Handbook of Forensic Psychiatric Practice for Capital Cases in Taiwan

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In association with:

THE DEATH PENALTY PROJECT
Forensic Psychiatry Chambers
Acknowledgements

This handbook was made possible by a grant from the British Office Taipei.

The Death Penalty Project and the Taiwan Alliance to End the Death Penalty would like to thank Nigel Eastman, Richard Latham, Marc Lyall, Leon Huang and Tim Green for drafting the text of the handbook, which is an indispensable, practical and informative guide for mental health professionals and all those involved in the criminal justice process in Taiwan. We are also grateful to Teoh Yee-San and Huang Yu-Fei for their comments and edits on the handbook. Sincere thanks are also due to the Taipei Bar Association and the Legal Aid Foundation in Taiwan, which have supported this publication and related activities for members of the legal and medical professions in Taiwan.
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Preface

Forensic psychiatry comprises the psychiatry of mental disorder and offending behaviour, ‘clinical forensic psychiatry’, plus law – both civil and criminal – as it relates to all psychiatry. There is civil law relevant to all those with mental disorders, most obviously mental health law, but also, potentially, many other branches of civil law. However, mentally disordered offenders are likely to be the subject of criminal law and will tend, in practice, to be subject more to the application of mental health and other law. Hence, practitioners of clinical forensic psychiatry will have much more involvement with legal psychiatry than occurs within general psychiatric practice. Put another way, clinical forensic psychiatry often underpins not only the assessment and treatment of mentally disordered offenders per se, but also assessment 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 to assist mental health professionals and lawyers engaged in capital trials, sentencing hearings, appeals and mercy hearings, specifically in Taiwan. It is based, however, upon a related handbook prepared for practitioners working in all common law jurisdictions where capital sentencing is retained, with particular reference to the Caribbean and East Africa. It draws on ordinary principles of forensic psychiatric practice, so much of the text applies more generally to all jurisdictions that adopt, for example, mental condition defences or pleas in mitigation.

The handbook is limited in its scope and depth to make it ‘user friendly’ within the mental health and legal contexts for which it is written. Hence, the abbreviated style does not allow for referencing of any sources. It is important, therefore, that we make it plain that we have relied heavily on the work of a large number of other authors and we thank them all, and acknowledge their copyright in their work. Much more detailed information relevant to general forensic practice, similarly presented without referencing, can be found in Eastman N, Adshead G, Fox S, Latham R, Whyte S (2012) Oxford Specialist Handbook of Forensic Psychiatry, Oxford University Press, pps 800.

This is a stand-alone, single-volume practitioners’ handbook for use by psychiatrists and psychologists, solicitors, barristers, prosecuting authorities and the courts, who are required to deal with capital crimes in Taiwan. It is intended to be relevant to all stages of the capital criminal justice process, from arrest and police interviews, through fitness to plead and to stand trial, to sentencing, appeal and mercy hearings. So it deals not only with ‘mental condition defences’ at trial, but also psycho-legal issues that can occur at all stages in capital cases.

Although the handbook is intended to be used by mental health and legal practitioners in relation to legal process, it is not intended to provide any absolute interpretation of the law. Rather, we have sought to describe the ‘frontier’ between law and mental health sciences, and to aid both mental health practitioners and lawyers in navigating that frontier. It follows that, in an individual case, much will depend upon the detailed legal definitions that apply. And we emphasise that nothing that we have described is intended to constitute legal advice.

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The handbook is designed to be accessible as a reliable source of information, focus and explanation for clinicians and lawyers. It attempts to give a statement of proper clinical practice within legal process, both in terms of clinical assessment and in relation to presenting medical evidence into an adversarial legal arena effectively. This includes clear descriptions of diagnostic principles and practice, with an emphasis on the use of accepted international classificatory systems of mental disorders. There is also a description of how the problems of using expert medical evidence within legal process can vary greatly with the nature of the diagnosis, as well as with the specific legal question(s) at hand.

Directed at the foregoing purposes, a model structure for forensic psychiatric assessment and report writing is described, including history taking and examination in the special context where the subject of assessment is often not a ‘patient’, but solely a ‘defendant’ or ‘appellant’. This further includes dealing with validation of diagnosis in a legal context and, by inference, appropriate means of legally challenging diagnosis. It also offers some ‘ways of thinking about’ core ethical issues that attend all forensic psychiatric practice, but which are particularly acutely focused in relation to clinical assessment and reporting upon capital cases.

The handbook is not only designed to be read ‘on its own’, but is also intended to be used in direct relation to education and training events offered by members of Forensic Psychiatry Chambers and The Death Penalty Project. It, effectively, amounts to a ‘course book’ for such education and training.

Finally, since much of the handbook is applicable to criminal legal contexts other than in capital cases, it is hoped that this will further enhance its utility.

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London
August 2015
CHAPTER ONE:
Clinical Forensic Psychiatry and Legal Psychiatry
As described in the Preface, forensic psychiatry comprises both 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, or legal psychiatry.

The handbook concentrates on presenting aspects of clinical forensic psychiatry; description of law per se relevant to capital trials, sentencing, mercy hearings and to the carrying out of execution are presented in a separate handbook, written by legal practitioners. However, a crucial ‘bridge’ between clinical forensic psychiatry and law as it relates to psychiatry is ‘the role of psychiatry within legal process’. And the handbook does ‘refer across’ to legal tests, so as to offer an understanding of the ‘frontier’ between psychiatry and elements of law applicable to capital cases (see Chapter 2 generally). So, for example, in the chapters which offer advice on assessment and report writing each 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 be properly conducted, in order to be directly relevant to, and ‘translated into’, (see Chapter 2) those individual tests.

Hence, what the handbook offers mainly is presentation of clinical information and method relevant particularly to stages of capital legal cases. It does not, therefore, offer a comprehensive guide broadly 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, he it under court originating orders or under civil mental health legislation, s/he should consult a comprehensive forensic psychiatric text, such as the Oxford Specialist Handbook of Forensic Psychiatry.

This handbook also cannot, and does not, offer a fully comprehensive and general guide to ‘practicing forensic psychiatry in the courts’. Rather, it offers a much reduced version of what might be found dealt with extensively within the Oxford Handbook, and focused particularly on the application of psychiatry within capital cases. By way of illustration of the point, 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 attempt is to offer skeletal information about a topic, sufficient to give the reader ‘the bare bones’ of a topic and sufficient to give him/her an ‘understanding’ of the topic.

As further illustrations of the ‘reduction’ which we have applied, the reader will find only limited coverage of ‘risk assessment’, and coverage which is focused particularly on presentation of risk assessments into legal proceedings. In addition only limited, ‘first principle’ coverage of ‘ethical issues’ and ‘ethical decision making’ in forensic psychiatry are included, with particular emphasis upon ethical issues for clinicians as they occur within capital cases.

In summary, therefore as described in the Oxford Handbook, clinical forensic psychiatry is concerned with the assessment and treatment of mental disorder where that disorder appears to be associated (not necessarily causally) with offending behaviour, whether or not the patient has been convicted. Clinical forensic psychiatry is also particularly closely engaged with law and legal psychiatry so that a clear understanding of law is necessary in order to practise clinically. For example, it is not possible to negotiate your patient out of the criminal justice system and into mental health care without knowledge of the relevant law. Clinical forensic psychiatry can be pursued effectively and ethically only if it is based on substantial knowledge of the law and legal process, and its interface with psychiatric practice (see
Chapter 2 of this present handbook). *Legal psychiatry* comprises all law relating to mental disorder, and to the treatment and care of those suffering from mental disorder. The relationship between psychiatry and the law is bilateral, comprising the giving of psychiatric evidence in a wide variety of civil and criminal legal contexts, and the use of law for clinical purposes and for the regulation of clinical practice. This 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 as disciplines, arising from the very different purposes of each discipline, and from the very different methods they apply in pursuing those differing disciplines. The constructs relating to ‘things mental’ which arise from the ‘human welfare’ objective of psychiatry are very different from those artifices of mental functioning and status that the law constructs for its objective of pursuit of welfare.

Again as described in the *Oxford Handbook*, the constructs in psychiatry are determined essentially by its pursuit of human welfare, including through understanding disorder in order to reverse it or its effects. By contrast, law pursues abstract justice, albeit that this may sometimes involve balancing the welfare of different parties against one another, or against societal welfare. Even within a discipline, different branches often give rise to different approaches to determining constructs.

Since criminal law at trial, for example, is concerned with responsibility or culpability, its definitions of mental disorder (and there are a number) are characteristically tight, and address justice and not human welfare. By contrast, the constructs utilised 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 for clinicians, where they are required to apply medical information and techniques in order to present 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 which is often alien to him/her (see Chapter 15).

**How forensic services are related**

The term ‘forensic’ refers to legally related work within psychiatry, the clinical services provided for mentally disordered offenders. Some of these services will be psychiatric, or forensic psychiatric, but many others will not be. This section seeks to explain the different forensic services and areas of practice.

**Criminal justice and court services**

Almost all professional groups can offer forensic testimony, so there are forensic entomologists and forensic accountants, as well as the more familiar forensic pathologists. Psychologists and psychiatrists who give expert testimony are acting as ‘forensic’ professionals, regardless of their usual clinical practice.

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2 Much of this description is taken from the *Oxford Handbook of Forensic Psychiatry* and is applicable to the UK.
Clinical mental health services provided to offenders may be offered by general psychiatrists, rehabilitation psychiatrists, substance misuse services or those psychiatrists (often forensic psychiatrists) working in secure settings. For some time, the term ‘forensic’ was only applied to those services that managed offenders and/or ‘risky’ patients, but it is now expected that many other services will also manage such patients.

Mental health services in prison

Since 2006, in the UK the NHS has provided inreach services to prisons, usually consisting of community psychiatric nurses, and some psychiatric/psychological consultancy, often with a dedicated health care centre. These personnel may be general adult practitioners, or sometimes forensic practitioners. In addition to the psychiatric services into prisons, the prison service also retains its own psychology service, primarily staffed by forensic psychologists.

In less developed economies such services are often more patchy and less integrated.

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, psychologists, art psychotherapists, medical psychotherapists, nurses, health care assistants, occupational therapists, social workers and pharmacists. Confusingly, some secure services will also employ forensic psychologists 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 care.

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

Specific staff groups

Forensic psychiatrists are psychiatrists, medically qualified initially, who have further training in the sub-specialty of forensic psychiatry.

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

Forensic psychologists are, by training, quite distinct from clinical psychologists, and typically have a master’s degree in their subject. They usually directly address offending behaviour, often not in the context
of mental disorder. Hence they often carry out risk assessments and oversee the psycho-educational programme for offenders, typically in prisons. They may or may not have any general mental health experience.

**Forensic psychotherapists** are trained psychotherapists who have specialised in working with mentally disordered offenders. They may or may not be medically qualified. They may work in specialist services or provide consultation and supervision for forensic multidisciplinary teams. They may deliver individual or group interventions.

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

**Probation officers** may be involved in supervision of mentally disordered offenders in the community, usually in collaboration with mental health professionals. Interventions may include measures aimed at risk reduction and rehabilitation. In the UK they also take on particular roles with sex offenders, and commonly co-ordinate sex offender interventions, sometimes with mental health service involvement. There may be interaction between probation officers and forensic psychiatrists in the production of reports used for sentencing convicted offenders, sometimes resulting in ‘joint working’ thereafter.

**Clinical forensic services in less developed economies**

Most health and related criminal justice services in less developed and particularly small economies cannot sustain the types of specialist forensic psychiatric services described above as available in the UK. The challenge, therefore, is for generic services to be capable of dealing, on relatively infrequent occasions, with complex forensic cases, including through liaison with the justice system. The purpose of this handbook is to enhance the training of such staff in order to assist in the provision of this capacity.
CHAPTER TWO: 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 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 whom they occur, 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. Meanwhile ‘thought disorder’, ‘depressed mood’ and ‘depersonalisation’, for example, represent mental state abnormalities, elements of which may occur in more than one diagnosis, but which may 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 also below).

By contrast, words or phrases such as ‘abnormality of mind’, ‘insanity’, ‘disease of the mind’, ‘responsibility’, ‘insanity’, ‘fitness to plead’, ‘fitness to be sentenced to death’ and ‘fitness to be executed’ occur solely within law, and as such have a solely legal meaning; they are legal artifices erected to serve the legal purpose of justice and, 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 even ‘insanity’ are examples.

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

Law is suffused with myriad legal constructs of mental functioning, which may appear to be ‘mental terms’, to which mental functioning, defined medically, may be evidentially relevant.
It follows that when the reader is confronted with, or addresses an apparently ‘mental’ word or phrase, s/he should explicitly consider: ‘Does it come from medicine, or psychology, or from law?’ Since the origin and nature of the term is crucial to effective functioning as a medical expert within a legal context.

