk management for the future. As such, in capital cases it can be relevant both at trial to the partial defence of 'diminished responsibility' and, if that fails and the defendant is convicted of murder, to the assessment of his/her risk of future serious offending, in terms of how it is applicable to the legal test for imposition of the discretionary death penalty of them being 'beyond reformation'.

In summary, in forensic psychiatric practice, diagnosis rarely – if ever – provides a complete explanation of behaviour, and formulation introduces necessary complexity and understanding, in the form of 'narrative'. The methods by which the two are achieved are distinct, as are their validity bases – although any notion that 'narrative' is inferior to diagnosis and should be excluded from legal consideration is rendered obviously false by recognition that much legal process is based upon narrative, often conflicting narratives. And the role of expert psychiatric and psychological evidence is to offer a 'melding' of narratives; that is, to suggest ways in which a psychiatric or psychological narrative fits into a given legal narrative, or into more than one conflicting narratives. Put simply, the court should ask itself the question: 'Does the defendant's mental state at the time of the alleged offence, and the proffered formulation of the offence, offer an enhanced legal understanding of the offence?'

The detail of formulation

The important factors in considering formulation relating to offending will include:

- Evidence of past association of particular symptoms with offending (including absence of symptoms when offending); presence of other factors when offending (for example, alcohol or drugs, or particular relationships), within recognition of a range of specific risks factors for future violence

Plus:

- Developmental factors, including early abuse or neglect
- Genetic vulnerability to mental disorder
- Loss of caregivers in early life
- Childhood antisocial behaviour
- Disrupted or insecure attachments
- Maladaptive nature of relationships in adult life
- Antisocial attitudes supporting offending
- Attitudes in support of commission of the alleged/index offence

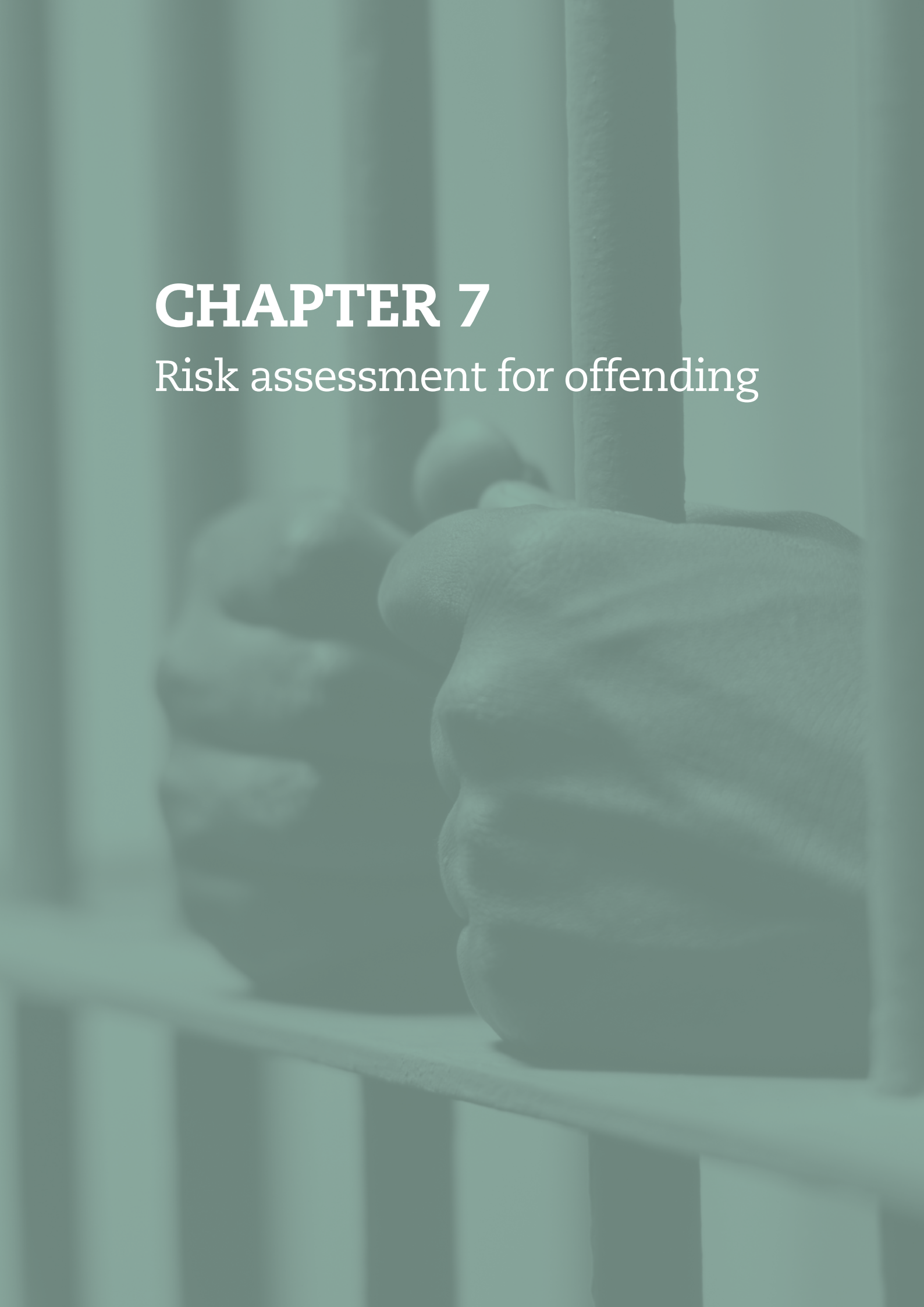
The gathering of necessary detailed information, and a thorough psychiatric assessment, allow for a formulation to be developed. Different ‘models’ of formulation exist among mental health professionals. The *biopsychosocial model* includes consideration of biological, psychological and social factors that predispose, precipitate or perpetuate the anticipated problem (for example, violent behaviour). Other different psychological or psychotherapeutic models incorporate their own methods of formulation, including *cognitive-behavioural* (where thoughts, feelings and behaviours are explored and linked), and *psychodynamic* (where psychological defences, drives and object relations might be considered). Formulation of violent behaviour will also properly include reference not only to risk factors, but also to protective factors; that is, factors that reduce the risk of future offending.

Conclusion

Clinical assessment conducted in a forensic context must be ‘uncontaminated’ in its process by that context. Yet it must be conducted, and then reported upon, looking towards the specific legal questions to which its results will be directed. Finessing this combination is both technically and ethically challenging, but achieving it is essential.

CHAPTER 7

Risk assessment for offending



Within psychiatry and psychology, risk assessment – and consequent risk management – is essentially a clinical, and not legal, activity. It is a tool of ‘safe management’ of patients, either in secure inpatient or community care. However, clearly the courts are often interested in expert opinion concerning the risk of further offending on the part of a defendant; including, in capital cases, in terms of whether the convicted defendant is likely to be ‘beyond reformation’ (see Chapter 12). Also, as already described, risk assessment is best expressed within ‘formulation’, so that it offers the ‘mirror image’ of causation of offending, relevant also to some mental condition defences. This said, it is important to be aware of the potential ethical implications of offering expert evidence directly applicable to decisions about punishment, by contrast with offering evidence at earlier stages of the criminal justice process (see below).

The purpose of this chapter is to offer the reader, clinician or lawyer, a guide to clinical risk assessment where the assessment will be used in legal decision-making, be it in relation to sentence imposition or release. The chapter should be read in conjunction with other relevant chapters of the Handbook, since risk assessment utilises a wide variety of techniques of forensic assessment and proposed treatment, as well as information about the relationship generally between mental disorder and offending.

The chapter does not deal comprehensively with risk assessment, management and treatment, since this Handbook approaches all topics in relation to specifically offering assistance to courts and parole boards, rather than being a guide designed for a clinical setting. Similarly, therefore, it does not deal with the risk of suicide but focuses on the risk of violence to others.

Risk assessment is ethically problematic

Risk assessment is fraught with ethical problems for the clinician – particularly so where the purpose is solely to assist the justice process, and even more so when it is applied to whether there should be imposition of the discretionary death penalty (see Chapter 12). In summary terms, the ethical problems are in terms of:

- Any technique chosen will have within it built-in value judgements, including judgements about what are acceptable levels of reliability and validity of assessment
- If a clinician takes on the task of risk assessment for legal purposes, it is crucially important for him to be clear about the boundaries of his role, and to be firm in communicating this to others
- The technical, and values based, limitations of risk assessment must also be made plain to the court
- And these points are of particular importance where the assessment is to be used in relation to imposition of the discretionary death penalty, by way of application to the established legal criterion of ‘beyond reformation’ (see Chapter 12)

Concerning the relevance of value judgements impinging upon risk assessment, albeit in the context of risk assessment within clinical practice and treating patients, the following perhaps captures the problem. Therefore, ‘ultimately, what we are really saying when we decide to detain a patient in a clinical context on grounds of risk is “the probability of this man, in his current circumstances and with his current symptoms, causing a serious harm...appears unacceptably high” (and) implicit within this formulation is the trade-off between preventing a feared harm by the patient, and harming the patient’s interests by

acting...(and) because harms cannot be predicted accurately, there will always be false positives; that is, situations in which action is taken against patients who would not have caused harm on that occasion – as well as false negatives, in which action is not taken and harm results’.³¹ And, quite clearly, where the role of risk assessment is in relation to punishment – and especially punishment by way of death – this concern has added significance.

Some clinicians eschew risk assessment in capital cases, on the basis that to do so potentially contravenes the ethical principle of ‘non-maleficence’; others accept that they owe a duty to society in accordance with the competing principle of ‘justice’.³² Of course, similar concerns might logically apply in relation to medical involvement within any stage of the justice process where imposition of the death penalty could be the ultimate outcome. However, giving evidence in relation to fitness to plead, or a possible mental condition defence to the charge, represents involvement less ‘proximate’ to the stage that directly addresses what sentence should be imposed once the defendant has been convicted.³³

Definition

‘Risk assessment’ is a term that is widely used, and often misused. However, it is a more appropriate term than ‘dangerousness’, which falsely implies that all risk of future violence resides in factors intrinsic to the individual concerned, rather than in interaction between factors in the individual and his environment. And this is of particular importance where risk assessment is used in penal sentencing, since the temptation for the courts is to concentrate on characteristics of the defendant to be punished rather than upon their – much more difficult to address – potential interactions with factors extrinsic to them. Indeed, in relation to the discretionary death penalty, one of the two established sentencing criteria for imposition is that the defendant is ‘beyond reformation’ (see Chapter 12).

Crucially, ‘zero risk’ is unachievable, and neither does ‘definite risk’ exist. Rather, ‘risk prediction’ amounts to a statement of the probability of a type of event occurring within a given time period. Such risk prediction is necessarily based upon an assessment that may take one of a number of forms; it will also likely have been conducted without benefiting from all the possible information that might be available.

The purpose of this chapter is, therefore, to offer guidance concerning ways of extracting good quality information potentially relevant to assessing the risk of future violence by an individual, so as to provide ‘a’ (not ‘the only possible’) risk assessment. Clearly, this implies that there could – perhaps, should – be more than one risk assessment conducted on a defendant, using different techniques; and that a ‘risk judgement’ then be taken based upon the various ‘perspectives on his risk’ thereby described.

An overview of risk assessment

In medical practice, assessment of an individual patient is based upon a combination of clinical assessment of the individual, originating in known symptoms and signs of particular diseases, and, if fortunate, in

³¹ *Oxford Handbook of Forensic Psychiatry*, pp II.118.

³² See Beauchamp T L and Childress J F (2013) *Principles of Biomedical Ethics*, Seventh Edition, Oxford University Press.

³³ See Eastman N L G and McNerny T, Psychiatrists and the Death Penalty: ethical principles and analogies, *Journal of Forensic Psychiatry*, Vol. 8, No. 3, December 1997, pp 583 – 601.

known pathological mechanisms. This is against a background of knowledge about the occurrence of particular conditions in members of the population carrying particular characteristics (the ‘epidemiology’ of any given condition).

Different approaches are applicable to prediction of violent behaviour in an individual with a known psychiatric diagnosis. Epidemiological data about the characteristics of populations of individuals with, for example, schizophrenia, are relevant in a background fashion, but are in no way sufficient for valid and reliable prediction to be achieved concerning an individual. Ultimately, the best basis of prediction lies in ‘knowledge of that individual, and his past pattern of violence, *and* associated variables’, than in knowledge of ‘people like him’.

Therefore, although risk assessment does utilise epidemiological data (often referred to as ‘actuarial data’) concerning the association of particular diagnoses or mental symptoms with violence, the focus of risk assessment for violence is the individual and their own ‘biography of violence’. This is expressed in terms of factors intrinsic to them *and* in terms of what circumstances – within them and within their environment – have been associated with violence they have previously exhibited, expressed in terms of ‘narratives’ of their past violent episodes, plus ‘formulation’ (with the aim of achieving an ‘understanding’ of such past episodes). Thus, for example, there is epidemiological evidence of only a very limited association between ‘command hallucinations’, within psychosis, and violent behaviour. Yet, in an individual defendant, there may be much evidence, in *his* history, of such an association.

Knowing what you are doing

In order to arrive at a ‘good’ risk assessment, the clinician must be clear and confident about what they ‘should’ be doing – in the same way that a clinical assessment such as a mental state examination, or an IQ assessment, has a clear set of parameters that guide the clinician. It is, therefore, important for there to be clear guidance and boundaries concerning the assessment of risk.

Everything is possible, but what is the probability of an outcome?

At its core, any risk assessment is commentary upon a likely outcome, or of number of outcomes. It is the *probability*, not the *possibility*, of a given event occurring that is described. It is *possible* for anyone to act violently, but it is more probable, for example, in someone who: has a history of violence (past behaviour); is impulsive (by personality); is interested in/rewarded by violence (by personality); has a history of gross interpersonal problems (past behaviour); and who often becomes intoxicated with alcohol or drugs (affecting concurrent mental state).

Different types of assessment approach/data gathering

The history of the science or art of risk assessment can be divided into stages, in terms of ‘generations’ of risk prediction methods, in that the discipline has moved through several periods of development, as follows:

- First generation: *unstructured clinicians' judgements*, exhibiting low accuracy because of problems stemming from a lack of consistency and agreement of method, resulting in low inter-rater reliability; difficulty with the replication of the process by which any single judgement was reached; and a lack of empirical evidence concerning immediate or long-term validity
- Second generation: *actuarial methods*, with assessors reaching judgements based upon statistical information according to set rules. Criticisms include focusing the assessment on a limited number of factors that are merely capable of measurement in populations; the exclusion of factors with face predictive validity; minimising of the importance of case specific, idiosyncratic factors; and the exclusion of the role and input of clinical judgement and expertise, thereby paralysing or undermining clinicians.
- Third generation: a move directly to risk management and prevention, in conjunction with identifying conditions under which risk will increase or decrease – this being criticised because it does not allow the identification of specific probability or absolute likelihood estimates of individual future risk with any reasonable degree of scientific or professional certainty
- Fourth generation: *structured clinical judgement*, which includes evidence based practice (taking the best evidence from the research, as already achieved in the case of the development of actuarial tools) and practice-based evidence (using clinical judgement, plus the appropriate use of actuarial information, to present a clear and globally-informed opinion)

Actuarial assessment

Although risk assessment resides ultimately in the individual, it is still important to identify factors that are known to be relevant in populations of individuals.

Statistical research has sought to identify, through statistical mapping, the factors that are related to the risk of violence. In general, such an approach appears to offer greater reliability and validity than unstructured clinical assessment of risk in the individual. However, the number and type of variables that are measurable in populations is extremely limited, and are almost entirely variables that are 'historical', so actuarial techniques are of very little use in terms of estimating, and reducing risk, in the individual.

Also, most studies conducted in order to gain data are not 'community' studies but studies of skewed populations, such as prisoners (within which the rate of mental disorder is measured) or mental hospital patients (within which the rate of violence is measured).

Any clinician utilising such data in the form of actuarial risk assessments must make themselves aware of the base rates for offending behaviours on which the scales are based, whether samples are from specific groups or more general populations, and whether the scale is used for only one type of behaviour.

The following risk assessments are examples of actuarial tools:

- *Violence Risk Appraisal Guide (VRAG)*
12 items are scored leading to a categorisation (low/medium/high) of reoffending likelihood

- *Risk Matrix 2000 (RM2000)*
Items are scored leading to a categorisation (low/medium/high/very high) of sexual reoffending likelihood
- *Psychopathy Checklist-Revised (PCL-R)* (see chapter 5)
High scores are a strong predictor of recidivism and violence in offenders and psychiatric individuals

The core problem, however, in the use of all psychometric tools of this nature lies in the necessary extrapolation from group risk prediction to prediction of risk in an individual. First, it has been established that the margin of error for the group is smaller than for an individual. Second, any statement arising from aggregate data as applied to an individual cannot be of the form ‘D has an X per cent chance of offending in Y fashion within T time’. Rather, the statement must read ‘D is a member of a group of individuals who together possess an X per cent chance of offending in Y fashion within T time’. It is these difficulties that have contributed to the drive to develop ‘the fourth generation’ of risk assessment, within which actuarial tools are used not as definitive predictors of risk but rather as information that can inform clinical opinion.

Structured professional judgement (SPJ)

This approach seeks to draw upon the strengths of actuarial assessment alongside the gathering and interpretation of data from clinical observations, skills and experience, all then directed at the making of a professional judgement that is clearly structured and may therefore robustly hold up against scrutiny. The embodiment of this approach is an instrument now widely used and respected within forensic psychiatry, the *Historical, Clinical, Risk Management-20 (HCR-20)*. A similar tool developed for assessing sexual violence risk is the *Risk for Sexual Violence Protocol (RSVP)*.

The Historical Clinical Risk Management (HCR-20v3)

The HCR-20^{v3} is a 20-item checklist designed to assess the risk for future violence, which is defined as ‘actual, attempted, or threatened harm to a person or persons’. It captures past, present and future factors, and determines the presence or absence of each of the 20 risk factors, according to three levels of certainty (‘absent’, ‘possibly present’, ‘definitely present’). The 20 items are divided into three scales: *historical* (history of problems with: violence; other antisocial behaviour; relationships; employment; substance use; major mental disorder; psychotic disorder; major mood disorder; other major mental disorders; personality disorder; traumatic experiences; violent attitudes; and treatment or supervision response); *clinical* (recent problems with: insight; violent ideation or intent; symptoms of major mental disorder; instability; and treatment or supervision response); and *risk management* (future problems with professional services; living situation; personal support; treatment or supervision response; compliance; and stress or coping). The latter scale represents essentially a ‘personalised template’ of risk factors, which can then be used directly within ‘risk management’ – wherein the more intractable or unmanageable are the risk factors, the higher is the ‘risk’.

If a structured clinical judgement tool is used, then prior training is required specifically in relation to that tool.

A structured approach

The following are suggestions for inclusion in a structured approach to risk assessment, but are not a guide to using a specific structured clinical judgement tool:

History of violence

- What is the total history of episodes of physical violence?
- Were they planned or impulsive, and what were the trigger factors?
- What was the nature of any relationship with the victim?
- Was there use of weapons in any offending?
- Is there evidence of parallel behaviours that may reflect pro-violence attitudes, such as bullying, coercion, and other purposefully unkind behaviour (since pro-offending attitudes and distorted thinking can be a maintaining factor for future violence)?
- Has there been any cruelty to animals, or/as well as to peers?
- Have there been 'boundary breaches'; such as cruelty to, or attacks upon, those in authority (teachers, police officers, parents)?
- What has been the level of historical ubiquity of violence; for example, has there been violence only to strangers, family, in relationships, children, or to multiple categories of victim?
- Has there been, or is there, any fascination with weapons?
- Were there any violence or antisocial attitudes evident in childhood?

Psychiatric factors

- What is the nature of the person's psychiatric disorder?
- Does the person tend only to commit acts of violence when floridly psychotic, or when suffering an episode of depression, for instance?
- Are there relevant individual symptoms (for example, 'command hallucinations') that have been associated with past violence?
- What cognitive factors might reasonably be associated, in the individual, with intellectual impairment?
- Does the person have insight into their mental health problems?

Substance misuse

- What is the history of substance misuse?
- Which drugs?
- What is the frequency and quantity of each drug use?
- Is there an association of drug use with offending?
- Has offending occurred during intoxication or withdrawal?
- Has there been offending related to funding drug habits?
- Are drugs used to self-medicate symptoms of mental illness?
- Have there been any long-term sequelae of drug use?

Head injury

- Has there been any history of head injury?
- How severe was the head injury?
- Has there been any personality change since the head injury?

- Have there been any long-term sequelae of any head injury?
- What was the temporal relationship between the occurrence of the head injury and the onset of violent behaviour?

Psychological factors

- Does the person hold attitudes supportive of violence?
- Does the person tend to hold grudges, resentments or grievances?
- Is there evidence of personality traits indicating a risk of violence?
- Is there evidence of sadism?
- Is there lack of empathy?
- Is there affective instability?
- Is there impulsivity?
- What level of insight does the person have into his or her own propensity for violence?

Contextual factors

- What circumstances were associated with previous violent acts?
- What was the nature of their relationships with others at the time of violent acts?
- How did the behaviour of other people contribute to, or trigger acts of violence?
- Who were their peers at the time of acts of violence?
- Did violence occur in the context of domestic dispute?
- Had the person experienced a recent loss?
- What was the person's access to weapons at the time of acts of violence?

This approach to risk factors both organises information and leads to 'formulation', wherein the information can be brought together (see below).

Actuarial versus clinical methods

There are risks in 'actuarial only' assessments, as the use of an inappropriate measure may result in either 'false positives' or 'false negatives'.

The crucial shortcoming of actuarial prediction is that, no matter how good the psychometric properties of a measure – and no matter how good may be the measure's sensitivity (ability to identify 'true positives'), or its specificity (ability to avoid 'false negatives') – with low-frequency, high-impact behaviours such as severe violence, there will always tend to be over-estimation of risk, leading to identification of high numbers of 'false positives'. Therefore, use of actuarial measures alone will tend to result in 'over-sentencing' individuals, where sentence is based upon risk assessment.

By contrast, risk assessment based upon an individual's own 'biography of violence' is open to bias originating in the clinical assessor, in terms of what variables s/he decides to include; what methods s/he employs; whether s/he includes both 'risk factors' and 'protective factors' (factors countervailing 'risk factors'); what thresholds they set; and so on. The best compromise is therefore likely to be a tool that incorporates both methods, such as the *HCR-20* or *RSVP*.

However, it is important to emphasise that, even using the HCR-20 or RSVP, the assessment is only as good as the data that is collected and ‘put into it’. And this serves to emphasise, in turn, that even adequate risk assessment is extremely time-consuming. Therefore, ‘quick and dirty’ risk assessment, by contrast, is highly unethical, and obviously so in the context of the potential for implementation of the death penalty.

Perspectives on risk of violence and risk judgement

A ‘comprehensive’ approach to risk assessment is likely to be best approached through adopting more than one method of ‘assessment’ of risk, so as to offer a ‘risk judgement’ based upon several methods, or ‘perspectives on risk’. This will allow – indeed, require – application of both actuarial and clinical methods, the latter likely to be most reliable when it is a ‘structured’ (rather than individual, idiosyncratic) clinical risk assessment. It will also allow for explicit consideration of the impact of different ‘values approaches’ as they are represented by the various assessment methods used.

Static and dynamic risk

Static factors do still offer the greatest predictive power, as they concentrate largely on historical factors known to be associated with offending in populations, or in the individual. The best predictor of future behaviour is still past behaviour – but as the factors and behaviour have occurred within an individual’s behavioural biography. However, static factors are always additive, usually negative, often tend improperly to out-weigh other data, and by definition are not open to change, by way of treatment or management.

Dynamic factors allow for inclusion of more detailed information in considering whether a particular individual is likely to offend, in what circumstances, and with what trigger factors. They also allow for consideration of protective factors, as well as helping to identify treatment or management targets which, in turn, offer the opportunity to assess risk change over time, and strategies for risk management.

Structured clinical judgment tools incorporate both static and dynamic factors.

Protective factors

Structured clinical judgement tools are deemed effective in identifying current, and in predicting future, risk of violence. However, they tend to overlook another important factor in risk prediction – the protective factors. These are factors that, when present, tend to *reduce* the individual’s risk and make them *less* unsafe to others. Factors known to reduce risk include stable and protective relationships; adherence to treatment; and stable accommodation and finances. Recently, new tools such as the *Structured Assessment of Protective Factors for Violence risk (SAPROF)* have been designed specifically to assess the protective factors in violence assessment. The SAPROF is an SPJ that was developed to identify protective factors that can compensate for the existing risk factors. It can be used with other SPJ tools, such as HCR-20^{v3}, or with actuarial tools. It consists of 17 protective factors that are organised into three scales: ‘internal’; ‘motivational’; and ‘external’.

‘Formulation’ of violent behaviour

‘Formulation’ is an approach to understanding behaviour (including violence) based upon the hypothesis that all behaviour has a ‘psychological function’. Hence, it is by way of analysis of the reasons for the behaviour that the behaviour can best be understood, and thereby may be open to change.

A formulation, therefore, offers not just functional analysis of one episode of behaviour but a comprehensive description of the likely genesis of the individual’s violent behaviour more generally, as well as inferring a road map for intervention.

All formulations may be treated as hypotheses that can be tested against the observed data.

Essentially, a formulation is a narrative; that is, a story of how this individual has come, and comes, to exhibit violent behaviour, including how they first came to do so.

In a formulation, the available information can be organised into the ‘5P’ factors:

- Problem risk behaviour
- Predisposing (or vulnerability) factors
 - Poor mental health
 - Impaired intellectual function
- Precipitating (or ‘trigger’) factors
 - Intoxication
 - Anger
 - Frustration
 - Loss
- Perpetuating (or maintaining) factors
 - Pro-offending attitudes
 - Presence of delinquent peers
 - Poor coping skills
- Protective factors
 - Presence of a supportive partner or family
 - Motivation to change

A ‘good formulation’ will also offer the advantage of drawing on information from clinical interview and psychometric testing, as well as collateral information, such as the reports of independent observers or family/friend informants.

A strength of the formulation approach is that it brings together all contextual factors into a ‘narrative’, allowing for a description of behaviour in context – thereby describing the circumstances, including sequences of events, of its occurrence, plus what led to it, and so inferring how repetition might be predicted.

A formulation approach, therefore, has substantial predictive power, in being able to ‘explain’ how (in what circumstances) a piece of behaviour may be repeated. This, in turn, may allow the identification of clear and practical risk management and treatment targets, as well as facilitating transparency with

the individual about what professionals think they need to do to change, in order to reduce their risk to others. Additionally, a formulation can be used to communicate clearly the risk information about the individual and to make recommendations arising from its implications.

A formulation can also be expressed, including with the subject, by presentation in diagram form. An example of such a formulation diagram is shown in Figure 1. The factors mentioned in the boxes are not exhaustive but offer some examples of the types of factors that might contribute to the offending behaviour of an individual.

Conclusion

There is no perfect risk assessment. Indeed, there is, rather, a range of potential risk assessments applicable to a defendant, utilising a range of techniques, each with its own intrinsic value judgements embedded within it. And it is hoped that this chapter has offered a guide to the use of both actuarial measures and the interpretation of clinical data, and to the values implicit in any given technique.

Finally, the following ‘risk assessment checklist’ may assist individuals carrying out, or interpreting, any given risk assessment:

- It is necessary to assess the defendant directly, and to ensure that you are able to gain from the interview his/her attitudes and beliefs
- It is also advisable not to over-emphasise what s/he has said to you at the expense of ‘factual’ – including actuarial – data and data in their own biography
- Obtain as much collateral information as possible; and do not be afraid to go back and ask for more if you are not clear
- Establish a formulation, so that you are able to understand, and communicate, an understanding of the offence and the offender
- Do not simply record an estimation of risk in a single word: ‘low’, ‘medium’ or ‘high’; such terms are meaningless, and both practically and ethically dangerous
- Be specific about the nature of the risk you are considering and the context: *‘The risk of serious violence if released into the community is’*, rather than *‘The risk is ...’*
- Choose risk assessment tools with reference to their psychometric properties, and be aware of their strengths and limitations. In this way, you can draw on the evidence base properly in order to guide your professional judgement
- Suggest a treatment or management plan that might address the offending behaviour, and thereby reduce risk
- Be explicit in your evidence both about the technical nature of the methods you have used and their intrinsic value judgements

Finally, remain constantly aware that risk assessment methods have been developed within psychiatry and psychology for clinical purposes, in the context of applying treatment and management techniques to the individual during an ongoing treatment regime. They are not designed for use as a ‘snapshot’ for a sentencing hearing but, rather, as a ‘cine film’ to aid clinical management. Yet, a judge is still likely to ask: ‘What is the risk today as I sentence?’

Figure 1

<p><i>Vulnerability factors</i></p> <ul style="list-style-type: none"> • <i>Mental health</i> • <i>IQ/Neurological difficulties</i> • <i>Poor self-esteem/image</i> • <i>Locus of control</i> • <i>Personality/early life insult</i> • <i>Attachment style</i> • <i>Modelling of problem behaviour</i> 	<p><i>Precipitants/triggers</i></p> <ul style="list-style-type: none"> • <i>Mood</i> • <i>Stress</i> • <i>Anger (context?)</i> • <i>Disinhibition</i> • <i>Loss</i> • <i>Financial difficulties</i>
<p><i>Problem(s)</i></p> <p>Insert description of offending behaviour and other significant issues here</p>	
<p><i>Maintaining factors</i></p> <ul style="list-style-type: none"> • Implicit theories • Attitudes or cognitions supporting offending • Minimisation/denial • Maladaptive coping • Low self-esteem • Problem behaviour is reinforcing/meeting a need • Support system collusive • Mental health • Immature defence mechanisms • Lack of support • Deviant peers 	<p><i>Protective factors</i></p> <ul style="list-style-type: none"> • Insight into difficulties/coping • Previous engagement in therapy • Psychologically minded • High IQ • High self-esteem • Willing to engage in treatment • Internal locus of control • High self-efficacy • Mature defence mechanisms • Functional coping strategy • Optimistic attributional style • Accepts there is a problem • Good social support
<p><i>Add psychometric information</i></p>	
<p><i>Stable dynamic factors</i></p> <p>For example:</p> <ul style="list-style-type: none"> • Antisocial peers and current social models • Family/partner/friends collude with excusing offending behaviour • Intimacy deficits/lack of supportive family/partner • Pro-offending attitudes • Self-regulation, that is, impulsivity, poor problem-solving skills, easily frustrated, hostility 	<p><i>Acute dynamic factors</i></p> <p>For example</p> <ul style="list-style-type: none"> • Opportunities to offend (for example, access to victims, weapons and so on) • Emotional collapse/crisis in personal life • Collapse of social support/end of relationship • Hostility being voiced • Substance misuse • Conflict with others • Distorted attitudes
<p><i>Recommendations/ Future Risk</i></p>	

CHAPTER 8

Report writing³⁴

³⁴For more detailed advice on report writing, the reader is referred to the *Oxford Handbook of Forensic Psychiatry*.