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

**Methods of inquiry**

Psychiatry, also psychology, and law, also differ in their methods of inquiry. Hence, all medicine is **investigative** in its approach, taking a judgment based upon all of the information available. However weighing some information more heavily in the judgment than others. By contrast, law is both **adversarial** in its method and **restrictive** of the information that it allows into that adversarial process; that is, what information is allowed in as ‘evidence’ is restricted for reasons of ‘fairness’. Hence, the psychiatrist will weigh all available data in a ‘hypothesis testing’ manner; whereas law assumes that ‘the truth’ (or at least ‘a truth’) will emerge by setting up opposing restricted data sets and argument 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 utilise data which is legally inadmissible. And this confronts him or her with a profound ethical dilemma, by way of there then being a head-on clash of paradigms.

**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, since they will both be asked questions within an adversarial mode, yet wish to answer within an investigative mode, and be stopped from doing so. They may also wish to rely upon particular data but be told that 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 concepts’ 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’ (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 then 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 often disparities in the meaning of words, and also in the method of inquiry (see further above, and below). Hence, in broad terms psychiatry, as a branch of medicine, adopts ‘categorical’ constructs, whereas clinical psychology adopts ‘dimensional’ ones.

The difference in constructs and methods of inquiry between psychiatry and psychology determine different incongruities between each and the law and legal process. In broad terms, psychiatry is ‘less incongruous’ with law than is psychology, because the more categorical and ‘binary’ approach it adopts is less incongruous with the similar ‘binary’ approach adopted within law. Hence 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 population.³

**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. Law is concerned with justice for all, including concern for the rights of both the defendant and victims, or society. Hence, the manner of striking the balance between pursuit of patient welfare and public protection is bound to be different between mental health care professionals and legal agencies. Psychiatry and law address related concerns with potentially different values, negotiating the interface between the two is ethically, and legally, both difficult and crucially important.

**Autopoiesis versus reflexivity**

**Varying degrees of incongruence**

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, its definitions of mental disorder (and there are a number) are characteristically tight, and, of course, address justice⁴ and not human welfare. By contrast, the constructs utilised 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). 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 concepts used in other disciplines.

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³ 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 which occur in law, such that the reader should interpret ‘medicine, or ‘psychiatry’, to infer the inclusion of psychology, unless we specify a distinction.

⁴ Justice can mean, from the perspective of the individual, proportionality, or ‘just deserts’. There are other meanings attributed to the concept also.
Family law, for example, is relatively reflexive; it adopts quite loose concepts and process, and 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 autopoetic, that is, non-reflexive. It employs only its own strictly defined concepts, within a strictly observed discourse and process, which greatly inhibits adoption of the concepts or methods of other disciplines, and this can seriously distort the meaning of concepts given in evidence. This is because it is preoccupied with ensuring that its procedures are scrupulously fair to defendants and prosecution.

However, law operating in a sentencing mode is less binary and less rigid in its approach, making it more accommodating of information admitted from experts in psychiatry and psychology. Hence, in administering the discretionary death penalty, although a court will be subject to sentencing guidelines, it will inevitably be more open and more flexible in its addressing 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.

**Translation between discourses**

As described in the Preface, the relationship between psychiatry (also other mental health disciplines) and the 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. Hence there must be ‘translation’ between, or across, discourses.

Put otherwise, law and psychiatry are therefore 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 diagnoses and diagnostic categories. Hence travelling from one 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.

Hence the route to proper, and just, use of psychiatric and psychological evidence within the criminal justice process, as well as to minimising misunderstanding, must be one of ‘each understanding the discourse of the other’, whilst 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 translation

Although a perfect translation may be impossible, 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

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, the nature of a wound and therefore how it was probably inflicted. Psychiatry deals with constructs apparently, but only apparently similar to those of law; for example, volition in psychiatry and intention in law. Although these are distinct constructs, they are apparently sufficiently close for the essential difference between them often not to be apparent to psychiatrists and lawyers. This can lead to mutual misunderstanding 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 involve a loss of reality testing, and/or the ability to recognise the true nature of actions. Similarly, ‘abnormality of mind’ within diminished responsibility, although appearing almost medical, is 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 separate diagnoses, so as to make a prognosis and to facilitate appropriate treatment, but not to determine whether the psychotic defendant should be found unfit to plead, or unfit for execution.

To the criminal law, the concepts of insanity and diminished responsibility exist only to allocate criminal responsibility justly, in different ways. It defines unfitness to plead in order to determine whether a fair trial is possible, and it defines fitness for execution in similar terms, of ‘whether it would be fair to execute’. Since, for example, the consequence of a finding of insanity is to remove responsibility entirely, whereas that of diminished responsibility is merely to reduce it, the law adopts different definitions which, to a doctor, look entirely inconsistent with one another, but which are legally coherent in their difference, given their different justice functions.

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’ s/he may hold, or to give an opinion on the matter on what
amounts to his or her own ‘made up’ legal definition. Instead s/he must ‘accept’ the law’s definition and simply give medical evidence which 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, deemed truthful or false, and given greater or lesser weight, all according to the *rules of evidence*.

To a psychiatrist, however, the same piece of information forms part of the patient’s *history*, or observation of their *mental state*, to be taken into consideration diagnostically or therapeutically. There is much less concern to consider in great detail and according to an established *standard of proof* whether each individual each piece of information 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, it 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 will be symptoms inconsistent with the diagnosis.

That is, medical process amounts to consideration of whether the information available is sufficient, taken together, to infer the diagnostic (or other) conclusion, rather as with a jigsaw puzzle, in terms of whether there are enough pieces of a particular picture to be convincing that the picture is really there. Such an approach infers that the combination of pieces of evidence can be mutually reinforcing in terms of the weight to be attached to each piece. Although law does sometimes apply, ‘corroboration’ probatively, validation in medicine is very different from truth finding in law.

These two very different approaches, not only 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 legal domains within which the law does adopt an investigative approach), what is at its core is ‘pattern recognition’, within a strictly medical paradigm.

**Methods of gathering and selecting information**

These also differ between law and psychiatry. Courts will only consider evidence that is put before it by the parties, and which is deemed ‘admissible’; it will then test each piece of information adversarially. A forensic psychiatrist will actively seek out information from the patient, corroborate or contrast it with that given by the others, and will look at anything available in an investigative fashion.

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5 However, if numerous or significant, they challenge the psychiatrist to question whether the perceived pattern (diagnosis, formulation) is correct, or the whole explanation.
Implications for forensic psychiatrists

These differences have several consequences for forensic psychiatrists.

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; some of which may be admissible and some not. In order to ascertain what weight to give that evidence should it be disputed, the court will wish to know the expert’s status (e.g. consultant, trainee), post, relevant qualifications and experience, and these should be stated in the report.

For the same reason, the sources of any information used by a psychiatrist should be made clear (patient, informant, records etc.), so that the court can apply its own approach to what it holds to be true.

There may be disparity between the information that a psychiatrist would use in determining a diagnosis 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 instance where, s/he is told that certain information cannot be considered by the court. There may be information that s/he is aware is inadmissible as evidence, but which may be diagnostically or clinically highly relevant. Reports should make clear how conclusions have been derived, and from which information.

Information contained within court proceedings for example witness statements, can be used as data by the forensic psychiatrist (by analogy with informant information in ordinary clinical practice). However, witness evidence may be contradictory, such that the expert has to make conditional statements (‘if the court believes A then the diagnosis of X is reinforced, if B then it is undermined’).

Information received from the criminal justice system should be given great weight if it has been considered and accepted by a court, because it will have been tested against the rules of evidence and been subjected to attempts by one or more parties to disprove it (so convictions should weigh more heavily in a risk assessment (see Chapter 7) than allegations, for example).

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 of the worst of the worst, or beyond reformation (see Chapter 12)

Psychiatry itself also uses legal processes to therapeutic ends, as when a psychiatrist decides to recommend detention for treatment under mental health legislation, including sometimes as part of their risk management plan.
Keeping boundaries via mutual understanding

A psychiatrist pursuing knowledge and understanding of the legal system does not run enhanced risk of being used improperly by it. Rather, knowledge and understanding is likely to encourage a boundaried 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 enough understanding of the other to operate effectively at the interface of their disciplines.

Co-operation not contamination

The objective must be mutual co-operation between psychiatry and law, without 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 aiming to affect justice, via contamination of their medical role.

However, the inherent bias of psychiatry towards welfare, rather than justice, can result in psychiatrists inadvertently or even deliberately, tailoring their opinions so as to achieve a result that they see as in the patient’s best interests, despite the law. Some may even give evidence tailored towards their own view of what would be the just outcome. This practice is ethically and legally indefensible.

Is there a 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 patient through treatment. These forces have caused 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
Convergence also implies the potential for movement away from the core objectives and values of medicine.

**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.
CHAPTER THREE:
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. The following summary of different mental disorders includes a description of ways in which they can enhance the risk of criminal offending. This is not an exhaustive exploration of the field and individual factors 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 upon population statistics. However, in general there is little robust evidence of 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 be associated with violent behaviour in the past, and are therefore relevant to the genesis of their violence, in terms of their own particular ‘biography of violence’. What follows are therefore descriptions 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, although much of this enhanced risk is mediated through concurrent drug abuse.

Symptoms particularly capable of enhancing risk in the individual include:

- Altered perceptions of external reality, including false perceptions of threat
- Delusional misinterpretation of other people’s identities, and of any threat they might pose
- Delusions of jealousy
- Delusions of love and subsequent experience of rejection
- 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

**Alcohol and drug misuse and dependence**

Drug and alcohol misuse is commonly seen in violent offenders and is predictive of violence in the aggregate. Of all mental disorders, this group is most strongly linked to offending and violence.

Mechanisms of enhanced risk of violence in the individual include:

- Disinhibition associated with intoxication
- Disorganised behaviour associated with intoxication

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6 We recommend Semple D and Smyth R (2009) *Oxford Handbook of Psychiatry*, Oxford University Press, Oxford, UK as being particularly useful in that is the ‘sister’ handbook to the *Oxford Specialist Handbook of Forensic Psychiatry* and is written in the same ‘handbook’, rather than ‘textbook’ style as the latter.
Mental Disorder and Criminal Behaviour

- Withdrawal states
- Paranoia
- Agitation and anxiety
- Neuropsychiatric effects of long-term use

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

**Personality disorder**

Personality disorders are a diverse group, and it is largely cluster B personality disorders that are seen in the context of serious crime (antisocial, borderline and narcissistic). The defining characteristics of these disorders include rule-breaking and criminal behaviour.

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. The smaller subset who exhibit 'psychopathy' (in terms of the definition by Hare, operationalised through the PCL-R assessment tool) are the more likely to exhibit serious violence.

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

- Transient psychosis altering perception of reality (often associated with stress or drug use)
- Paranoid cognitions and alteration in the 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 capacity for reflection
- Need for risk-taking or excitement
- Grandiosity and contempt for others

**Mania**

Individuals with mania may be predisposed to violence and offending because of the symptoms they experience, but any empirical association is weak. Potential mechanisms include:

- Elation
- High levels of anxiety and agitation
- Impaired judgement
- Impulsivity
- Hypersexuality
- Psychosis where present (see above)
Depression

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

- Hopelessness impacting on judgment
- Increased perception of criticism or threat
- 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 battle have demonstrated enhanced irritability, aggression and substance misuse, leading to enhanced violent offending.

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

- High levels of anxiety and arousal
- Hypervigilance or preparedness – being ‘on the lookout’ and highly sensitive to threat
- High levels of impulsivity and anger
- Triggering from flashbacks
- Higher levels of dissociation
- Nightmares resulting in violent actions during sleep

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 on 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, and because aspects of their condition 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

**Acquired brain injury**

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

• Frontal lobe damage leading to
  • Impaired planning ability and organisation of behaviour
  • Disinhibition
  • Impulsive behaviour
  • Increased aggression
• Cognitive impairment might alter understanding of legal boundaries

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

**Epilepsy and sleep disorders**

Although rarely associated with serious violence, these disorders can be raised in relation to defences at trial. The following issues can arise:

• Ictal violence (during a seizure) in complex partial seizures
• Post-ictal or inter-ictal violence associated with confusion, disorientation or psychosis
• Violence during a sleep disorder episode

**Conclusion**

Even where there are observed associations at a population level between a defendant’s mental disorder and offending, in an individual case this can be only of background relevance. In preparing reports for courts what is crucial is a description of how, in the defendant, his disorder is likely to have led to offending, including in terms both of an apparent past association, in him, past between given symptoms and offending within his own ‘biography of offending’, and in the ‘formulation’ of his current offending. (see Chapter 7)
CHAPTER FOUR:
Forensic Psychiatric Assessment
Overview

The form and detail of any psychiatric assessment depends upon the context of the assessment and any action that is likely to be needed; for example, the approach taken when seeing a patient who presents himself to hospital suffering with psychosis and asking for treatment will be different from the interview techniques and assessment process used when seeing a defendant facing serious criminal charges in prison, with the aim of preparing a court report. Each psychiatric interview is therefore different, specific to the circumstances and particularly in forensic psychiatry to the legal question that needs to be addressed.

The ethical issues that pertain will also be dependent upon the context and purpose of the assessment. 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). The relationship between assessor and assessee is different, as are the implications of the assessment for the assessee.

There are, however, general principles that apply to all forensic assessments, since assessing a defendant for court requires application of the same clinical techniques as assessment of a patient, even though the result may be applied to legal rather than medical questions.

The general aim of any psychiatric interview is to elicit symptoms of mental disorder, if there be such, and to understand these symptoms in terms of diagnosis and implications for behaviour. The reader should therefore consult a general psychiatry text for detailed advice about assessment. However, a forensic assessment also requires particular clinical focus upon antisocial behaviour, attempting to ascertain its relationship with mental symptoms experienced, or disabilities inherent in the individual’s condition, including in terms of ‘formulation’ (see Chapter 6).

Also, 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. Hence, 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 the 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 utilisation of more and different information. Hence, it commonly requires collection of much more collateral information, plus information of history back to childhood, as well as consideration of information contained within legal papers that are relevant to diagnosis (for example, evidence in witness statements of abnormal behaviour in the defendant).

Specialist investigations may also 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 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
investigation, even where the index of suspicion would not be high enough to warrant such investigation in an ordinary clinical situation.

Within the clinical assessment itself attention will also be paid to the possibility of feigning of symptoms beyond what might routinely be pursued in an ordinary clinical assessment.

What is special about the context?

The purpose of any forensic psychiatric assessment will usually also imply the need to provide frank advice to the patient’s legal advisors. Further, there is likely to be no direct effect on the patient’s clinical care, which marks the assessment out very clearly from a general adult psychiatric assessment.

However, for example by making recommendations about detention in hospital rather than prison, a forensic psychiatric assessment can lead to therapy and treatment.

Difference by stage of death penalty case

As with all forensic assessments, those assessments in death penalty cases can be for pre-trial, trial or sentencing issues. However, one clear difference in regard to sentencing reports is that they will be directed towards legal criteria, which are usually that of ‘beyond reformation’ which are utilised in determining whether the discretionary death penalty should be imposed. There may also be relevance of psychiatric factors to the other legal test of ‘the worst of the worst’, where the court addresses 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). Reports might also be requested in relation to mercy hearings, where ‘softer’ mental condition data may be relevant than within a sentencing hearing. Finally, a report may be requested in relation to whether a convicted prisoner awaiting execution is ‘fit for execution’.

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

The relationship between doctor and assessee is different in a forensic context than 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 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 on them to do so, both ‘externally’ from lawyers and ‘internally’ from
knowledge of the potential consequences of not taking part in an assessment, in terms of not having access to a potential mental condition defence or mitigation factors in sentencing. Therefore, the process is less collaborative.

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

There is also a risk of ‘doing harm’ to a defendant assessed, for example, where data is elicited which implies 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 ‘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 non-medical that is, ‘forensicist’ role, s/he then adopts and applies medical techniques, and this includes techniques of empathy and other techniques which are clearly medical and which aim to extract information from the defendant. Hence, s/he is quite clearly ‘being a doctor’. And, even if s/he thinks s/he is not, the defendant will soon forget the initial warning about role and quickly ‘experience’ the alleged forensicist as a 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 harm too far’ and will only accept instruction in capital cases from the defence, although this position emphasises the importance of being aware of the potential impact on assessment of one’s own ‘values set’, in terms of the potential for bias, and of acting ‘honestly’ (see Chapter 15).

Even where a doctor is instructed by the defence, if s/he is not adequately competent to conduct the assessment, then s/he can clearly ‘do harm’ by way of not, for example, eliciting medical information which would likely assist the defendant legally. And that is quite obviously ethically wholly unacceptable.

**Before accepting instructions**

If approached to conduct a forensic assessment, the first question to be asked is whether the proposed assessment is within your field of expertise; or whether, even if it ‘just is’, whether it would be more so 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 a neuropsychologist be instructed alongside a forensic psychiatrist). To reach a view on this a detailed letter of instruction is required. Even before this, there is often much to be gained from an informal discussion with a defendant’s legal advisors,
encompassing clinical information as it can best be gained at this stage, plus what legal questions
the lawyer wishes addressed by way of expert evidence. Also, do not accept instructions without
confirming that you are able to prepare the report within the timescale expected.

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?
- 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 for all concerned to decline a case at this stage than after having seen the defendant,
incurs costs and wasting time; even worse to find yourself in court being asked questions to which
the answer is ‘I don’t know’, and ‘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 on mental function and behaviour,
for example, describing the implications of acute psychosis on a patient’s ability to control their
actions. Other questions are likely to be suitable only for those with particular expertise beyond
those 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.

Consider also whether taking instructions in a particular case could lead to any conflict of interest.
This might include providing an independent report on a patient under your care already, 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.

Finally, once you have accepted a case, clarify the instructions, including any relevant legal constructs
or terminology.

Instructions in capital cases

Legal questions potentially asked in capital cases, at varying legal stages include, in summary:

- Capacity assessments
- Capacity to waive rights to appeal
- Capacity to have understood police caution
- Reliability of confessions, including compliance and suggestibility
- Fitness to plead and stand trial
- Mental disorder at time of offence
- Diminished responsibility
- Insanity
- Automatism
- Capacity to have formed the requisite intention
• Assessment in relation to mitigation
• Assessment of risk of future violence
• Assessment in relation to appeal against conviction and/or sentence
• Assessment in relation to a mercy hearing
• Assessment of capacity to be executed

**Before the interview**

Time spent preparing is generally time well spent. Before leaving your base to conduct an assessment, ensure you have the contact details of the solicitor who is co-ordinating the assessment. Check:

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

**Sources of information**

Ideally, case papers will have been provided to you some weeks in advance of the assessment. The amount of documents can vary widely. Have you received all that you need? A bare minimum is likely to be a case summary and prosecution witness statements, plus police interviews with the defendant. Medical notes will need to be seen, but are sometimes hard for legal representatives to locate and often arrive late in the assessment process. Without seeing the patient, it is sometimes impossible to know how important these are likely to be; if the patient reports a long psychiatric history, then detailed medical records are likely to be crucial. Good practice is, however, always 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 patient in relation to this is likely to be important. Hence, while it is sometimes unavoidable that the patient interview takes place without the medical notes, it is certainly far from desirable.

Thought should be given as to what opportunities there will be to gather further information; for example, will it be possible to speak to doctors who are involved in the patient’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 take with you; a full set of case papers or a summary?

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 every sense.

As regards interviewer safety, very often psychiatrists will face the prospect of interviewing patients who are not known to them. A scared or anxious interviewer will be distracted. Sensible precautions can 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’ll be. The interviewer should 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. Many would consider placing themselves squarely behind a desk as overly formal and this runs 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 patient but allowing a more relaxed interaction. Some rooms will have alarms and the position of these should be noted. It is useful to know 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 to find that it triggers a full scale response from the prison security team.

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 sensitive. Prison officers, particularly those guarding death row inmates in the Caribbean, are often reluctant to leave the room while an interview is conducted. This can lead to awkward situations. Negotiation in advance is required to ensure privacy, with the provision of a letter agreeing to this from the governor of the prison. Any expectation of ideal conditions is likely to be disappointed and compromises will need to be made. However, there must be a limit to compromise. Facilities to examine 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 s/he is, what the purpose of the assessment is, 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 to all.

Explaining the absence of confidentiality is necessary. It is crucial that the defendant is aware that anything he says can get to the court. Patients typically meet doctors with the expectation of privacy and secrecy. In this, and other ways, forensic assessments are different from consultations in other forms of medicine, and this must be made clear at the outset. An attempt should be made to record their acceptance of the terms of the interview, at least by way of making a note of it.
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, and via informing the prosecution, who can then contact the defence, if you are instructed by the State.

The interview

In ‘normal’ forensic practice patients are typically seen on their own. This is likely to be advisable in death penalty cases too, since the presence of someone else can distort clinical interaction, or inhibit it. However, occasionally, particularly for psychiatrists conducting assessments overseas, it is worth at least considering whether the presence of a defendant’s legal representative, or an advocate or interpreter, is on balance advisable, especially in interpreting cultural nuances of communication and behaviour.

Experienced psychiatrists will have developed their own style of interview. In contrast to most general adult patients, forensic assessees may have a motivation to conceal and distort information; a favourable forensic evaluation might lead to freedom or the annulment of the death penalty. Therefore, there can be no assumption of honesty. A sense of detachment between interviewer and patient is required, but so is empathy a difficult balance to achieve but an essential one. Consideration should be given to adopting techniques specifically designed to determine whether there is feigning or exaggeration of symptoms (see Chapter 5).

During the interview attention needs to be paid to non-verbal cues. The interviewer should attend to any emotional problems presented by the patient; offering a tissue to a tearful patient can help build rapport. Whilst a degree of testing of emotional response for example by challenging statements made by patients is arguably an integral part of any psychiatric assessment, deliberately aggravating a patient for example by holding prolonged eye contact should clearly be avoided. Although the interviewer needs to control the assessment, particularly if time is short.

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 even if just mentally can help, particularly in complex cases, which death penalty assessments often are, or where the interviewer is more anxious than normal. 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. Again, techniques for validation of interview material are described in Chapter 5. Open questions should always precede closed ones.

The focus of any death penalty assessment will be the index offence. However, there might be strong and understandable reasons why the defendant is reluctant to talk about this, including fears of incriminating himself if the assessment is pre-conviction, or worries about jeopardising the chances of an appeal against the death penalty. Assessors need to be accepting of this.

The good interviewer will allow the patient to talk freely. They will check their understanding of what is said. The interview process should be fluid, with the information that is gathered used to generate and then test hypotheses in an advancing process of exploration, within an active process. This means taking care that, while allowing flexibility, no areas are left unexplored. The proficient interviewer,
being mindful of potential diagnoses, whether made by reference to ICD-10 or DSM-IV, will likely want to explore for related symptoms, and for evidence for and against disorders.

Ensure that you have asked any necessary questions at the interface between the clinical assessment and the legal questions to which you know the information will be applied.

Some interviews are more difficult than others. Disturbed patients often benefit from being given time, space and reassurance as to the interviewer’s interest in them. However, don’t 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.

At the conclusion of an interview, it should be explained to the defendant what happens next, with approximate timescales for the production of a report if possible. It is never appropriate to tell the defendant your conclusions. Aside from taking proper time to read all available information and to think, your opinion and its implications have to be taken into the context of all the evidence in the case as a whole, and legal opinion on the totality of the evidence, of which yours is only one part, even if it is an important part. Hence, information to the defendant about your opinion should come from his lawyer, whether you have been instructed by the defence or prosecution.

**Interpreters**

Many interviews in death penalty cases will need to be conducted with the help of an interpreter, if not in terms of language per se, then in terms of culture (if the doctor comes from a different culture). The choice of interpreter is important, but in practice might be limited.

There are clear difficulties with using family members in this role, although it might be felt expedient in certain situations; not least in regard to confidentiality, the difficulty for defendants in speaking about unpleasant events in the family, or the shame that a defendant might feel in reporting symptoms of mental illness or details of an offence in front of a family member.

A professional interpreter who has some experience of psychiatric interviews is to be preferred, particularly for death penalty work. They should not be known to the defendant, and should preferably belong to an organisation that offers training. It is especially important that the interpreter is able to maintain confidentiality. Sometimes these quite basic requirements are hard to meet in practice.

**Note taking**

Clinicians will have their own ways of taking notes, their own idiosyncratic notations and abbreviations. Note taking should not interrupt the flow of what ideally will appear like a natural conversation. However, notes are a matter of legal record. They need to be understandable at least to you accurate, and full enough for you to later prepare a report.
**Should you write down the questions asked (with the responses)?**

This has merits. A very full account of the interview is then available to the court, and particularly of how symptoms of mental disorder emerged during the interview. However, it is laborious and can spoil the flow of both interview and report. In practice it is probably best to write notes in summary form, and in the third person, but to ensure that topics that may be legally crucial are recorded verbatim, with answers recorded in the first person, as they are spoken by the defendant.