Aims

A psychiatric report should not simply describe the subject's diagnosis, if there is such. It should describe all relevant, sometimes complex, psychiatric issues, including diagnosis and the effects of diagnosis, and also formulation. It should then explain the relevance of these descriptions in providing answers to the legal questions that you have been told are at issue. Beyond this, however, it should also tell the story of the defendant's life in a way that is structured, comprehensive and comprehensible.

There must be sufficient detailing of the information that has been relied upon in reaching conclusions, so that the reader can see the rationale for the opinion expressed; that is, the report must be reasoned. And it should be prepared and written with non-medical readers in mind. Almost invariably, the audience in the first instance will be either the defendant's legal representatives or those prosecuting, then the other lawyers, and finally the judge –that is, intelligent lay persons, but with little knowledge of medicine and psychiatry. The report will also form the basis of your oral evidence to the jury, or judge, and so should be written with this clearly in mind.

Of course, the report is designed to assist the court and not the instructing party. It will, therefore, need to express and demonstrate 'the three "I"s' of being an expert witness: 'impartiality', 'independence' and 'integrity'.

General advice

Structuring the report is key to achieving the foregoing aims. First, data and opinion should not occur in the same sections of the report. The data used, and relied upon, should be clearly laid out, and separately laid out from the opinion expressed on that information. Further, the court needs to be able to identify where each piece of information used in the report came from, since the source may infer perception of its levels of reliability and validity, and as some information may be in dispute and subject to determination by the court (where this is known by the author, it may be necessary to express 'conditional' opinions, in terms of 'if the court decides X is correct, then my opinion is A, if Y then B'). Also, while short reports are to be preferred (and are more likely to be read), they need to contain sufficient information to justify the opinion expressed, plus reference to information which goes against the author's opinion, with an explanation of how he comes to his view. Breaking the report down into sections, therefore, allows for categorisation of data, separate from opinion, and of one source of information against another. It will also assist others to read the report efficiently.

Some authors prefer to number paragraphs. This has advantages – notably, that specific passages can be easily referred to in court, also making it easier for the author of the report to avoid appearing muddled when under pressure. However, numbered paragraphs can make a report clunky and lifeless, and distract from the flow of the narrative – so it is often wise to draft the text first and then add numbering at the end.

Remember that long sentences are difficult to read. A psychiatric report is not a work of literature, and clarity is the overriding goal. Simple and short sentences are to be preferred. Also, any technical terms used should be immediately explained (a bracket with explanation placed after first use of the term is convenient). Finally, ambiguity is a plague to be avoided at all costs; the aim should be that any single sentence is open to only one interpretation.

Most authors will dictate their report, and it is often helpful to do this as soon after seeing the defendant as possible – although it is foolish to dictate prior to having read all relevant information. Proof-reading is vital, even though it can be tiresome; lawyers use language in a precise fashion, and will cross-examine you in terms of the precise words you used, so loose language is a major hostage to fortune.

Structure of the report

It will be helpful to readers of the report if you adopt a ‘system’ of headings, sub-headings and sub-sub-headings that directly reflects the structure of the report and separation of information from opinion, and of different sources of information.

Introduction

Firstly, describe who you are and how you have to write the report. These matters need to be clarified early in any report, including who asked you to prepare the report and what questions you have been asked to answer.

The process by which you compiled the report should be clearly presented, including how you gathered the facts on which you rely. Primarily, this will be by way of an interview with the defendant, so describe where and when this took place, who was present and how long the interview(s) lasted. If there was any aspect of the interview setting that might have adversely influenced the information you gained, make this clear. The defendant’s acceptance of the terms under which the interview was conducted should also be recorded. Either here, or in the body of your account of the interviews with the defendant, describe what ‘other evidence’ you were aware of at the time of the interviews, and so could put to the defendant; and mention what emerged afterwards. The documents seen should also be listed. If there is information that you would have wished to see that would, or could, have been relevant to your clinical opinion, but either was not available or you were not permitted to see (for example, evidence deemed legally to be inadmissible or covered by legal privilege), you should also refer to this; lack of significant information is relevant to how robust is the opinion you are able to express.

You know why you are writing the report, as do the lawyers who read it. But once a written report is produced, it becomes a document that forms part of an individual’s legal files, and potentially also medical records, with the possibility for it to be cited in future legal processes, or to be sought by those subsequently treating the defendant. Therefore, it might be read by others who are unfamiliar with the circumstances under which the report was initially prepared. Therefore, placing the assessment in context by providing a brief background history, in order to orientate readers at the start of the report, is important.

Small font should be avoided, and sufficient space should be left at the margins for lawyers and judges to place notations.

Interview

The interview that was conducted with the defendant must be clearly recorded. There are a variety of ways of doing this. One is to provide a near-verbatim transcript of the interview. This can give a good sense of the flow of the interview, as well as perhaps clues as to, for example, the presence of formal thought disorder, the preoccupations of the defendant and how he responded to challenge. Alternatively, the defendant's account can be summarised and rearranged to fit the structure preferred by the author. However, whichever approach is adopted, it is important to quote verbatim comments by the defendant that could be of major legal relevance or of particular importance clinically. Other information can be quoted in the third person.

Whatever method, or combination of methods, is chosen, it is important to make clear what the defendant volunteered and what information was elicited by way of direct questioning.

Writing in terms of 'Mr A said ...' or 'Mr A told me...' makes it clear that it is his account that is being reported – albeit this approach runs the risk of making the report stilted and difficult to read. However, the use of direct quotes from an interview can bring the individual to life for the reader, and can allow his/her voice to emerge. Usually a mixture of methods of reporting what was said will be optimal.

Recording the questions asked, with the defendant's responses, can provide a real insight into how s/he reacted within the interview. However, recording both question and answer accurately is difficult during an interview, unless the interviewer is skilled at some form of shorthand; and what a defendant says sometimes makes little sense on paper in the absence of body language and intonation (although this can be described alongside the quote). This said, again it may be particularly important to record verbatim questions and answers relating to legally or clinically important matters.

The patient's emotional or bodily responses should be noted – for example, the observation that they became tearful when talking about their dead dog, but not their dying mother, might be of significance. Again, there is a danger that this extra information will hinder the flow of the account, so one solution is to place the emotional or bodily reactions of the defendant in brackets as you go, next to the point of the interview where each was witnessed, and then to include such information within your 'mental state examination'.

Mental state examination

The length of the mental state examination that is recorded varies between authors, from a few lines to many paragraphs. Some include only positive findings. However, there is also a need to report important negatives too; for example the absence of psychotic signs. This said, it might not be necessary, for instance, to list every typical schizophrenic sign that is not present. It is only the absence of signs that one might have suspected could have been present that should be noted. Where questions about symptoms were put that might be relevant to the validity of the account of the defendant – for example, questions about symptoms that would *not* be expected in disorders under likely consideration – these should be included.

The detail in which the cognitive examination is recorded will vary from case to case. In most, it will probably suffice to report that there were no gross abnormalities, and to give some indication of the

defendant's general level of intelligence. Where cognition is at issue, the account will be detailed, based upon a range of 'bedside' cognitive tests. Any such findings can then be referred across to any detailed cognitive assessment that might have been conducted, usually by a clinical neuropsychologist.

Information from other sources

Where medical or psychological investigations have been pursued other than by the reporting doctor, the findings and their expert interpretation, relevant to the opinion expressed by the doctor, should be summarised. This is necessary even where the results are in medical records available to the lawyers or court, or where they are in reports written for the court. In regard to the latter, any report arising from prosecution instruction will automatically be made available to the court. However, a report commissioned by the defence does not have to be used; and if the defence decides not to disclose it, this can cause technical and ethical difficulties for an expert who has already seen it and considers its contents to be of medical relevance. He will have to decide whether or not the findings can honestly be ignored in coming to a medical opinion and, if not, then a head-on clash between the medical and legal paradigms is exposed – and this will present the doctor with a profound ethical dilemma.

The author needs to bear in mind that the court will be aware of the other information that he has seen – specifically, prosecution witness statements, police interviews, defence interviews, and other expert reports. Why, then, bother to include anything at all from these documents? There are two main reasons. First, the importance of 'showing your working' – the court needs to see the building blocks upon which your opinion is founded, as well as to be made aware that you have taken account of legal information that goes either for or against your opinion. Second, if asked to give oral evidence perhaps several months after seeing the defendant, it is far quicker and easier to review the other evidence that you thought relevant at the time you produced the report by reading your report rather than by having to re-read the prosecution bundle or detailed and lengthy medical records. That is, the 'architecture' – indeed, 'underpinnings' – of your opinion will not only be immediately evident to others, it will also be clear to you.

Nonetheless, it is likely that the court will not thank the author that includes pages of additional information without any rationale for it being rehearsed. Extract only those elements of the prosecution witness statements, for example, that were relevant to you reaching your view on the defendant's mental state at the time of the offence, or at some other relevant time.

As regards prior medical records, it can be difficult to summarise these. However, alongside other reports, they will contain additional data of possible relevance to your own opinion, and relevant extracts must either be rehearsed verbatim or summarised. It is the data that is crucial, rather the prior diagnoses made, although the latter may also be relevant. Obvious examples include accounts of a defendant's mental state on receipt on remand in prison, or leading up to the alleged offence.

The author needs to be alive to the possible suggestion of 'selective editing', and by doing so altering the meaning of the records.

Indeed, a crucial point is that there must not be editing either of which sources of information are rehearsed or of which parts of a given source of information are rehearsed, that could give rise to bias – or the appearance of bias – in the expression of your opinion.

Opinion

Reports are produced in order to inform in relation to specific legal questions posed, including in terms of ‘psycholegal mapping’ (see Chapter 2).

There is much advantage in initially summarising and formulating the case from a psychiatric viewpoint; that is, providing an opinion on the ‘psychiatric’ (as distinct from legal) issues in the case, including allowing the court to see the author’s ‘workings’ – particularly how he arrived at his view of the defendant’s current mental condition, and also mental state – on a particular occasion.

A subsequent section of the opinion can then deal with ‘legal implications’; that is, not to express a view on any legal ‘ultimate issue’ but describe how the defendant’s mental state on a particular occasion can reasonably be seen to ‘map onto’ any relevant legal test (again see Chapter 2). The ‘particular occasion’ may be some time in the past, for example, at the time of commission of the *actus reus* if the matter at issue is a mental condition defence. It may also be currently, if what is at issue, for example, is the defendant’s mental condition in regard to sentencing, including to death, or their capacity to be executed.

Where any reliance is placed upon other reports available to the court arising, for example, from a clinical psychologist, the expert’s clinical opinion should be adopted and melded into your own diagnostic or formulation opinion. And where there are conflicting opinions from another clinical discipline, they each should be acknowledged in ‘conditional’ terms in respect of their impact upon your own opinion.

It is important, here, to emphasise that it is erroneous to take the position that it is not possible to give an opinion upon a defendant’s likely mental state at some time in the past, for example, when s/ he committed the *actus reus*. The courts depend upon expert opinion as best it can be given in regard to a defendant’s state on commission of an alleged offence; and retrospective reconstruction of a likely mental state is entirely possible and valid. What is not valid, or ethical, is to offer a reconstruction without making clear upon what information it is based, including both medical and legal; how reliable your view is likely to be; and how different information, or a different interpretation of any information, would alter your reconstruction.

As already advised, any medical terminology necessarily used should be explained in lay terms, conveniently in brackets after first reference to the term, or by way of a glossary provided at the end of the report if multiple terms have to be used.

It is expected by the courts that experts will draw not only on their training and experience in reaching their opinion, but also sometimes from research findings. Any such relevant findings should be included, with papers attached if necessary.

Similarly, diagnoses made should be buttressed by attachment of a copy of the diagnosis as it appears in either DSM-5 or ICD10 (see also below).

Expression of diagnosis

Diagnoses should be reached through using the DSM-5 or ICD10 criteria. However, neither should serve as a checklist; sometimes legal representatives will attempt to ‘tick off’ symptoms of a disorder that

are present or absent. Both systems operate properly as guidance and should not be seen as substitutes for clinical judgement

In certain reports – for example, reports that are prepared pre-trial – some basic facts may not have been established. In addition, facts may, within a trial, be in dispute. And different sets of ‘facts’ might well lead to different medical conclusions, or to different strengths of medical opinion. So, as already indicated, the good expert will give an opinion expressed ‘conditional on court findings of fact’ terms. He must not adopt any view on matters of fact open to court determination (see also below).

Possible alternative opinions

Any potentially opposing view is important to present, even if there is no report in the papers that poses it, and so are the reasons why you do not hold it – for example, why you think a defendant is not malingering and actually suffers from schizophrenia (if you do not, others will). Showing that you have considered other viewpoints is evidence of being balanced and fair-minded; and conclusions that are reasoned are far more likely to be respected by the court and lawyers for both sides. Crucially, however, you should have considered all potential opinions in detail before you came to your conclusions – requiring yourself to include in the report all opinions you considered will ensure that your own thinking is robust.

Medical limits

It is not for experts to usurp the functions of the court. Offering an opinion on guilt, or on sentence – ‘the ultimate issue’ – is clearly inappropriate. However, some would argue that it is also wrong to give an opinion on, for example, whether a defendant meets the legal test for insanity, as this is also the ultimate issue for the court to determine, and may depend upon detailed legal interpretation of the test. The expert can describe the defendant’s likely mental state at the relevant time, and how this might be seen to ‘map onto’ the legal test, depending upon interpretation of the test, but fall short of saying that it does, or does not. Or he may write that whether it does, or in what manner, depends upon either or both legal interpretation of the test and/or factual findings by the court; that is, to give ‘conditional’ opinions.

Declaration

Reports should conclude with a statement of truth – in regard to matters directly within the expert’s knowledge as described in the report – and independence. Model forms of declaration are contained, for example, within the practice directions for courts within UK.

Suggested report structure

The following is only one way of writing in terms of the advice given above, but may be of use to the reader:

- Cover page
- Basic details, such as name of client, date of birth, summary of criminal charges
- Name and address of instructing party
- Purpose of assessment and instructions

- Detail of interviews, including dates of appointments, where seen, and total amount of time seen
- List of all other sources of information, in detail (if not in an Appendix)
- Details of information obtained from interview with the defendant
- Mental state examination
- Details of information from other sources, other interviews, medical records, other records
- Extracts from legal papers relevant to opinion expressed
- Description of any tests applied, including by others
- Information from other reports
- Psychiatric opinion expressed in medical terms, including diagnosis and formulation
- Legal implications, including the relevance of the psychiatric opinion to the legal issues raised
- Summary of opinion
- Declaration of truth and independence
- Appendices, including of raw data if appropriate, plus or minus full list of documents seen (if not listed in body of the report)
- Brief curriculum vitae, including description of professional status, qualifications and affiliations; also details of clinical and medicolegal experience and areas of claimed expertise

Disclosure

The completed report is likely to be the property of the third party who requested the report (usually the instructing party), and so you will not be permitted to disclose the report without their permission, unless there is a significant risk of death or serious harm to others arising from non-disclosure, or if there is another overriding public interest in its disclosure for the administration of justice. Reports commissioned by the prosecution are automatically made available to the defence and court; those commissioned by the defence can be 'not used' and, therefore, suppressed.

Changing and adding to reports

Reports should not be changed or amended if requested unless:

- Information should be excluded because it is subject to legal privilege
- Information has no relevance to any medical opinion (whether the one you hold or another conflicting opinion) or to mapping of that opinion onto a legal test

Addendum reports may be requested for enhanced clarity; expansion of particular points; to consider new evidence; or to take account of others' reports – for example, as submitted by 'the other side'.

Where there are disputed opinions, the court will often ask that there be a 'meeting of experts', with production then of a 'joint statement', the purpose of which will be to elucidate what the areas of disagreement are, and the bases for such disagreement. The statement should be short, and is not an opportunity for an expert to rehearse again why he believes his opinion to be the correct one; rather, the report of each expert 'lies behind' expression of his disagreement with the other expert as summarised within the joint statement.

Some important issues of which to be aware

- Be acutely aware of distinctions between differing legal and medical concepts of mental disorder (see Chapter 2)
- Establish what you have been told, or know, are the relevant legal tests to be applied, so as to avoid inadvertently addressing legal issues by careless use of medical language
- Do not go beyond your instructions, in terms of the legal questions to which you apply your clinical opinion, unless this has been agreed with the instructing lawyer. It is not for an expert to determine what are the legal questions in play
- Be particularly careful in the reporting of any risk assessment you have constructed, the techniques of which are designed for clinical purposes of treatment and risk management, and not for determining decisions on punishment (see Chapter 7)
- If there is no diagnosed mental disorder, consider very carefully whether you should provide an opinion at all
- Never recommend punishment; and consider carefully your ethical position on the provision of expert opinion where the use to which it will be put is punishment
- It is unlikely that mental disorder can ever be said to have ‘caused’ an offence, so take care in describing associations between mental disorder and behavior to ensure that they are expressed cautiously and reasonably, and in terms of ‘narrative’ (see Chapters 3, 7 and 11)



CHAPTER 9

Giving evidence in court ³⁵

³⁵ For more detailed advice on appearing in court, the reader is referred to the *Oxford Handbook of Forensic Psychiatry*.

If a doctor prepares a written report for court proceedings then there is an obligation on him to attend any subsequent court hearing if requested to do so, whether by the court or by a legal representative in the case. This is, potentially, a daunting prospect, and careful preparation will be needed.

This chapter offers advice concerning how to prepare to give oral evidence in court, and the process of giving evidence.

Timing

Court hearings are usually, although not always, planned weeks or sometimes months in advance. Dates are difficult to change once fixed, and so it is important that, after a written report is prepared, the doctor communicates dates that they cannot attend court, especially holiday dates, to the legal representatives who have instructed them. If the court chooses to go ahead regardless and sit on a day when you have said you cannot attend, then there are firm grounds to try to refuse. However, in the end, a witness summons can be issued to compel a doctor, like any other witness, to attend; but, at the very least, if proper notice has been given by the doctor that he is unavailable, expenses will need to be paid, even if this involves a return air fare from a holiday resort.

In the UK, the Criminal Justice Council Experts Protocol (June 2005) makes it clear that those instructing experts have an obligation to take all reasonable steps to ascertain the availability of them before trial dates are fixed, and keep experts updated with the timetable of a hearing.

Preparation

Check, and double check, the practical arrangements for the day you are due to attend court – for example, the address of the court and the time of the hearing.

Giving expert evidence should not be the first time you have ever attended a court. If you have never had the opportunity to shadow another expert, then it should at least be possible to sit in the public gallery and watch proceedings. By doing so, you can gain some familiarity with the layout of the court, the ‘roles that people play’ during a hearing and – perhaps most importantly – the atmosphere, tone and discourse of a court hearing. If possible, it is far better to go with a colleague who is due to give evidence – preferably an experienced colleague – and to observe expert evidence being given, and then to discuss it with him afterwards.

Giving evidence for the first time should be avoided if the case is a capital case; that is, do not accept instructions in a capital case without already having substantial previous experience of giving evidence in other types of major and contested trial – ideally, in homicide trials.

Your written report is the basis of your oral evidence, and should have been written in the knowledge that every word and phrase written will be open to close scrutiny and cross-examination. Hence, good oral evidence relies upon provision of a good report. Indeed, sometimes the quality of your report will dictate whether you need to go to court at all; the expression of a clear and reasoned opinion, which takes into account all the material you have been presented with, and which adequately addresses any opposing

view, is likely to reduce the chances of having to give oral evidence. However, in some cases attendance at court will still be required, particularly if more than one expert has been instructed and the experts have arrived at differing conclusions, either clinically or in terms of expression of the relevance of any clinical findings to the legal questions at hand.

The provision of a good written report should determine that the process of giving oral evidence will be a far less challenging experience than otherwise would have been the case.

During the preparation of a written report, the expert is likely to have read and drawn upon a large volume of written material, so including a summary of the relevant parts of this in the written report (see Chapter 8) will obviate the need to go laboriously through the material again before you attend court (although you may still wish to ensure that you ‘know the bundles’).

The contemporaneous handwritten notes from the interviews conducted with the subject to produce the report need to be kept securely and brought to court on the day of the hearing, in case any party wishes to read and/or to question you about this material.

A key to feeling confident in court is having a sound understanding of the interface between psychiatry and law, both in general and specifically in regard to the case at hand, including as expressed in your own report and the reports of others.

An expert is almost always permitted to refer to his report and to his notes while giving evidence. Mark up your report, and the reports of other experts, so that you can quickly find important passages, and can recall what else you may wish to emphasise. In complex cases, it may assist to make your own evidential notes, perhaps in the form of a ‘mind map’; this can not only help you piece together the connections between the different items of evidence you have used, or disregarded, but can also help you in thinking through how best to explain your conclusions – and, importantly, what those who do not agree with you are likely to see as the weak points in your opinion.

Often, especially in complex cases, it is helpful to both lawyer and doctor to meet before the hearing in order to go through the evidence to be given. Although this might be ‘on the steps of the court’, in a serious or complex case it should be through a conference with counsel – and it certainly must be so in a capital case. Such a meeting will give the doctor the opportunity to highlight to the lawyer aspects of their evidence that they believe are especially important, and for them both to anticipate challenges to the doctor’s opinion. Most likely the lawyer concerned will have little knowledge of psychiatry – certainly much less than the expert witness – and without guidance they may misunderstand a part of a report or not foresee what, to the expert, might be an obvious challenge. A good barrister will anticipate cross-examination points and rehearse them with the doctor in conference.

Perhaps unfairly, it is important for an expert entering a courtroom to give a good first impression. Dress formally, ‘one stage more formally than you would do at work’ is a helpful rule of thumb. Conservative clothes should be preferred.

Process

General advice

- Speak slowly and clearly; if you speak too fast you will more likely confuse yourself, use too many words, and so open up more avenues for challenge – and, in any event, you will be asked to slow down
- As far as possible, simplify your opinion, especially in front of a jury
- Use concrete metaphors in order to get over abstract concepts
- Avoid the use of jargon, or if you have to use it, simplify and explain it
- If you are asked a question implying a dichotomous choice of answers then use ‘yes, but...’ as a response; if you are challenged that, by doing so, you are being a ‘self re-examining’ witness then resort to the judge and argue, if true, that to give a simple ‘yes or no’ reply will have the effect of misleading the court

Before the hearing itself

In the UK, the timing for the hearing of criminal cases is often not finalised until the preceding afternoon. Each court has a List Office, which can provide details, and listing sheets are printed and displayed typically in the main reception area of each court.

Airport-style security is in operation at most courts, including metal detectors and rub-down searches. Certain items, such as dictaphones, are sometimes prohibited. Mobile phones are usually allowed, although should be switched off when in the courtroom itself.

Courts are typically busy places. If you do not know who you are looking for, they can be hard to find – especially as, at least in the UK, many people will be wearing identical wigs. If you cannot locate a lawyer you need to find, ask the court usher, who will be dressed in a black gown and who will typically wander in and out of court. Alternatively, have a call put out from reception.

Check with the lawyer whether you may sit in court to hear other evidence be given (although ordinary witnesses are not permitted to sit in court before they give their evidence, the same does not usually apply to expert witnesses, since it may be necessary for an expert witness to hear the evidence of another expert, the defendant or other witnesses).

Check also the words to use to address the judge; this varies according to the type of court, and seniority of the judge. (As a last resort, listen to what term the lawyers are using.)

On entering, if the court is sitting, bow slightly in the direction of the judge, and then take a seat; if you have been invited to do so, sit behind the lawyers for ‘your side’.

You will be ‘called’ to give evidence almost invariably by the lawyer who has asked you to prepare the report (rarely, where your opinion assists only ‘the other side’, you may be ‘given over’ to that side and called by them). While nerves are to be expected, it is important to attempt to portray a confident demeanour, initially while walking from your seat to the witness box. Once there, you will be asked to take a religious oath or make the affirmation. This is a good point at which to ‘get the measure of the hall’, in public speaking terms; in order to get your speed and volume of speech right, and to get used to hearing the

sound of your own voice. Stand, even when invited to sit; it is easier to appear to speak with authority from a standing rather than a sitting position.

The process of giving evidence is divided into three parts: examination in chief, cross-examination and re-examination.

Examination in chief

The purpose of giving evidence is to help the judge and jury reach the correct conclusion in a case, not to help the legal representatives who requested your attendance at court; also, questions asked by counsel are asked always ‘for the court’, even though they may sound partisan. Therefore, stand with your feet facing the judge or jury (the latter in a criminal trial, the former in an appeal); this helps give the impression that you are talking directly to those who, in the end, have to reach a decision based upon the evidence that they hear. The process of giving evidence does not amount to a conversation with a barrister merely observed by others. It is also easier to concentrate if you do not look at the person asking a question; however rude it may feel not to look at the questioner, it is not, and will not be perceived to be so by the court.

Some courtrooms will have poor acoustics, so it is important to speak loudly and clearly. Also judges will often take detailed handwritten notes of the evidence given; and if you speak too fast you will be told to slow down. Try to speak at a rate that ‘follows the judge’s pen’.

The examination in chief, which is conducted by the legal representative who instructed you to prepare your written report, cannot include leading questions, and will typically start with the expert being invited to describe their experience and qualifications.

The judge will have seen your report, but the jury will not. You will likely be asked to speak to, and explain, different aspects of your report. Simply reading out aloud what you have written is likely to appear clumsy, and runs the risk of losing the attention of the jury. Summarising aspects of the report is what is required.

Giving oral evidence is an exercise in communication and can be thought of as akin to teaching, since the straightforward aim is to allow the jury – people who are very unlikely to have any specialist knowledge of psychiatry – to understand your opinion.

Jargon should be avoided or, if unavoidable – for example, because another expert has used it – should be explained in simple language.

Juries often find it easier to understand a defendant’s mental condition if this is explained in terms of a narrative that brings together the various strands of evidence to which the expert has had access. Use of analogy and metaphor can greatly help explain difficult, often abstract concepts (for example, in explaining ‘what is personality?’ you might suggest that traits are akin to ‘patches’ in a ‘patchwork quilt’, where someone who is disordered has ‘too many of a restricted number of colours’).

The examination in chief is a chance to describe fully your conclusions and your reasoning; and the questions asked should be taken as the opportunity to give a full account of your opinion and the

information and reasoning upon which it is based. Remember, however, that all that is said in this part of proceedings can be challenged in cross-examination. So choose your words with great care, and avoid ‘too many ways of saying the same thing’, since more words infers more room under cross-examination for challenge or exposure of potential – even minor – inconsistencies.

Cross-examination

Cross-examination is the opportunity for the legal representatives of the party, or parties, opposing the side that called you to discredit your opinion, or to suggest doubt in your competency in the mind of jury. And leading questions are allowed.

Again, face the jury, or judge, and not the cross-examining barrister. Aside from the advantages of doing so already listed, in regard to cross-examination it also has the added advantage of reducing the impact on you of questions being accompanied by aggressive body language and eye contact on the part of the barrister.

Keep calm, especially if your competence is questioned. It is, perhaps, useful to remind yourself that any attack is not personal; the legal representative is merely intellectually ‘testing the evidence’. And if the barrister becomes angry, or feigns such, it is likely that you are being successful in getting over your evidence as you would wish to do. Control the pace of your evidence giving and, more particularly, the questions asked by taking time to consider your answers.

Appearing balanced and honest is likely to impress members of the jury and judge, as well as being ‘correct’. Conceding points that clearly go against your view contributes to a sense of reasonableness, as well as being proper practice. Equally, if new evidence has emerged since you wrote your report and, as a result of that evidence, your conclusion has altered, if only somewhat, then it is right to be clear about this.

If you do not know the answer to a question, then say so; any other response would be improper.

Be clear where your expertise ends; equally, express your view with confidence.

If interrupted, finish your point, if necessary by way of recourse to the judge.

Beware of agreeing too readily with apparently innocuous propositions; so listen carefully to any question and consider how it fits in with other questions that have been, or might then, be asked. Try, therefore, to see ‘where a line of questioning is going’, not in order to become adversarial but so as to avoid being taken down a road that might ultimately cause you to misrepresent your opinion. And do not answer questions that are not asked.

Cross-examining lawyers are trained to seek ‘yes or no’ answers. The purpose of doing so is often to ‘disaggregate’ your evidence so as to dismantle it via ‘a thousand cuts’, whereas proper reference to aspects of your evidence, and facts that mutually reinforce one another will maintain the integrity of your evidence. The analogy of building blocks of a structure, reinforcing the support of one another is appropriate. And giving an opinion qualified by caveats is perfectly acceptable – that is, ‘yes, but...’.

One of the roles of the judge is to ensure that the questioning process is fair, and a witness can turn for guidance to the judge if he is concerned about the implications of answering a question as it has been posed, or if he does not understand a question, or if believes that a question is beyond their expertise.

Re-examination

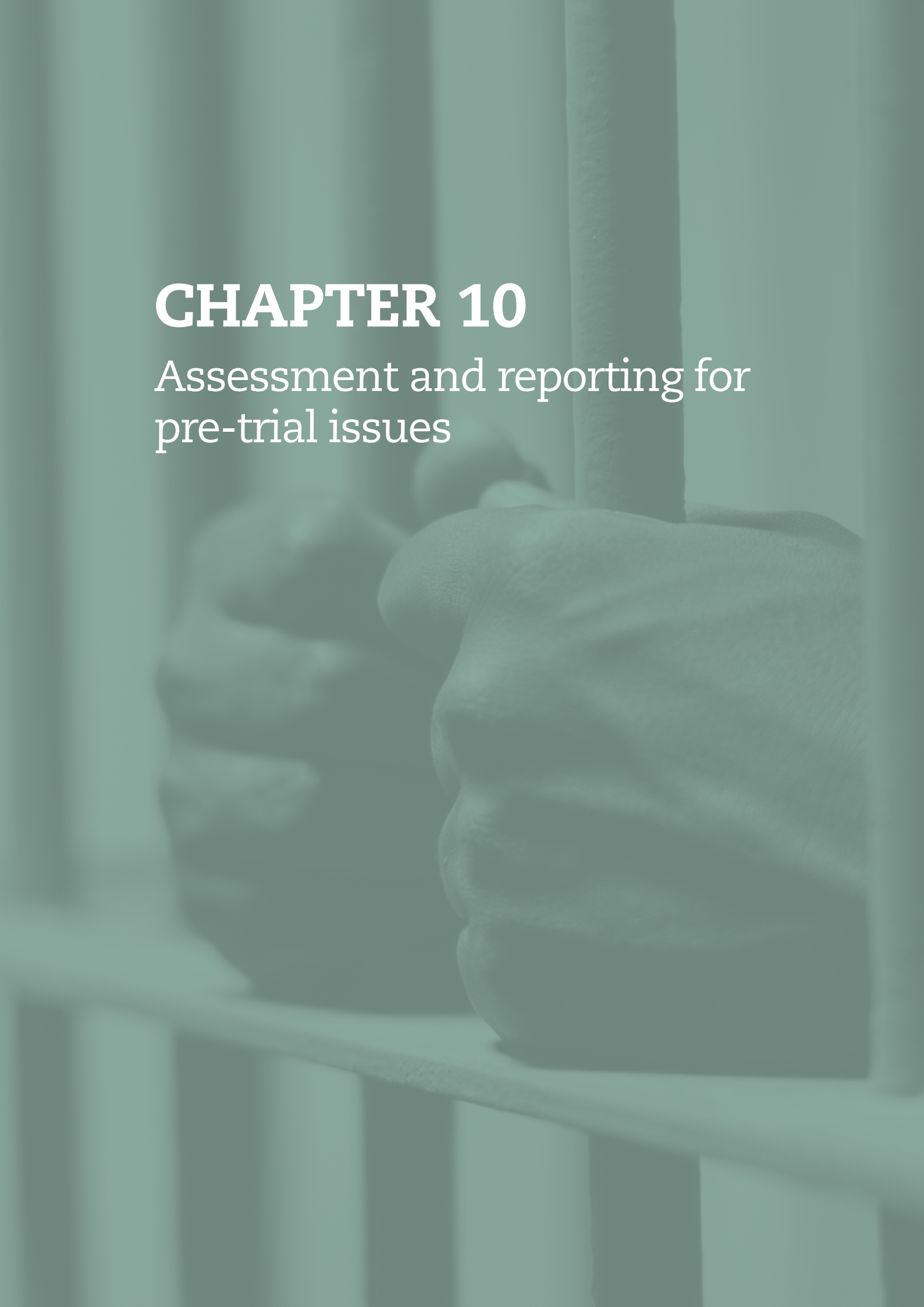
The barrister from your side will subsequently try to repair any damage done in cross-examination, by way of 're-examination'.