**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 be put to him or her. Also, the mental state of the defendant can be observed on two separate occasions, with noting of any changes or inconsistencies between the two interviews. This is likely to be especially important in cases of suspected personality disorder.

**Collateral information**

Obtaining a collateral history is important in any forensic assessment. There are a variety of potential sources for this. Friends or family members could be interviewed, for example, although often this is not possible. As well as case papers and medical records, other potential written sources of information include school and social services records (see above); all should be matched against the patient’s account. Such a process of triangulation, presuming that the information obtained is consistent, allows the clinician to express an opinion with a greater degree of certainty than would otherwise be the case. Gathering information from others may be subject to special rules if they are also witnesses, requiring consent from the prosecution (there is usually no difficulty in questioning defence witnesses if you are instructed by that side).

**Physical examination and investigations**

Mental disorders can have an organic cause. If such a cause is established, it can not only have significant clinical effects, but it can also have important legal consequences, ultimately even in terms of legal automatism. Notwithstanding its importance, it can be practically difficult to conduct a physical examination, particularly in prison because of a lack of privacy and a lack of equipment (see above). The examiner is also placing himself in close contact with the defendant and could possibly expose himself or herself to an enhanced risk of violence. However, such examination may be necessary.

Specialist investigations such as EEG, MRI brain and CT head scans are now commonplace in clinical practice in Western Europe and the USA. There is far less often no access to such technologies in practice for those detained in prison in parts of Africa. 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 felt that they are crucial, then representations probably made by the defendant’s solicitor, supported by a letter from 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 which is local to the prison if at all possible.

Beyond this, though, it can reasonably be argued that where the death penalty may be imposed ‘no stone should be left unturned’ in terms of 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 death cases, but also minimum medical standards, based upon equivalence with what would be available in a developed country.

**Personality assessment**

There are particular issues concerning the assessment of personality, including towards a possible diagnosis of personality disorder.

There is complexity in defining personality, with varying weight attached to social aspects, individual capacities, affective traits, psychological defences and cognitive abnormalities.

Personality disorder is defined in psychiatric manuals and relies on the condition being enduring, developing or manifesting in early life and reaching a severity to have significant impact on functioning.

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.

The clinical interview is important in assessment of personality, but should always be combined with other information from a wide range of sources. Usually it will be necessary for there to be psychological testing by way of personality psychometrics, thereby describing personality structure. 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.

**Psychological testing**

Psychological testing is described in more detail in Chapter 5. 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.
Medical involvement in capital cases

Some have argued that clinicians who undertake assessment 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 medico-legal reports. There is substantial ‘expertise in being a medico-legal expert’ which goes beyond 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 done such a report before. And in jurisdictions retaining the death penalty the stakes are far higher, given that there is no ability to set error 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 provoke anxieties in clinicians; 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 includes 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. So advice on relevant law, including legal tests, should be sought and fully understood, if not already known to the doctor. Also, if they have never worked in a country which retains the death penalty, and/or in a less developed country where services are limited, then this will add a further element of lack of experience.

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 which maintain the death penalty on a discretionary basis. (See Chapter 7)

After an assessment is concluded, it can often be valuable to discuss the findings with an experienced colleague in an anonymised way. This allows the opportunity for reflection from a position of some distance, and for tentative conclusions to be challenged and, if necessary, revised. This advice is particularly relevant to a doctor who has little experience of assessment of defendants in capital cases, but no doctor should be too proud to seek discussion with a colleague.
CHAPTER FIVE:
Psychological Assessment
This chapter offers guidance as to best practice concerning a range of matters that clinical psychologists are routinely asked to comment upon in relation to criminal trials.

This is a practical guide which deals with assessment methodologies and concentrates on psychometric assessment, describing some of the more widely used tests in each area (chosen for their robust psychometric properties), also offering an ‘at a glance’ guide in Appendix 1. Appendix 2 offers a brief description of each of the psychometric measures referred to in the text. These two appendices may be used as quick reference guides to appropriate practice.

Use of psychometric tests

Psychometric tests and other sources of information

A central premise of clinical psychology is that all behaviour has a psychological function, and so a clinical psychology assessment offers an explanation of what may appear to be unusual, maladaptive or bizarre behaviour. Such assessment may employ formal testing of an aspect of mental functioning, for example of an individual’s intelligence quotient (IQ), by way of a standardised measure that compares the functioning of one individual with their age and culture matched peers.

Other assessments may place the behaviour in question in the context of the individual’s personality functioning, in order to describe their personality traits, plus any dysfunction they may exhibit, again as measured against a population of ‘normal’ peers, including determining whether it is sufficient to amount to ‘personality disorder’ (note psychologists define personality disorder in terms of ‘deviation from the statistical norm, whereas psychiatrists require evidence of dysfunction in aspects of normal activities of living).

All of these tests should only be used in conjunction with a thorough clinical interview and information from collateral sources (see Chapter 4 for a suggested list).

Choice of tests

In choosing which tests to administer, the following criteria must be satisfied before a test may be properly used:

- Are the tests culturally appropriate?
  - Have the tests been validated in the population from which the subject comes?
  - Do not use tests when there is uncertainty about their cultural validity
- Does the normative sample that the test was developed from match the individual to be tested?
  - Including demographic and clinical information
  - If the two do not match then, again, it will not be possible to draw valid conclusions about the individual assessed from the test data
  - Some tests, such as the WAIS-IV (a test of intelligence), have been developed extensively so as to cover ethnic diversity, age differences and offer a broad normative database
  - Others, such as the MCMI-III (a questionnaire used to assess personality) have been developed for use with clinical and forensic populations only and should not be used with individuals not falling within those categories
Psychological Assessment

• Only tests whose psychometric properties suggest reliability and validity should be used (these properties will be reported in the manual which accompanies the tests). Where the only tests available have poor content, criterion, test-re-test, or inter-rater reliability, their results should be interpreted with caution. (In practice, modern tests that have been accepted for publication and use have all established sufficient reliability and validly, but some old tests are still in use and should be examined carefully to ensure that this criterion is satisfied)

Assessment of clinical symptoms and syndromes

Assessment of mood symptoms

It may be useful to take some psychometric measurement in addition to clinical assessment of the individual’s mood, as this may have a bearing on their current capacity to engage in clinical psychology assessment; it may also assist in understanding some of their behaviour at the time of an alleged offence and during subsequent police interviews and court hearings. The Beck Anxiety Inventory (BAI), Beck Depression Inventory version two (BDI-II), and the Hospital Anxiety and Depression Scale (HADS) are all suitable measures in this regard.

Assessment of personality

No psychological assessment can replace thorough clinical assessment, including taking a collateral history, when attempting to assess personality. Personality assessments can be particularly susceptible to cultural validity problems as they were largely developed with Western cultural values. This does not prohibit the use of standardised tests, but indicates an advanced level of caution when interpreting the results. Commonly used personality assessments include:

• Millon Clinical Multi-axial Inventory – third edition (MCMI-III)
• Minnesota Multiphasic Personality Inventory (MMPI)
• Personality Assessment Inventory (PAI)

Assessment of pre-morbid intellectual functioning

These tests are necessary in order to determine whether there has been damage to the brain by virtue of brain injury caused by: trauma, hypoxia, in order to exclude inherent poor functioning, and to determine whether, on other tests, change has occurred.

Pre-morbid psychometric measures have been developed following research observations that the ability to read, which is learnt early in an individual’s development, is less vulnerable to change following brain injury, decay and functional illness, than other abilities. Therefore, tests have been developed that use non-phonetic words (e.g. cough, gist, debt etc.). Valid and reliable tests have been developed that can estimate pre-morbid IQ with scoring that can be directly compared with measures of current functioning, as well as being compared with a normal distribution curve of data from a representative sample.

Given the re-calibration of intellectual functioning tests being completed every few years, due to the Flynn effect (the observation that IQ worldwide is increasing year on year), it is important to use the
correct pre-morbid measure for each version of the WAIS-IV. New assessments should use the Test of Pre-Morbid Functioning (TOPF). Assessments using the WAIS-III should use the Weschler Test of Adult Reading (WTAR) and the WAIS-R should be paired with the National Test of Adult Reading (NART).

**Assessment of current intellectual functioning**

A range of tests of current intellectual functioning, memory and concentration (WAIS-IV, WMS-IV) will usually be required, along with executive functioning testing (BADS, Stroop, Trailmaking). The combination of pre-morbid and current tests allows for opinions to be given about cognitive decline, or, support the notion of developmental impairment or learning disability.

**Substance misuse**

The link between substance misuse and offending has been well established, and the nature of the misuse in an individual is important to understand in terms of identification of treatment targets (relevant where advice on sentencing is offered, or for a parole hearing).

One of the most robust measures of harmful substance misuse is the Leeds Dependency Questionnaire (LDQ). This is a self-report measure, with the associated drawbacks, but it does offer a measure of change over time in a meaningful way. A further strength of the LDQ is that it offers a guide as to how severe the dependence is.

Some specific personality testing thought to be related to substance misusers, including the Sensation Seeking Scale (SSS), may be used.

**Memory disorder/amnesia**

Apparent absence of memory (amnesia) is a common topic of assessment for clinical psychologists, both in 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 why memory loss may have occurred (through organic brain deficit or psychological factors).

The question of ‘why’ memory loss has occurred is often the most important question for the court. The determination of whether the cause is organic or psychogenic, or functional, may be difficult to achieve, particularly when one is also considering the possibility that the individual may be malingering (see below).

Some researchers divide amnesic states into ‘discrete’ and ‘persistent’ loss and suggests the following possible reasons for each.

Medical causes of discrete temporary amnesia may include:

- Toxic confusional states (including alcohol intoxication)
- Head injury
- Epileptic seizures
Psychological Assessment

- Hypoglycemic attack
- Post-electroconvulsive therapy confusional states
- Transient global amnesia syndrome

Persistent memory impairment may be caused by medical conditions such as:

- Epilepsy
- Sleep disorders
- Cerebral tumour
- Insulin shock

Psychological descriptions include the phenomenon of dissociation at the time of the offence, resulting in a lack of ability to recall events, with high emotional arousal at the time of an incident leading to poor recall subsequently; plus emotional state dependant memory, where recall can only occur if the individual returns to the emotional state he was in at the time of the offence.

A different form of dissociation explains amnesia in that, although there may not have been a high state of arousal at the time of earlier events, the events are too painful to recall subsequently, such that the person 'dissociates' away from doing so, referred to as 'psychogenic amnesia'.

Although caution must be exercised in assessing the validity of claimed amnesia for offences, there is clear research evidence that, even among those who have been convicted and have no opportunity for appeal, their memories for the offence remain poor.

In summary, therefore, it is likely that amnesia for an offence may be induced by three main mechanisms that are not mutually exclusive:

1. Intense emotional arousal at the time of commission of the offence
2. Dissociation away from recollection of the event ('psychogenic amnesia')
3. Alcoholic blackout (acute intoxication at the time of the offence, usually in the context of chronic alcohol abuse)

It may be that longer amnesic periods tend to be as the result of alcohol intoxication or dissociation away from recollection, with emotional arousal being associated with shorter amnesic episodes. Courts will routinely be interested in possible malingering of memory difficulties, which is an area in which psychological assessment may be of assistance.

The presence of amnesia itself does not support any psychiatric defence. However sometimes amnesia, if not 'psychogenic' (see above), may suggest mental abnormality at the time of the offence, which then may be relevant to a psychiatric defence. It may be that the amnesia is determined by dementia, a psychotic illness, severe depression, alcohol dependency or other psychological factors.

Assessment should always consider the possibility of underlying brain dysfunction, and if there is anything in the individual's history or clinical presentation to suggest this, then a full neuropsychological and scanning assessment should be undertaken (see above).
**Malingering**

Malingering, which can be amnesia or a wide range of other mental symptoms, is common in forensic psychology assessments.

Malingering of psychological difficulties, such as poor memory, is sometimes referred to as ‘faking bad’, which is in contrast to another phenomenon of deception that is, attempting to ‘fake good’, where the person attempts to present themselves in a more favourable light than would be discovered upon objective review.

Many tests of personality, including the Millon Clinical Multi-axial Inventory (third edition) and the Personality Assessment Inventory have built-in validity scales that detect ‘faking good’ as part of a global assessment of personality functioning.

Other measures have been designed to concentrate in more detail on the detection of those who are trying to ‘fake good’. The most commonly used of these is the Paulhus Deception Scale. This measure contains scores for both ‘self-deceptive enhancement’ and ‘impression management’.