Re-examination is confined to elucidation, sometimes further exploration, solely of matters that arose in cross-examination, and no new issues or argument may be introduced without leave of the court. Re-examination is generally short if the process of cross-examination has been unsuccessful in undermining the expert's opinion; lengthy re-examination usually means that you have been undermined in important ways.

At the end of the evidence – and sometimes also during it – the judge can ask questions. Answer these as carefully and thoroughly as you can. Sometimes this will involve explaining earlier answers given, clarifying points already made, or answering what may amount to new questions that have occurred to the judge as being important. It is unusual for the judge to ask more than a small number of questions.

CHAPTER 10

Assessment and reporting for
pre-trial issues



Assessments directed at ‘pre-trial issues’ are of defendants who remain innocent, facing charges that remain *alleged* offences. A mental health assessment might be focused upon a specific capacity, competency, or competencies, loosely thought of³⁶, and it may sometimes require retrospective evaluation of the defendant’s mental state – for example, in relation to having been able to ‘understand a caution’, ‘fitness to have been detained’ or ‘fitness to have been interviewed by the police’ (which might, in turn, be relevant to the reliability of a confession). Other assessments, which might be considered to be more straightforward, will relate to the defendant’s current mental state, and the impact of this upon a specific ability, including ‘fitness to plead and stand trial’ and ‘fitness to waive the right to legal representation’. Each ‘capacity’ is distinct and defined legally in relation to a particular legal stage and question.

Principles of assessing for pre-trial issues

General principles of assessment will apply (see earlier Chapter 4), including:

- Full psychiatric assessment
- Reviewing all available information, specifically in regard to the alleged offence, arrest and police interviewing, including:
 - Transcripts and recordings of police interviews
 - Custody records
 - Any medical findings during police custody, including in relation to ‘fitness to be detained’ and ‘to be interviewed’
 - Witness statement observations of behaviour or demeanour where relevant to a pre-trial issue
 - Specialist testing, including ‘suggestibility’ and ‘compliance’, also intelligence and personality testing by a qualified psychologist (see Chapter 5)

Competence to understand a police caution

The expert must use all the available information in order to attempt to reconstruct the likely mental state at the time a police caution was delivered. This should include the custody record, any witness statements referring to demeanour or behaviour, descriptions of the defendant’s response to the caution at the time, and consideration of the way in which his/her understanding was checked. If possible, complete transcripts of the interactions between defendant and police should be read, although the application of caution is unlikely to be included. Additionally, if a doctor or other health professional has seen a defendant, their contemporaneous notes should be considered.

Clinical assessment of the defendant should include their recollection of the caution, their understanding now of the police caution, and an attempt to test their understanding of components of it. The assessment is not conducted simply in order to note the presence of any mental disorder or vulnerability at the time

³⁶Not legally thought of, since the term ‘capacity’ has particular, and varying, meaning in a number of legal contexts, and no place in some – for example, in regard to ‘fitness to be tried’ (see later text).

the caution was given, but also to interpret the impact of any likely mental abnormality on their ability to comprehend the caution.

A suggested structure for considering this issue is as follows:

- Would they have had the ability to understand the words, and the meaning of those words?
- If not, why not?
- Were they likely preoccupied or distracted, for example by psychosis?
- Did they possess insufficient intellectual capacity to understand?•
- Were they intoxicated with substances, or suffering withdrawal?
- Could they consider the impact of the caution upon their situation in deciding how to respond?
- Did they confirm their understanding, or acquiesce solely in response to overly direct or forceful questioning relating to their understanding?
- Was the caution repeated in a simplified way that might have lead them to understand it?
- Is there any evidence that the defendant has an ability to understand the police caution now?

Fitness to have been interviewed

This issue is of legal significance because of its implications for the likely reliability of admissions or confessions (see below), or their evidential admissibility. Again, there is a need to give an opinion on the likely mental state of the defendant at the time of any interview, and then to consider the likely impact of this upon their ability to have participated in an interview and nature of that participation – albeit there is no strictly defined legal definition of unfitness in the UK.

It is very unusual for a psychiatrist to be asked to make an assessment at the time of interviews conducted by the police, since it will usually be undertaken by a forensic medical examiner, commonly a general practitioner. Therefore, assessment by a psychiatrist is usually retrospective.

However, the fact that another doctor thought, even seeing the defendant at the time of the interview, that the defendant was fit is not necessarily definitive. He is not likely to have been a consultant psychiatrist, and might well not have had sufficient time to consider the issue in detail, to have had access to relevant background medical information about the defendant or, indeed, to have been competent to make the assessment.

Assessment will involve consideration of the following factors:

- What was the defendant's likely mental state at the time of interview?
- And:
- What impact (if any) would this likely have had on the defendant's ability to understand the purpose of the interview?
- What impact (if any) would it likely have had on their ability to understand questions?
- What impact (if any) would it likely have had on their ability to respond to questions?
- What impact (if any) would it likely have had on the nature of their answers?

- Is there evidence in the interview transcripts or recordings of the defendant being unable to understand questions, or being influenced in their answers by aspects of their abnormal mental state?
- Is there evidence that the interview caused significant mental distress or harm, and that this had an impact on their understanding of questions or their answers?
- Was there any aspect of their mental disorder or abnormal mental state that likely rendered them particularly susceptible to the methods or styles of questioning adopted?
- Is there evidence on assessment now, for example, of their intelligence, suggestibility or compliance (see Chapter 5) that would likely have impacted upon their answers?
- Is there evidence in the transcripts or recording of such susceptibility and impact?

As will be apparent from the above list of questions, although fitness to be interviewed in the police station will have been assessed in advance of the interview, in assessing fitness in retrospect, consideration of the transcript or recording of the interview may be essential – it may not be sufficient merely to describe likely mental state abnormalities, without regard to the interview transcripts.

Indeed, a doctor who might have assessed the defendant prior to the interviews for ‘fitness’ will not, of course, have had the opportunity to observe how the defendant subsequently performed in the police interviews. So his evidence will be based upon a significantly lesser data set than that available to a psychiatrist or psychologist assessing retrospectively what *was* the defendant’s likely fitness when interviewed. And, certainly, only the later-appointed expert is in a position to give an opinion on reliability as it likely operated in the interviews, which can be studied for such influence (see below).

As such, it is necessary to consider the nature of the questions asked in relation to what is now known, was known or should have been evident at the time about the specific disabilities of the defendant. It may well be necessary, therefore, to examine their responses when asked about understanding; for example, do they simply respond ‘yes’ to questions about understanding or are they asked, and able to confirm, understanding? Is there evidence that questions are likely to have been too complex or subtle, based upon what is now known of the disabilities of the defendant? Is there evidence of misunderstanding; answering questions that have not been asked; long pauses; or answers that seem to avoid the subject?

Reliability of confessions

Here, there is a clear overlap with the issue of fitness to have been interviewed, in that the mental state and the detail of the transcripts or tapes of the interviews must be addressed in the ways described above. Of course, the presence of mental disorder or other mental abnormality does not equate to confessions, or other admissions, being unreliable; there must be consideration of the likely impact of any disabilities upon the responses given. Also, unreliability is not equivalent to falsehood; a confession could be unreliable and yet true. The proper term to use is therefore not ‘false confession’ but ‘rebutted confession’.

Psychological assessment in relation to rebutted confessions

There has been categorisation of ‘rebutted confessions’ arising largely out of the work of clinical psychologists in terms of:

- A *voluntary* false confession might be expressed, for example, in order to protect the true perpetrator
- A *coerced-compliant* confession occurs in the face of coercion or forceful questioning and is made in order to avoid conflict, or through fear of harm, and is rendered more likely by the defendant being unusually ‘compliant’, or ‘acquiescent’ (see Chapter 5, also below).
- A *coerced-internalised* confession occurs when a suspect wrongly believes their confession to be true – characteristically associated with police interviewing that involves asking leading questions, including questions that feed information covertly to the individual, which he then comes to believe, whether or not accompanied by coercive behaviour. This is made more likely with the trait of *suggestibility* (again see Chapter 5, also below).
- Mental disorder or abnormality can be associated with high *compliance*, *suggestibility* or *acquiescence*. Therefore, it may be necessary for there to be joint assessment concerning these aspects by a clinical psychologist (see below) and a psychiatrist – the latter evaluating whether there is evidence of a mental disorder that might predispose the defendant to one of these routes (or another route) to vulnerability to rebutted confession.

Further individual defendant factors relevant to a later rebutted confession, whether or not associated with enhanced suggestibility or compliance, include:

- High susceptibility to distress, leading to confusion
- High levels of false guilt from mental disorder, leading to a predisposition to confession
- Mental disorder characterised by fantasy and/or a desire for notoriety or fame
- Learning disability impairing the ability to understand the questions or consequences of answers

The assessment of whether police interviews were ‘oppressive’ is a specialist area, and the definition of what is considered oppressive can vary in different jurisdictions. Also, what might be experienced as oppressive by one person might not be so by another, so there is a proper expert role directed at describing how an individual’s mental disorder or abnormal mental state might lead them to perceive an interview as unusually oppressive.

In assessing a defendant who rebuts a previous confession, in addition to your own clinical interview, consider the following:

- The transcripts of the interview
- Any records of rest or sleep
- Any evidence from transcripts or recordings of confusion or misunderstanding
- Any evidence from transcripts of changing replies to questions in response to oppressive techniques
- Any evidence from transcripts of information being fed to the defendant, either overtly or covertly, and then ‘adopted’ by them (this may reflect *suggestibility*, *acquiescence*, or *compliance*, or some combination of the three)

Also, some defendants may refuse to answer questions properly, or remain silent. If some mental abnormality that has been identified appears related to this, it should be stated, so that the court can decide whether no adverse inference should be drawn from the inadequate nature of their responses,

or lack of response. Notably, in some jurisdictions, the fact of mental disorder may, based upon expert evidence, determine that the judge directs the jury that they should draw no adverse inference from the defendant's silence (a similar provision applies in English law in respect of such a defendant not giving evidence at their trial, if their disorder implies that it would be 'undesirable' that they do so).

If, on the basis of expert evidence, the conclusion is reached, by one or more of the above 'mental routes', that an interview, or parts thereof, is/are likely to be 'unreliable', then there will be a '*voir dire*' (trial within a trial), wherein the judge will hear expert, and sometimes other, evidence in order to decide what evidence should be allowed to go before the jury. If, after this, the relevant interview material – or some of it – is still left in the trial, the same expert evidence may then be repeated before the jury, in order to assist them in determining whether they should give normal or less than normal 'weight' to the evidence.

Finally, individuals with low IQ – and others also – can exhibit abnormal *compliance*, *suggestibility* or *acquiescence*. There is also a general tendency among this group towards *confabulation* (making up a memory to fill a memory gap). However, none of these phenomena is necessarily present in people with intellectual disabilities; so, as in some other circumstances, the best approach to forming an opinion on their presence or absence may be through the use of the psychological tests already described here briefly, and in detail in Chapter 5.

Fitness to plead and stand trial

The assessment of a defendant's fitness to plead and stand trial is based on their mental state or condition at the time of trial. And the trial can only proceed if the defendant is fit to plead and stand trial. Psychiatric and/or psychological evidence directed towards the issue is required, if it is raised (by either side or by the judge), but the issue is ultimately determined against a legal test. There might be subtle differences in the legal test for 'unfitness' in different jurisdictions, but in common law jurisdictions all derive from the case of *R v Pritchard*, expanded by *R v M (John)*, in terms of:

- Whether the defendant is of sufficient intellect to comprehend the course of the proceedings of the trial, so as to make a proper defence; to challenge a juror to whom he might wish to object; and to understand the details of the evidence

This is usually interpreted as relating to separate criteria of:

- Understanding the charges
- Deciding on whether to enter a guilty or not guilty plea
- Being able to challenge a juror
- Being able to instruct legal representatives before and during any trial
- Following and understanding the details of the evidence
- Giving evidence in their own defence

As will be apparent, this sets a narrow (solely 'cognitive') and high threshold test for finding unfitness.³⁷

³⁷ For example, there is no requirement of an ability in terms of 'effective participation in the trial', as has been recommended by the Law Commission for England and Wales.

Notably, also, ‘amnesia for an offence’ is insufficient to render the defendant unfit to plead (*R v Podola* [1959]), driven by public policy and based upon the notion that the defendant can still respond to evidence presented against him (although, some of this evidence could relate to a period of which he validly cannot recall anything).

Assessment should be as close to trial as possible; and if an assessment in relation to fitness to plead is not conducted close to trial, there should be reassessment.

The assessment should include a full psychiatric assessment, but specifically should include the following:

- Asking the defendant to give an account of why they are required to attend court
- Enquiring about their understanding of the legal process
- Enquiring about their understanding of the different roles of people in court
- If necessary, explaining the basic procedure and considering their ability to understand and retain this information
- Enquiring about their account of the offence, and whether they are aware of and understand what witnesses have described
- Enquiring about their understanding of any of the likely evidence against them (this must be specific to the case)
- If they indicate a particular plea, asking them to explain the reasons for them deciding upon it (they may have been advised against this, which can make assessment difficult)
- Examining witness statements and interviews with them for evidence of understanding *per se*, and of their relevance

Any form of mental abnormality *might* be relevant to determining unfitness to plead and stand trial, although no mental disorder automatically determines a defendant as unfit to plead; and there is no test that can ‘diagnose’ someone as unfit to plead.

Competency tools are used in some jurisdictions, but they assist in the legal determination rather than replacing it.

Psychosis and learning disability might be assumed to be the disorders most relevant to unfitness. However, even holding delusions about the facts relating to the *actus* does not necessarily infer unfitness; that is, there is legal distinction between ‘unfitness’ and ‘failure to act in one’s own best interest’ (*R v Robertson* [1968]).

The following mental abnormalities have been judged not necessarily to infer unfitness:

- Delusions that might lead to incorrect challenge of a juror
- Memory loss for the offence
- Giving implausible or unreliable instructions or answers to questions
- Delusions about the likely punishment

The following symptoms or impairments might be relevant:

- Impairment in the capacity to concentrate
- Specific delusions, or other psychotic symptoms relevant to entering a plea (but see R v Robertson [1968])
- Memory impairment not for the alleged offence but so as directly to inhibit performance on one of the Pritchard criteria (but see R v Podola [1959] above)
- Global cognitive impairment
- Amnesic syndrome

The report provided should include opinions on:

- Diagnosis and formulation, with specific reference to symptoms that have been confirmed

There should then be:

- Specific reference to each of the criteria for fitness to plead; and whether or not the symptoms, impairments or disorders described impact on each of these abilities and, if so, in what manner (defendants are required to have all the abilities described, and so a failure on any one will result in unfitness to plead)

There may then be expression of opinion on:

- Whether they are unfit to plead and stand trial, based on the absence of certain required abilities. That is unless there is any uncertainty about how the psychiatric evidence relates to the legal test, including through any ambiguity there might be concerning the legal meaning of the test, in general, or as it might apply to the defendant. ^[PL17]

The expert evidence will then be considered by the judge or jury (depending on the jurisdiction), accompanied in most jurisdictions by oral evidence. A defendant found unfit to plead cannot then be tried and sentenced in the ordinary way.

In the UK, ‘unfitness’ against the Pritchard criteria does not directly result in a legal finding of ‘unfitness to plead’, in that there also then has to be a ‘trial of the facts’ – that is, of the ‘*actus reus*’. And only if the defendant is found to have ‘done the act’ is s/he dealt with as being legally ‘unfit to plead’ (see below).

In many jurisdictions, a finding of unfitness to plead can result legally, in some manner, in transfer to hospital. If this is the case, then a recommendation will have to be made, unless the finding automatically determines hospitalisation. Even if this is not the case in the jurisdiction at hand, advice should be offered concerning any measures – including therapeutic measures – which might be taken to reverse the defendant’s unfitness to plead, advising on the likelihood of success and the likely timescale required.

If the unfitness can be reversed reasonably quickly, advice should be given to the court to delay any ‘unfitness hearing’ until a later date, as it might be avoided.

Psychological assessment in relation to fitness to plead

Clinical psychologists and neuropsychologists can administer psychometry that can be relevant to determining fitness to plead, in terms of whether the defendant’s ability to understand information, concentrate for lengthy periods, communicate with their legal representatives, and form judgments in order to issue instructions, is impaired. They can also assess whether the defendant has adequate ability to cope with the rigours of cross-examination.

Testing can be for:

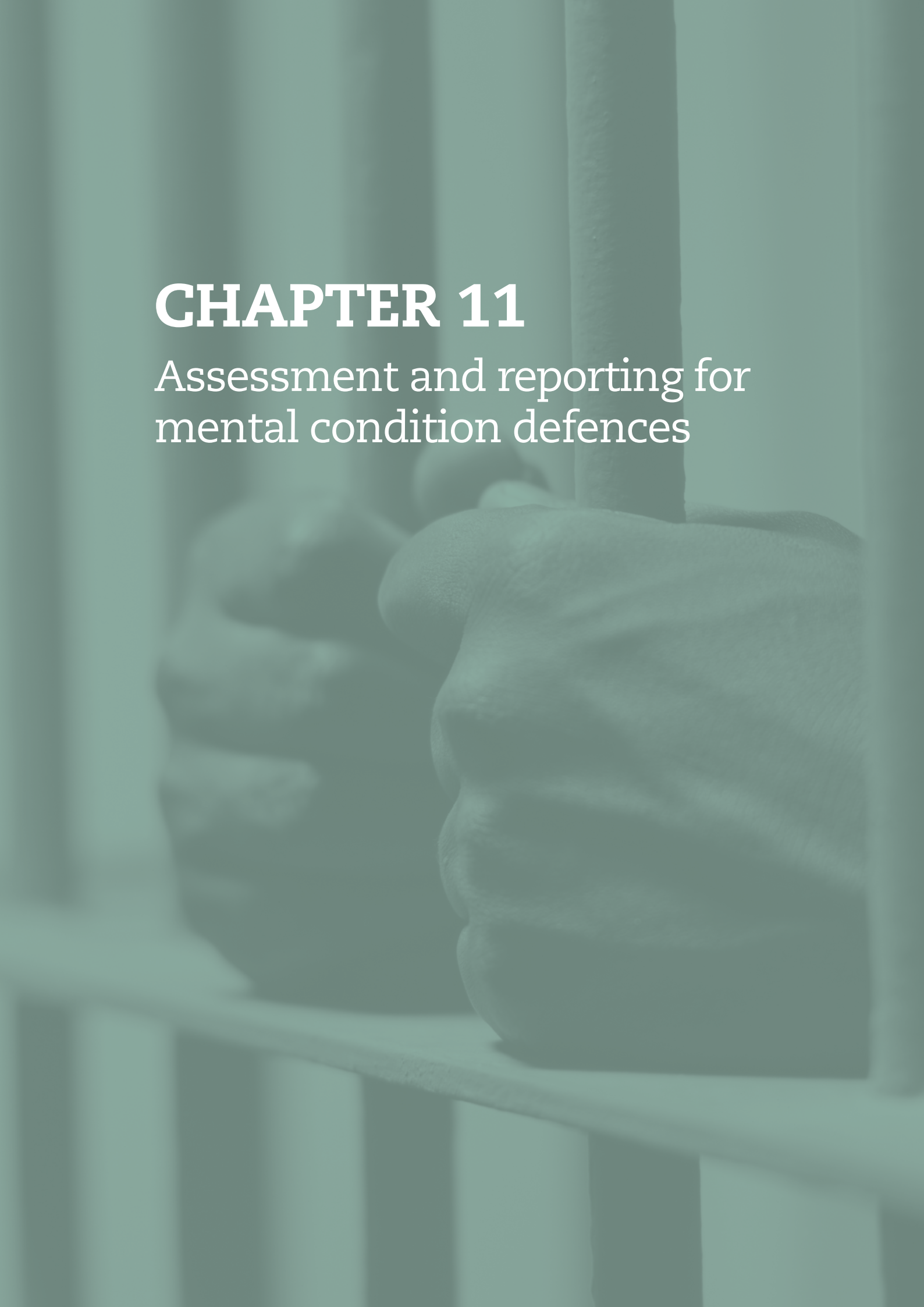
- Current intellectual functioning (IQ) – for example, via the Weschler Adult Intelligence Scale (fourth edition). Individuals with low IQ are likely to have greater difficulty in understanding evidence, and may either require special measures to assist them at court or may be so impaired as to be not fit to plead.
- Language skills – for instance the British Picture Vocabulary Scale (version 2). This offers the assessor information concerning how well the individual understands a discussion, including inferences about how well they may understand discussions with their legal representatives, and how they may be able to manage in Court.
- Memory functioning – assessed, for example, via the Weschler Memory Scale, version 4, or for more compromised individuals, the Rivermead Behavioural Memory Test (third edition) can offer information on the person’s ability to concentrate and retain information, which is likely to be important in respect of their ability to follow proceedings.

Conclusion

Be aware that assessment for issues relevant pre-trial may also infer assessment relevant to some legal questions that may be at stake at trial – albeit further assessment or testing may also be required. However, subsequent to any conviction – for example, concerning sentencing and ‘fitness for execution’ – further clinical assessment will be required, in order to offer evidence in relation to what amount to very different legal matters.

CHAPTER 11

Assessment and reporting for
mental condition defences



Introduction

Law adopts its own various ‘mental constructs’, defined towards the purpose of justice, and not to reflect medical constructs. Therefore, psychiatric evidence is only potentially ‘relevant to’, or ‘probative of’, a mental condition test and not ‘definitive of it’. However, it is crucial for an expert to know, and fully understand, ‘what is the test’ that is at issue, in order to ensure that, in collecting clinical information, interpreting past clinical records and also considering relevant legal documents, he does so in a manner that can maximally assist legal determination. That is, that he can offer correct ‘psycholegal mapping’ (see Chapter 2).

Guilt of most offences requires coincidence of an *actus reus* (guilty act) and *mens rea* (guilty mind). And most mental condition defences go towards negating the latter – although one (‘automatism’) is usually thought of as addressing the former, in that an action must be a ‘willed action’.

Mental condition defences are either ‘total’, resulting in a finding of ‘not guilty’, or ‘partial’, resulting in conviction of a lesser offence.

Psychiatric evidence can also be relevant to jury consideration of whether the defendant had the capacity to form the required *mens rea* for the offence charged, or to assist the jury in its consideration of whether s/he likely formed such *mens rea* (although the expert must not offer an opinion on the ‘ultimate issue’ of whether the defendant did, in fact, form it), even though there may be no question of a mental condition defence per se. It can also be relevant, though in a much more restricted fashion, in the context of other defences that are not mental condition defences per se; for example, ‘provocation’, ‘self-defence’ and ‘duress’.

Insanity

Insanity is a complete defence to any crime charged requiring a mental element, and success in raising it results in a finding of ‘not guilty by reason of insanity’ (or, in some jurisdictions, ‘guilty but insane’). In most common law jurisdictions, this infers very limited ‘disposal’ options, which are usually directed at treatment. Despite its name sounding medical, it is a legal test, legally defined – and defined both in very narrow terms and with a very high threshold.

There is a general presumption of sanity, so that the defence has to be raised (by either side or the judge, in most jurisdictions).

The legal test derives from an English case concerning a man called M’Naghten in 1843, within which it was determined that insanity applies where:

At the time of the committing of the act, the party accused 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, he *did not know what he was doing was wrong* [italics added]

Disease of the mind is not determined by reference to a category or diagnosis of mental disorder but solely legally. It incorporates disorders that affect both mind and brain, and can include, for example, not only ‘functional’ mental illness, but also epilepsy, cerebro-vascular disease, brain tumours,

and metabolic diseases affecting cognitive functioning, which might not, for instance, be viewed by psychiatrists as amounting to mental illness.

It also goes beyond even neurological conditions in that, in *Attorney General for Northern Ireland v Bratty* [1963], it was determined that the term included essentially ‘*anything* which resulted in violence and was prone to recur’ [italics added]. This broadening of the category beyond anything that looks at all medical was clearly determined by the perceived exigencies of justice and public protection, in that fashioning the definition amounted to determining whether the defendant would be found to have been in an ‘automatism’ (see below) that was ‘insane’, which would have allowed detention, or ‘non-insane’, which would have resulted in him simply walking free.

Defect of reason infers, from a psychiatric perspective, a very narrowly and restrictively defined disability; that is, a defect of cognition, not of perception, emotion or volition.

Not knowing the nature and quality of the act is also a very narrow and restrictive form of defect of reason. And, although reason might be impaired by virtue of psychosis – for example, if a defendant had a belief that the act of strangling someone was a way of exorcising demons – most even floridly psychotic individuals’ delusional beliefs do not come within its terms. This limb of the test relates essentially to knowing the nature of the physical act the defendant was doing. It therefore represents an extremely limited form of ‘defect of reason’.

Not knowing that the act was wrong is both again a highly restricted form of ‘defect of reason’ in itself and is further limited by being defined, in *R v Windle* [1951], to mean not knowing that it was *legally* wrong, not whether it was *morally* wrong. However, it is a test that can be satisfied by the effects of psychosis having been present at the time of the offence. For example, a person who falsely believed that they were licensed by a secret service to kill people, such that he was not acting unlawfully, would come within the terms of this limb of the test. It might also be argued that someone who, though capable of knowing that what he was doing was legally wrong was, at the time of commission of the offence, so subject to ‘psychotic drive’ that he was not capable of paying attention to, or did not pay attention to, the legal wrongfulness of what he was doing. That is, he did not ‘appreciate’ that what he was doing was legally wrong. However, there is no legal decision in UK jurisdictions as yet that supports this legal contention – albeit, faced with defendants who, at the time of commission of the offence were clearly severely psychotic, judges not unusually encourage the prosecution to accept a plea of insanity.

There are variations of this test in different jurisdictions, and any mental health opinion must be mapped onto the test specific to that jurisdiction, with the opinion making explicit specific reference to the relevant test.

In summary terms, however, in all common law jurisdictions the defence of insanity is usually extremely narrowly defined, with a high threshold, and therefore is applicable to only a small number of extremely psychotic or brain-disordered defendants.

The issue of insanity is determined, as with any other defence, by a jury.

Clinical assessment

Any mental health expert addressing a case where insanity might apply must consider the likely mental state of the defendant solely at the time of the alleged offence, and in dissected detail. The assessment must go beyond making a diagnosis and retrospective determination of the likely mental state at the time of commission of the *actus reus*, and also address the defendant's functional abilities at that time, specifically in terms of the limbs of the legal test. Therefore, clinical assessment will need to address specifically:

- The defendant's understanding of their actions *per se* at the time
- The defendant's knowledge of the legality of their actions at the time – albeit a lack of knowledge now might tend to suggest a lack at the time of commission of the *actus reus*, it is clearly not definitive of it
- Any explanation by the defendant of his behaviour that might suggest knowledge of its illegality

Consider also whether either of the following applies:

- Evading of police during the later stages of the process of committing the *actus*, or soon thereafter
- Comments made by the defendant close to the material time, or subsequently in retrospect

The clinical syndromes most likely to be relevant to a defence of insanity are psychoses and acute or chronic brain syndromes.

If the act was carried out impulsively, or through 'loss of control', then that is unlikely to come within the terms of insanity

Automatism

Automatism is a complete defence to any criminal charge. It is not identical to medical concepts of automatism. Rather, in law it is defined as the commission of an action that the mind of the defendant did not will. The defendant effectively pleads that their actions were completely involuntary. Therefore, an impulsive or irresistible response is not an involuntary one. Further, an automatism can be defined as a sane 'or 'insane' automatism, dependent upon whether the cause of the automatism was a legal 'disease of the mind', as defined within the law relating to 'insanity' (see above). As such, a finding of 'insane automatism' will amount to a finding of 'not guilty by reason of insanity' (or of 'guilty but insane') (see above). However, a finding of non-insane automatism results in full acquittal.

Insane or non-insane automatism

The distinction between insane and non-insane automatism is not based on the presence at the time of a medical condition or diagnosis. If the cause is intrinsic to the defendant, in the absence of any 'external blow' (for example, in a post concussion confusional state), then the cause of the automatism will be determined to have been a legal 'disease of the mind', and the automatism to have been an insane automatism. However, since any intrinsic factor can determine the presence of a legal disease of the mind, this can lead to incongruence with medical notions of 'disease', in that an epileptic seizure, parasomnia, hypoglycaemia arising from diabetes, or cerebral ischaemia can lead to a finding of insane

automatism, these not being conditions that psychiatrists would consider ‘diseases of the mind’. However, less incongruity is inferred in relation to a state of ‘dissociation’, if the defendant has an inherent tendency mentally to dissociate.

By contrast, if the cause of the automatism was external to the defendant, such as in concussion after head injury, or hypoglycaemia occurring after insulin administration, then the automatism amounts to being ‘non-insane’, with resultant total acquittal. The distinction is, therefore, related to the interpretation of whether the cause was external, determined in *R v Quick*, and not based upon any category of mental disorder defined medically.

Where the cause of the automatism was ‘mental dissociation’ (see below), and such dissociation resulted from an ‘external blow’ – be it a physical or psychological ‘blow’ – the legal determination will be in terms of non-insane automatism. Thus, for example, mental dissociation triggered by intense fear caused externally, as in battle, will amount to non-insane automatism. However, the presence of personality disorder, for example, ‘emotionally unstable personality disorder’, which renders the person more likely to dissociate will – if they did dissociate at the time of commission of the *actus* – result in a finding of ‘insane automatism’. If the defendant was both more vulnerable to dissociation than the ordinary person and was subjected to an external blow, mental or physical, then it may be open to argument as to how the causal balance should be struck medically, and interpreted legally (*R v T* [1990]).

Notably, the defence of automatism is not available to a defendant whose actions were ‘involuntary’ by virtue of intoxication at the material time (although a different defence may, very rarely, apply, in terms of the defendant having been incapable of forming the specific intent required as the *mens rea* for the offence – see below).

Clinical issues

Consideration of automatism relates to the likely mental state of the defendant at the time of the *actus* and, akin to assessment for insanity, will require both retrospective reconstruction of the defendant’s mental state, and careful dissection of both that state and its cause. Dependent upon the likely disorder present, assessment may require medical expertise going beyond psychiatry, including neurology or neuropsychiatry.

There may also be a need for very specific and expert neurological expertise, in relation, for example, to consideration of epilepsy or sleep disorder. Such assessment will need to consider:

- Is the neurological disorder confirmed, and supported, by having been pre-existing?
- Was the act in some way characteristic of that disorder?
- Was there any obvious motive, planning or premeditation?
- Is there any evidence of there having been ordinary consciousness at the time?

In regard to any possible form of automatism, be it neurological or functional in origin, it will be necessary to consider:

- Was the action uncharacteristic of the defendant’s ordinary characteristic behaviour?
- Is there evidence of motive?
- Was the offence concealed?

Assessment of ‘functional’ (non-organic) automatism is particularly difficult and problematic. Most commonly, the mental condition at issue is that of ‘dissociation’; and this is extremely difficult to diagnose with confidence, and to defend in legal proceedings. A necessary, but in no way sufficient, condition for there to have been dissociation at the time of the *actus* is amnesia for the act. But what is also required is evidence per se that the defendant did dissociate at the time, in that amnesia can simply be ‘psychogenic amnesia’; that is, amnesia by way of ‘dissociation away from memories laid down’, rather than amnesia arising because the memories were not laid down, because the defendant was dissociated at the time (see Chapter 5)

What is required, therefore, is ‘amnesia plus’; that is, plus evidence from the clinical story that the defendant dissociated at the time of the *actus*; that his actions were ‘uncharacteristic’; and that there is a reasonable explanation of ‘why’, or ‘how he came to’, dissociate. This may involve description of his personality type or disorder, or of some other form of mental disorder that made him particularly vulnerable to mental dissociation, plus evidence of a ‘trigger’ that likely acted upon such vulnerability.

Depersonalisation and derealisation symptoms that the individual later recalls experiencing are suggestive of ‘partial dissociation’. These would not be sufficient for a finding of a legal automatism; however, a history of such symptoms in the past might add to other evidence suggestive of ‘total dissociation’ associated with the *actus*.

Incapacity to form specific intent

The *mens rea* for an offence is the state of mind necessary to have been present for the defendant to be convicted of the offence charged. It is specific to the crime, and may amount to ‘intention’ or ‘recklessness’, for example. Therefore, whether the defendant had the required *mens rea* for the offence is not a question for expert comment, in that it goes to ‘the ultimate issue’ of his guilt or innocence.

However, whether the defendant likely had *the capacity* to form the necessary intent (if intent is what is required) at the time of the alleged offence can be commented upon by an expert – although determination of both this issue and whether the defendant did, in fact, form the required intent is still ultimately for the jury to determine.

The foregoing said, the defence of incapacity to form intent applies only to crimes requiring ‘specific intent’, in that offences are distinguished into those requiring ‘specific intent’ and those requiring only ‘basic intent’. However, distinguishing between the two categories is not straightforward, with little discernable logic underlying the two categories. Thus, any expert instructed should ask to be informed as to what the required intention is for the offence charged and whether the offence is one requiring specific or only basic intent.

The most common context of consideration of ‘capacity to form specific intent’ is that of ‘voluntary intoxication’. The only circumstances wherein such intoxication can absolve a defendant from responsibility is where they were so intoxicated that they were incapable of forming the required intent for the offence (*R v Majewski* [1977]). However, this potential defence is only available where the offence charged is one requiring ‘specific’, and not merely ‘basic’, intent. And, in any event, the bar is set very high for a

positive finding, in that what is required is that the defendant was hardly capable of controlling their bodily actions.

Psychiatric evidence can also be relevant to jury consideration of whether the defendant, *in fact*, formed the relevant *mens rea*, beyond just whether s/he was capable of doing so – in that s/he may have suffered from a mental disorder that should be seen as affecting the likelihood that, on a particular occasion, s/he did or did not form the relevant intention.

For example, a mental condition which likely resulted in preoccupation and ‘distraction’, such as depressive illness, might be relevant to jury consideration of whether the defendant ‘formed the intention’ (an example might be in regard to ‘theft’, where the defendant is required, in law, to have taken something belonging to another ‘with the intention of permanently depriving them of it’; a specific example is a severely depressed defendant charged with shoplifting). Of course, if the condition made it more likely that they did, in fact, form the relevant intention (for example, committing theft in order to be punished, because of believing that they ‘deserved to be punished’), then that would go towards a finding not of their innocence but of their guilt.

Clinical issues

It is crucial to establish the legal intent in relation to which offence you are being asked to give an opinion, as advised by the instructing lawyer. And clearly the issue relates to their mental state at the time of the alleged offence.

In summary terms, as with ‘insanity’ and ‘automatism’, what is required is to establish whether any condition was present at the time that made it more likely that they did not have the capacity to form the relevant intent, plus detailed determination of the nature of their likely symptoms at the time, and of how these might have interfered with the relevant capacity. Again, what is relevant is not just symptoms *per se*, but also their impact upon the relevant capacity. For example, delusions might interfere with the capacity to form intent for some crimes or, indeed, be relevant to jury consideration of whether, in fact, they did form such intent. Severely abnormal mood states, severe agitation or poor concentration might also affect the capacity to form intent, or the likelihood that they did so. Cognitive impairment might also be relevant.

In relation to intoxication with drugs or alcohol, the likely degree of intoxication should be estimated. However, it is important to note that ‘the amount consumed *per se*’ is not necessarily indicative of likely ability to function, in that this will depend upon ‘tolerance’, and therefore consumption habit, as well as personal idiosyncrasy. And, as regards attempting directly to assess the defendant’s likely ability to function at the relevant time, ordinary witness statements are likely to be more reliable than an attempt medically to reconstruct their mental state retrospectively.

Diminished responsibility

Diminished responsibility is a partial defence, and available only in relation to a charge of murder in most common law jurisdictions. Therefore, if the victim of a severe attack manages to ‘cling onto life’, such that the defendant can be charged only with attempted murder, it does not apply. The result of a successful

plea is that the defendant is convicted of manslaughter rather than murder, which may be of crucial importance where conviction for murder results in either a mandatory or discretionary death sentence.

It is a partial defence that can be raised only by the defence; such that, if the defendant refuses to plead it, he will be convicted of murder. This can cause major difficulties, and injustices, in that a floridly psychotic defendant, for example, may have a very strong partial defence available to him yet, because of his delusional beliefs concurrent with the trial, refuse to plead it. And, if he does not come within the very stringent legal terms of being ‘unfit to plead’ (see Chapter 10), he will be convicted of murder, when in ‘natural justice’ he should be convicted only of manslaughter. The severe impact of this injustice in a jurisdiction retaining the death penalty is obvious; such a defendant will thereby be improperly vulnerable to such a sentence – albeit his disorder would likely result in him not being sentenced to death if the penalty is discretionary in nature.

Of course, in any jurisdiction retaining the mandatory death penalty on conviction of murder, the injustice is stark and real. The defendant will only be able properly to avoid execution by way of his disorder either being considered within the ‘mercy hearing’ stage, which is conducted within the executive and not at court (albeit there are legal requirements to its conduct (see Chapter 13)); or by the court happening to determine that he is ‘unfit for execution’ (see Chapter 12).

The legal test in regard to ‘diminished responsibility’ in most common law jurisdictions is that a person 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 cause 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’ [italics added].^{38,39}

Abnormality of mind is further defined (in *R v Byrne* [1960]) as ‘a state of mind so different from that of the ordinary person that the reasonable man would term it abnormal’. The term is also defined so as to include ‘the mind in all its aspects’; and so, in contrast with insanity, it can potentially include any type of mental state abnormality or mental condition.

There is no psychiatric disorder that automatically qualifies as ‘abnormality of mind’; so, while mental health evidence is essential to support the determination (*R v Dix* [1982]), it is ultimately a condition that the reasonable man would term ‘abnormal’. Hence, the construct is a ‘lay’ one, albeit to which psychiatric evidence is relevant.

Schizophrenia and paranoid psychosis, mood disorders and learning disability might be obvious qualifying disorders; however, personality disorder, premenstrual stress, post-natal depression, battered woman syndrome, alcohol dependence syndrome (but see below) and post-traumatic stress disorder have also been accepted as diagnoses that can form the foundation of the defence.

³⁸ Prior to reform of the test, by way of the Coroners and Justice Act 2009, in England and Wales, S2 Homicide Act 1957; and Northern Ireland S5 Criminal Justice Act (NI) 1966.

³⁹ Reform in England and Wales, under S52, Coroners and Justice Act, 2009, has substituted a much more ‘medically based’ definition of ‘diminished responsibility’, written in terms of the defendant having been subject to ‘substantially impaired capacity to understand their own actions, or to exercise rational judgment, or to exercise self control’, ‘arising from a recognised medical condition’, ‘which caused ... or was a significant contributory factor in causing, the killing’ (without any explicit reference to ‘mental responsibility’ per se, which is inferred if the terms of the defence are made out).

A diagnosis of ‘substance dependence syndrome’, resulting in acute voluntary intoxication at the time of commission of the offence, cannot be used as the relevant ‘abnormality of mind’ within the defence, unless it was such as to cause ‘an irresistible impulse to take the first drink (or drug) of the day’, so the intoxication ceases to be viewed as ‘voluntary’ (*R v Tandy* [1989]).⁴⁰

The ‘second limb’ of the test is not clearly for expert evidence comment, in that ‘mental responsibility’ is not a medical concept. However, clearly, expert evidence will assist its legal determination. That is, an expert may properly describe the nature of the defendant’s likely abnormal mental state at the time of the killing, and may also properly describe how that abnormal mental state likely contributed to the ‘narrative’ of the offence, while leaving the jury to determine whether that ‘translates’ reasonably into substantial impairment of mental responsibility (of course, there may be competing, defence and prosecution, narratives of the offence, between which the jury will have to choose, and also then determine the relevance or not of the alleged ‘abnormality of mind’).

A further reason for not commenting upon ‘diminished responsibility’ per se is that there may be evidence in dispute, concerning likely symptoms (based upon witness evidence) or (again) concerning the ‘narrative’ of the killing, which the jury will have to determine before deciding upon the relevance of any expertly described likely mental state abnormalities. For the expert to give an opinion on diminished responsibility per se would make them into a ‘thirteenth jury person’.

The abnormality of mind that has been described should, therefore, be discussed in terms of emotional state, perception, cognition, consciousness and volition, plus the likely effects of any state upon behaviour. For example, if a person was in a state of depression with psychosis, there may likely have been an impairment of their ability to appreciate the long-term consequences of their actions (individuals who are depressed typically ‘see no further than the end of their noses’, through preoccupation); their perception of the actions of others; or their perception of their own self-worth. It may have also affected their ability to concentrate or comprehend that a situation may have been impaired. Description of the likely impact of any such mental abnormalities on behaviour, including in terms of a narrative of the killing, may then allow a jury to make a decision on the ultimate issue as to whether this was sufficient substantially to impair their mental responsibility.

Finally, evidence addressing the defendant’s abnormality of mind can be combined with consideration of ‘triggers’ that might likely have operated upon that abnormality. That is, by analogy with fragile bone syndrome, wherein a fracture might not occur spontaneously but likely will do so if subjected to a particular type and degree of force. However, this is not to be confused with the role of expert evidence in respect of the alternative partial defence of ‘provocation’ (see below).

Clinical issues

The clinical interview should be conducted as soon as possible after the alleged offence occurred. In practice, however, instructions might not be received until some months (or even years) after the offence; and this emphasises the importance of access to medical records, the custody record upon arrest, as well as witness statements and police interviews with the defendant.

⁴⁰ More recent case law has modified this stringent test somewhat, but its essence remains.

General advice on assessment applies. In particular, however, any mental symptoms likely present at the time of the killing should be described in detail. Mental symptoms prior, and subsequent to the time of the offence will inform; however, unless there was a clinical assessment close to that time, what will be required is retrospective reconstruction from clinical interview, aided by additional information about the defendant's clinical state as it may have been known to have been at other times, combined with reference to any evidence in the case that goes to the defendant's likely mental state at the time of the killing.

An account of the killing from the defendant should be sought, in order to contribute to an attempt at describing how any mental symptoms may contribute to a reasonable 'narrative' of the killing. Ask for their account using open questions as much as possible. Record verbatim comments and ask them to pause, or repeat, if this is difficult. Asking about the alleged offence may itself reveal psychiatric symptoms of relevance; but also establish how, or whether, any mental symptoms that have been assessed as likely present close to the killing relate to the killing.

Provocation

Provocation is also a partial defence to murder, although it may not be available in all common law jurisdictions. Successful pleading of the defence will result in a conviction of manslaughter as opposed to murder.

In the broad terms provocation requires:

- Sudden and temporary loss of mastery over the mind (*R v Duffy* [1949]) (the 'subjective test')⁴¹
- Caused by *things said or done* by the victim (sometimes by another)
- The requirement that the things said or done would have caused a loss of self-control in a *reasonable person* (the 'objective test')

The defence is clearly not a 'mental condition' defence, but expert psychiatric or psychological evidence can be relevant to it if the substance of the defence per se is made out. That is, expert evidence can 'add something' to the defence if the basis of the defence is established. And expert evidence can be relevant evidence in regard to both the objective and subjective tests.

The subjective test

With the subjective test, expert medical evidence of abnormality at the time of the killing – although insufficient for 'diminished responsibility' – may serve to suggest that there was, in fact, loss of mastery over the mind (albeit such loss of mastery must have been both 'provoked', to the standard required by the law, and 'reasonable', again to the standard required by the law, see below).

⁴¹ Within law in England and Wales, the defence has been abolished, with substitution, by way of S58, Coroners and Justice Act 2009, of a defence of 'loss of control'; this 'need not be sudden', but the required objective level of 'trigger' ('things said or done') has been raised substantially, and 'sexual infidelity' is explicitly excluded as a potential trigger (although it can form 'a trigger with other triggers' – see *R v Clinton*).

Further, evidence in relation to the defendant's susceptibility to having been provoked – including in the way that he was allegedly provoked – may be relevant to jury consideration of whether, in fact, s/he did lose control.

Examples include:

- A history of childhood sexual abuse in relation to a perceived sexual assault in adulthood prior to the killing
- Learning disability or other cognitive impairment
- Paranoid personality traits or paranoid psychosis
- Impulsive personality traits
- Low self-esteem associated with depression

Simply having the character trait of being easily moved to lose control cannot, however, be used as evidence in favour of the defence of provocation, because 'the reasonable man' test applies (see below). However, where the factor relates specifically to their 'woundability' in response to things said or done, it may also be relevant to the objective test (again, see below).

The objective 'reasonable person' test

As regards the objective test, the 'reasonable person' is, in law, someone of the age, race and culture of the defendant. And, beyond this, expert evidence in relation to the defendant's particular susceptibility to being 'woundable' by particular things said or done may be relevant to consideration of whether someone with those 'characteristics' of the defendant would reasonably have lost mastery over their mind. Again, however, any characteristics that go merely to his general violent 'reactivity' are excluded (so that characteristics that may have aided proof of the subjective test of 'loss of mastery over the mind' cannot be relevant to whether the 'reasonable man' would have lost control (the objective test)).

The following are examples of such 'woundability' and linkage to things said or done:

- Chronic spousal assaults, whether leading to PTSD or not, which causes the defendant to perceive that they are worth no more than abuse, such that a 'final assault' is reasonably perceived as 'playing upon' such poor self-esteem
- Low self-esteem associated with depression, with words or actions by the victim directed at such (although a reduced threshold to losing control and being violent, by way of the same depression, would not come within the terms of characteristics modifying the 'reasonable person')
- Impotence caused by an anxiety disorder, where the defendant was taunted about such impotence
- A history of childhood sexual abuse, where the defendant was subjected to a perceived sexual assault in adulthood prior to the killing

The defences of 'diminished responsibility' and 'provocation' can be pleaded 'in tandem', and so some aspects of a given body of expert psychiatric evidence can often be applied to both defences, within the terms of their differing legal relevance. Although this must tax the jury, in terms of being told by the defence barrister: 'My client is mentally disordered and so is less than responsible; or, if you don't accept that, then he is the reasonable man who lost control in response to provocation.'

Self-defence⁴²

As with provocation, self-defence is clearly not a mental condition defence. Indeed, self-defence is not even a 'defence'; rather it is an 'excuse' for conduct that would otherwise be unlawful, with resultant acquittal. However, a defendant's mental condition can be relevant to how they perceive the threat to which they have allegedly been subjected.

For self-defence to apply, the conduct concerned must have been 'necessary'; that is, the objective of defending oneself could not reasonably have been achieved in a lawful manner (such as by running away). Further, there must have been 'reasonable force' applied that was also 'proportional', in the circumstances, to the threat posed and the harm that might reasonably have been perceived as likely to have occurred.

The test of whether the force used was reasonable is objective; that is, 'would a reasonable person have used that type and amount of force in those circumstances, bearing in mind the difficulty of making such a judgement in the heat of the moment?'

However, the 'circumstances' are determined subjectively, in that they are the circumstances that the defendant believed (reasonably or otherwise) to exist. And 'relevant circumstances' include whether the defendant initially provoked their attacker, or struck the first blow, or sought revenge, all of which will make it more difficult (but not impossible) for them to claim justification. The location of the attack is also relevant – so that it is easier to claim self-defence, for example, if one is attacked in one's own home.

The role of psychiatric or psychological evidence in support of self-defence is limited to assistance in understanding how mental disorder in the defendant might have affected what s/he might have believed the 'circumstances' to be. The courts in England and Wales have repeatedly refused to allow evidence of mental disorder to be taken into account within the objective test of whether the force used was reasonable and proportionate. For example, in *R v Martin (Anthony)* [2002], the court held that the defendant's misperception of risk due to his paranoid personality disorder and depression was not relevant to the objective test of whether the force he used (a gun, in that case) was 'reasonable'. Even in a case involving a floridly psychotic patient (*R v Cannan* [1971]), the defendant's mental disorder was discounted.

Assessment where the excuse of 'self-defence' is at issue, therefore, must take account of not only the defendant's mental condition, at the time of the alleged offence, but also the affect upon his/her functioning within the restrictive terms just described.

Duress

Again, duress is not, of course, a mental condition defence. However, in limited circumstances, a defendant's mental condition, defined medically, can be relevant to the defence. Specifically, the defence of duress assumes a defendant of 'reasonable fortitude'. Hence, if a defendant suffers from a mental condition that determines that they lack reasonable fortitude, then expert evidence of that condition

⁴² Much of the text of this section is taken directly from Eastman N, Adshead G, Fox S, Latham R, Whyte S (2012) Oxford Specialist Handbook of Forensic Psychiatry, Oxford University Press, pps IV.46–47.

can serve to overturn the assumption. However, at least in England and Wales, there must have been a medically diagnosable condition present (*R v Bowen* [1996]), and operating to as to reduce fortitude.

Most commonly this involves a defendant, typically a woman, who has been ‘traumatised’ by abuse, in conjunction with being used as a ‘drug mule’. However, in line with *R v Bowen*, ‘having been traumatised’ is not sufficient in itself to modify the presumption of ‘reasonable fortitude’; rather, the defendant must, at the time of the alleged duress, have been suffering from a diagnosable condition, for example post-traumatic stress disorder or a generalised anxiety state, or depressive disorder.

Intoxication

Voluntary intoxication is not a defence to any criminal offence, unless it results in incapacity to form intent where the offence charged is requiring of ‘specific intent’ (see above in regard to ‘incapacity to form specific intent’).

However, even then, if it can be shown that the required specific intent was formed before the intoxication occurred, then conviction can be based upon this – since, if the criminal behaviour was to some extent ‘foreseeable’ upon intoxication, then the doctrine of ‘prior fault’ applies, and the mental state effects of intoxication are irrelevant.

Where there is a basis for a plea of diminished responsibility but the defendant was also intoxicated, the law in England and Wales determines that such intoxication is not fatal to the defence but has to be taken into consideration in causal terms. Under the unreformed defence (see above), what was required for the defence to be successful was that the ‘abnormality of mind’ was sufficient of itself to have substantially impaired the defendant’s mental responsibility’ (*R v Dietschman*); under the reformed defence, the situation is similar in that the ‘abnormality of mental functioning’ need only be ‘a significant cause’ of the killing (so that intoxication might still have been an additional cause).

Voluntary intoxication cannot alone lead to a successful defence of automatism or insanity. However, mental disorder arising from the long-term use of substances – for example, brain damage – could (if other criteria are satisfied) lead to a finding of insane automatism or insanity.

As regards intoxication within other defences, see above.

Amnesia

Amnesia is relevant to offences only where it is valid and might suggest that the defendant was in an abnormal mental state at the time of an offence. And, of course, claimed amnesia may be either ‘psychogenic’ (that is, recollection of data laid down at the time of the offence is not accessed), or ‘organic’ (brain-based). Alternatively, it may amount consciously to a way of avoiding discussing, or acknowledging, an offence – or arise from a mistaken belief that amnesia in itself would constitute a defence.

Amnesia is not, therefore, a defence but might (in fact, rarely) be relevant to any of the legal tests above.

Amnesia might also contribute to any assessment of the reliability of a defendant (or witness).

Mental health experts might, therefore, be instructed on any the following issues:

- Is the claimed amnesia likely to be genuine?
- Does the amnesia relate to any underlying mental or bodily condition?
- Does the amnesia suggest the defendant lacked the capacity to form the requisite mens rea for the alleged offence, by virtue of what it suggests was his likely mental state at the time of commission of the offence?
- Does the amnesia suggest any mental condition that might be validly relevant to another defence, or partial defences – for example, insanity, diminished responsibility or provocation?

Clinical issues

Consider:

- Is there any indication of a more generalised memory disorder?
- Are all medical and legal records available, so that any evidence that the defendant has recalled details on other occasions can be considered?
- The association between any physical trauma and amnesia
- Specific memory testing if a more generalised memory disorder is suspected
- Previous episodes of amnesia, gleaned from the defendant, or informants, or from past medical records (see Chapter 5 for more detailed discussion of the assessment of memory and amnesia)

It can be difficult to distinguish between dissociative amnesia ('psychogenic amnesia') and the effect upon subsequent memory of a dissociative state occurring at the time of an offence (see also above). However, dissociative amnesia is often patchy, associated with events of emotional significance, and can gradually resolve. Dissociation having occurred at the time of an offence, with subsequent claimed amnesia, might be suggested by additional factors in terms of:

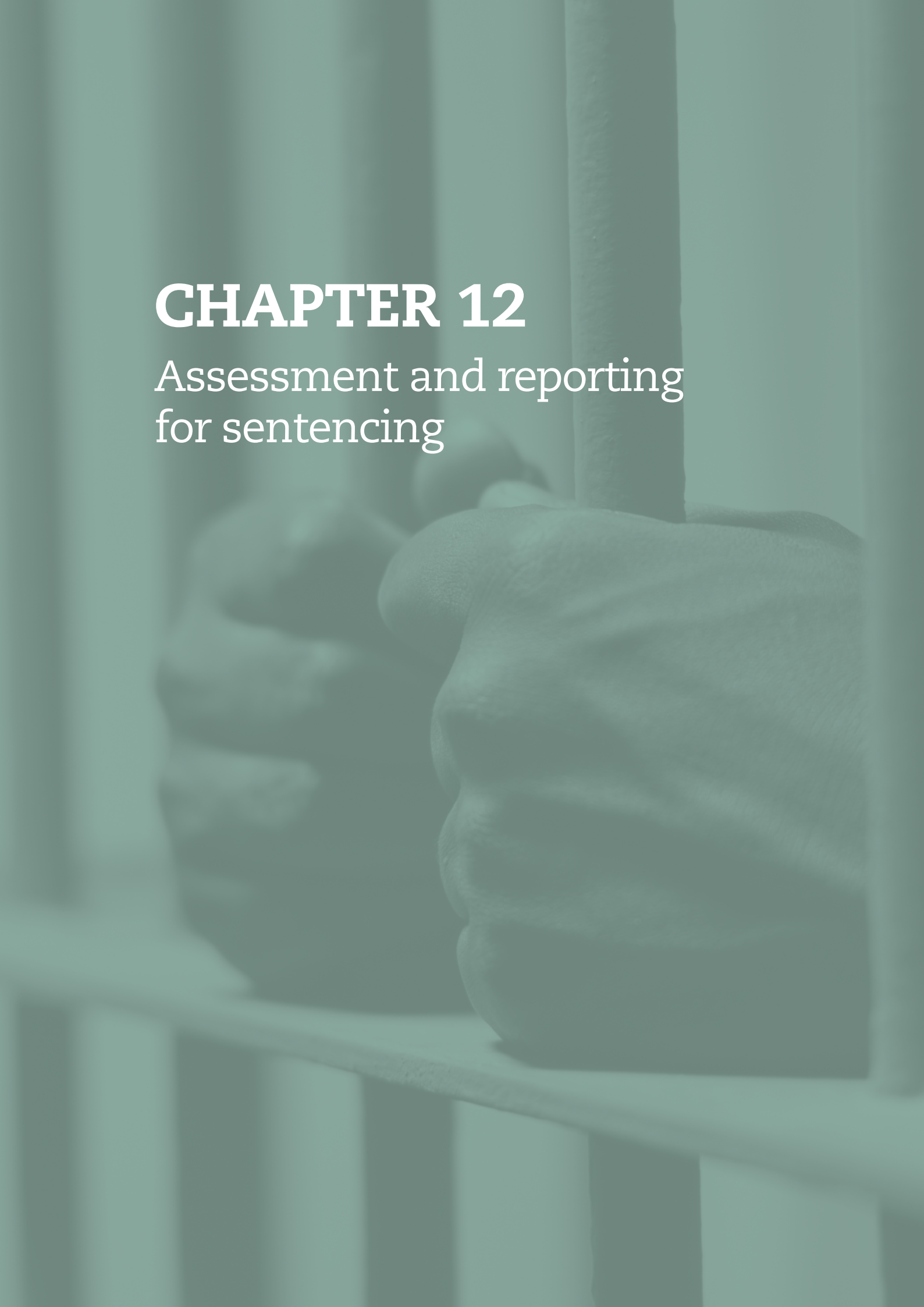
- Evidence suggestive of depersonalisation or derealisation at the earlier time
- Dense amnesia for the offence itself
- 'Out of character' actions
- Observed confusion after the offence
- Other factors associated with dissociation, including traumatic brain injury and previous episodes of dissociation, depersonalisation and derealisation

Conclusion

The clinical background of psychiatrists will tend naturally towards them not 'noticing' the huge disparity that there is between clinical constructs and legal constructs defined within mental condition defences, or other legal defences admitting of the relevance of mental disorder. Crucial to careful and bounded expert practice, therefore, is constantly to hold in mind that any expert evidence offered is directed at application to, or 'mapping onto', a legal construct or test.

CHAPTER 12

Assessment and reporting for sentencing



Introduction

Writing a report for a sentencing hearing is, in most criminal legal circumstances, quite different from writing for an aspect of an earlier stage in the criminal justice process. Whereas many of the legal tests to which reports for earlier stages are directed tend to be both closely defined and ‘binary’ (a defendant is found ‘insane’ or not, for example), sentencing guidelines tend to be broader and more ‘graded’ in nature, or in their implications (except for the application of mandatory sentences) – for example in terms of the length of a prison sentence to be imposed. And even though imposition of the discretionary death sentence is, of course, binary – in that it is either imposed or not – the legal tests applied for sentencing are much less tightly defined than many of the other legal tests with which an expert has to deal. Hence, whereas at earlier stages the more ‘graded’ nature of psychiatry and psychology is inherently incongruent with the more ‘binary’ nature of most legal tests to which it is applied, there is less of such incongruence in the context of sentencing.

A further difference, certainly for the expert, is that writing a report for use in a sentencing hearing involves him much more ‘proximately’ in the determination of punishment than does writing a report for a pre-trial, or trial-stage issue, wherein his opinion is more ‘remote’ in its implications for punishment, dealing ultimately only with issues relevant to the determination of guilt or innocence.⁴³ And this has major ethical implications, certainly for doctors, in terms of the nature of their influence over the determination of ‘doing harm’ – that is, ‘maleficence’ (see Chapter 15 for more detailed discussion of ethical aspects of the utilisation of medical evidence directed not just towards legal determination of guilt, but also punishment) – while concern over the application of clinical risk assessment techniques towards sentencing raises not only ethical, but also technical, issues (see Chapter 7).

Sentencing jurisprudence and mental disorder

Within sentencing jurisprudence, severe mental disorder (for example, psychosis) has sometimes been seen as ‘punishment enough’ (or, at least, ‘in part’), so as properly to lessen the legal punishment imposed. And, in relation to learning disability, there is international human rights prohibition of imposition of the death penalty (and of execution per se), simply upon establishing, and acceptance by the court, of the diagnosis; and there is authority for extension of this principle to anyone with a serious mental disorder (those who are ‘idiots’ or ‘insane’). This principle is applied irrespective of whether the mental disorder posited was present at the time of any offence.

Therefore, where sentencing is discretionary, or can be graded, mental health expertise can quite obviously be relevant to its determination, in terms of either *mitigation* of penal punishment or imposition of a ‘hospital disposal’ (if law within the jurisdiction allows such, through either penal or mental health legislation) – or, alternatively, to *risk-based public protection sentencing*, which effectively enhances punishment (at least from the subjective perspective of the defendant). The rest of this chapter deals with each of these bases for use of expert evidence.

⁴³ See Eastman N L G and McNerny T, Psychiatrists and the Death Penalty: ethical principals and analogies, *Journal of Forensic Psychiatry*, Vol. 8, No. 3, December 1997, pp 583 – 601.

Beyond the foregoing apparently discrete ‘categorisation’ of the sentencing, however, there may be ‘crossover’ of intention, or effect, in that information collected towards possible mitigation or hospital disposal purposes, and explained in those terms to the defendant, might then be used for an entirely different judicial purpose.

An example of this as it may apply to the detriment of the defendant is where an expert collects data to determine whether there was, or is, mental disorder present, concludes in the negative – for instance, excluding either mitigation or ‘sentence to hospital’ – yet the court then applies some of the data in the report to the court’s own approach to sentencing (for example, utilising its own risk assessment), so the effect of the expert report can be to enhance, rather than mitigate, punishment. Or the expert might be requested, in the context of a known or suspected mental disorder diagnosis, to carry out an assessment in respect of possible ‘hospital disposal’. Yet, despite the expert recommending such a hospital disposal, the court may reject the recommendation, and again go on to use the data collected clinically concerning the disorder, as well as a clinical risk assessment included in the report, towards determining an enhanced sentence.

Mitigation

The essence of mitigation legally lies in consideration of either/both the nature of the offence per se, including its severity, and/or the nature of the defendant, and his past behaviour. And it is in the latter regard, which can include ‘characterological’ aspects, that expert psychiatric and psychological evidence – in terms of disorder per se, or symptoms, and in terms of risk assessment – may be considered relevant, including specifically to discretionary imposition of the death penalty (see below).

Both aggravating and mitigating factors are taken into account when sentencing convicted offenders, except in the context, of course, of application of a mandatory sentence. An aggravating factor is any factor taken to indicate enhanced culpability, and tends to result in more severe sentencing. A mitigating factor has the opposite effect, and can include factors relating to mental ill health, disability and even sometimes personality disorder. So, for example, mental factors that were deemed ‘insufficient’ to establish a mental condition defence at trial may still be relevant within sentencing in mitigation – including in deciding what determinate prison sentence shall be imposed in respect of any conviction that does not require imposition of a mandatory sentence.