Six potential strategies to detect malingering are well recognised:

1. **Floor effect** – identification of the individual as performing at the bottom of a particular test, being unable to provide even the most basic information or manage a very simple task (the ‘coin in the hand’ test is an example of testing using this strategy).
2. **Symptom validity testing** – individuals are presented with a forced choice alternative and may perform significantly below what would be expected by chance, raising the suspicion of malingering.
3. **Performance curve** – attempts at malingering fail when fakers fail easy items but pass more difficult ones.
4. **Magnitude of error** – the qualitative and quantitative features of wrong answer are examined for evidence of symptom exaggeration or fabricated deficits.
5. **Atypical presentations** – where performance is different across similar tests, or across re-administration of the same tests over time. Caution is needed with this approach as some head injuries may also cause this phenomenon.
6. **Psychological sequelae** – malingerers may fake symptoms that are not directly related to their alleged complaint.

Many tests have been developed to detect malingering of mental illness. The best known of these are the Millar Forensic Assessment of Symptoms (MFAST), the Structured Interview of Reported Symptoms (SIRS) and the Structured Inventory of Malingered Symptomatology (SIMS). These interview methods offer information that may guide the identification of malingerers, in tandem with collateral information. Caution should be exercised when using these measures as they are vulnerable to false positive conclusions in individuals with a highly acquiescent personality style (see above).

In regard to malingered amnesia it will be important to administer the Tombaugh Test of Memory Malingering (TOMM).
Another test that has strong predictive accuracy in the detection of malingering is the Ravens Standard Progressive Matrices (RSPM). This has the advantage of acting as what is widely accepted to be a culture-free measure of general intellectual ability but can also be used as a means of detecting sub-optimal effort.

An expert opinion that an individual is malingering can have major consequences in legal settings. Therefore caution should be used in using the term ‘malingering’. There is common consensus that use of this term should not be based on testing alone, but should be placed in the context of all relevant collateral information. Assessment should include consideration of the following factors:

- Inconsistencies between neuropsychological domains (e.g. impaired attention but normal memory)
- Inconsistencies between neuropsychological test scores and the suspected aetiology of any brain dysfunction (e.g. normal IQ and memory scores in alleged hypoxic brain injury)
- Inconsistencies between the neuropsychological test scores and the medical evidence regarding severity of injury (e.g. low test scores more commonly associated with coma rather than no loss of consciousness)
- Inconsistencies between the neuropsychological test scores and behavioural presentation (e.g. being able to offer autobiographical information whilst failing tests of recent and remote memory)

**Traumatic brain injury and the impact on behaviour**

Behavioural sequelae of prior head injury include deficits in executive functioning, sometimes also called dysexecutive syndrome. However, this may be a feature of an individual’s presentation in a number of different disorders, including diffuse traumatic brain injury, (non-organic) personality disorder, depression, and paranoid schizophrenia amongst other conditions.

Executive functioning refers to an individual’s ability to manage situations that involve planning or decision-making, error correction or troubleshooting, in situations where responses are not already well learned or which contain novel sequences of actions, and in situations which either require the overcoming of a strong habitual response, or resistance to temptation. Deficits in this area of mental process may frequently be seen among offenders, and it will be important for the court to understand not only whether it originates in organic or non-organic disorder, and if the latter whether it reflects solely personality disorder, but also the scale of the impairment.

Several measures exist to assist in understanding the nature and magnitude of executive functioning impairment. The most robustly and best normed are:

- The Behavioural Assessment of Dysexecutive Syndrome (BADS)
- The Stroop Neuropsychological Screening Test
- The Controlled Oral Word Association Test (often called FAS)
- The Reitan Trail Making Test
Suggestibility and compliance

*Suggestibility* describes a characteristic whereby an individual is so unsure of themselves that they will take on what others tell them as their own belief, neglecting or rejecting what they had previously autonomously thought.

*Compliance* describes a characteristic within which the individual does not change their own beliefs but goes along with what is being put to them, either in order to avoid conflict or to be accepted by others. The characteristic of either suggestibility or compliance, or both, may be present in an individual, as a tendency, but whether such a tendency operated in a given situation is open to proof, or not.

Suggestibility and compliance may enhance the likelihood that an individual has been coerced by others into criminal activity, although the recognised test of suggestibility was developed specifically in relation to ‘interrogative’ situations, and indeed it is properly referred to as ‘interrogative suggestibility’.

Assessment should be conducted with a full clinical interview, a review of collateral information, including an interview with an informant if possible, and the application of the Gudjonsson Suggestibility Scale (version one or two) and the Gudjonsson Compliance Scale (Form D for the individual or Form E for an informant). These measures have good reliability and validity and offer, helpfully, normative comparison data for both the general population and for Court referrals.

Psychology and legal questions

There are multiple legal contexts within which one or more of these areas of psychological functioning can be relevant to legal tests and process. Psychological evidence relevant to specific legal issues is considered within the relevant sections of the handbook covering these legal issues (Chapters 10-13).
Diagnosis allows for the categorisation of mental disorders based upon internationally recognised criteria. Diagnosis will usually be the starting point from which much which is important clinically and legally will flow, including in terms of some likely relevance to legal questions at issue. Psychiatric diagnoses are almost all based on the presence of signs and symptoms, and do not rest on establishing aetiology or pathology. In other words, they are often best viewed as syndromes rather than diseases. This can lead to questioning of the validity of the diagnosis in legal settings, where criticism might be levelled at the psychiatrist for making a diagnosis based on what the patient has told them. However, diagnosis relies upon far more than merely what the patient, or defendant, tells the doctor.

Formulation goes beyond diagnosis in that it amounts to offering an ‘understanding’ of the individual’s mental functioning and behaviour, in terms of symptoms but also in terms of ‘psychological mechanisms’.

Process

The diagnostic process should always incorporate all available information, including collateral information from family and friends when possible. Establishing the presence of symptoms should not be approached with naivety, but with recognition that someone engaged in legal proceedings might seek to fabricate or exaggerate symptoms. The consistency of symptoms with other reports, any incongruity between the description of symptoms and their apparent manifestation, the reporting of highly unusual or unheard of symptoms, or the over-reporting of symptoms should all be considered. If there is significant concern about the veracity of symptoms reported, then 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 effectively to achieve and relatively unusual. And what is looked for, as in all medicine, is whether there are enough ‘pieces of the picture in the jigsaw’ 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. This goes beyond the legal analogy of ‘corroborating evidence’, in that there is mutual reinforcement of the likely validity of pieces ‘across the picture’, whilst the presence of pieces that ‘do not fit’ will tend to cast doubt on the picture that is observed.

In psychiatry, and in particular in capital cases, since the values of the assessor can potentially be somewhat determining of decisions about diagnosis, it is important to have insight into one’s values and to recognise that they can influence decision making. Such insight is an important safeguard against bias, alongside a conscious adherence to the pursuit of honesty.

Classification

Diagnosis should be based on one of the two recognised classification systems: The World Health Organization’s *International Classification of Diseases, 10th Edition (ICD-10)* or the American Psychiatric Association’s *Diagnostic and Statistical Manual, 4th Edition (DSM-IV)*. Both of these manuals are periodically revised and new editions of each are 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 by non-clinicians. Indeed, the DSM-IV 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. Hence it is crucial that the legal process does not drag doctors into apparent over-reliance on the classification systems at the expense of clinical judgment. That said, if a diagnosis is made, despite insufficient 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

The validity of diagnosis in different cultures is mitigated to some extent by the international consensus methods used in agreeing criteria in ICD-10. There may, however, be issues relating to the validity of specific instruments (if used) 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. If tools are used that require self-rating based on 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 on 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 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 medico-legal settings (e.g. SCAN or SCID-II). Training is required if these tools are to be used. This also means that doctors should not comment upon the tools applied and interpreted by other experts, unless they have been trained to administer those instruments themselves.

The following is a summary of some significant difference between classification systems:

<table>
<thead>
<tr>
<th>ICD-10 (Chapter V)</th>
<th>DSM-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classification system</td>
<td>Diagnostic nomenclature</td>
</tr>
<tr>
<td>Designed for collection of data and includes diagnoses of questionable validity</td>
<td>Only contains categories with diagnostic validity</td>
</tr>
<tr>
<td>Diagnosis almost exclusively based on symptoms</td>
<td>Almost all diagnoses include an impairment in functioning criterion</td>
</tr>
<tr>
<td>Schizotypal disorder described with schizophrenia</td>
<td>Schizotypal disorder described with personality disorders</td>
</tr>
<tr>
<td>Symptoms of schizophrenia must be present for one month</td>
<td>Symptoms of schizophrenia must be present for six months</td>
</tr>
<tr>
<td>No specific criteria for narcissistic personality disorder</td>
<td>Specific criteria for narcissistic personality disorder</td>
</tr>
</tbody>
</table>
Communication of diagnostic information in 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

**Diagnosis, behaviour and offence**

There should be careful separation of diagnosis from behaviour or criminal offences. Hence, 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. A child sex-offender might fulfill diagnostic criteria for paedophilia but neither the behaviour nor the conviction makes the diagnosis, and they should not be confused. Similarly, arson is not a clinical diagnosis. There is no diagnosis that is directly equivalent to any legal finding, and it is improper to convert an offence into a condition. 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. Hence, 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 described in Chapter 2. Very rarely does the law ‘incorporate’ a medical notion into itself as a legal test or criterion, and perhaps a diagnosis of learning disability (mental retardation) does itself come close to determining illegality of imposition of the death penalty, and may also inhibit legally execution per se.

**Specific considerations when making diagnoses in capital cases**

**Intellectual disability**

Intellectual disability is synonymous with learning disability or mental retardation, and can be a classification of great importance in capital cases. It is unusual in that the diagnosis itself might be equivalent to the ultimate legal determination: a classification of someone as mentally retarded might automatically excuse them from a capital sentence (see also above). However, a clinical diagnosis will not always be accepted if the basis of that diagnosis is rejected. In the United States, legal definitions of mental retardation differ between states.

The diagnosis is of significant importance and should be approached carefully. In DSM-IV there are three broad criteria that need to be satisfied: i) sub-average general intelligence; ii) limitations in adaptive functioning; and iii) 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. Any assessment of IQ incorporates some possibility of error and so, whilst
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 with respect to reliability, but there is a danger that the precise IQ is overemphasised. For example, a defendant with an IQ of 71 but with significant impairment in adaptive functioning might still fulfill the criteria for intellectual disability. In any event an IQ score is subject, statistically, to potential inaccuracy by way of 4 points in either direction.

Adaptive functioning is complex and for most prisoners the expectations of their functioning are limited. Function 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. The assessment can be difficult to establish in prison and it may be particularly important to gain collateral information about function in the community.

**Formulation**

Diagnosis is almost inevitably followed by formulation, both in clinical practice and medico-legal practice. Diagnosis provides a reliable and succinct way to communicate the category within which that person falls in terms of the nature of their disorder, but it is limited as regards inferring an understanding of the individual. Formulation is more hypothetical and incorporates the underlying causes, precipitants and maintaining factors associated with a person’s mental disorder and behaviour; essentially it amounts to offering an ‘understanding’ of the individual’s mental functioning and of its relationship with his offending (see Chapter 7).

As in many other types of criminal case, in a capital case it is likely that the formulation will represent a ‘causal bridge’ between the diagnosis of the disorder and the offending behaviour. 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. Such formulation of a case can be applied, not only to elucidate how past offences came to be committed, but to also, offer a foundation for risk assessment and risk management for the future. Hence 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 risk of future serious offending in terms applicable to the legal test for imposition of the discretionary death penalty of being ‘beyond reformation’.

In summary, in forensic psychiatric practice, diagnosis rarely provides a complete explanation for behaviour, and formulation introduces necessary complexity and understanding into the process. However, the methods by which the two are achieved are entirely distinct, as are their validity bases.

**The detail of formulation**

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

- 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 index offence
• Specific risks factors for future violence

The gathering of necessary information and a thorough psychiatric assessment allow for the formulation to be developed. Different models of formulation exist amongst mental health professionals. The biopsychosocial model includes consideration of biological, psychological and social factors that either predispose, precipitate or perpetuate the anticipated problem (for example, violent behaviour). 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 include reference, not only to risk factors, but also to protective factors that reduce the risk of future offending.
CHAPTER SEVEN: Risk Assessment
Process not theory

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, for example sentencing 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.

Risk assessment for legal purposes

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

Risk assessment is ethically problematic

Risk assessment is fraught with ethical problems for the clinician, and particularly so where the purpose is solely to assist the justice process.

- Any technique chosen will have within it built in value judgments, including judgements about what is an acceptable level of reliability and validity
- If a clinician takes on the task of risk assessment for legal purposes, it is crucially important for them to be clear about the boundaries of their role, and to be firm in communicating this to others
- This is particularly the case where the assessment is to be used in relation to the established legal criterion for imposition of the discretionary death penalty of ‘beyond reformation’ (see Chapter 12)

Some clinicians eschew risk assessment in capital cases, on the basis that not 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’.

Definition

Risk assessment is a term that is widely used, and often mis-used. However, it is a more appropriate term than ‘dangerousness’, which falsely assumes that all risk of future violence resides in factors intrinsic to the individual concerned, rather than in interaction between factors both in the individual and in his environment.

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 benefitting 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 the risk of future violence by an individual, so as to provide a (not ‘the only possible’) risk assessment.

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 known pathological mechanisms, on the 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, is relevant, but is in no way sufficient for valid and reliable prediction concerning an individual. Ultimately, the best basis of prediction lies in knowledge of that individual, and his past pattern of violence, and associated variables, rather than in knowledge of ‘people like him’.

Hence, 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’, expressed both in terms of factors intrinsic to them, and of what circumstances, within them and within their environment, have been associated with violence they have previously exhibited. It is also expressed in terms of ‘narratives’ of their past violent episodes, plus ‘formulation’ (with the aim of achieving an ‘understanding’ of such past episodes).

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 a comment on a likely outcome. 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 risk assessment can be divided into stages, in terms of ‘generations’ of risk prediction, in that the discipline has moved though several periods of development, as follows:

- **First generation**: *unstructured clinicians’ judgements*, exhibiting low accuracy due to problems with a lack of consistency and agreement of method, resulting in a low inter-rater reliability, difficulty with the replication of the process by which any single judgment 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, with criticisms including focusing the assessment on a limited number of factors which are capable of measurement in populations; the exclusion of factors with face predictive validity; the minimising of the importance of case specific, idiosyncratic factors; and the exclusion of the role and input of clinical judgement and expertise, thereby paralysing/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 in terms that 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 judgment*, 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 judgment plus the appropriate use of actuarial information, so as 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 both increase and decrease the violence occurring 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 are very limited, and are also limited almost entirely to variables which are ‘historical’; actuarial techniques are of very little use in terms of 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 upon which the scales are based, whether samples are from specific groups or from more general populations, and whether the scale is used for only one type of behaviour. The following risk assessments are examples of actuarial tools:
• VRAG (Violence Risk Appraisal Guide)
  • 12 items are scored leading to a categorisation (low/medium/high) of reoffending likelihood
• RM2000 (Risk Matrix 2000)
  • Items are scored leading to a categorisation (low/medium/high/very high) of sexual reoffending likelihood

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 which 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 clinical judgement**

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 clearly structured professional judgment that may therefore hold against scrutiny. The embodiment of this approach is an instrument – now widely used and respected within forensic psychiatry – the HCR-20. A similar tool developed for assessing sexual violence risk is the RSVP.

Training is required and recommended if a structured clinical judgment tool is used.

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

**History of violence**

• All episodes of physical violence
• Were they planned or impulsive; what were the trigger factors?
• What was the nature of any relationship with the victim?
• Any use of weapons in offending
• Parallel behaviours that may reflect pro-violence attitudes, such as bullying, coercion, and other purposefully unkind behaviour, since pre-offending attitudes and distorted thinking can be a maintaining factor for future violence
• Any cruelty to animals, as well as to peers
• ‘Boundary breeches’ such as cruelty to, or attacks upon, those in authority (teachers, police officers, parents)
• Identify the level of historical ubiquity of violence; for example, whether there has been violence only to strangers, family, in relationships, children, or to multiple categories of victim
• Any fascination with weapons
**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 command hallucinations?
- Relevance of cognitive factors that might be associated with intellectual impairment

**Substance misuse**

- What is the history of substance misuse
- Which drugs?
- Frequency and quantity of each drug used
- Association of drug use with offending
- During intoxication or withdrawal
- Associated with 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?
- Have there been any long-term sequelae of head injury?
- What is the relationship of 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?
- Sadism
- Lack of empathy
- Affective instability
- What level of insight does the person have into their own propensity for violence?

**Contextual factors**

- What circumstances were associated with previous violent acts?
- What was the nature of their relationships at the time of violent acts?
- How did the behaviour of other people contribute to 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 the ‘formulation’ where 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 with actuarial prediction is that, no matter how good the psychometric properties of a measure, and no matter how good 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’. Hence, 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 he decides to include, what methods he employs, whether they include both ‘risk factors’ and ‘protective 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.

**Perspectives on risk of violence and risk judgment**

It is impossible to avoid use of ‘judgment’ in risk assessment. And if there is to be judgment, it is likely to be best approached through adopting more than one method of assessment of risk, so as to then make a ‘risk judgment’ based upon the several ‘perspectives on risk’. This allows, indeed requires, application of both actuarial and clinical methods, the latter likely being most reliable when it is a ‘structured’ (rather than individual, idiosyncratic) clinical risk assessment.

**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. The best predictor of future behaviour is still past behaviour. *Static factors* are always additive, usually negative and often tend to out-weigh other data.

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. It also allows for consideration of protective factors, as well as helping to identify treatment targets which, in turn, offer the opportunity to measure change over time, and strategies for risk management. Structured clinical judgment tools incorporate static and dynamic factors.
Protective factors

In the past, risk assessment laid great emphasis on historical offending and anti-social behaviour. This often yielded a score that inferred that there was no scope for the individual to reduce their perceived risk. More recently, protective factors have been brought into consideration in risk assessments, including in the development of new psychometric measures, such as the Short-Term Assessment of Risk and Treatability (START).

‘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 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 story, or narrative; that is, a story of how this individual comes to exhibit violent behaviour, including how they first came to do so.

In a formulation, the factors that affect behaviour are usually broken down into the following categories:

- Vulnerability factors
  - Poor mental health
  - Impaired intellectual function
- Precipitant (or ‘trigger’) factors
  - Intoxication
  - Anger
  - Frustration
  - Loss
- 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, describing the circumstances, including sequence of events, of its occurrence, and what led to it, thereby inferring how repetition might be predicted in the future.

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 risk.

A formulation can be expressed, including with the patient, 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 in an individual.
Vulnerability factors
- Mental health
- IQ/Neurological difficulties
- Poor self-esteem/image
- Locus of control
- Personality/Early life insult
- Attachment style
- Modelling of problem behaviour

Precipitants / triggers
- Mood
- Stress
- Anger (context?)
- Disinhibited
- Loss
- Financial difficulties

Problems
(Insert description of offending behaviour and other significant issues here)

Maintaining factors
- 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

Protective factors
- 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

Stable dynamic factors
For example:
- Anti-social 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 problems solving skills, easily frustrated, hostility

Acute dynamic factors
For example:
- Opportunities to offend (e.g. access to victims, weapons etc.)
- Emotional collapse/crisis in personal life
- Collapse of social support/end of relationship
- Hostility being voiced
- Substance misuse
- Conflict with others
- Distorted attitudes

Recommendations/ Future risk

Then add psychometric info.
Conclusion

There is no perfect risk assessment. It is hoped that this chapter has offered a guide to the use of both actuarial measures and the interpretation of clinical data.

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

- Obtain as much collateral information as possible. Don’t be afraid to go back and ask for more if you are not clear
- It is advisable to ‘see the body’ and ensure that you are able to get from the interview the attitudes and beliefs of the individual. It is also advisable not to overemphasise what they have said to you at the expense of ‘factual’, including actuarial, data
- 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
- Be specific about the nature of the risk you are considering and the context: The risk of serious violence if released into the community…rather than the risk is…
- Choose risk assessment tools with reference to their psychometric properties and be aware of their strengths and limitations. This way you can draw on the evidence base properly to guide your professional judgement
- Suggest a treatment or management plan that might address the offending behaviour
CHAPTER EIGHT:
Report Writing

For 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 be such. It should describe all relevant, sometimes complex, psychiatric issues, including diagnosis and the effects of diagnosis, also formulation, and explain the relevance of these descriptions to providing answers to the legal questions that are at issue. Beyond this, however, it should also tell the story of the defendant’s life in a way that is structured, comprehensible and comprehensive.

There must be sufficient detailing of the information that has been relied on in reaching conclusions, in order 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. Usually, the audience in the first instance will be the defendant’s legal representatives, other lawyers and the judge; in other words, intelligent laymen but with little knowledge of medicine and psychiatry. The report will also form the basis of your oral evidence to the jury, and should be written with this in mind.

Of course, the report is designed to assist the Court and not the instructing party. And it will therefore need to demonstrate ‘the three I’s’ of being an expert witness: that is, impartiality (and the appearance of 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 kept separate from the opinion expressed upon that information. Further, the Court needs to be able to identify where each piece of information used in the report came from, since source may imply level of reliability and validity, and since 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 such as: ‘If the court decides X is correct, then my opinion is A, if Y then B’. Also, whilst short reports are to be preferred (and are more likely to be read), they need to contain sufficient information to justify the opinion expressed. Reference to information which goes against the author’s opinion should also be included, with explanation of how s/he comes to his view. Breaking the report down into sections therefore allows for categorisation separately of data 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, 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 detract from the flow of the narrative.

Long sentences are hard to read. A psychiatric report is not a work of literature, and clarity is the over-riding 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; however it is not sensible 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 serious 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, which 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 come to have written 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 have gathered the facts on which you rely. Primarily this will be by way of an interview(s) with the defendant, so describe where and when these took place, who was present and how long the interview(s) lasted. 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; say what emerged afterwards. The documents seen should also be listed. If there is information which you would have wished to see but either was not available, or you were not permitted to see it (for example, evidence deemed legally to be inadmissible) which would have been relevant to your clinical opinion, then you should also refer to this, since lack of relevant information is also relevant to how robust the opinion you express is.

You know why you’re writing the report, as do the people – lawyers – who read it. But once a written report is produced, it becomes a document that forms part of a patient’s medical record and legal files, with the potential to be sought by those treating the defendant subsequently, or to be cited in future legal processes. Hence, it might be read by others who are unfamiliar with the circumstances held when 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, can be worthwhile. Small fonts 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 clues, perhaps, as to 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 re-arranged to fit the structure preferred by the author. However, whichever approach is adopted, it is important to quote verbatim things said by him that could be of major legal relevance.

Whatever method 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 ‘Mr A said….Mr A told me…’ makes it clear that it is his account that is being reported. However, this approach runs the risk of making the report stilted and difficult to read. And the use of direct quotes from an interview can bring the patient to life for the reader, allowing the voice of the patient to emerge.

Recording the questions asked with the defendant’s responses can provide a real insight into how 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). That said, again it may be particularly important to record verbatim questions and answers relating to legally important matters.

The patient’s emotional 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, though, there is a danger that this extra information will hinder the flow of the account. A solution is to place the emotional reaction of the defendant in brackets next to the point of the interview where it was witnessed.

**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 a need to report important negatives too, for example the absence of psychotic signs. This said, it might not be necessary 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.

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.

**Information from other sources**

Where medical or psychological investigations – including those described in reports provided to lawyers or the court – have been carried out on the defendant other than by the doctor reporting, the findings relevant to the opinion expressed by the doctor should be summarised. This is necessary
even where the results are in 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 instructions will automatically be made available to the court. However, if a report has been commissioned by the defence, then it will be for that side to decide whether it should be used, and this can cause difficulties for an expert who has seen the report and considers its contents to be of medical relevance. S/he will have to decide whether the findings can honestly be ignored in coming to a medical opinion, or not. If not then the situation of a head-on clash between the medical and legal paradigms is exposed, and this will present the doctor with an 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, and other expert reports. Why then bother to include anything at all from these documents? There are two main reasons: first, ‘showing your working’, in that 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 information which goes somewhat against your opinion; second, if asked, perhaps several months after seeing the defendant, to give oral evidence, 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. That is, the ‘architecture’ of your report will not only be immediately evident to others, it will be so to you.

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

As regards prior medical records, it can be hard to summarise these but, alongside other reports, they will contain additional data of possible relevance to your own opinion and such 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.

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

**Opinion**

Reports are produced in order to inform in relation to specific legal questions posed. So, should only an opinion on these issues be expressed?

Many will find an 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’, and particularly how they arrived at their view of the defendant’s mental condition, and of his/her mental state on a particular occasion. A subsequent section of the opinion can then deal with ‘legal implications’ – that is, not expressing a view on any legal ‘ultimate issue’, but describing how the defendant’s mental state on a particular occasion can reasonably be seen to ‘translate’ into the legal test at hand (see Chapter 2), which should
itself be cited verbatim. 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 psychiatric defence, or currently, if what is at issue is the defendant’s mental condition in regard to sentencing, including to death, or capacity to be executed.