Beyond this, within jurisdictions retaining the discretionary death penalty upon conviction of murder, or some other capital offence, psychiatric and psychological factors that at trial fell short of laying the foundation for a mental condition defence – for example ‘diminished responsibility’ – can take on great significance in terms of relevance to one of the established legal tests applied within discretionary capital sentencing, those of ‘beyond reformation’ and ‘the worst of the worst’ (see below).

More fundamentally, a particular form of mental disorder can sometimes, of itself, inhibit or prohibit imposition of, in particular, the death penalty; thus, a diagnosis of ‘learning disability’, according to international jurisprudence, prohibits application of the death penalty.

Finally, as already described, in contrast to all of the foregoing, a court may take into account mental disorder in a fashion that effectively enhances punishment – where the disorder is considered likely to

increase the risk of further violent offending, thereby potentially drawing experts into presenting ‘risk assessments’, under the umbrella of assessment for possible mitigation.

Mitigation factors

Issues – some relating to mental disorder – commonly considered relevant as mitigating factors include (see below for the detail of factors relevant individually to each of ‘the two tests’ relating to discretionary imposition of the death penalty):

- Abnormal mental state at time of offence
- Young age at the time of the offence
- The defendant having acted under duress or coercion
- The defendant having lacked a measure of ‘reasonable fortitude’ in regard to duress or coercion, or within conviction based upon ‘joint enterprise’, than the normal person – albeit they have been convicted of the offence
- Abnormal mental state at time of sentence
- Absence of previous offending
- The defendant was impaired in their capacity to understand the nature of their actions, albeit falling short of founding a defence
- The defendant was impaired such that he was limited in his ability to follow social, moral or legal norms
- The defendant was/is learning disabled
- The defendant’s character was/is ‘abnormal’

Mental disorder and imposition of the discretionary death sentence

There are two legal criteria established in regard specifically to discretionary imposition of the death penalty, to which expert mental health evidence is potentially relevant.

First, whether the offence was ‘*the worst of the worst*’, sometimes referred to as ‘*the rarest of the rare*’ (although, logically, the two may not necessarily accord one with the other, they are used interchangeably by the courts). And here it is possible – though uncommon in practice – that psychiatric or psychological evidence might be regarded as relevant, to the extent that the court may take into consideration not just the defendant’s actions, but also the nature of his thinking, or other aspects of his mental state, at the time of the offence (akin to consideration at trial of both the nature of the *actus reus* and the detail of thinking lying behind, or within, the *mens rea*)

Second, if it is determined that the case does qualify within the category as ‘the worst of the worst’, then the court will consider whether the defendant is ‘*beyond reformation*’, and here, almost always, expert evidence will potentially be relevant, albeit alongside other evidence about the defendant’s ‘character’.

Assessment for potential mitigation or hospital sentencing

Any diagnosis of mental disorder at either the time of any offence or at the time of sentence should be clearly described. If a report has been requested solely in relation to sentencing, there should be a description of any relationship there may be between any mental disorder and the offence, as well as of the defendant's current mental state.

However, a psychiatrist should *never* give an opinion recommending any penal sentence, or its avoidance, including in regard to capital sentencing. Sentencing is a matter for the court, albeit subject in part on occasion to the hearing of expert evidence.

More generally, there should be care to avoid becoming 'an advocate' for the defendant, whatever your beliefs and personal values about the death penalty, for example; and the expert should also refrain from excusing or defending the defendant, thereby resorting to moral judgement, where judgement properly resides in the judge.

Any diagnosis present of learning disability or mental retardation is particularly important, as it is likely, in respect of a capital hearing, to be a bar to execution. Low intelligence, even in the absence of mental retardation or frank learning disability, might also be a relevant mitigating factor – again, particularly in regard to capital sentencing.

The assessment will follow general principles. However, data collected should be capable of application beyond establishing a diagnosis per se, with concentration particularly upon formulation. Therefore, particularly thorough attention should be given to individual characteristics, experiences and background, going beyond merely attempting to determine whether any personality features are sufficient, for example, to make an ICD10 or DSM-5 diagnosis of 'personality disorder'. In short, assessment is directed at exposing any 'mental pathology', whether or not there can be formal diagnosis; and this is particularly and obviously the case in regard to discretionary capital sentencing, because of the court's application of 'the two sentencing principles' (again see below).

Detailed information about family background, and relationships more generally, should be collected, with specific inquiry about any experience of sexual or physical abuse; plus detailed information should be gathered about experiences of any mental symptoms experienced throughout life.

Therefore, the mental health expert might reasonably address the following issues as examples of factors relevant to mitigation (though this is not an exhaustive list):

- Is there, or has there ever been, any mental disorder present; and, if so, what were its implications for the defendant's behaviour?
- Were there psychological factors operating so as to affect the defendant's judgement or ability to exercise control?
- Are there any developmental (social and psychological) factors that have shaped the person's character, including in response to stress or trauma?
- Is there any empirical evidence concerning the impact on other people with experiences of trauma similar to those of the defendant?

- What effect did adverse experiences in his/her early life (for example, physical or emotional trauma, abuse, or neglect) have upon his/her development?
- Was the defendant exposed to risk factors for subsequent violence in their development – this being relevant to ‘risk assessment’ (see Chapter 7)?

Collateral information will be particularly important, both to inform opinion in relation to the clinical interview and to provide objective sources of information. And this might serve to provide information of a type that is not gathered by direct interview, in the form of records, which should include, if possible:

- Psychiatric records
- Medical records
- Perinatal records
- Childhood development records
- Special educational needs assessments
- School reports and disciplinary records
- Records from care homes or foster homes
- Social work records
- Statements from family and friends
- Police records, statements and court transcripts
- Previous probation records

Neuropsychological and/or personality tests may also be employed, by psychologists, and either/both presented to the court separately or/and incorporated within a psychiatric report (see Chapter 5).

Reporting for sentence in respect of potential mitigation

The report will follow the general model with extensive consideration of early development and family history, as well as of significant events at different life stages – very much in the model of ‘formulation’ (see Chapter 6).

Even though the person is convicted there should be consideration of the offence with the defendant. This will inform in terms of determining an understanding of the offence, in respect of their disorder – if there is one – and any narrative connection between the two. Within this, the report should address specific questions concerning the defendant’s mental state at the time of any offence, and also issues of capacity in relation to their understanding of their conduct, plus exercise of rational judgement and self-control (by analogy with reformed ‘diminished responsibility’ under the law of England and Wales⁴⁴).

The following aspects of the mental health assessment are examples of factors that might be considered by the court to be relevant as mitigating factors (though not an exhaustive list):

- Birth complications
- Childhood neglect or abuse

⁴⁴Albeit Section 52, Coroners and Justice Act (2009) amending Section 2, Homicide Act 1957 does not, of course, apply to jurisdictions other than that of England and Wales, in the ‘looser’ context of sentencing, such factors may well be of persuasive power in other jurisdictions, especially those that utilise the Judicial Committee of the Privy Council.

- Developmental delay
- Family history of mental health problems
- Childhood mental disorders, including ADHD, intellectual disability and mood disorders
- A history of intra-familial violence during the defendant's upbringing
- Inconsistent schooling
- Inconsistent caregivers and disrupted attachments
- Loss of significant caregivers in childhood
- Experience of victimisation as an adult
- Psychiatric disorders in adulthood
- Physical illnesses, including head injury and neurological disorders
- Lack of access to healthcare in order to remediate the effects of disorder

Assessment and reporting concerning risk of violence

(This section should be read in close conjunction with consideration of Chapter 7.)

There are a number of factors that might be within the domain of the mental health expert concerning the assessment of the risk of future violence (the notion of 'dangerousness' is misplaced, in that the risk of violence being repeated is dependent upon factors both intrinsic and extrinsic to the defendant, as well as upon their interaction (see Chapter 7).

Risk assessment is fraught with methodological difficulties and uncertainties concerning its validity and reliability (again, see Chapter 7); and this, together with the implications of 'doing harm' by way of clinician involvement in sentencing – especially capital sentencing – means that it is an ethical minefield. Certainly, for a doctor, the advice from some would be 'if there is not a diagnosable condition, then do not comment upon risk', since to do so will take the clinician far from ordinary clinical practice, as well as cause him to apply clinically derived 'cine film' risk assessment techniques to 'snapshot' judicial risk assessment (see Chapter 6). However, clinical psychologists operate based upon a paradigm that does not depend upon – even sometimes eschews – 'diagnosis', and emphasises 'understanding (even normal) behaviour', so that their approach may be more flexible.⁴⁵

At the outset, clarity should be sought from instructing lawyers as to the issue before the court, and the potential relevance of any evidence you may give.

The process of clinical risk assessment is usually pursued with the purpose of identifying appropriate therapeutic interventions, which – as already explained – is in stark contrast to it being utilised for a determination of whether someone should receive, for example, a capital sentence. And, although risk assessment is a core aspect of psychiatric practice, used in clinical practice it is a dynamic activity based upon the risk of a specific type of harm occurring in specified circumstances and within a given time period.

⁴⁵ There is a risk of doctors 'riding conflicting horses' here, in that the advice in regard to risk assessment is, to say the least, 'be extremely cautious, or eschew'; whereas, in regard to mitigation, we have advised collecting a wide range of data at all relevant to 'mental pathology', whether or not there is, or beyond any diagnosable condition. However, the courts accept the former as relevant to mitigation, and explicitly so in regard to the tests for discretionary capital sentencing.

And so we offer the following further advice:

- Any assessment where risk assessment is to be included, or where data gathered could be used by the court in this regard in its own terms, should incorporate specific informed consent-taking
- Any risk assessment method used should only be of a type appropriate for the person you are assessing. Also, the user must have received relevant training in the method, and have a clear understanding of the limitations of that method and of risk assessment generally.
- Any opinion on risk should stay within medical boundaries and not address legal concepts directly
- The sentencing judge will be concerned about the probability that an individual will act in a way that will be a threat to the public. However, there is no probability per se that can be reliably applied to any defendant; so there must be careful consideration and documentation of the limitations of accuracy of individual risk predictions
- Categorisation of someone as ‘high-’ medium-’ or ‘low-’ risk should not be adopted (see Chapter 6)

Risk assessment in detail

Consider carefully whether the assessment methods used are empirically sound for the person you are assessing; do not, for example, use a risk assessment tool for a person with intellectual disability that has no validity demonstrated for this group. And establish at the outset what question is being asked, and whether you are confident that you can answer the direct question posed (for example, ‘What is the probability that this defendant will kill again?’ is not a question to which you could validly and reliably answer); and then inform the person instructing you of your initial view on the question.

Instructions can all be about future violence but with very different types of implied response, for example:

- What is the risk of future violence?
- Please predict the likelihood of serious violence in prison.
- What is the risk of further homicide after release from prison?

Certainly, underlying any request for risk assessment must be the question: ‘In what circumstance?’

Therefore, concerning the test of ‘beyond reformation’ (see below), it may be that the defendant is considered likely to be at much higher risk of repeated severe violence were he to be in the community than in prison. And if, in avoiding the death penalty, he will be incarcerated in any event for many years, perhaps effectively for ‘whole life’ (even if not sentenced to such in name), then he is far less ‘beyond reformation’ – if that is addressed in terms solely of the risk of future violence – in prison than he would be in the community.

So, since risk assessment in clinical practice is always context-specific, ask ‘In relation to what circumstance(s) do you wish risk to be assessed?’ So, if there is a question about ‘risk after release’, this should be addressed within that specific context (although this might be extremely difficult, given the great uncertainty about risk factors potentially relevant 20 or 30 years into the future).

Actuarially (see Chapter 7), there are generally low rates of serious violence by people convicted of capital offences. And the rate is lower for prisoners whose sentences have been commuted (compared with those in prison awaiting execution). Indeed, rates of prison homicide are low. Accepting that it is not possible validly to go from ‘the group’ to ‘the individual’ (see Chapter 7), this would infer that the most likely risk prediction to be correct is that an individual will not commit a further act of serious violence.

Assessment should consider those factors that have been demonstrated to be both ‘risk’ and ‘protective’ ones for future violence (see Chapter 7 generally on risk assessment techniques); this will include both static and dynamic factors (again, see Chapter 7).

Reporting upon risk

The communication of risk information is sensitive, and there should be a clear relationship between the information you have used and the opinions you give.

So:

- Record clearly the exact nature of the risk questions that have been posed
- Explain clearly the limits of any risk assessment method you have used
- If any actuarial data is presented, emphasise that such data relates to groups and not to the defendant individually (for example, if a person is found to fall within a group that has a 40 per cent risk of committing an act of serious violence in prison, that does not equate with saying that there is a 40 per cent probability that the defendant under consideration will commit an act of serious violence)
- Make clear if your risk assessment is not validated on the population or context you are considering
- Make clear the period of time over which any risk prediction applies; available population data will often have been gathered over a limited follow-up period
- Do not use terms like ‘high-risk’ or ‘low-risk’, at least not without significant qualification; and emphasise that risk assessment is concerned with ‘description of factors and circumstances relevant to the individual defendant’
- Emphasise the uncertainty inherent in risk assessment

Risk assessment in capital sentencing

As already described, the now accepted two ‘sequential’ criteria for imposition of the discretionary death penalty are that the offence was ‘the worst of the worst’; and, if it is deemed to have been, that the defendant is ‘beyond reformation’.

‘The worst of the worst’

This concept is quite explicitly a legal one, in that capital sentencing should be reserved for those crimes considered legally, or criminologically, ‘the worst of the worst’ or ‘the rarest of the rare’.

To the extent that within the test there is consideration of the thinking and mental state of the defendant at the time he committed the offence (by way of expert evidence), the presence of mitigating factors

directly relating to the nature and severity of the offence – including those within the remit of the mental health expert – is often likely to rule out a finding in favour of the test being met (see above).

So, for example, even if a mental disorder defence has been unsuccessful at trial the psychiatric data and opinion upon which the unsuccessful plea was based is likely to have a bearing on the sentencing. For example, if a plea of ‘diminished responsibility’ failed not in terms of there having been no abnormality of mind but in terms of its impact having been insufficient to determine ‘*substantial* impairment of mental responsibility’, then the mental abnormality might still be perceived as reducing responsibility sufficient not to apply the death penalty.

However, the ultimate question about whether an offence is sufficiently heinous to be considered ‘the worst of the worst’ should not be addressed by a mental health expert, since there will be factors relevant to the test going far beyond mental health issues.

‘Beyond reformation’

Only a defendant who has committed an offence that is ‘the worst of the worst’ and who is then considered to be ‘beyond reformation’ will be properly sentenced to death; and, as already described, psychiatric and psychological data and opinion can be directly applied to that test, in respect of both ‘risk assessment’ and ‘treatability’.

In regard to ‘risk assessment’, all of the cautions already described apply, but writ large. And, further, the limitations of risk assessment lay the ground for much ‘values incursion’ into the assessor (wherein his attitude to the death penalty can impact upon his reporting upon risk).

Risk assessment is naturally linked to the ‘treatability’ of the defendant’s condition, which clearly is the proper subject of expert opinion. However, risk can be reduced not only by ‘change in the defendant’ but also by ‘external’ measures (such as mode of containment); and, therefore, the absence of any real prospect of successful treatment per se (which might reasonably infer ‘some measure of change within the defendant’) does not mean that, expressed in terms of ‘risk management’ or ‘risk reduction’, the defendant is ‘beyond reformation’. (See generally Chapter 7.)

Psychological assessment and the possibility of reformation

When considering an individual’s suitability for psychological, as opposed to psychiatric, treatment or management – which may then suggest the capacity for ‘reform’, including via risk reduction – it is particularly important to consider the following questions:

- Is the person motivated to change?
- Is the person too psychologically ‘defended’ against beginning to change?
- Where is the person on an accepted measure of ‘changes of change’ cycle?
- Does the person accept responsibility for their behaviour; or do they seek to locate responsibility elsewhere (‘externalise’ responsibility)?

There are effective psychological treatments that demonstrate measurable, meaningful change for a great many psychological and psychiatric disorders, as well as specific groups of offenders, including those expressing:

- Psychotic illness
- Personality disorder
- Neurological disability
- Violence
- Arson
- Sexual offending

Remorse

Often, within both sentencing and decision-making by parole boards concerning release, much attention is paid to whether the defendant or prisoner expresses ‘remorse’.

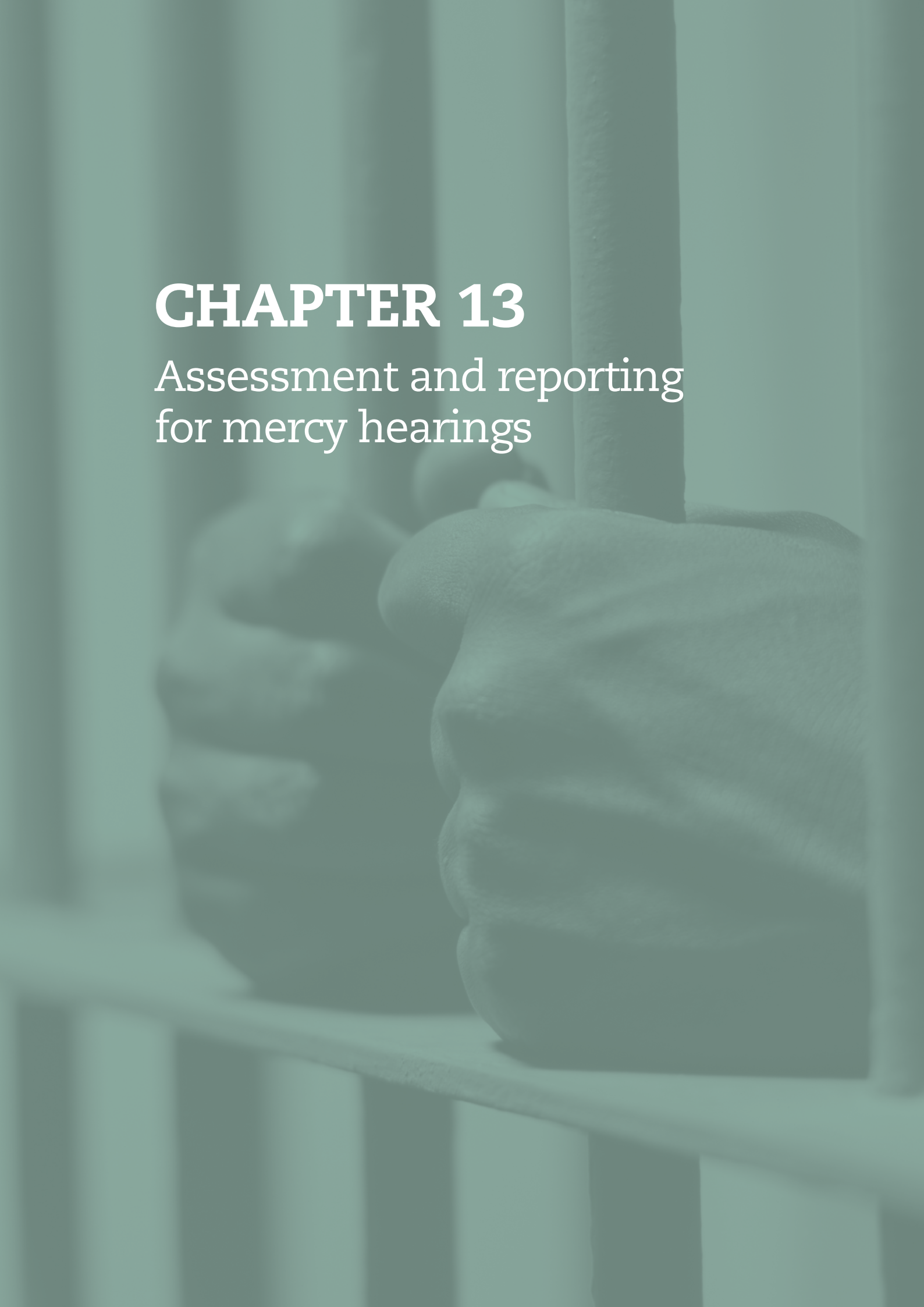
Remorse is complex to define, including philosophically, and extremely problematic for a mental health expert to comment upon directly. Indeed, it is questionable whether he should do so. There can be reporting of a defendant’s views on their offending, for example; but the interpretation of whether these views amount to remorse, or to what degree of remorse they amount, is very far from straightforward. ‘Remorse’ is a moral construct lacking any directly and obviously correlated mental constructs. So while there can be expert comment upon, for example, ‘blame attribution’, whether, how, or to what extent that psychological construct relates to ‘remorse’ must be for legal determination, in the absence of expert comment.

Conclusion

The undertaking of assessments by mental health professionals directed at sentencing hearings, and the reporting of those assessments to courts, is fraught with technical and ethical difficulty – especially so in respect of capital sentencing hearings. However, it is perhaps ‘necessary’ – and obviously so in the latter context, given the nature of the legal rules that determine discretionary capital sentencing – unless the psychiatrist or psychologist adopts a position of ‘total avoidance’. Defendants facing the possibility of imposition of the death penalty perhaps have a right to such assessments. However, the presence of technical and ethical ‘bear traps’ for the professional concerned determines that it should be approached with extreme care, caution and ethical reflection.

CHAPTER 13

Assessment and reporting
for mercy hearings



The mercy stage will be the only post-trial stage at which mental health evidence is considered in mitigation in jurisdictions where the death penalty is mandatory. The presence of mental disorder, and other more broadly defined mitigating factors as listed in Chapter 12, will therefore be particularly important to describe in these jurisdictions. Although there is a legal requirement that there be legal representation at a mercy hearing, there are no legal tests established relevant to the exercise of mercy. Indeed, this is unsurprising given that the hearing is not a court hearing but a hearing conducted by the executive. The extent or severity of mental disorder, or other mental factors, that will carry weight in determining the exercise of mercy is therefore uncertain. However, in summary terms, and beyond factors briefly dealt with below, some of the same mitigating factors described in Chapter 12 may be relevant, subject to legal instruction.

The nature of mental disorder

There is relatively clear legal authority that severe mental illnesses such as schizophrenia or mental retardation will result in mercy; but it is less clear whether milder (less than diagnosable) mental retardation, personality disorder or milder forms of mental illness, such as less than psychotic depression, will likely result in the exercise of mercy.

Clinical assessment

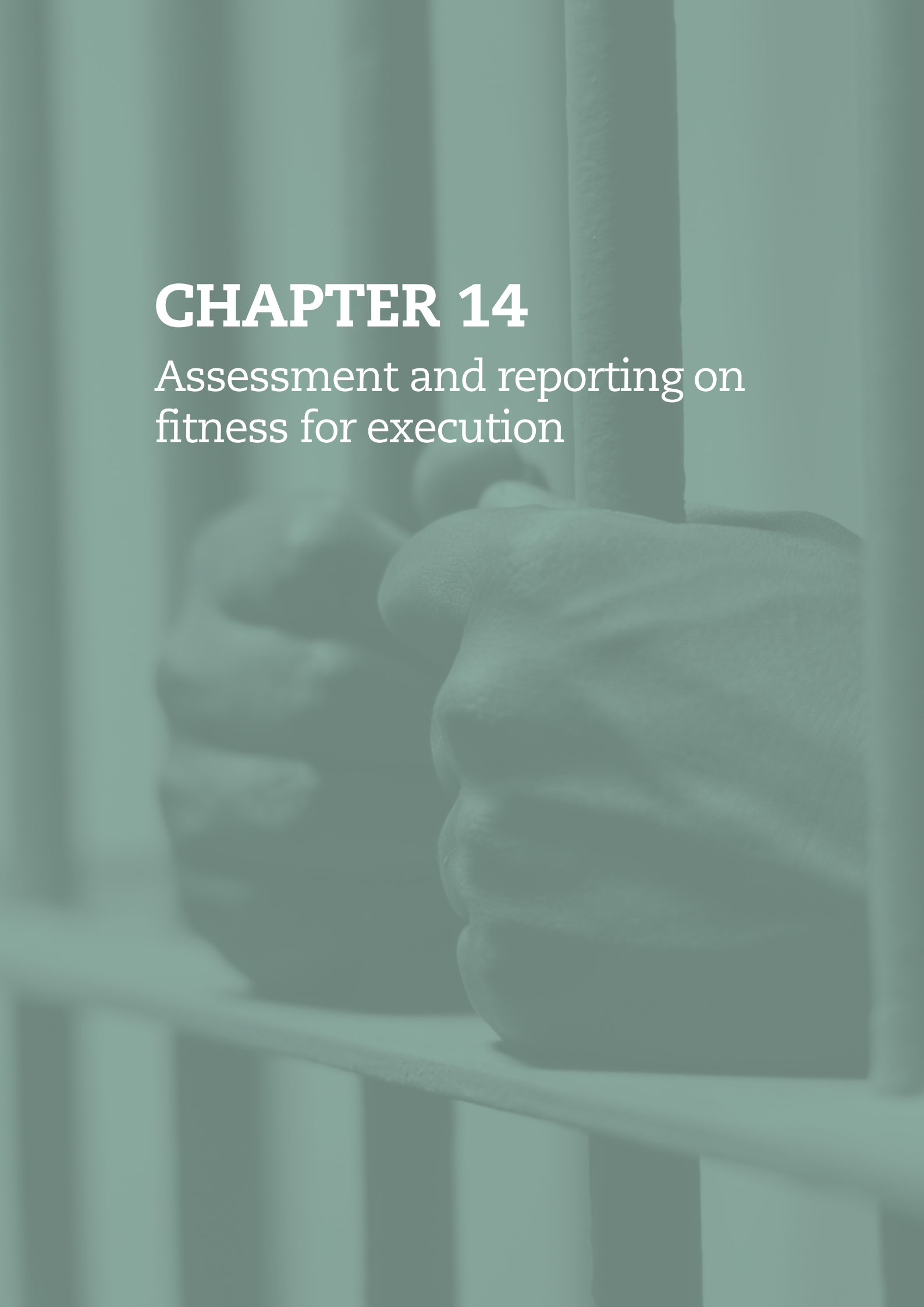
Since there are no legally defined criteria for the exercise of mercy – merely an argument that, in natural justice, mercy should be extended to someone suffering from mental disorder – there can be no detailed advice on clinical assessment. Rather, the reader might reasonably cull advice from previous chapters that appears likely to be useful.

Reporting

Again, the lack of specific legal criteria for the exercise of mercy determines that it is sensible to take individual instructions from the defendant's lawyer in each case, and to draft the report in response to whatever questions are posed to you.

CHAPTER 14

Assessment and reporting on
fitness for execution



The legal test for ‘fitness for execution’ in common law jurisdictions relies upon a case from the USA, that of *Ford v Wainwright*.

Comprehension of execution

A mental health expert may be asked to comment upon a person’s capacity to comprehend the nature of the death penalty and why it has been imposed upon him, as well as upon the significance of any mental disorder from which he suffers for such ability.

The test is based upon the notion that execution should only be applied to individuals who are aware of the nature of the punishment and why they have been sentenced to such punishment, including having moral comprehension of ‘culpability’ and ‘retribution’. So if, for example, the perpetrator is not able to make a moral connection between the crime and the punishment, then such punishment is considered necessarily to fail in its retributive function.

The American Bar Association test might assist in understanding the possible purpose, and focus, of mental health evidence:

A convict is incompetent to be executed if, as a result of mental illness or mental retardation, the convict cannot understand the nature of the pending proceedings, what he or she was tried for, the reasons for the punishment or the nature of the punishment. A convict is also incompetent if, as a result of mental illness or mental retardation, the convict lacks sufficient capacity to recognise or understand any fact which might exist which would make the punishment unjust or unlawful, or lacks the ability to convey such information to the court.

The clinical interview should consider, therefore, these different facets in relation to any diagnosed medical or psychiatric condition, and specifically the convict’s:

- Understanding of the reasons for punishment
- Understanding of the nature of the punishment itself, including its finality
- Ability to reason and weigh up matters relevant to his current legal situation
- Ability to provide instructions to legal representatives

Assessment and reporting on fitness for execution

Clinical assessment will be directed particularly at the questions raised immediately above, while any report should be directed to issues as raised by lawyers for the convict.

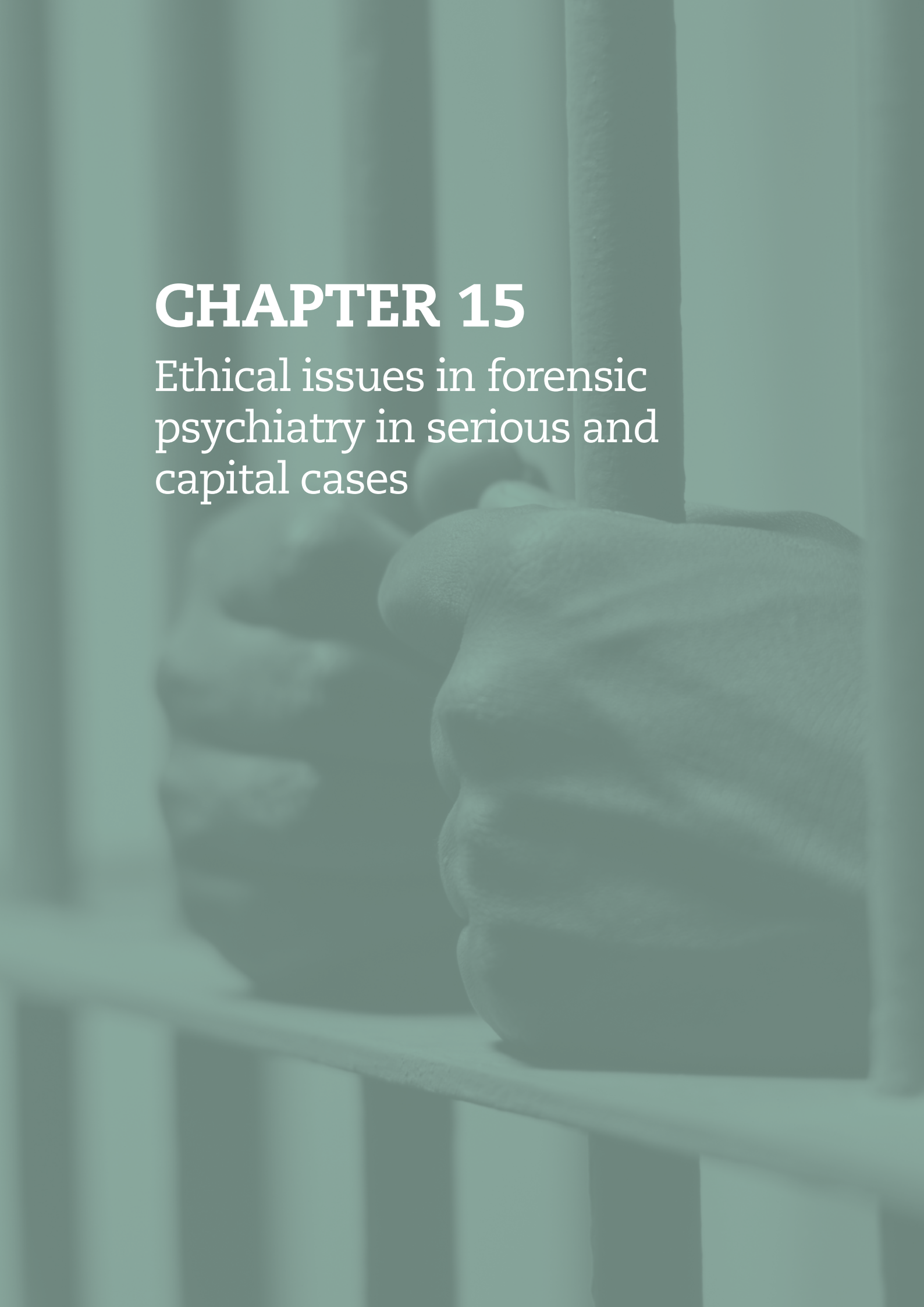
Recommendations concerning treatment ‘to make fit’

Where the cause of unfitness for execution is potentially reversible, such as sometimes where the condition is a severe psychosis, the ‘impossible ethical question’ arises for any doctor responsible for the convict in the prison, or any doctor advising on fitness on the instructions of the convict’s lawyers, as to whether

medical treatment should be applied in order potentially to make him fit. On the one hand, he will be suffering as a result of his psychosis, on the other hand treatment will/may result in his execution. This is – among a range of profound ethical dilemmas posed to doctors in any way involved in capital trials (see Chapter 15), – perhaps the most difficult question to answer; and a question the answer to which can be arrived at only by the individual doctor in each separate case. The dilemma brings into direct conflict the duty to treat a patient (who is also a convict) in medical need with the duty not to do harm, however that harm might arise. Also, there may be a perceived conflict between the duty to do no harm to one's patient and the societal duty upon the doctor as citizen to facilitate the lawful exercise of justice.