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, if necessary with papers attached. Similarly, diagnoses used should be accompanied by a copy of the diagnosis as it appears in either ICD-10 or DSM-IV (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 – as are the reasons why you do not hold to it, for example why you think a defendant is not malingering and actually suffers from schizophrenia. If you don’t, others will. Showing that you have considered other viewpoints is evidence of being balanced and fair minded. Conclusions that are reasoned are far more likely to be respected by the court, and by lawyers for both sides.

**Diagnosis**

Diagnoses should be reached through using the ICD-10 or DSM-IV criteria. However, neither should serve as checklists; 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 judgment.

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

**Medical limits**

It is not for experts to usurp the functions of the court. Offering an opinion on guilt or 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. That is, s/he can describe the defendant’s mental state at the relevant time, and how this might be seen to ‘translate’ into the legal test, but should stop short of saying that it does. Or s/he may write that whether it does, or in what manner, depends upon factual findings by the court, that is, give ‘conditional’ opinions.
A report should conclude with a statement of its truth and independence. Model forms of declaration are contained within the practice directions for courts within the 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 date 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/s 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 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, plus details of clinical and medico-legal experience

**Disclosure**

The completed report is likely to be the property of the third party who requested the report (usually the instructing party) 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 that it be disclosed 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 the medical opinion

Addendum reports may be requested for clarity, expansion of particular points, or to consider new evidence.

Issues to be aware of

• Be 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
• Be careful in the reporting of risk assessments; the purpose of such reporting is quite distinct from that addressing diagnosis and formulation for some reason other than sentencing
• If there is no diagnosed mental disorder, then consider very carefully whether you are able to provide an opinion at all
• Never recommend punishment
• Do not go beyond your instructions, unless this has been discussed with the instructing lawyer
• 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 behaviour – that they are expressed cautiously and reasonably
CHAPTER NINE:
Giving evidence in court
If a mental health professional prepares a written report for court proceedings then there is a reasonable expectation that they attend the 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 describes how to prepare to give oral evidence in court and the process of giving evidence. As much as the Code of Criminal Procedure (CCP) for Taiwan now requires the court to investigate evidence when it is materially relevant to the interests of the defendant, most of the time the court enjoys broad discretion as to whether it wishes to investigate evidence or not (Paragraph 2, Art. 163). The trial, while “adversarial” in name, can sometimes more closely resemble an inquisitorial process. In any event, this should lead to proper questioning of witnesses by both defence and prosecution although the judge also retains the right to question witnesses, and very commonly exercises this right based on what he has reviewed in the case file.

**Timing**

Court hearings are usually, although not always, planned weeks, sometimes months, in advance. The judge assigned to the case sets the initial trial date. You might be subpoenaed to attend court. The subpoena will state your name, gender and residence, and some other details required for personal identification. It might include the principal facts of the case to be heard (in Taiwan, however, as the principal issues that will be heard are usually disclosed to the expert in advance via official letters from the court and/or other forms of communication, such facts/issues will not appear in the subpoena) and the date, time and place that you must appear. The subpoena will be served in advance; it may be at least 24 hours or even 7 to 30 days before the date of appearance.

Criminal trials often occur in stages, separated by weeks or even months. Check when you are likely to be required to attend court. Communicate properly (communication via phone followed by written confirmation work best to cover both efficiency and assurance) and clearly as to your availability when scheduling with the court clerk. Once the date for you to give your expert testimony in court is set, you will receive a subpoena from the court days or even weeks in advance.

**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. Such information is typically on the subpoena, including another reminder to bring your personal identification for confirmation with the bailiff upon your arrival. You may also communicate with the court (usually handled by the clerk) if you intend to use visual aids or additional material (e.g. supporting papers to your testimony). Bear in mind that such supportive material may not always be admitted unless they are thoroughly reviewed, or even cross-examined, by the parties, although occasionally the court does actively admit them.

Giving expert evidence should not be the first time you attend a court. If there has never been the opportunity to shadow another expert then try and ensure that you have had the opportunity to visit a courtroom before you give evidence for the first time. If you are called by the defence or the
Giving evidence in court

prosecution (rather than appointed by the court), it is recommended that you communicate with them in advance for a general understanding of the criminal court procedure, in particular in capital cases. 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 and tone of a court hearing.

Attending court to give evidence for the first time in a capital case should be avoided by not accepting instructions in the first instance without adequate experience, unless the doctor already has substantial experience of giving evidence in other types of major and contested trials, ideally in homicide trials.

Your written report is the basis of your oral evidence, and should have been written in the knowledge that every phrase and word written is open to scrutiny and cross-examination. Hence, good oral evidence relies upon provision of a good report. To some degree the quality of your report will dictate whether you need to go to court at all, although it is commonly recognised and supported by law in Taiwan that it is the defendant’s right to confront any witness, including the expert giving testimony in court, by means of cross examination through his/her counsel.

The quality of your written report will hinge on a reasoned conclusion which takes into account all the material you have been presented with, and which adequately addresses any opposing view. However, besides what we have discussed above, 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.

The provision of a good written report should mean that the process of giving oral evidence is far less challenging an 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 amount of written material. Including a summary of the relevant parts of this in the written report (see Chapter 8) will obviate the need to laboriously go through the material again.

The contemporaneous handwritten notes, along with the audio or video recording (if any), 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 the doctor about this material. The expert may also produce all such materials for all parties before the court hearing and the examination in order to facilitate relevant evidence hearing and cross-examination. Should your interviews with the defendant have been recorded by a prison officer or the court, contact the court clerk well in advance to arrange for the recordings to be available during your appearance.

As a witness you will be required to sign an affidavit confirming that you will tell the truth in court. Bear in mind that a breach of this will not just open you and your practice up to an professional criticism in court, but is likely to lead to follow-up prosecution of criminal perjury under Taiwanese laws.

A key to feeling confident at court is having a sound knowledge both of the nature of the interface between law and psychiatry in general and of the case, including of your own report and the reports of others. While experts are almost always permitted to refer to their report and to their notes whilst giving evidence, you may want to think twice before deciding to answer most of the defence counsel/prosecutor/judge’s questions by constantly referring back to the report without giving any substantial
explanation, or simply by saying “It’s all in the report. I don’t think I need to explain/repeat.” Markup your report, and the reports of other experts, so that you can quickly find important passages, and recall what else you may wish to emphasise.

Often, especially in complex cases, it is helpful to both instructing lawyer and doctor to meet before the hearing in order to go through the evidence to be given. This gives 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 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 lawyer will anticipate cross-examination points and rehearse them with the doctor in conference. However, in the vast majority of cases the court appoints the psychiatrist and so it is unlikely that this meeting can occur.

If indeed the expert and the instructing defence lawyer meet before the hearing, it is not unwise (nor uncommon) to make a request to record the entire discussion if you can secure the lawyer’s approval in advance, or simply ask the lawyer to do it. One of the major reasons to do this is to avoid allegations of ‘coaching’. Sometimes prosecutors will accuse or, more commonly, insinuate that the expert has been “coached” by the defence counsel, in order to damage the expert’s credibility and the weight of his/her report before the court (although the court in practice may not always entertain such accusations or insinuation). A well-prepared lawyer would counter such damaging arguments from the prosecution, and a recording might assist in this matter being addressed.

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 to work’ is a helpful rule of thumb. Conservative clothes are to 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.
- Should interpreters be involved, pause regularly to facilitate thorough translation for the defendant.
- As far as possible simplify your opinion.
- 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.
- Do not attempt to answer questions you do not comprehend completely.
- If you are asked a question implying a dichotomous choice of answers then use “yes, but…” as a response. Explain, if true, that to give a simple ‘yes or no’ reply will have the effect of misleading the court. If you genuinely feel that your professional views as an expert cannot be adequately covered by a simple “yes” or “no,” make sure you explain this in court and seek your examiner’s approval to explain further with concise language. Most lawyers, prosecutors included, are usually reasonable enough to allow explanation or exploration of a certain concept to a certain degree. If such request does not work with the examiner, you may raise your concern with the court if your instructing lawyer does not object.
Before the hearing itself

Airport style security is in operation at most courts, including metal detectors, bag/briefcase search or inspections, and rub down searches. Certain items, such as dictaphones, are sometimes prohibited. Mobile phones are allowed, although should be switched off when in the courtroom itself. Recordings in the courtroom are almost always prohibited and may lead to criminal prosecutions under Taiwanese laws.

Check with the lawyer whether you may sit in court to hear other evidence be given, perhaps from another expert or the defendant. In most cases the trials, and all hearings are open to public and sitting-in should not be a problem. But cases may be very different when sexual assaults, domestic violence, or minors are involved. The court may order in part or entirety a trial to be held in private (i.e. a closed trial). If this is the case, even as an instructed or appointed expert witness, you may most likely only attend the hearing when you testify.

Check also the words to use to address the judge; this varies according to the type of court. (As a last resort listen to what term the lawyers are using). When in doubt, it is perfectly fine to consult with your instructing lawyer first.

On entering, if the court is sitting, bow or nod slightly in the direction of the judge and then take a seat, if you have been invited to sit behind the lawyers.

You will be ‘called’ to give evidence by the lawyer who has asked you to prepare the report or by the court. Whilst nerves are to be expected, it is important to attempt to portray a confident demeanor, initially whilst walking from your seat to the witness box. You will be asked by the court (and under the bailiff’s assistance) to read aloud the contents of your affidavit as part of the swear-in process before testifying. This is a legal requisite. This is a good point at which to ‘get the measure of the hall’, in public speaking terms, to get your speed 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 than from a sitting position.

After you have been examined by the presiding judge so as to confirm your identity, the prosecution or defence lawyer will examine you. If both parties intend to call you as an expert witness they will decide by agreement who calls you. The presiding judge will resolve this if agreement cannot be reached. The process of examining your evidence occurs in stages.

Direct examination

The purpose of giving evidence is to help the judge reach the correct conclusion in a case, not to help the legal representatives who requested your attendance at court; also, questions asked by lawyers are asked always ‘for the court’, even though they may sound partisan. Hence, stand (or if you prefer sitting) with your feet facing the judge; this helps give the impression that you are talking directly to the person whom, in the end, has to reach a decision based on the evidence that they hear. This also has the advantage of reducing the risk of a subsequent set of questions from a hostile answer being accompanied by aggressive body language and eye contact. 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 by the court.

Some courtrooms will have poor acoustics so it is important to speak loudly and clearly. Although all criminal proceedings in court are typically recorded, as an expert you still need to count on yourself to deliver your opinion to the court, as it rarely happens for a judge to refer back to the court recordings unless a party seeks to resolve certain procedural disputes in law. Judges may take handwritten notes of the evidence given, or simply listen to the witness. But most importantly, it is the court clerk who types in realtime on a computer the court report, attempting to keep an accurate summary of what has been said. If you speak too fast, not only might you lose the judge or be told to slow down, but the clerk may not take down what you say accurately. Therefore, try to speak at a rate that follows the clerk’s typing and review periodically what has been typed in the screen. Make corrections instantly if you find any mistake in the words typed into the court record when necessary.

The direct examination, which is conducted by the legal representative who has called you is subject to specific rules. No leading questions may be asked except in the following circumstances:

- The personal identity, education, experience of the expert witness
- Matters clearly not in dispute
- Refreshing the memory of experts with a vague memory
- If the expert appears to be hostile or antagonistic
- If the expert appears to be trying to avoid answering
- If your evidence is inconsistent with any written statement or report you have provided

Jargon should be avoided, or if unavoidable, for example, because another expert has used it, should then be explained in simple language. Giving oral evidence can be thought of as akin to teaching; the aim is to allow the judge to understand your opinion.

The direct examination is a chance to fully describe 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 the proceedings can be challenged in cross-examination. Choose your words with great care; and avoid too many ‘ways of saying the same thing’, since more words infer more room for challenge or exposure of potential, even minor, inconsistencies under cross examination.

Cross Examination

Cross-examination is the opportunity for the legal representatives of the party, or parties, opposing you to discredit your opinion, or to suggest doubt in your competency in the mind of the judge. Leading questions are allowed.

Keep calm, especially if your credentials or competence are questioned. It is perhaps useful to remind yourself that any attack is not personal (and most of the time it is not); the legal representative is merely intellectually ‘testing the evidence’.
Control the pace of the evidence giving, and more particularly the questions asked, by taking time to consider your answers.

Appearing balanced and honest is likely to impress the judge, as well as being ‘right’. Conceding points that clearly go against you contributes to a sense of reasonableness. 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.

It is not unwise to confront and admit to your professional limits in court, questioned by the opposing party or not. 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. You are an expert on mental disorder and the impact of mental disorder. You are not there to decide on the outcome or give an opinion as to the facts of any case. You should also refrain from responding to any questions about the law or legal concepts (e.g. the defendant’s criminal responsibility with regards to Article 57 of the Criminal Code of Taiwan).