CHAPTER 15

Ethical issues in forensic
psychiatry in serious and
capital cases



What is ‘clinical ethics’?

‘Clinical ethics’ amounts to application of a reflective process to a clinical case within which there are issues concerning not just what might be the outcome of different actions, between which a choice has to be made, but what *should* be done. That is, whereas medical science is *positive* (describing how things are, or would be under different circumstances), clinical ethics is *normative* (describing what ought to be done). In simple terms, it is the ‘oughts’ of clinical practice.

The focus of all ethics is determining what ‘rights’ and ‘duties’ are, or should be, ‘in play’; and resolving conflict between competing rights, or competing duties, or between rights and duties which compete with one another.

There are competing ‘schools’ of ethics – that is, alternative forms of reflective process. However, the key ‘first step’ within the practice of clinical ethics lies in recognition of *what is* the normative, or ethical, question at hand, before then applying a reasoning process towards coming to a decision as to what to do – that is, deciding ‘what ought to be done’.

There is rarely – perhaps never – ‘a right answer’ to an ethical conundrum. Rather, what is at stake is coming to ‘a *justifiable* answer’, and doing so in a manner that makes clear the nature of the justification. Put another way, it is ‘biting the ethical bullet’, and doing so with ethical insight both into what form of ethical justification you are applying and into the basis upon which you have decided to choose one course of action over another competing course.

Therefore, achieving an ‘ethical distillation’, or understanding the details ethically, of a particular situation – including the consequences of different courses of action – plus relevant duties and responsibilities, is vital in pursuing ethical practice. What matters is *process* rather than *outcome*; that is, the quality of an ethical decision lies in the process that led to it.

The schools of ethics most commonly referred to within medicine are the ‘four principles’ and ‘utilitarian’ approaches (see below). These two approaches essentially contrast a ‘principled’ approach with comparing, but then evaluating, the total ‘impact’ on different parties of alternative courses of action.

Conflicting duties and dual roles

Ethical dilemmas arise commonly in all clinical practice, more commonly in mental health practice, and with added frequency and difficulty in forensic mental health care. And they perhaps reach the peak of complexity and severity of implications in capital cases.

A *core conflict* arises from the fact that forensic psychiatrists commonly owe a duty not only to the patients they assess and treat, but also to society and to the justice system. Therefore, they owe a duty not only to treat their patients, but also to protect society from the possibility of harm arising from those they treat; and they may also owe a duty to the administration of justice through adopting the role of expert witness. The former ethical conflict arises through accepting a duty to the individual the doctor assesses and treats and a duty directed towards the welfare of others. The latter amounts to substituting for the

usual therapeutic role and duty to a patient the role of expert within legal proceedings, in the absence of any therapeutic role or endeavour – albeit the doctor may still feel some form of residual therapeutic duty to the individual he assesses.

Medical involvement in legal process in serious criminal and capital cases lends itself most obviously to clinical ethical analysis in terms of a ‘principled’ approach.

The ethical principles that are most commonly considered to underpin most medical practice (‘the four principles’) include *autonomy*, *beneficence*, *non-maleficence* and a *duty to respect justice*. And, among these, it is the duty to respect patient autonomy that is generally considered ‘first amongst equals’ within clinical medicine.

The *duty to respect justice* can be taken either simply as ‘the duty to act fairly to people’ – for example, in terms of allocation of scarce medical resources between patients – or in terms of a duty to assist the state in its proper formal exercise of justice. It will be immediately obvious that the practice of forensic psychiatry poses greater challenges to ‘ordinary accepted clinical ethical practice’, as described above, than, say, surgery.

This is made obvious by any circumstance where there is conflict between respecting patient autonomy and protecting the public. And, where a doctor acts as an expert witness, he might appear to all but abandon ‘*respect for autonomy*’ in favour of a duty to assist the state in the exercise of justice. Therefore, it might reasonably be perceived that, as a mental health expert giving evidence, your overriding duty is to the court, thereby potentially undermining the more usual balancing of conflicting ethical principles by doctors.

Involvement in capital cases might be seen as focusing upon the ‘unusual nature’ of forensic psychiatric practice to an extreme degree, particularly in terms of the usual requirement of *non-maleficence*. That is, in all expert witness work, respect for justice essentially overrides respect for autonomy, and non-maleficence; however, appearing as an expert witness in regard to capital legal proceedings amounts to a doctor privileging justice over non-maleficence writ large.

As a result, some doctors argue that participation in death penalty proceedings amounts to ‘a step too far’ away from usual medical ethical practice and principles, through being equivalent to ‘participation’ in the process of execution – or at least in facilitating or legitimising legal process which can lead to such punishment – therefore fundamentally contravening the principle ‘do no harm’.

One ‘partial solution’ to this fundamental objection to appearing as an expert witness in capital proceedings lies in appearing only for the defence in such cases. However, this runs the risk of being perceived as, or even of being, partial in one’s approach to the role of expert witness. And the only escape from such a danger lies in ensuring that skills are applied fairly, as they would be clinically in a non-litigious situation, and that one is insightful into the risk of bias arising from applying medical ethical principles to an essentially legal context. So again, what is crucial is *process* (see above).

Alternatively, some distinguish ethically between involvement within different stages of the justice process applied in capital cases, in terms of the degree of ‘remoteness’ of the doctor’s role from execution per se.⁴⁶

⁴⁶ See Eastman N L G and McInerney T, Psychiatrists and the Death Penalty: ethical principals and analogies, *Journal of Forensic Psychiatry*, Vol. 8, No. 3, December 1997, pp 583 – 601

Therefore, assessment of ‘fitness for interview’ of a suspect in a murder enquiry might be seen as more remote from an individual being executed than assessment of ‘fitness to plead’ in a capital trial, whereas giving evidence towards determining whether a mental condition defence is available to a defendant in a capital trial might reasonably be seen as more remote from execution per se than the former two stages, but less remote than medical involvement in a capital sentencing hearing – or in assessing for fitness for execution.

Expertise

A key domain of clinical ethics lies in the duty to acquire and maintain medical expertise. However, in relation to expert witness work, this includes a duty not just to maintain clinical competence, but also to acquire and maintain specific medicolegal competence; that is, competence at the interface between psychiatry and law (see Chapter 2). And such a duty is clearly greatly emphasised in the context of capital legal proceedings, where the consequences of less than fully competent practice can be both ‘ultimately severe’ and irreversible, in terms of ‘doing harm’. So remaining within the limits of your expertise is paramount, and this may require you to refuse involvement in a case, since undertaking to be an expert witness in a case – even for the defence – can be far more harmful in its implications for both the defendant and for justice than refusing to do so if you are not adequately competent. And, finally, there is a duty to develop and maintain competence in the ethics of practice; that is, having competence in ethically analysing aspects of practice (as we seek to describe in this chapter).

Ethical codes

Ethical codes can offer a template, or aid to the process of reasoning required to reach an ethical decision. However, they are often written in such broad terms as often to be less than fully helpful within the circumstances of an individual case and dilemma. Such codes are also not substitutes for good ethical reasoning. Each professional will have a set of ethical codes that they are bound to consider. The World Psychiatric Association (WPA), the American Psychiatric Association (APA) and the General Medical Council (GMC) all publish ethical codes. Similar codes exist for psychologists. The American Academy of Psychiatry and the Law publishes ethical guidance specifically for the practice of forensic psychiatry.

Some overall ‘national’ codes concerned with the practice of forensic psychiatry include codes within them directed specifically at medical involvement in capital proceedings.

Bias and its minimisation in expert witness practice⁴⁷

Key questions in regard to bias, and its minimisation, are: (1) What *is* bias in expert witness practice (EWP); (2) What are the *sources* of EWP bias; (3) What are common *expressions* of EWP bias; and (4) How can we (individually and ‘corporately’) *minimise* EWP bias?

⁴⁷ Much of the text on ‘bias’ is taken from the text of a paper in preparation, Eastman N, Adshead G and Rix K, ‘Sources and Routes to Expression of Bias in Expert Witness Practice’, commissioned for *Advances in Psychiatric Treatment*.

What is bias?

In physical terms, 'bias' can be seen in 'a slanting line' or an 'uneven bowl' (within the notion of 'built-in' bias), so it can be distinguished in terms of bias as being either 'cause' or 'effect' (that is, bias 'in a bowl' (cause) or in its 'trajectory' (effect)). We can also distinguish 'fixed' bias ('always in one direction') from 'variable' bias ('applied to clinical issues and to clinico-legal issues, depending upon circumstance' – for example, whether instructed by defence or prosecution). Further, we can distinguish 'implicit' (without awareness) or 'explicit' (with awareness) bias, where explicit bias is more likely to be evident to others than implicit, such that 'implicit' bias presents a greater challenge to 'recognise' and 'counter'. And so we focus here on 'implicit' bias

Note, however, that courts (and therefore experts in courts) are potentially 'inherently' biased in their process in regard to incorporation of expert evidence, in terms of approaching '*a* truth' and not '*the* truth' (for example, because of rules of evidence restricting admissibility of information, and also because of the defined burdens and standards of proof required). So the 'truth' found depends upon the data collected and then allowed as evidence, and the model used for inference from data (by both the courts and experts). Therefore, minimising bias aims at not distorting the particular 'truth' that arises out of the expert opinion expressed from legal usage, or translation of that expert opinion, the core objective should be to 'aim to aid the effecting of justice' within its rules, and not to 'aim to affect justice outcome'

What are the sources of bias?

Decades of research have demonstrated that cognitive biases (that is, unconscious bias) are commonplace and very difficult to eradicate. And a wide variety of types of 'cognitive distortion' can give rise to bias, 'driven by' a range of factors, from *within the expert* (including, for example, sometimes as a reflection of his *relationship with the subject of assessment*, or from *pressure exerted* by the side that has instructed the expert). However, a further source – or at least facilitator – of bias lies in *the adversarial system itself* within which expert evidence is placed.

As regards bias *from within the expert*, he is bound, in some measure, to reflect his own values within the professional work undertaken. Indeed, certainly within clinical medical practice, great benefit to the patient may arise from the doctor who is treating them investing something of himself in the relationship; so doctors are not, and should not be, 'automatons'. And this necessarily goes hand in hand with the expression, in some measure, of the doctor's values. What is crucially important, however, is not that the doctor attempts to wipe from the exchange his/her own values but that he is aware of the fact and potential impact of his/her own values.

The source of a doctor's values lies, of course, within his own upbringing, culture and religion, and may be expressed in the political views he holds; that is, in factors solely 'within him'. However, his personal values will also have been influenced by corporate professional values that he has 'learned', or otherwise adopted, from his training and professional exposure, including from his own sub-specialty.

Bias can also be determined by *the relationship between expert and subject*, arising from the nature of the interaction between the two, including in terms of 'counter-transference' experienced by the expert. Therefore, a subject may naturally induce 'sympathy' in an expert, but not in another. However, such

individual factors aside, a professional ‘ethic of care’, inherent to the practice of medicine, will, for almost all doctors, determine that the subject’s legal status as ‘defendant’ is moderated within the expert’s conception of him by the dominance of an ethic of care, which tends naturally to treat legal subjects as ‘patients’. Indeed, the fact that the expert will necessarily utilise the same medical techniques in assessing a defendant as he would do in assessing a patient must make it almost impossible to eschew some aspect of the ethic of care on the part of the expert.

Therefore, the conception of medical expert as ‘not acting as a doctor’ but as ‘being a forensicist’ – that is, a professional no longer subject to the usual array of medical ethics – must surely amount to a ‘false professional alibi’. Despite any ‘initial assertion’ on the part of the expert that he ‘is not being a doctor’ within the exchange, the mere utilisation of medical methods of assessment will inevitably lure the subject away from this view; and surely, the doctor too will tend to drift automatically towards a medical ethic by virtue of operating medical technique. So, for the expert, medical technique and medical ethic are, in some measure, indivisible.

There are at least two forms of *influence of the adversarial process per se* on the expression of expert opinion. First, and most obviously, the fact of an expert having been instructed by one side itself can bear influence. Second, irrespective of whichever side has instructed an expert, the very nature of the adversarial process can influence the expression of expert opinion.

Clearly, *being instructed by a particular side* can be accompanied by the (improper) expression of overt or covert, but objective, pressure upon the expert. Such pressure should, of course, be resisted. However, whether it is ‘fully resisted’ or merely only ‘partially (even minimally) resisted’ may be at issue; and there can be subtle shifts of emphasis expressed by the expert in response to pressure.

The origin of either a conscious or unconscious response to such pressure may be in terms simply of a natural ‘wish to please’ within a relationship. Alternatively, it may be driven crudely by the wish to be instructed again by the same lawyers, be it for the defence or prosecution – or even by the pursuit of financial gain, likely consequent upon subsequent instruction. Or there may be a laudable wish ‘to keep a balance’ between being instructed by defence and prosecution such that, ironically, the wish to ‘keep a balance’ within an expert’s practice may result, in an individual case, in him/her consciously or unconsciously yielding to overt or covert – intended or unintended – pressure from the side instructing on this particular occasion.

A further potential source of bias within the adversarial system is expressed in terms of ‘winning’ and ‘losing’, in that it is perhaps inevitable that some aspect of ‘wishing to win’, rather than being disinterested in the result, will apply even to the expert. Therefore, if an expert holds to an opinion in which he believes, it is likely that he will hope that his opinion will be vindicated; and vindication becomes identified with the side that instructed him ‘winning’.

As regards *the impact of the adversarial process per se*, one effect of the use of an adversarial route to determining ‘truth’ – in fact, ‘a truth’ (see above) – is that there is a likely tendency for this very process not necessarily to determine bias in terms of ‘what opinion’ is expressed but ‘with what strength’. So, the ultimate focus of the adversarial process, expressed within ‘cross-examination’, can push an expert more into his corner than s/he actually is.

A further effect of adversarial legal process is that the side initially ‘asking the questions’ of the expert automatically limits the domains of response of the expert and the mode of addressing aspects of those domains. That is, the question asked of an expert, and the manner of it being asked, must bear upon the boundaries and manner of expression of expert opinion.

A more general ‘driver’ of bias relates to ‘the lens through which’ a case is seen. Beyond even what questions are asked, and how they are put, the whole manner in which a legal side ‘puts its case’ (a legal concept) can exert subtle influences upon how the expert addresses those questions put to him. Essentially, within adversarial legal process, the case is presented through two conflicting ‘lenses’; and the lens through which the expert is asked to view the case is likely to have some impact upon his/her answers to the questions put.

Finally, the location of the burden of proof can influence the expression of expert opinion. Where the side instructing an expert bears the burden of proof, this will determine a need for the expert to be ‘active’ in addressing questions; whereas, when the burden is on the opposing side, his role is likely more to tend towards the ‘passive’. Also, the usual standard of proof – ‘on the balance of probability’ – lays ground for expression of difference by experts instructed by opposite sides where the issue is finely balanced; the expert called by the side with whom the burden of proof rests tends to ‘fall to that side’, while the expert for the other side falls ‘just to the other side’.

What are common expressions of bias?

As the sources of bias in the formation of an expert’s opinion may not be consciously determined, the expert may adopt routes to expression of such bias unconsciously. However, since the routes to the expression of opinion are essentially ‘practical’, and relate directly to ‘technique’, their adoption is more likely to be at least partly conscious, albeit such adoption may become ‘a hardly-conscious habit’. And some routes, which arise automatically from, or are facilitated by, operation of the adversarial legal process, are unavoidable. So, how may bias be pursued, or expressed, whether consciously or unconsciously?

The core of most routes to the expression of bias again lies in the legal adversarial process per se, and in failure of a medical expert to maintain his use of investigative medical technique, by oversight; or by being drawn into the adversarial process unknowingly; or by consciously adopting an ‘adversarial medical’ method, which is not ‘the medical method’ (which is ‘investigative’ in nature) – that is, being drawn from the home paradigm into a foreign one.

Adversarial legal argument operates on the basis of ‘disaggregation, selection, and selective emphasis’. Therefore, although ‘selectivity’ is an approach to consideration of evidence properly outlawed for the expert (albeit each side in a dispute must ‘acknowledge’ all the evidence), techniques of cross-examination and argument – especially if conducted before a jury – emphasise some evidence and de-emphasise other evidence.

By contrast, medical assessment properly conducted requires ‘investigative’ method, in that the scientist starts with a blank sheet, admits all evidence, and weighs all evidence fairly and comes to a balanced view (indeed, the term ‘fair test’ is at the heart of scientific experimentation and investigation). So, by definition, scientific enquiry eschews ‘selectivity’. However, where medicine is used within an adversarial legal process, there is a risk of ‘contamination’ of medical process in the expression of medical opinion.

For example, where, in ‘diminished responsibility’, the onus for raising the defence is on the defence – such that it produces a report that the prosecution may then seek to rebut – there is a risk that the prosecution expert will distort independent clinical practice; that is, interview the defendant, and consider the medical and legal papers, in terms of the question ‘Does the defence report stack up?’ Most crudely observed, it is not uncommon for a prosecution psychiatrist, having read a defence expert’s report supporting ‘diminished responsibility’, not to carry out his/her own full medical assessment, as he would do in an ordinary clinical context or if he did not have access to the defence medical report. It is not even unknown for a prosecution expert simply, or mainly, to ‘go through with the defendant the defence report’, in order to determine whether there are any ‘holes’ in it. And, while this may be a valid approach where s/he is merely offering ‘advice to counsel’ (see Chapter 4), rather than ‘assessing the defendant for court’, it is not acceptable practice in the latter context.

In summary, therefore, the adversarial legal sequence that occurs in regard to consideration of the partial defence of ‘diminished responsibility’ runs a high risk of contaminating – or at least laying the foundation for potential contamination of – medical investigative assessment. And this is illustrative of a more general problem of contamination of investigative medicine by adversarial law.

As regards individual routes to the expression of bias, much of the above text applies, plus the following:

First, although frank selectivity in regard to data – either from medical records or legal papers – would not only potentially invalidate an opinion but would draw criticism or sanction from the court, as with adversarial ‘arguing of a case,’ selectivity can be subtle in terms not of ‘exclusion and inclusion’ but ‘relative emphasis’.

Second, and more generally, it is possible to approach an assessment, or drafting of a report, in terms of ‘constructing a case’ via emphasis of particular data, or a particular interpretation of data. That is, to begin with a pre-conceived constructed case.

Third, although there is usually legal prohibition of experts expressing opinion on ‘the ultimate legal issue’, in the expression of expert psychiatric opinion the dividing line between ‘matters medical’ and ‘issues legal’ can be blurred (so that the expert can effectively become ‘a thirteenth jury person’, including by taking a view on factual matters which are in dispute). And this can represent expression of ‘ultimate bias’.

How can bias be minimised?

It is wise to start with recognition that ‘objectivity’ is impossible to achieve, even though its pursuit should be the goal. So, however careful one may be self-monitoring to avoid bias, there will always be ‘values incursion’, and even unrecognised bias. Hence, an understanding of the potential sources and routes to expression of bias, plus ‘self-reflection’ and ‘honesty’, are probably ultimately the best safeguards. That is, perhaps the only (albeit ‘inadequate’) approach we can have to avoiding bias is via ‘ethical insight’, plus pursuit of ‘honesty’.

However, the *attempt* to achieve objectivity, and certainly the *pursuit* of honesty, are crucially important goals within good clinical ethical practice. And clarity in defining any underlying ethical question at

hand, and in defining and acknowledging a given form of reflective process, will offer the best protection against the ‘unrealised’ operation of personal bias.

So, in practical terms, in an individual case, consider the following factors:

- Have you considered your own values and beliefs, and also how your opinion is at risk of being unduly influenced by these?
- Have you given thought to alternative opinions and to why you do not favour them; and might the reason lie in your own personal values?
- Is there any element of you giving an opinion based upon a personal or professional ‘hobby horse’?

And, consider especially:

- Do you have personal interest in the case, or specific personal values and beliefs that could bias you (for example, in a capital case, a belief for or against imposition of the death penalty per se)?
- Are you at risk of pretending that you are ‘unbiased’? This is ethically more dangerous than acknowledging your likely sources of bias, and attempting to be as honest as you can and seeking insight into ‘your ethical self’.

However, all of the foregoing emphasises the need for peer review of expert witness practice, and the avoidance of ‘isolated’ practice. This must address both technical competence, including a real understanding of the interface between medicine and law – itself a safeguard against bias (if not abused so as to pursue bias) – and ethical probity, including insight into, and attempts to deal with/avoid, bias.

Feedback from lawyers is very useful concerning aspects of ‘efficiency’ and clarity of expression, including relevance to the legal questions in play. However, review by lawyers is likely intrinsically to be based upon whether they perceived that the doctor’s report aided their side’s case or not, so such review is likely itself to be biased.

Therefore, peer review – whether it be pursued in regard to individual cases or in aggregate terms through ‘360 degree appraisal’ – can only be applied validly by inclusion of major input from other psychiatrists who engage in similar work.

The ‘ethical politics’ of forensic psychiatry

Much of the latter text, dealing with means towards minimising bias, is relevant to a broader topic that might be termed ‘the ethical politics of forensic psychiatry’. However, beyond the foregoing, given that forensic psychiatrists (or general psychiatrists drawn into forensic practice) deal with individuals who either or both pose a potential risk of offending to others and/or are defendants in court, the ethics of such practice can veer towards politics.

As already described, within much forensic psychiatric practice, the balance struck between the four ethical principles of medical ethics of Beauchamp and Childress is focused much more towards justice – at the expense of autonomy and non-maleficence – than is the case in clinical practice, which is untrammelled by public protection and involvement with the criminal courts. And this can draw clinicians into political spheres, sometimes without their conscious awareness.

This is most acutely focused in jurisdictions that retain the death penalty – both in relation to capital trials per se and, by association, in relation to all courtroom practice. And, where the doctor is employed by the state, the pressure placed upon him can be substantial – even if unintentionally by the state and generated solely from the expert's awareness of his contract of employment. So, beyond any 'cultural' effects upon the values applied to forensic practice by a clinician, there may well be exposure to political influence. Most obviously, in a jurisdiction where the death penalty is politically popular, it is likely to be more difficult for an expert to hold the line of 'minimally biased' courtroom practice in capital trials.

Finally, the 'contractual' problem goes hand-in-hand with a particular problem in small jurisdictions, where there will likely be few psychiatrists, all of whom are employed by the state. This places a particular – and enhanced – burden on such doctors in regard to minimising bias. This is further emphasised by such doctors having little natural exposure to 'peer review' within their work, again, because of their limited numbers.

Relationship with the defendant

A defendant is not a 'patient', and both the doctor and defendant should be fully aware of this from the outset.

However, while 'telling' a defendant that your role is not that of a doctor assessing and treating a patient is crucial and necessary, this distinction may well not – indeed, likely will not – continue to be understood and appreciated by the defendant, or even the doctor sometimes, as the assessment proceeds. This is because the doctor necessarily applies medical techniques to the assessment, some of which involve techniques of communication that simply make it feel to the defendant that you are 'being a doctor' (see also below in relation to the notion of being a 'forensicist'). However, this likely lack of appreciation of the unusual relationship must at least be acknowledged and kept 'in mind' as much as is possible.

Informed consent

The clinician should make available to the defendant they are assessing all information that might affect their decision on whether to cooperate with the assessment. This should include *the nature and purpose of the assessment* and your instructions, *your duty to the court*, and *the limits of confidentiality*. It is also important to make it clear that the purpose of the assessment is not so as to offer treatment (although you might recommend treatment in some cases). And there is clearly an even greater need for a defendant to be fully informed of all of the foregoing prior to an assessment in a capital case.

Clinician or forensicist

A major ethical debate has been pursued particularly in the United States for at least two decades concerning the role of doctors in criminal proceedings, including capital proceedings, specifically in terms

of whether they set aside their medical identity – and ethical principles associated with that identity – when they assess a defendant. That is, whether the medical ethical duty of ‘non-maleficence’ simply does not apply to a doctor assessing a defendant because, in that context, the doctor’s sole duty is to ‘justice’, and to the court.

In validating this ethical approach, it is suggested that the doctor assessing a defendant is not ‘being a doctor’; rather s/he is being ‘a forensicist’, somewhat akin to being a forensic scientist.

However, forensic scientists do not deal directly with individuals to whom they might owe a duty – that of honesty; and they certainly do not, in other circumstances, ‘treat’ individuals. And herein lies a potential, perhaps crucial, flaw in the forensicist ‘alibi’; in utilising medical techniques, a doctor necessarily uses techniques of communication that make it nigh on impossible to maintain in the defendant the belief – however strongly asserted at the outset by the assessor – that the assessor is ‘not being a doctor’.

An even more fundamental ethical counter to the forensicist alibi, however, lies in the fact that the doctor is still utilising clinical techniques that are designed for, and originate, in the pursuit of human welfare by way of treatment. That is, he is applying medical techniques to an individual where the result can be ‘maleficent’.

The crucial concern about the forensicist alibi, however, is that ‘pretending’ you are not being a doctor is ethically more dangerous than acknowledging that you are being one, and then dealing with, and coping with the profound ethical dilemmas that this raises in assessing defendants. Once again, ethical insight offers the greatest ethical protection.

Involvement in capital trials

Proximity to execution

As suggested (above) some doctors adopt an approach to involvement in capital trials based upon ‘how proximate’ to execution per se their posited involvement is, in terms of legal stage.

Therefore, a doctor may be prepared to assess a suspect in a murder inquiry for his ‘competence to be interviewed’, or to assess a defendant for his ‘fitness to plead’ or whether he has available to him a ‘mental condition defence’, yet be unprepared to be involved in one or more stages that apply after conviction.

We proceed on the basis of acceptance of involvement up to the point of conviction, and address involvement in subsequent stages – albeit accepting that some will ‘draw the line’ at less ‘proximate’ stages.

Sentencing

Where a court is considering whether to impose the discretionary death penalty, it will necessarily be required that there be psychiatric and/or psychological assessment (see Chapter 12).

Here there is the possibility of ‘doing harm’ to a defendant – although only through not finding there to be psychiatrically originating mitigating factors present in the defendant. For a doctor instructed by the defence or prosecution, therefore, his causing of harm can arise only through honestly finding no

mitigating psychiatric factors, for example, in terms of the test of ‘beyond reformation’, or perhaps also in terms of the test of ‘the worst of the worst’ in respect of capital sentencing (again, see Chapter 12).

What is crucial, therefore, is honesty of clinical assessment and insight into the potential impact of one’s own values – including personal beliefs about the death penalty and its application – on the assessment.

Mercy

Similar considerations apply to psychiatric assessment in relation to the exercise of mercy as to assessment for sentencing, in terms of honest assessment and insight into the potential impact of one’s own attitude to the death penalty.

Competence to be executed

It would be anathema to some doctors to declare a convict fit or competent to be executed, on the basis that it can never be ethically justifiable for a doctor to use their skills in order to facilitate punishment by death. So, where it is legally required that a convict be ‘medically certified’ as fit for execution, such doctors would refuse to certify any convict, on the basis that this would facilitate the causation of ‘ultimate harm’.

Where there is legally a presumption of fitness, however, harm caused by a doctor can only be – as in regard to sentencing or mercy hearings – by way of finding no relevant disorder.

Treatment to restore competence to be executed

The treatment of a mentally disordered prisoner solely for the purpose of restoring their competence to be executed is considered by almost all medical bodies to be unethical.

However, where a convict is in extreme mental distress, arising from a treatable mental condition, it may be considered that there is also an ethical imperative to treat the condition. And, where such treatment is likely to restore competence for execution, an ‘almost impossible’ ethical dilemma is posed, in terms of balancing harms (see also Chapter 12).

If the convict remains competent to consent to or refuse treatment, then he should make the decision. However, mental disorder that has removed competence to be executed will most likely also have removed competence to consent to treatment, and so involvement of the convict’s lawyer in the decision is required. This may appear to offer ‘resolution’ of the doctor’s ethical dilemma. However, such apparent resolution is illusory, since even if the advocate offers an opinion, it is still the doctor who ultimately has to decide ‘whether to treat’.

Conclusion

Medical involvement in serious criminal legal proceedings, and particularly proceedings related to imposition of the death penalty, is both profoundly ethically problematic and open to the strongest of

emotion and opinion. It is an ethical cauldron. And this emphasises the importance of calm, considered, insightful and reasoned deliberation and reflection. It is hoped that this chapter will offer some assistance to clinicians faced with involvement in serious criminal – but particularly death penalty – cases towards achieving such deliberation and reflection. Therein lies the best route to confidence that ethical process has been pursued as well as it can be.

The authors would welcome contact from colleagues about specific clinical and clinico-legal ethical dilemmas they have encountered, in the hope that open dialogue will serve to enhance ethical practice in this very difficult field.

APPENDICES



Appendix 1: Psychological assessment quick reference guide

Psychological factor	Psychometric test
Current general intelligence	<ul style="list-style-type: none"> • Wechsler Adult Intelligence Scale, fourth edition (WAIS-IV) • Ravens Progressive Matrices
Pre-morbid estimate of intellectual functioning	<ul style="list-style-type: none"> • National Adult Reading Test (NART) • Schonell Graded Reading Test • Wechsler Test of Adult Reading (WTAR) • Wechsler Test of Pre-morbid Functioning (TOPF)
Memory functioning	<ul style="list-style-type: none"> • Wechsler Memory Scale, fourth edition (WMS-IV) • Rey-Ostreith Complex Figure Test
Executive functioning	<ul style="list-style-type: none"> • Behavioural Assessment of Dysexecutive Syndrome (BADS) • Controlled Oral Work Association Test • Reitan Trailmaking test • Haying and Brixton tests • Stroop Neuropsychological Screening Test
Language	<ul style="list-style-type: none"> • British Picture Vocabulary Scale (version 2) • Graded Naming Test
Suggestibility	<ul style="list-style-type: none"> • Gudjonsson Suggestibility Scale (version 1 or 2)
Compliance	<ul style="list-style-type: none"> • Gudjonsson Compliance Scale (Form D for the individual or Form E for an informant)
Mood	<ul style="list-style-type: none"> • Beck Anxiety Inventory (BAI) • Beck Depression Inventory version two (BDI-II) • Hospital Anxiety and Depression Scale (HADS) • State/Trait Anger inventory (STAXI)
Personality functioning	<ul style="list-style-type: none"> • Millon Clinical Multi-axial Inventory – third edition (MCMI-III) • Minnesota Multiphasic Personality Inventory (MMPI) • Personality Assessment Inventory (PAI)
Substance misuse	<ul style="list-style-type: none"> • Leeds Dependency Questionnaire (LDQ) • Sensation Seeking Scale (SSS)
Dissociation	<ul style="list-style-type: none"> • Dissociative Experiences Scale (DES)
Sub-optimal effort/ malingering	<ul style="list-style-type: none"> • Test of Memory Malingering (TOMM) • Ravens Standard Progressive Matrices • Millar Forensic Assessment of Symptoms (MFAST) • Structured interview of Reported Symptoms (SIRS) • Structured Inventory of Malingered Symptomatology (SIMS) • Paulhus Deception Scale

NB: This is not an exhaustive list, but represents some of the most commonly used measures with robust psychometric properties.

Appendix 2: Recommended psychological assessments

Wechsler Adult Intelligence Scale Fourth Edition (WAIS-IV)

The Wechsler Adult Intelligence Scale UK – Fourth Edition (WAIS-IV) is a standardised psychometric measure offering an estimate of an individual's intellectual functioning.

Wechsler Memory Scale (Fourth Edition)

The Wechsler Memory Scale UK – Fourth Edition (WMS-IV) is a standardised psychometric measure offering an estimate of an individual's memory functioning.

Controlled Oral Word Association Test (COWAT)

This is a 'bedside' test used to assess an individual's executive functioning, specifically their ability spontaneously to create lists, follow rules and shift sets. It has internationally recognised normative data developed from clinical and non-clinical populations.

Millon Clinical Multi-Axial Inventory, third edition (MCMI-III)

The MCMI-III is a test designed to assess a number of major patterns of personality and emotional disorder.

Coin-in-the-hand test

This is a test which appears to be superficially difficult but which is actually very easy, and is a test that even individuals with dense organic amnesia will complete correctly 10 out of 10 times. It is a test of memory malingering.

Beck Depression Inventory, Version 2 (BDI-II)

The BDI II is a 21-item self-report measure that is designed to assess the severity of a depression in adolescents and adults. It is the most widely accepted measure in clinical psychology and psychiatry for assessing the severity of depression.

Tests of Attitudes Towards Violence – Maudsley Violence Questionnaire (MVQ)

This self-report questionnaire measures a range of cognitions, relating to violent behaviour, that justify the use of violence in response to threatened self-esteem, plus the legitimising of violent acts in a variety of circumstances.

The Stroop Neuropsychological Screening Test

This test examines an individual's ability to inhibit their automatic response to the stimulus of a word. It is used as part of the assessment of executive function.

The Reitan Trailmaking Test

This test requires subjects visually to scan a page and draw a line between ascending numbers in Part A, and then alternate between numbers and letters in Part B. This assesses subject's ability to shift their attention and problem solving abilities, as well as assessing their visuospatial awareness.

Rey-Ostreith Complex Figure Test

This is a test of an individual's ability to reproduce a complex diagram, firstly by copying it, then again immediately from memory, and again from memory following a delay of 45 minutes. It is thought to be a measure of memory that is relatively free from cultural bias. It also incorporates aspects of executive function.

Raven's Progressive Matrices

This is a test of abstract reasoning. Participants are presented with a pattern that has a part missing. They are then asked to choose from a range of options that might fit into the blank space. This test has been well normed with both children and adults and is thought of as a largely 'culture-free' test of general reasoning ability.

Test of Effort

The test assesses the effort that the individual is making in order to ascertain whether a subject is engaging in testing appropriately, or is attempting to 'fake bad' for a purpose of secondary gain – such as to perform on testing in such a way as to suggest they are more mentally compromised than is actually the case.

Test of Memory Malingering (TOMM)

The TOMM is a 50-item recognition test for adults that includes two learning trials and a retention trial.

Gudjonsson Suggestibility Scale (GSS I)

The Gudjonsson Suggestibility Scale offers psychometric assessment of the degree to which an individual may be acquiescent to, and take on and believe, the suggestion of others.

Gudjonsson Compliance Scale Form D

The Gudjonsson Compliance Scale is administered in tandem with the Gudjonsson Suggestibility Scale. It is a 20-question self-report instrument yielding information about the extent to which the individual feels that they must follow the direction and requests of others, rather than being self-determining in their behaviour.

Test of Depictive Responding – Paulhus Deception Scale (PDS)

This 40-item questionnaire measures respondents' tendencies to give socially desirable responses on self-report. It contains two sub-scales: self-deceptive enhancement (the tendency to give honest but inflated self-descriptions); and impression management (the tendency to give inflated self-descriptions to an audience). The PDS is therefore thought to capture the two principal forms of socially desirable responding with two (relatively independent) sub-scales.

Dissociative Experiences Scale

The Dissociative Experiences Scale (DES) is a psychological self-assessment questionnaire that measures dissociative symptoms.

State-Trait Anger Expression Inventory-2 (STAXI-2)

The State-Trait Anger Expression Inventory-2 (STAXI-2) is a 57-item inventory that measures the intensity of anger as an emotional state (State Anger) and the disposition to experience angry feelings as a personality trait (Trait Anger).

Leeds Dependency Questionnaire (LDQ)

The LDQ measures substance dependence.

Sensation Seeking Scale

This test assesses individual differences in terms of sensory stimulation preferences. So there are people who prefer a strong stimulation and display a behaviour that manifests a greater desire for sensations, and there are those who prefer a low sensory stimulation. The scale is a questionnaire designed to measure how much stimulation a person requires and the extent to which they enjoy the excitement.

Appendix 3: Diagnostic classifications: ICD10 and DSM-5 Ethical codes

The following table lists the diagnoses the APA Diagnostic and Statistical Manual, 5th edition, (DSM-5), and the WHO International Classification of Diseases, 10th edition (ICD10) (a new edition of ICD is due to be published soon). ICD-10 is presented in the order described in the manual but significant reorganisation of DSM (from DSM4-TR) makes direct comparison between the two classifications much more difficult. Hence DSM-5 diagnoses are grouped so as to assist in comparing them with ICD-10, but are not presented in the order they appear in the manual. It is for this reason that headings are omitted for DSM-5.

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Organic, including symptomatic, mental disorders (F01-F09)</i>	
<ul style="list-style-type: none"> • Vascular dementia (F01) <ul style="list-style-type: none"> • Vascular dementia of acute onset (F01.0) • Multi-infarct dementia (F01.1) • Subcortical vascular dementia (F01.2) • Mixed cortical and subcortical vascular dementia (F01.3) • Other vascular dementia (F01.8) • Vascular dementia, unspecified (F01.9) • Unspecified dementia (F03) • Organic amnesic syndrome, not induced by alcohol and other psychoactive substances (F04) • Delirium, not induced by alcohol and other psychoactive substances (F05) <ul style="list-style-type: none"> • Delirium not superimposed on dementia, so described (F05.0) • Delirium superimposed on dementia (F05.1) • Other delirium (F05.8) • Delirium, unspecified (F05.9) • Other mental disorders due to brain damage and dysfunction and to physical disease (F06) <ul style="list-style-type: none"> • Organic hallucinosis (F06.0) • Organic catatonic disorder (F06.1) • Organic delusional [schizophrenia-like] disorder (F06.2) • Organic mood [affective] disorders (F06.3) • Organic anxiety disorder (F06.4) • Organic dissociative disorder (F06.5) • Organic emotionally labile [asthenic] disorder (F06.6) • Mild cognitive disorder (F06.7) • Other specified mental disorders due to brain damage and dysfunction and to physical disease (F06.8) • Unspecified mental disorder due to brain damage and dysfunction and to physical disease (F06.9) 	<ul style="list-style-type: none"> • Major vascular neurocognitive disorder, probable, without behavioural disturbance • Major vascular neurocognitive disorder, probable, with behavioural disturbance • Major frontotemporal neurocognitive disorder, probable, without behavioural disturbance • Major neurocognitive disorder due to Alzheimer's disease, probable, without behavioural disturbance • Major neurocognitive disorder due to another medical condition, without behavioural disturbance • Major neurocognitive disorder due to HIV infection, without behavioural disturbance • Major neurocognitive disorder due to Huntington's disease, without behavioural disturbance • Major neurocognitive disorder due to multiple etiologies, without behavioural disturbance • Major neurocognitive disorder due to Parkinson's disease, probable, without behavioural disturbance • Major neurocognitive disorder due to prion disease, without behavioural disturbance • Major neurocognitive disorder due to traumatic brain injury, without behavioural disturbance • Neurocognitive disorder with Lewy bodies, probable, without behavioural disturbance • Frontotemporal neurocognitive disorder, probable, with behavioural disturbance • Neurocognitive disorder due to Alzheimer's disease, probable, with behavioural disturbance • Major neurocognitive disorder due to another medical condition, with behavioural disturbance • Major neurocognitive disorder due to HIV infection, with behavioural disturbance • Major neurocognitive disorder due to Huntington's disease, with behavioural disturbance • Major neurocognitive disorder due to multiple etiologies, with behavioural disturbance

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Organic, including symptomatic, mental disorders (F01-F09)</i>	
<ul style="list-style-type: none"> • Personality and behavioural disorders due to brain disease, damage, and dysfunction (F07) <ul style="list-style-type: none"> • Organic personality disorder (F07.0) • Postencephalitic syndrome (F07.1) • Postconcussional syndrome (F07.2) • Other organic personality and behavioural disorders due to brain disease, damage, and dysfunction (F07.8) • Unspecified organic personality and behavioural disorder due to brain disease, damage, and dysfunction (F07.9) • Unspecified organic or symptomatic mental disorder (F09) 	<ul style="list-style-type: none"> • Major neurocognitive disorder due to Parkinson's disease, probable, with behavioural disturbance • Major neurocognitive disorder due to prion disease, with behavioural disturbance • Major neurocognitive disorder due to traumatic brain injury, with behavioural disturbance • Major neurocognitive disorder with Lewy bodies, probable, with behavioural disturbance • Delirium due to another medical condition • Delirium due to multiple etiologies • Psychotic disorder due to another medical condition, with hallucinations • Catatonia associated with another mental disorder (catatonia specifier) • Catatonic disorder due to another medical condition • Unspecified catatonia • Psychotic disorder due to another medical condition, with delusions • Depressive disorder due to another medical condition, with depressive features • Depressive disorder due to another medical condition, with major depressive-like episode • Bipolar and related disorder due to another medical condition, with manic features • Bipolar and related disorder due to another medical condition, with manic- or hypomanic-like episodes • Bipolar and related disorder due to another medical condition, with mixed features • Depressive disorder due to another medical condition, with mixed features • Anxiety disorder due to another medical condition • Obsessive-compulsive and related disorder due to another medical condition • Other specified mental disorder due to another medical condition • Personality change due to another medical condition • Unspecified mental disorder due to another medical condition
<i>Mental and behavioural disorders due to psychoactive substance use (F10-F19)</i>	
<ul style="list-style-type: none"> • Mental and behavioural disorders due to use of alcohol (F10) <ul style="list-style-type: none"> • Acute intoxication (F10.0) • Harmful use (F10.1) • Dependence syndrome (F10.2) • Withdrawal state (F10.3) • Withdrawal state with delirium (F10.4) • Psychotic disorder (F10.5) • Amnesic syndrome (F10.6) 	<ul style="list-style-type: none"> • Alcohol use disorder, mild • Alcohol intoxication delirium, with mild use disorder • Alcohol intoxication, with mild use disorder • Alcohol-induced bipolar and related disorder, with mild use disorder • Alcohol-induced depressive disorder, with mild use disorder • Alcohol-induced psychotic disorder, with mild use disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Mental and behavioural disorders due to psychoactive substance use (F10-F19)</i>	
<ul style="list-style-type: none"> • Residual and late-onset psychotic disorder (F10.7) • Other mental and behavioural disorders (F10.8) • Unspecified mental and behavioural disorder (F10.9) • Mental and behavioural disorders due to use of opioids (F11) <ul style="list-style-type: none"> • Acute intoxication (F11.0) • Harmful use (F11.1) • Dependence syndrome (F11.2) • Withdrawal state (F11.3) • Withdrawal state with delirium (F11.4) • Psychotic disorder (F11.5) • Amnesic syndrome (F11.6) • Residual and late-onset psychotic disorder (F11.7) • Other mental and behavioural disorders (F11.8) • Unspecified mental and behavioural disorder (F11.9) • Mental and behavioural disorders due to use of cannabinoids (F12) <ul style="list-style-type: none"> • Acute intoxication (F12.0) • Harmful use (F12.1) • Dependence syndrome (F12.2) • Withdrawal state (F12.3) • Withdrawal state with delirium (F12.4) • Psychotic disorder (F12.5) • Amnesic syndrome (F12.6) • Residual and late-onset psychotic disorder (F12.7) • Other mental and behavioural disorders (F12.8) • Unspecified mental and behavioural disorder (F12.9) • Mental and behavioural disorders due to use of sedatives or hypnotics (F13) <ul style="list-style-type: none"> • Acute intoxication (F13.0) • Harmful use (F13.1) • Dependence syndrome (F13.2) • Withdrawal state (F13.3) • Withdrawal state with delirium (F13.4) • Psychotic disorder (F13.5) • Amnesic syndrome (F13.6) • Residual and late-onset psychotic disorder (F13.7) • Other mental and behavioural disorders (F13.8) • Unspecified mental and behavioural disorder (F13.9) • Mental and behavioural disorders due to use of cocaine (F14) <ul style="list-style-type: none"> • Acute intoxication (F14.0) 	<ul style="list-style-type: none"> • Alcohol use disorder, mild • Alcohol intoxication delirium, with mild use disorder • Alcohol intoxication, with mild use disorder • Alcohol-induced bipolar and related disorder, with mild use disorder • Alcohol-induced depressive disorder, with mild use disorder • Alcohol-induced psychotic disorder, with mild use disorder • Alcohol-induced anxiety disorder, with mild use disorder • Alcohol-induced sexual dysfunction, with mild use disorder • Alcohol-induced sleep disorder, with mild use disorder • Alcohol use disorder, Moderate • Alcohol use disorder, Severe • Alcohol intoxication delirium, with moderate or severe use disorder • Alcohol intoxication, with moderate or severe use disorder • Alcohol withdrawal delirium • Alcohol withdrawal, with perceptual disturbances • Alcohol withdrawal, without perceptual disturbances • Alcohol-induced bipolar and related disorder, with moderate or severe use disorder • Alcohol-induced depressive disorder, with moderate or severe use disorder • Alcohol-induced psychotic disorder, with moderate or severe use disorder • Alcohol-induced major neurocognitive disorder, amnesic confabulatory type, with moderate or severe use disorder • Alcohol-induced major neurocognitive disorder, nonamnesic confabulatory type, with moderate or severe use disorder • Alcohol-induced anxiety disorder, with moderate or severe use disorder • Alcohol-induced sexual dysfunction, with moderate or severe use disorder • Alcohol-induced sleep disorder, with moderate or severe use disorder • Alcohol-induced mild neurocognitive disorder, with moderate or severe use disorder • Alcohol intoxication delirium, without use disorder • Alcohol intoxication, without use disorder • Alcohol-induced bipolar and related disorder, without use disorder • Alcohol-induced major neurocognitive disorder, nonamnesic confabulatory type, without use disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Mental and behavioural disorders due to psychoactive substance use (F10-F19)</i>	
<ul style="list-style-type: none"> • Harmful use (F14.1) • Dependence syndrome (F14.2) • Withdrawal state (F14.3) • Withdrawal state with delirium (F14.4) • Psychotic disorder (F14.5) • Amnesic syndrome (F14.6) • Residual and late-onset psychotic disorder (F14.7) • Other mental and behavioural disorders (F14.8) • Unspecified mental and behavioural disorder (F14.9) • Mental and behavioural disorders due to use of other stimulants, including caffeine (F15) <ul style="list-style-type: none"> • Acute intoxication (F15.0) • Harmful use (F15.1) • Dependence syndrome (F15.2) • Withdrawal state (F15.3) • Withdrawal state with delirium (F15.4) • Psychotic disorder (F15.5) • Amnesic syndrome (F15.6) • Residual and late-onset psychotic disorder (F15.7) • Other mental and behavioural disorders (F15.8) • Unspecified mental and behavioural disorder (F15.9) • Mental and behavioural disorders due to use of hallucinogens (F16) <ul style="list-style-type: none"> • Acute intoxication (F16.0) • Harmful use (F16.1) • Dependence syndrome (F16.2) • Withdrawal state (F16.3) • Withdrawal state with delirium (F16.4) • Psychotic disorder (F16.5) • Amnesic syndrome (F16.6) • Residual and late-onset psychotic disorder (F16.7) • Other mental and behavioural disorders (F16.8) • Unspecified mental and behavioural disorder (F16.9) • Mental and behavioural disorders due to use of tobacco (F17) <ul style="list-style-type: none"> • Acute intoxication (F17.0) • Harmful use (F17.1) • Dependence syndrome (F17.2) • Withdrawal state (F17.3) • Withdrawal state with delirium (F17.4) • Psychotic disorder (F17.5) • Amnesic syndrome (F17.6) • Residual and late-onset psychotic disorder (F17.7) 	<ul style="list-style-type: none"> • Alcohol-induced anxiety disorder, without use disorder • Alcohol-induced sexual dysfunction, without use disorder • Alcohol-induced sleep disorder, without use disorder • Alcohol-induced mild neurocognitive disorder, without use disorder • Unspecified alcohol-related disorder • Opioid use disorder, mild • Opioid intoxication delirium, with mild use disorder • Opioid intoxication, with perceptual disturbances, with mild use disorder • Opioid intoxication, without perceptual disturbances, with mild use disorder • Opioid-induced depressive disorder, with mild use disorder • Opioid-induced sexual dysfunction, with mild use disorder • Opioid-induced sleep disorder, with mild use disorder • Opioid-induced anxiety disorder, with mild use disorder • Opioid use disorder, moderate • Opioid use disorder, severe • Opioid intoxication delirium, with moderate or severe use disorder • Opioid intoxication, with perceptual disturbances, with moderate or severe use disorder • Opioid intoxication, without perceptual disturbances, with moderate or severe use disorder • Opioid withdrawal • Opioid withdrawal delirium • Opioid-induced depressive disorder, with moderate or severe use disorder • Opioid-induced sexual dysfunction, with moderate or severe use disorder • Opioid-induced sleep disorder, with moderate or severe use disorder • Opioid-induced anxiety disorder, with moderate or severe use disorder • Opioid intoxication delirium, without use disorder • Opioid-induced delirium • Opioid intoxication, with perceptual disturbances, without use disorder • Opioid intoxication, Without perceptual disturbances, without use disorder • Opioid-induced depressive disorder, without use disorder • Opioid-induced sexual dysfunction, without use disorder • Opioid-induced sleep disorder, without use disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Mental and behavioural disorders due to psychoactive substance use (F10-F19)</i>	
<ul style="list-style-type: none"> • Other mental and behavioural disorders (F17.8) • Unspecified mental and behavioural disorder (F17.9) • Mental and behavioural disorders due to use of volatile solvents (F18) <ul style="list-style-type: none"> • Acute intoxication (F18.0) • Harmful use (F18.1) • Dependence syndrome (F18.2) • Withdrawal state (F18.3) • Withdrawal state with delirium (F18.4) • Psychotic disorder (F18.5) • Amnesic syndrome (F18.6) • Residual and late-onset psychotic disorder (F18.7) • Other mental and behavioural disorders (F18.8) • Unspecified mental and behavioural disorder (F18.9) • Mental and behavioural disorders due to multiple-drug use and use of other psychoactive substances (F19) <ul style="list-style-type: none"> • Acute intoxication (F19.0) • Harmful use (F19.1) • Dependence syndrome (F19.2) • Withdrawal state (F19.3) • Withdrawal state with delirium (F19.4) • Psychotic disorder (F19.5) • Amnesic syndrome (F19.6) • Residual and late-onset psychotic disorder (F19.7) • Other mental and behavioural disorders (F19.8) • Unspecified mental and behavioural disorder (F19.9) 	<ul style="list-style-type: none"> • Opioid-induced anxiety disorder, without use disorder • Unspecified opioid-related disorder • Cannabis use disorder, mild • Cannabis intoxication delirium, with mild use disorder • Cannabis intoxication, with perceptual disturbances, with mild use disorder • Cannabis intoxication, without perceptual disturbances, with mild use disorder • Cannabis-induced psychotic disorder, with mild use disorder • Cannabis-induced anxiety disorder, with mild use disorder • Cannabis-induced sleep disorder, with mild use disorder • Cannabis use disorder, moderate • Cannabis use disorder, severe • Cannabis intoxication delirium, with moderate or severe use disorder • Cannabis intoxication, with perceptual disturbances, with moderate or severe use disorder • Cannabis intoxication, without perceptual disturbances, with moderate or severe use disorder • Cannabis-induced psychotic disorder, with moderate or severe use disorder • Cannabis-induced anxiety disorder, with moderate or severe use disorder • Cannabis withdrawal • Cannabis-induced sleep disorder, with moderate or severe use disorder • Cannabis intoxication delirium, without use disorder • Cannabis intoxication, with perceptual disturbances, without use disorder • Cannabis intoxication, without perceptual disturbances, without use disorder • Cannabis-induced psychotic disorder, without use disorder • Cannabis-induced anxiety disorder, without use disorder • Cannabis-induced sleep disorder, without use disorder • Unspecified cannabis-related disorder <p>NB the same categorisation is then used for other substances.</p>
<i>Schizophrenia, schizotypal and delusional disorders (F20-F29)</i>	
<ul style="list-style-type: none"> • Schizophrenia (F20) <ul style="list-style-type: none"> • Paranoid schizophrenia (F20.0) • Hebephrenic schizophrenia (F20.1) • Catatonic schizophrenia (F20.2) 	<ul style="list-style-type: none"> • Schizophreniform disorder • Schizophrenia • Schizotypal personality disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
Schizophrenia, schizotypal and delusional disorders (F20-F29)	
<ul style="list-style-type: none"> • Undifferentiated schizophrenia (F20.3) • Postschizophrenic depression (F20.4) • Residual schizophrenia (F20.5) • Simple schizophrenia (F20.6) • Other schizophrenia (F20.8) • Schizophrenia, unspecified (F20.9) • Schizotypal disorder (F21) • Persistent delusional disorders (F22) • Delusional disorder (F22.0) <ul style="list-style-type: none"> • Other persistent delusional disorders (F22.8) • Persistent delusional disorder, unspecified (F22.9) • Acute and transient psychotic disorders (F23) • Acute polymorphic psychotic disorder without symptoms of schizophrenia (F23.0) <ul style="list-style-type: none"> • Acute polymorphic psychotic disorder with symptoms of schizophrenia (F23.1) • Acute schizophrenia-like psychotic disorder (F23.2) • Other acute predominantly delusional psychotic disorders (F23.3) • Other acute and transient psychotic disorders (F23.8) • Acute and transient psychotic disorder, unspecified (F23.9) • Induced delusional disorder (F24) • Schizoaffective disorders (F25) <ul style="list-style-type: none"> • Schizoaffective disorder, manic type (F25.0) • Schizoaffective disorder, depressive type (F25.1) • Schizoaffective disorder, mixed type (F25.2) • Other schizoaffective disorders (F25.8) • Schizoaffective disorder, unspecified (F25.9) • Other nonorganic psychotic disorders (F28) • Unspecified nonorganic psychosis (F29) 	<ul style="list-style-type: none"> • Delusional disorder • Brief psychotic disorder • Schizoaffective disorder, bipolar type • Schizoaffective disorder, depressive type • Other specified schizophrenia spectrum and other psychotic disorder • Unspecified schizophrenia spectrum and other psychotic disorder
Mood [affective] disorders (F30-F39)	
<ul style="list-style-type: none"> • Manic episode (F30) <ul style="list-style-type: none"> • Hypomania (F30.0) • Mania without psychotic symptoms (F30.1) • Mania with psychotic symptoms (F30.2) • Other manic episodes (F30.8) • Manic episode, unspecified (F30.9) • Bipolar affective disorder (F31) • Bipolar affective disorder, current episode <ul style="list-style-type: none"> • hypomanic (F31.0) • manic without psychotic symptoms (F31.1) • manic with psychotic symptoms (F31.2) • mild or moderate depression (F31.3) • severe depression without psychotic symptoms (F31.4) • severe depression with psychotic symptoms (F31.5) • mixed (F31.6) 	<ul style="list-style-type: none"> • Bipolar I disorder, current or most recent episode hypomanic • Bipolar I disorder, current or most recent episode manic, mild • Bipolar I disorder, current or most recent episode manic, moderate • Bipolar I disorder, current or most recent episode manic, severe • Bipolar I disorder, current or most recent episode manic, with psychotic features • Bipolar I disorder, current or most recent episode depressed, mild • Bipolar I disorder, current or most recent episode depressed, moderate • Bipolar I disorder, current or most recent episode depressed, severe

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
Mood [affective] disorders (F30-F39)	
<ul style="list-style-type: none"> • Bipolar affective disorder, currently in remission (F31.7) • Other bipolar affective disorders (F31.8) • Bipolar affective disorder, unspecified (F31.9) • Depressive episode (F32) • Mild depressive episode (F32.0) <ul style="list-style-type: none"> • Moderate depressive episode (F32.1) • Severe depressive episode without psychotic symptoms (F32.2) • Severe depressive episode with psychotic symptoms (F32.3) • Other depressive episodes (F32.8) • Depressive episode, unspecified (F32.9) • Recurrent depressive disorder (F33) <ul style="list-style-type: none"> • Recurrent depressive disorder, current episode mild (F33.0) • Recurrent depressive disorder, current episode moderate (F33.1) • Recurrent depressive disorder, current episode severe without psychotic symptoms (F33.2) • Recurrent depressive disorder, current episode severe with psychotic symptoms (F33.3) • Recurrent depressive disorder, currently in remission (F33.4) • Other recurrent depressive disorders (F33.8) • Recurrent depressive disorder, unspecified (F33.9) • Persistent mood [affective] disorders (F34) <ul style="list-style-type: none"> • Cyclothymia (F34.0) • Dysthymia (F34.1) • Other persistent mood [affective] disorders (F34.8) • Persistent mood [affective] disorder, unspecified (F34.9) • Other mood [affective] disorders (F38) <ul style="list-style-type: none"> • Other single mood [affective] disorders (F38.0) • Other recurrent mood [affective] disorders (F38.1) • Other specified mood [affective] disorders (F38.8) • Unspecified mood [affective] disorder (F39) 	<ul style="list-style-type: none"> • Bipolar I disorder, current or most recent episode depressed, with psychotic features • Bipolar I disorder, current or most recent episode hypomanic, in partial remission • Bipolar I disorder, current or most recent episode manic, in partial remission • Bipolar I disorder, current or most recent episode hypomanic, in full remission • Bipolar I disorder, current or most recent episode manic, in full remission • Bipolar I disorder, current or most recent episode depressed, in partial remission • Bipolar I disorder, current or most recent episode depressed, in full remission • Bipolar II disorder • Other specified bipolar and related disorder • Bipolar I disorder, current or most recent episode depressed, unspecified • Bipolar I disorder, current or most recent episode hypomanic, unspecified • Bipolar I disorder, current or most recent episode manic, unspecified • Bipolar I disorder, current or most recent episode unspecified • Unspecified bipolar and related disorder • Major depressive disorder, single episode, mild • Major depressive disorder, single episode, moderate • Major depressive disorder, single episode, severe • Major depressive disorder, single episode, with psychotic features • Major depressive disorder, single episode, in partial remission • Major depressive disorder, single episode, in full remission • Other specified depressive disorder • Major depressive disorder, single episode, unspecified • Unspecified depressive disorder • Major depressive disorder, recurrent episode, mild • Major depressive disorder, recurrent episode, moderate • Major depressive disorder, recurrent episode, severe • Major depressive disorder, recurrent episode, with psychotic features • Major depressive disorder, recurrent episode, in partial remission • Major depressive disorder, recurrent episode, in full remission • Major depressive disorder, recurrent episode, unspecified • Cyclothymic disorder • Persistent depressive disorder (dysthymia) • Disruptive mood dysregulation disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Neurotic, stress-related and somatoform disorders (F40-F48)</i>	
<ul style="list-style-type: none"> • Phobic anxiety disorders (F40) <ul style="list-style-type: none"> • Agoraphobia (F40.0) • Social phobias (F40.1) • Specific (isolated) phobias (F40.2) • Other phobic anxiety disorders (F40.8) • Phobic anxiety disorder, unspecified (F40.9) • Other anxiety disorders (F41) <ul style="list-style-type: none"> • Panic disorder [episodic paroxysmal anxiety] (F41.0) • Generalised anxiety disorder (F41.1) • Mixed anxiety and depressive disorder (F41.2) • Other mixed anxiety disorders (F41.3) • Other specified anxiety disorders (F41.8) • Anxiety disorder, unspecified (F41.9) • Obsessive-compulsive disorder (F42) <ul style="list-style-type: none"> • Predominantly obsessional thoughts or ruminations (F42.0) • Predominantly compulsive acts [obsessional rituals] (F42.1) • Mixed obsessional thoughts and acts (F42.2) • Other obsessive-compulsive disorders (F42.8) • Obsessive-compulsive disorder, unspecified (F42.9) • Reaction to severe stress, and adjustment disorders (F43) <ul style="list-style-type: none"> • Acute stress reaction (F43.0) • Posttraumatic stress disorder (F43.1) • Adjustment disorders (F43.2) • Other reactions to severe stress (F43.8) • Reaction to severe stress, unspecified (F43.9) • Dissociative [conversion] disorders (F44) <ul style="list-style-type: none"> • Dissociative amnesia (F44.0) • Dissociative fugue (F44.1) • Dissociative stupor (F44.2) • Trance and possession disorders (F44.3) • Dissociative motor disorders (F44.4) • Dissociative convulsions (F44.5) • Dissociative anesthesia and sensory loss (F44.6) • Mixed dissociative [conversion] disorders (F44.7) • Other dissociative [conversion] disorders (F44.8) • Dissociative [conversion] disorder, unspecified (F44.9) • Somatoform disorders (F45) <ul style="list-style-type: none"> • Somatization disorder (F45.0) • Undifferentiated somatoform disorder (F45.1) • Hypochondriacal disorder (F45.2) • Somatoform autonomic dysfunction (F45.3) • Persistent somatoform pain disorder (F45.4) • Other somatoform disorders (F45.8) • Somatoform disorder, unspecified (F45.9) 	<ul style="list-style-type: none"> • Agoraphobia • Social anxiety disorder (social phobia) • Specific phobia, animal • Specific phobia, natural environment • Specific phobia, fear of blood • Specific phobia, fear of injections and transfusions • Specific phobia, fear of other medical care • Specific phobia, fear of injury • Specific phobia, situational • Specific phobia, other • Panic disorder • Generalized anxiety disorder • Other specified anxiety disorder • Unspecified anxiety disorder • Hoarding disorder • Obsessive-compulsive disorder • Other specified obsessive-compulsive and related disorder • Unspecified obsessive-compulsive and related disorder • Acute stress disorder • Posttraumatic stress disorder • Adjustment disorder, unspecified • Adjustment disorder, with depressed mood • Adjustment disorder, with anxiety • Adjustment disorder, with disturbance of conduct • Adjustment disorder, with mixed anxiety and depressed mood • Adjustment disorder, with mixed disturbance of emotions and conduct • Other specified trauma- and stressor-related disorder • Unspecified trauma- and stressor-related disorder • Dissociative amnesia • Dissociative amnesia, with dissociative fugue • Conversion disorder (functional neurological symptom disorder), with abnormal movement • Conversion disorder (functional neurological symptom disorder), with speech symptoms • Conversion disorder (functional neurological symptom disorder), with swallowing symptoms • Conversion disorder (functional neurological symptom disorder), with weakness/paralysis • Conversion disorder (functional neurological symptom disorder), with attacks or seizures • Conversion disorder (functional neurological symptom disorder), with anesthesia or sensory loss • Conversion disorder (functional neurological symptom disorder), with special sensory symptoms • Conversion disorder (functional neurological symptom disorder), with mixed symptoms • Dissociative identity disorder • Other specified dissociative disorder • Unspecified dissociative disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Neurotic, stress-related and somatoform disorders (F40-F48)</i>	
<ul style="list-style-type: none"> • Other neurotic disorders (F48) <ul style="list-style-type: none"> • Neurasthenia (F48.0) • Depersonalisation-derealisation syndrome (F48.1) • Other specified neurotic disorders (F48.8) • Neurotic disorder, unspecified (F48.9) 	<ul style="list-style-type: none"> • Somatic symptom disorder • Illness anxiety disorder
<i>Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)</i>	
<ul style="list-style-type: none"> • Eating disorders (F50) <ul style="list-style-type: none"> • Anorexia nervosa (F50.0) • Atypical anorexia nervosa (F50.1) • Bulimia nervosa (F50.2) • Atypical bulimia nervosa (F50.3) • Overeating associated with other psychological disturbances (F50.4) • Vomiting associated with other psychological disturbances (F50.5) • Other eating disorders (F50.8) • Eating disorder, unspecified (F50.9) • Nonorganic sleep disorders (F51) <ul style="list-style-type: none"> • Nonorganic insomnia (F51.0) • Nonorganic hypersomnia (F51.1) • Nonorganic disorder of the sleep-wake schedule (F51.2) • Sleepwalking [somnambulism] (F51.3) • Sleep terrors [night terrors] (F51.4) • Nightmares (F51.5) • Other nonorganic sleep disorders (F51.8) • Nonorganic sleep disorder, unspecified (F51.9) • Sexual dysfunction, not caused by organic disorder or disease (F52) <ul style="list-style-type: none"> • Lack or loss of sexual desire (F52.0) • Sexual aversion and lack of sexual enjoyment (F52.1) • Failure of genital response (F52.2) • Orgasmic dysfunction (F52.3) • Premature ejaculation (F52.4) • Nonorganic vaginismus (F52.5) • Nonorganic dyspareunia (F52.6) • Excessive sexual drive (F52.7) • Other sexual dysfunction, not caused by organic disorder or disease (F52.8) • Unspecified sexual dysfunction, not caused by organic disorder or disease (F52.9) • Mental and behavioural disorders associated with the puerperium, not elsewhere classified (F53) <ul style="list-style-type: none"> • Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified (F53.0) • Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified (F53.1) 	<ul style="list-style-type: none"> • Body dysmorphic disorder • Other specified somatic symptom and related disorder • Unspecified somatic symptom and related disorder • Depersonalisation/derealisation disorder • Anorexia nervosa, restricting type • Anorexia nervosa, binge-eating/purging type • Bulimia nervosa • Avoidant/restrictive food intake disorder • Binge-eating disorder • Other specified feeding or eating disorder • Pica, in adults • Unspecified feeding or eating disorder • Non-rapid eye movement sleep arousal disorders, sleepwalking type • Non-rapid eye movement sleep arousal disorders, sleep terror type • Nightmare disorder • Male hypoactive sexual desire disorder • Erectile disorder • Female sexual interest/arousal disorder • Female orgasmic disorder • Delayed ejaculation • Premature (early) ejaculation • Genito-pelvic pain/penetration disorder • Other specified sexual dysfunction • Unspecified sexual dysfunction • Psychological factors affecting other medical conditions

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)</i>	
<ul style="list-style-type: none"> • Other mental and behavioural disorders associated with the puerperium, not elsewhere classified (F53.8) • Puerperal mental disorder, unspecified (F53.9) • Psychological and behavioural factors associated with disorders or diseases classified elsewhere (F54) • Abuse of non-dependence-producing substances (F55) • Unspecified behavioural syndromes associated with physiological disturbances and physical factors (F59) 	
<i>Disorders of adult personality and behaviour (F60-F69)</i>	
<ul style="list-style-type: none"> • Specific personality disorders (F60) <ul style="list-style-type: none"> • Paranoid personality disorder (F60.0) • Schizoid personality disorder (F60.1) • Dissocial personality disorder (F60.2) • Emotionally unstable personality disorder (F60.3) • Histrionic personality disorder (F60.4) • Anankastic personality disorder (F60.5) • Anxious [avoidant] personality disorder (F60.6) • Dependent personality disorder (F60.7) • Other specific personality disorders (F60.8) • Personality disorder, unspecified (F60.9) • Mixed and other personality disorders (F61) <ul style="list-style-type: none"> • Enduring personality changes, not attributable to brain damage and disease (F62) • Enduring personality change after catastrophic experience (F62.0) • Enduring personality change after psychiatric illness (F62.1) • Other enduring personality changes (F62.8) • Enduring personality change, unspecified (F62.9) • Habit and impulse disorders (F63) <ul style="list-style-type: none"> • Pathological gambling (F63.0) • Pathological fire-setting [pyromania] (F63.1) • Pathological stealing [kleptomania] (F63.2) • Trichotillomania (F63.3) • Other habit and impulse disorders (F63.8) • Habit and impulse disorder, unspecified (F63.9) • Gender identity disorders (F64) <ul style="list-style-type: none"> • Transsexualism (F64.0) • Dual-role transvestism (F64.1) • Gender identity disorder of childhood (F64.2) • Other gender identity disorders (F64.8) • Gender identity disorder, unspecified (F64.9) • Disorders of sexual preference (F65) <ul style="list-style-type: none"> • Fetishism (F65.0) 	<ul style="list-style-type: none"> • Paranoid personality disorder • Schizoid personality disorder • Antisocial personality disorder • Borderline personality disorder • Histrionic personality disorder • Obsessive-compulsive personality disorder • Avoidant personality disorder • Dependent personality disorder • Narcissistic personality disorder • Other specified personality disorder • Unspecified personality disorder <ul style="list-style-type: none"> • Gambling disorder • Pyromania • Kleptomania • Trichotillomania (hair-pulling disorder) • Intermittent explosive disorder <ul style="list-style-type: none"> • Gender dysphoria in adolescents and adults • Gender dysphoria in children • Other specified gender dysphoria • Unspecified gender dysphoria <ul style="list-style-type: none"> • Fetishistic disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Disorders of adult personality and behaviour (F60-F69)</i>	
<ul style="list-style-type: none"> • Fetishistic transvestism (F65.1) • Exhibitionism (F65.2) • Voyeurism (F65.3) • Paedophilia (F65.4) • Sadomasochism (F65.5) • Multiple disorders of sexual preference (F65.6) • Other disorders of sexual preference (F65.8) • Disorder of sexual preference, unspecified (F65.9) • Psychological and behavioural disorders associated with sexual development and orientation (F66) <ul style="list-style-type: none"> • Sexual maturation disorder (F66.0) • Egodystonic sexual orientation (F66.1) • Sexual relationship disorder (F66.2) • Other psychosexual development disorders (F66.8) • Psychosexual development disorder, unspecified (F66.9) • Other disorders of adult personality and behaviour (F68) <ul style="list-style-type: none"> • Elaboration of physical symptoms for psychological reasons (F68.0) • Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder] (F68.1) • Other specified disorders of adult personality and behaviour (F68.8) • Unspecified disorder of adult personality and behaviour (F69) 	<ul style="list-style-type: none"> • Transvestic disorder • Exhibitionistic disorder • Voyeuristic disorder • Paedophilic disorder • Sexual masochism disorder • Sexual sadism disorder • Frotteuristic disorder • Other specified paraphilic disorder • Unspecified paraphilic disorder • Factitious disorder
<i>Mental retardation (F70-F79)</i>	
<ul style="list-style-type: none"> • Mild mental retardation (F70) • Moderate mental retardation (F71) • Severe mental retardation (F72) • Profound mental retardation (F73) • Other mental retardation (F78) • Unspecified mental retardation (F79) 	<ul style="list-style-type: none"> • Intellectual disability (intellectual developmental disorder), mild • Intellectual disability (intellectual developmental disorder), moderate • Intellectual disability (intellectual developmental disorder), severe • Intellectual disability (intellectual developmental disorder), profound • Unspecified intellectual disability (intellectual developmental disorder)
<i>Disorders of psychological development (F80-F89)</i>	
<ul style="list-style-type: none"> • Specific developmental disorders of speech and language (F80) <ul style="list-style-type: none"> • Specific speech articulation disorder (F80.0) • Expressive language disorder (F80.1) • Receptive language disorder (F80.2) • Acquired aphasia with epilepsy [Landau-Kleffner] (F80.3) • Other developmental disorders of speech and language (F80.8) 	<ul style="list-style-type: none"> • Speech sound disorder • Childhood-onset fluency disorder (stuttering) • Social (pragmatic) communication disorder • Language disorder • Unspecified communication disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Disorders of psychological development (F80-F89)</i>	
<ul style="list-style-type: none"> • Developmental disorder of speech and language, unspecified (F80.9) • Specific developmental disorders of scholastic skills (F81) <ul style="list-style-type: none"> • Specific reading disorder (F81.0) • Specific spelling disorder (F81.1) • Specific disorder of arithmetical skills (F81.2) • Mixed disorder of scholastic skills (F81.3) • Other developmental disorders of scholastic skills (F81.8) • Developmental disorder of scholastic skills, unspecified (F81.9) • Specific developmental disorder of motor function (F82) • Mixed specific developmental disorders (F83) • Pervasive developmental disorders (F84) <ul style="list-style-type: none"> • Childhood autism (F84.0) • Atypical autism (F84.1) • Rett's syndrome (F84.2) • Other childhood disintegrative disorder (F84.3) • Overactive disorder associated with mental retardation and stereotyped movements (F84.4) • Asperger's syndrome (F84.5) • Other pervasive developmental disorders (F84.8) • Pervasive developmental disorder, unspecified (F84.9) • Other disorders of psychological development (F88) • Unspecified disorder of psychological development (F89) 	<ul style="list-style-type: none"> • Specific learning disorder, with impairment in reading • Specific learning disorder, with impairment in mathematics • Specific learning disorder, with impairment in written expression • Developmental coordination disorder • Autism spectrum disorder • Global developmental delay • Other specified neurodevelopmental disorder • Unspecified neurodevelopmental disorder
<i>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)</i>	
<ul style="list-style-type: none"> • Hyperkinetic disorders (F90) <ul style="list-style-type: none"> • Disturbance of activity and attention (F90.0) • Hyperkinetic conduct disorder (F90.1) • Other hyperkinetic disorders (F90.8) • Hyperkinetic disorder, unspecified (F90.9) • Conduct disorders (F91) <ul style="list-style-type: none"> • Conduct disorder confined to the family context (F91.0) • Unsocialised conduct disorder (F91.1) • Socialised conduct disorder (F91.2) • Oppositional defiant disorder (F91.3) • Other conduct disorders (F91.8) • Conduct disorder, unspecified (F91.9) • Mixed disorders of conduct and emotions (F92) <ul style="list-style-type: none"> • Depressive conduct disorder (F92.0) • Other mixed disorders of conduct and emotions (F92.8) 	<ul style="list-style-type: none"> • Attention-deficit/hyperactivity disorder, predominantly inattentive presentation • Attention-deficit/hyperactivity disorder, predominantly hyperactive/impulsive presentation • Attention-deficit/hyperactivity disorder, combined presentation • Other specified attention-deficit/hyperactivity disorder • Unspecified attention-deficit/hyperactivity disorder • Conduct disorder, childhood-onset type • Conduct disorder, adolescent-onset type • Oppositional defiant disorder • Other specified disruptive, impulse-control, and conduct disorder • Conduct disorder, unspecified onset • Unspecified disruptive, impulse-control, and conduct disorder

ICD-10 Mental and behavioural disorders (F01-F99)	DSM-5 – Mental disorders
<i>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)</i>	
<ul style="list-style-type: none"> • Mixed disorder of conduct and emotions, unspecified (F92.9) • Emotional disorders with onset specific to childhood (F93) <ul style="list-style-type: none"> • Separation anxiety disorder of childhood (F93.0) • Phobic anxiety disorder of childhood (F93.1) • Social anxiety disorder of childhood (F93.2) • Sibling rivalry disorder (F93.3) • Other childhood emotional disorders (F93.8) • Childhood emotional disorder, unspecified (F93.9) • Disorders of social functioning with onset specific to childhood and adolescence (F94) <ul style="list-style-type: none"> • Elective mutism (F94.0) • Reactive attachment disorder of childhood (F94.1) • Disinhibited attachment disorder of childhood (F94.2) • Other childhood disorders of social functioning (F94.8) • Childhood disorder of social functioning, unspecified (F94.9) • Tic disorders (F95) <ul style="list-style-type: none"> • Transient tic disorder (F95.0) • Chronic motor or vocal tic disorder (F95.1) • Combined vocal and multiple motor tic disorder [de la Tourette] (F95.2) • Other tic disorders (F95.8) • Tic disorder, unspecified (F95.9) • Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F98) <ul style="list-style-type: none"> • Nonorganic enuresis (F98.0) • Nonorganic encopresis (F98.1) • Feeding disorder of infancy and childhood (F98.2) • Pica of infancy and childhood (F98.3) • Stereotyped movement disorders (F98.4) • Stuttering [stammering] (F98.5) • Cluttering (F98.6) • Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F98.8) • Unspecified behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F98.9) • Unspecified mental disorder (F99) • Mental disorder, not otherwise specified (F99) 	<ul style="list-style-type: none"> • Separation anxiety disorder • Selective mutism • Reactive attachment disorder • Disinhibited social engagement disorder • Provisional tic disorder <ul style="list-style-type: none"> • Persistent (chronic) motor or vocal tic disorder • Tourette's disorder • Other specified tic disorder • Unspecified tic disorder <ul style="list-style-type: none"> • Enuresis • Encopresis • Rumination disorder • Pica, in children • Stereotypic movement disorder • Adult-onset fluency disorder • Other specified mental disorder • Unspecified mental disorder

Appendix 4: Legal cases

R v Ahluwalia [1993] 96 CrAppR 133
 Bratty v Attorney-General for Northern Ireland [1963] AC 386
 R v Byrne [1960] 2 QB 396
 R v Bowen [1996] 2 CrAppR 157
 R v Jason Cann [2005] EWCA Crim 2264
 R v Cannes [1971] 1 WLR 1600.
 R v Clinton [2012] EWCA Crim 2
 R v Dietschmann [2003] 1 AC 1209
 R v Dix [1982] CrimLR 302
 R v Duffy [1949] 1 All ER 932
 Ford v Wainwright, [1986] 477 US 399
 HM Attorney-General for Jersey v Holley [2005] 3 WLR 29
 R v Jogee [2016] UKSC 8
 R v M (John) [2003] EWCA Crim 3452
 R v Martin (Anthony) [2002] 1 CrAppR 27
 DPP v Majewski [1976] UKHL 2
 R v M'Naghten [1843] 10 CI & F 200
 R v Quick [1973] 3 WLR 26
 R v Pritchard [1836] 7 CP 303
 R v Podola [1960] 1 QB 325
 R v Robertson [1968] 3 AllER 557
 R v Stewart [2009] 1 WLR 2507
 R v Sullivan [1984] AC 156
 R v T [1990] CrimLR 256
 R v Tandy [1989] 1 WLR 350
 Trimmingham v the State (St Vincent and The Grenadines) [2009] UKPC 25
 R v Windle [1952] 2 QB 826
 R v Wood [2008] EWCACrim 1305

Appendix 5: Ethical codes

The following pages reproduce extracts from ethical codes and professional guidelines that are particularly relevant to forensic psychiatrists.

General Medical Council

Good Medical Practice (2006)

- Writing reports and CVs, giving evidence and signing documents.
- You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.
- You must always be honest about your experience, qualifications and position, particularly when applying for posts.
- You must do your best to make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and that you must not deliberately leave out relevant information.
- If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.
- If you are asked to give evidence or act as a witness in litigation or formal inquiries, you must be honest in all your spoken and written statements. You must make clear the limits of your knowledge or competence.
- You must cooperate fully with any formal inquiry into the treatment of a patient and with any complaints procedure that applies to your work. You must disclose to anyone entitled to ask for it any information relevant to an investigation into your own or a colleague's conduct, performance or health. In doing so, you must follow the guidance in Confidentiality: Protecting and providing information.
- You must assist the coroner or procurator fiscal in an inquest or inquiry into a patient's death by responding to their enquiries and by offering all relevant information. You are entitled to remain silent only when your evidence may lead to criminal proceedings being taken against you.

Royal College of Psychiatrists

Good Psychiatric Practice (Third Edition, 2009)

Patients, their carers, their families and the public need good psychiatrists. Good psychiatrists make the care of their patients their first concern: they are competent; keep their knowledge up to date; are able and willing to use new research evidence to inform practice; establish and maintain good relationships with patients, carers, families and colleagues; are honest and trustworthy, and act with integrity. Good psychiatrists have good communication skills, respect for others and are sensitive to the views of their patients, carers and families.

A good psychiatrist must be able to consider the ethical implications of treatment and clinical management regimes. The principles of fairness, respect, equality, dignity and autonomy are considered fundamental to good ethical psychiatric practice. A good psychiatrist will take these issues into account when making decisions, and will need to pay particular attention to issues concerning boundaries and the vulnerability of individual patients. A good psychiatrist will not enter into a relationship with a patient or with someone who has been a patient...

Good Psychiatric Practice: Confidentiality and Information-Sharing

- Express consent should be sought where sharing of information outside the healthcare team is anticipated.
- Competent refusals made before death should be respected after death unless there are overriding circumstances.
- Information should not be shared within inter-agency teams without consent.
- At CPA meetings, the psychiatrist's duty of confidentiality must be acknowledged and respected if information is to be shared.
- If non-team members are to be involved in your patient's care (including attending team meetings), you should discuss it with the patient.
- If you attend a meeting arranged by an outside agency, consider and record your decisions about disclosure to them. Remember, the agency to which you disclose information may apply standards of confidentiality different from your own.
- In situations with dual obligations you must be clear in explaining your role to your patient, and in seeking consent.
- For court proceedings, you do not have to disclose in the absence of a court order unless you have consent or there are grounds to override refusal.
- It is sometimes justifiable for a psychiatrist to pass on patient information without consent or statutory authority. Such situations include:
 - where death or serious harm may occur to a third party, whether or not a criminal offence (e.g. disclosure of threat of serious harm to a named person, on the expectation that this would prevent the harm)
 - when a disclosure may assist in the prevention, detection or prosecution of a serious crime, especially crimes against the person; or conversely in situations where it is necessary to the defence of a case to ensure that there is no miscarriage of justice
 - where the patient is a health professional and the psychiatrist has concerns over that person's fitness to practise
 - where a psychiatrist has concerns over a patient's fitness to drive
 - where a psychiatrist has concerns over a patient's fitness to hold a firearms licence.
- When deciding to disclose you must take a wide range of factors into account. You must communicate with your patient; it is advisable to discuss the proposed disclosure with appropriate colleagues or organisations.
- You have a duty to cooperate with MAPPA. You do not have an obligation to disclose. Public interest will be an important factor for your consideration.

You should normally seek written consent before drafting a report. However, where there is a statutory obligation or there are overriding considerations, consent is not required. Remember to make your role clear to the patient when seeking consent, and disclose only the necessary information.

American Academy of Psychiatry and the Law

Ethical Guidelines for the Practice of Forensic Psychiatry

...Forensic psychiatrists practice at the interface of law and psychiatry, each of which has developed its own institutions, policies, procedures, values, and vocabulary. As a consequence, the practice of forensic psychiatry entails inherent potentials for complications, conflicts, misunderstandings and abuses.

Psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society. In doing so, they should be bound by underlying ethical principles of respect for persons, honesty, justice, and social responsibility. However, when a treatment relationship exists, such as in correctional settings, the usual physician-patient duties apply.

Confidentiality

...Psychiatrists should maintain confidentiality to the extent possible, given the legal context. Special attention should be paid to the evaluatee's understanding of medical confidentiality. A forensic evaluation requires notice to the evaluatee and to collateral sources of reasonably anticipated limitations on confidentiality. Information or reports derived from a forensic evaluation are subject to the rules of confidentiality that apply to the particular evaluation, and any disclosure should be restricted accordingly. ... Psychiatrists should indicate for whom they are conducting the examination and what they will do with the information obtained. At the beginning of a forensic evaluation, care should be taken to explicitly inform the evaluatee that the psychiatrist is not the evaluatee's 'doctor'. Psychiatrists have a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluatee may develop the belief that there is a treatment relationship...

Consent

At the outset of a face-to-face evaluation, notice should be given to the evaluatee of the nature and purpose of the evaluation and the limits of its confidentiality. The informed consent of the person undergoing the forensic evaluation should be obtained when necessary and feasible. If the evaluatee is not competent to give consent, the evaluator should follow the appropriate laws of the jurisdiction...

It is important to appreciate that in particular situations, such as court-ordered evaluations for competency to stand trial or involuntary commitment, neither assent nor informed consent is required. In such cases, psychiatrists should inform the evaluatee that, if the evaluatee refuses to participate in the evaluation, this fact might be included in any report or testimony. If the evaluatee does not appear capable of understanding the information provided regarding the evaluation, this impression should also be included in any report and, when feasible, in testimony.

Absent a court order, psychiatrists should not perform forensic evaluations for the prosecution or the government on persons who have not consulted with legal counsel when such persons are: known to be charged [or] under investigation...

Consent to treatment in a jail or prison or in other criminal justice settings is different from consent for a forensic evaluation. Psychiatrists providing treatment in such settings should be familiar with the jurisdiction's regulations governing patients' rights regarding treatment.

Honesty and Striving for Objectivity

When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity [despite being] retained by one party to a civil or criminal matter...

Psychiatrists practicing in a forensic role enhance the honesty and objectivity of their work by basing their forensic opinions, forensic reports and forensic testimony on all available data. They communicate the honesty of their work, efforts to attain objectivity, and the soundness of their clinical opinion, by distinguishing, to the extent possible, between verified and unverified information as well as among clinical 'facts', 'inferences', and 'impressions'.

Psychiatrists should not distort their opinion in the service of the retaining party. Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination...

In custody cases, honesty and objectivity require that all parties be interviewed, if possible, before an opinion is rendered. When this is not possible, or is not done for any reason, this should be clearly indicated in the forensic psychiatrist's report and testimony. If one parent has not been interviewed, even after deliberate effort, it may be inappropriate to comment on that parent's fitness as a parent. Any comments on the fitness of a parent who has not been interviewed should be qualified and the data for the opinion clearly indicated.

Contingency fees undermine honesty and efforts to attain objectivity and should not be accepted. Retainer fees, however, do not create the same problems in regard to honesty and efforts to attain objectivity and, therefore, may be accepted.

Psychiatrists who take on a forensic role for patients they are treating may adversely affect the therapeutic relationship with them. Forensic evaluations usually require interviewing corroborative sources, exposing information to public scrutiny, or subjecting evaluatees and the treatment itself to potentially damaging cross-examination. The forensic evaluation and the credibility of the practitioner may also be undermined by conflicts inherent in the differing clinical and forensic roles. Treating psychiatrists should therefore generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes.

Treating psychiatrists appearing as 'fact' witnesses should be sensitive to the unnecessary disclosure of private information or the possible misinterpretation of testimony as 'expert' opinion. In situations when the dual role is required or unavoidable (such as Workers' Compensation, disability evaluations, civil commitment, or guardianship hearings), sensitivity to differences between clinical and legal obligations remains important...

Qualifications

Expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience.

When providing expert opinion, reports, and testimony, psychiatrists should present their qualifications accurately and precisely...

World Psychiatric Association Declaration of Madrid

Psychiatry is a medical discipline concerned with the prevention of mental disorders in the population, the provision of the best possible treatment for mental disorders, the rehabilitation of individuals suffering from mental illness and the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are **least restrictive** to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the **equitable allocation** of health resources.

It is the duty of psychiatrists to keep abreast of **scientific developments** of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.

The patient should be accepted as a partner by right in the therapeutic process. The psychiatrist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with all **relevant information** so as to empower the patient to come to a rational decision according to personal values and preferences.

When the patient is gravely disabled, incapacitated and/or incompetent to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. **No treatment should be provided against the patient's will**, unless withholding treatment would endanger the life of the patient and/or the life of others. Treatment must always be in the **best interest** of the patient.

When psychiatrists are requested to assess a person, it is their duty first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when psychiatrists are involved in third party situations.

Information obtained in the therapeutic relationship is private to the patient and should be **kept in confidence** and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or personal benefit. Breach of confidentiality may only be appropriate when required by law (as in obligatory reporting of child abuse) or when serious physical or mental harm to the patient or to a third person would ensue if confidentiality were maintained; whenever possible, psychiatrists should first advise the patient about the action to be taken...

Biographies

Professor Nigel Eastman is emeritus professor of law and ethics in psychiatry at St George's, University of London and an honorary consultant forensic psychiatrist in the National Health Service. Alongside his medical training, he was called to the Bar. He has, over a long career, carried out research and published widely on the relationship between law and psychiatry, and is first author of the *Oxford Specialist Handbook of Forensic Psychiatry*. A major focus of his work has been in regard to public policy concerning law and psychiatry, and he has, for example, been an advisor to the Law Commission for England and Wales and given evidence to UK Parliamentary Select Committees in this context. He has 30 years' experience of clinical forensic psychiatry. He also has extensive experience of acting as an expert witness in both criminal and civil proceedings, at all court levels, both in the UK and in the jurisdictions of other countries, including in relation to more than 500 murder cases, involving many capital cases undertaken *pro bono*. Throughout his career he has provided education and training to doctors, lawyers and the judiciary at the interface of law and psychiatry, both in the UK and abroad. He is a member of Forensic Psychiatry Chambers.

Dr Sanya Krljes is a clinical forensic psychologist in the Forensic Mental Health Service of the South West London and St George's Mental Health NHS Trust. She holds doctorates in cognitive neuroscience and clinical psychology, and has published a number of articles on the subject of neuropsychology and cognitive neuroscience. She has extensive experience of conducting complex psychology and neuropsychology assessments and of preparing court reports in relation to murder and sexual offences trials, often being high-profile in nature.

Dr Richard Latham is a full-time consultant forensic psychiatrist working in the NHS in London. His current clinical practice involves the care of people detained under English mental health legislation in a secure hospital. In addition to being medically qualified he holds a Master's degree in mental health law, for which his thesis concerned expert mental health evidence. He is an author of the *Oxford Specialist Handbook of Forensic Psychiatry* and has contributed chapters on mental health law, risk assessment and management to edited texts. He has an expert witness practice in two areas of law, serious crime and mental capacity law. His expert witness practice has included numerous murder cases, high-profile terrorist extradition cases and landmark cases involving mental capacity and refusal of medical treatment. He works *pro bono* for the Death Penalty Project and has conducted assessments on appellants in Kenya, Trinidad and Tobago, St Vincent and Belize. He has also conducted training sessions in Barbados, Trinidad and Tobago, Jamaica, Kenya and Taiwan on the use of expert evidence in capital cases. He is a member of Forensic Psychiatry Chambers.

Dr Marc Lyall trained in both general adult and forensic psychiatry. For the past 10 years he has worked as a consultant forensic psychiatrist in a medium secure unit in the East End of London. He is also an honorary clinical senior lecturer in psychiatry at the Barts and London School of Medicine and an examiner for the UK Royal College of Psychiatrists. Dr Lyall regularly prepares reports for the UK courts in criminal proceedings. On behalf of the Death Penalty Project, he has carried out assessments of defendants facing very serious criminal allegations in Malawi, the Democratic Republic of Congo and Trinidad and Tobago. He has also contributed to training events for doctors, lawyers and judges in the UK and in foreign jurisdictions. He is a member of Forensic Psychiatry Chambers.

The Death Penalty Project

The Death Penalty Project is a legal action charity working to promote and protect the human rights of those facing the death penalty.

We provide free legal representation to death row prisoners around the world, with a focus on Commonwealth countries, to highlight miscarriages of justice and breaches of human rights. We also assist other vulnerable prisoners, including juveniles, prisoners who are serving long-term sentences and those who suffer from mental health issues. For more than three decades, our work has played a critical role in identifying miscarriages of justice, promoting minimum fair-trial guarantees in capital cases and in establishing violations of domestic and international law. Through our legal work, the application of the death penalty has been restricted in many countries in line with international human rights standards. To complement our legal activities, we conduct capacity building activities (such as training for defence lawyers, prosecutors, members of the judiciary), and commission studies on criminal justice and human rights issues relating to the death penalty.

Since 2011, we have been delivering capacity building support on forensic psychiatric practice to lawyers and mental health professionals working in countries that retain the death penalty. In many capital jurisdictions, mental health issues are not raised at trial or insufficiently addressed by the courts. Few prisoners receive mental health assessments, which may impact on the safety of their convictions. Our training programmes seek to address gaps in the protection afforded to those with mental disorder and promote the implementation of minimum standards. We have delivered training programmes in many countries in the Caribbean, Africa and Asia and we are constantly expanding to new jurisdictions. This updated Handbook and the compendium Casebook will accompany future training programmes, providing an invaluable reference guide for mental health professionals and instructing lawyers.

Forensic Psychiatry Chambers

Forensic Psychiatry Chambers is a medical chambers comprising experienced psychiatrists, who provide psychiatric advice and expert reports to courts and to the legal profession, in the UK and in other common law jurisdictions. Its members are independent practitioners. However, they operate in a collegiate context, offering collective knowledge and experience to courts and lawyers, as well as supporting a peer-review approach to their work that aims to support technically high-quality and ethical expert witness practice. A number of its members are committed to pro bono practice in the context of human rights law, including in regard to capital cases. The chambers also provides education and training to mental health professionals, lawyers and courts, in the UK and in other jurisdictions.



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