Beware of agreeing too readily with apparently innocuous propositions; listen carefully to the question and consider how it fits in with other questions that have been, or might then, be asked. Do not answer questions that are not asked. Giving an opinion qualified by caveats is perfectly acceptable, that is ‘yes, but...’.

Lawyers are trained to seek ‘yes or no’ answers; much of psychiatry is far from black and white. The purpose is often to ‘disaggregate’ your evidence so as dismantle it via ‘a thousand cuts’; where proper reference to aspects of your evidence, and of facts, which mutually reinforce one another will maintain the integrity of the evidence. The analogy of building blocks of a building reinforcing the support of one another is appropriate.

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

**Redirect examination**

Redirect examination is, like the direct examination, conducted by the legal representatives who instructed you to prepare the report. It is confined to an explanation of matters arising out of cross-examination, and no new facts or argument may be introduced without the leave of the court. Redirect examination is generally short if the process of cross-examination has been unsuccessful in undermining the expert’s opinion.

**Re cross-examination**

Finally, re cross-examination is made by the lawyer opposing your opinion. This gives an opportunity for further cross-examination of the expert.
At the end of the evidence, sometimes also during, the judge can ask questions: answer them as carefully and thoroughly as you can. Sometimes this will involve explaining earlier answers given, or clarifying points made, or answering what amount to new questions, which have occurred to the judge. You may not leave the court without permission of the presiding judge when your evidence is finished. You are also strongly advised to review the court records, typed by the clerk, containing your evidence in full-length, to see if any clerical error or misunderstanding is entered. Do not forget to sign the court record printed after you have completed giving your evidence and the cross-examination before you leave the courtroom.

**Rules of examination of an expert witness**

Article 166-7 of the CPP prohibits certain ways of examination and can therefore be objected to by the opposing party/counsel:

- The question is unrelated to the subject case or the matter revealed by examination;
- The examination is conducted by ways of threat, insult, fraud or other improper means;
- The question is abstract;
- The question is unjustifiably leading;
- The examination is based on hypothetical facts or facts unsupported by evidence
- Repeated questions
- Asking the witness to state his personal opinion on facts, speculation or comment
- Asking the expert to address matters they have not personally examined.

Given the above legal grounds, as an expert to the court you need to understand and remember it is not your responsibility, nor your prerogative, to determine whether any of the questions fall under the above realm of “objectionable” questioning. The objection is almost always for the opposing party/counsel to make, and exclusively ruled by the court upon any such objection properly raised with a supporting ground. As an expert, just like any witness, you are not allowed to decide whether a question is answerable or objectionable in court. You must, nonetheless, pause for the court’s instant ruling and await the court’s instruction upon any objection before you proceed with your testimony and answering the questions.
CHAPTER TEN: Assessment and reporting for pre-trial issues
Assessments before trial are prior to any establishment of guilt or innocence. Offences remain alleged offences. The mental health assessment might be focused on a specific competency, or competencies. These may require retrospective evaluation of the defendant’s mental state, in relation to having understood a caution, fitness to be interviewed, or reliability of confessions. Others, which might be considered to be more straightforward will relate to the defendant’s current mental state and the impact of this on a specific ability, including fitness to plead and stand trial, and fitness to waive the right to legal representation. Other assessments conducted pre-trial will relate to mental condition defences. It is likely that one assessment will be requested to answer all questions relating to pre-trial and trial issues.

Principles of assessing pre-trial issues

General principles of assessment will apply (see earlier chapter):
- Full psychiatric assessment
- Review all available information, specifically contemporary to the alleged offence, arrest and police interviewing
- 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 of the available information in order to attempt to reconstruct the likely mental state at the time a police caution (including informing a suspect of their right to silence and right to a lawyer) was delivered. This should include 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 understanding was checked. If possible, complete transcripts should be read, although the caution is unlikely to be included.

Additionally, if a doctor or other health professional has seen a defendant in a police station their contemporaneous notes should be considered.

The assessment of the defendant should also include their recollection of the caution, their understanding now of the police caution and some 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 the caution was given but 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:
Assessment and reporting for pre-trial issues

- Would they have had the ability to understand the words and the meaning of those words?
- If not, why not? Were they likely to have been preoccupied or distracted by psychosis? Did they possess insufficient intellectual capacity to understand?
- Was there any intoxication with substances or were they suffering withdrawal from substances?
- Could they consider the impact of the caution in deciding how to then proceed?
- Have they confirmed their understanding, or acquiesced in response to direct or forceful questions relating to understanding?
- Has the caution been repeated in a simplified way that might have led to understanding?
- Is there any evidence of 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). 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 on their ability to have participated in an interview, and the nature of that participation.

Assessment will involve consideration of the following factors:

- What was the likely mental state at the time of interview?
- What impact (if any) would this have had on their ability to understand the purpose of the interview?
- What impact (if any) would this have had on their ability to understand questions?
- What impact (if any) would this have had on their ability to respond to questions?
- Is there evidence in the interview transcripts or recordings of them being unable to understand questions?
- Is there evidence that the interview caused significant mental distress or harm?
- Is there any aspect of their mental disorder or mental state that rendered them particularly suggestible or susceptible to methods or styles of questioning?

The transcript of the interview or the statements from the police interview will assist in relation to considering these questions. Consider the nature of the questions in relation to what is now known, or was evident, about the specific abilities of the defendant in question. Examine their responses when asked about understanding: do they simply respond ‘yes’ to questions about understanding or are they asked and able to confirm understanding? Is there evidence that questions are too complex or subtle, based on the known abilities of the defendant? Is there evidence of misunderstanding; answering questions that have not been asked; long pauses; answers that seem to avoid the subject? In addition, consider whether the defendant has prior experience of the criminal justice system and how such experience might affect the defendant’s current fitness to be interviewed.
Reliability of confessions?

There is a clear overlap with the issue of fitness to have been interviewed. It is clear that the presence of mental disorder or other mental abnormality does not equate to confessions or other admission being unreliable. There must be consideration of the impact of any disability on any responses given.

There has been some attempt in medical and psychological literature to categorise false confessions:

- A voluntary false confession might be to protect the true perpetrator
- A coerced-compliant confession occurs in the face of coercion or forceful questioning; it might also be made to avoid conflict or for fear of harm.
- A coerced-internalised confession occurs when a suspect wrongly believes that their confession is true; it may be associated with police interviewing characterised by shouting, rudeness or threatening behavior, combined with asking effectively leading questions, including questions which feed information covertly to the individual which he then comes to believe (see Chapter 5).

Mental disorder or abnormality can be relevant to one or all of these, by increasing the risk of the person being compliant, by exaggerating susceptibility to police techniques, or by creating a state of misunderstanding on the part of the defendant.

Further individual defendant factors might include:

- Higher susceptibility to distress, leading to confusion
- Higher suggestibility due to mental disorder, leading to eagerness to please and impress
- High levels of false guilt from mental disorder, leading to a predisposition to confession
- Mental disorder characterised by fantasy and a desire for notoriety or fame
- Intellectual disability impairing the ability to understand the questions, formulate and communicate answers, or consequences of answers

The assessment of whether police interviews are oppressive is a specialist area and the definition of what is considered oppressive can vary in different jurisdictions. What might be oppressive for one person might not be so for another, and so there is a role for describing how an individual’s mental disorder, or abnormal mental state might lead to them perceiving an interview as unusually oppressive. The defendant’s prior experience of the criminal justice system may also affect their perceptions of an interview.

In addition consider the following:

- The statements of the interview or transcripts if available.
- Any records of rest or sleep
- Any evidence from transcripts or recordings of confusion or misunderstanding
- Any evidence from transcripts of changing of responses to questions in response to oppressive techniques
- Any evidence from transcripts of information being fed to the defendant and then ‘adopted’ by him
Some defendants may remain silent or refuse to answer questions properly. If their mental abnormality is related to this then this should be stated, so that the court does not draw any adverse inference from their responses or lack of response.

**Psychological assessment in relation to confessions**

Individuals with low IQ, but some others also, can exhibit abnormal acquiescence, compliance or suggestibility. There is also a general tendency among this group towards confabulation (making up a memory to fill a memory gap).

None of these phenomena are necessarily present in people with intellectual disabilities although known to be more likely, and the best approach to forming an opinion on their presence or absence may be through the use of appropriate psychometric tests.

Within police interviews, the individual may behave so as to avoid the anxiety of conflict inherent to the situation by agreeing to what is put to them (either acquiescing with what is being put to them or being compliant), with the potential for emitting falsely incriminating statements or even confessions (see Chapter 5).

**Insanity at trial**

In many jurisdictions this is referred to as ‘fitness to plead and stand trial’. Article 294 of the CPP provides that if an accused is insane, the trial shall be suspended until he recovers and that if an accused is unable to attend court because of sickness, the trial shall be suspended until he is able to appear in court.

Putting aside the uncertainty surrounding the definition of the term “insane” in Art. 294 the assessment of a defendant’s mental condition in relation to being tried is based upon their mental state or condition at the time of trial. The trial can only proceed if the defendant is ‘sane’. Psychiatric and/or psychological evidence directed towards the issue is required but the issue is ultimately determined legally. It is uncommon for this finding to be made in Taiwanese courts in the absence of psychiatric/psychological evidence, or in the presence of evidence to the contrary.

There is no clear description of what ‘insane’ means in law but there should be full consideration of whether there is any mental disorder, in medical terms. This assessment should also properly consider the effect of any mental disorder on their ability to attend court and participate in the trial process. This might include:

- Understanding the charges
- Deciding on whether to enter a guilty or not guilty plea
- Being able to instruct intelligibly legal representatives before and during any trial
- Understanding the details of the evidence
- Giving evidence in their own defence
- Deciding on whether to testify and ability to testify
- Ability to behave properly during court proceedings and at trial
Assessment should be as close to trial as possible and the assessment should include a full psychiatric assessment but specifically include the following:

- Ask the defendant to give an account of why they are required to attend court
- Enquire about their understanding of the legal process
- Enquire about their understanding of the different roles of people in court, including their own
- If necessary explain the basic procedure and consider their ability to retain the information
- Enquire about their account of the offence and whether they are aware of what witnesses have described
- Enquire about their understanding of any likely evidence against them (this must be specific to the case)
- If they indicate a particular plea ask them to explain the reasons for this (they may have been advised against this which can make assessment difficult)
- Examine witness statements and interviews with them for evidence of understanding

Any form of mental abnormality might be relevant to the abilities described, although no mental disorder automatically confirms someone as insane in law.

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

The following symptoms or impairments might be relevant:

- Impairment in concentration
- Specific delusions or other psychotic symptoms relevant to entering a plea
- Memory and sensory impairments not for the alleged offence but so as directly to inhibit performance in court
- Global cognitive impairment
- Inability to interact and communicate normally that may affect defendants' ability to relate to their lawyer

The report should include opinions on diagnosis and formulation with specific reference to symptoms that have been confirmed. There should then be specific reference to the impact of any mental disorder on the abilities that might be necessary for participation in a trial.

**Psychological assessment for insanity at trial**

Clinical psychologists, and neuropsychologists, can administer psychometric tests that will be relevant to determining insanity, in terms of whether the defendant's ability to understand information, concentrate for lengthy periods, communicate with their legal representatives, and form judgements in order to issue instructions, is impaired, plus whether they have adequate ability to cope with the rigors of cross examination. Obtain collateral and background information about the defendant's medical, psychiatric and substance use history, as well as prior experience of the criminal justice system.
• **Current intellectual functioning (IQ).** 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 such as to infer that the person is not fit to plead.

• **Language skills.** This offers the assessor information concerning how well the individual understands a discussion, including inferences about how well they may understand discussion with their legal representatives, and how they may be able to manage in court.

• **Memory functioning.** This offers information on the person’s ability to concentrate and retain information, which is important for their ability to follow proceedings.

**Conclusion**

Be aware that assessment for issues relevant pre-trial may also involve the assessment of relevant legal questions at trial. However, subsequently if there is conviction, for example, in terms of 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 questions.
CHAPTER ELEVEN: Assessment and reporting for mental condition defences
Introduction

As is true of any legal test, psychiatric evidence is only potentially ‘relevant to’ a mental condition test and not ‘definitive of it’. And this may be especially important and therefore cannot be emphasised enough in a legal environment as Taiwan’s, as most practitioners of law usually do not have scientific training and possess no advanced knowledge from disciplines relevant to law, in particular mental health sciences such as psychiatry or psychology. However, it is crucial to know ‘what is the test’ which is at issue, in order to ensure that, in collecting clinical information, and interpreting past clinical records and also considering relevance of legal documents, you do so in a manner that can maximally assist legal determination.

Mental condition defences are either ‘total’, possibly resulting in a finding of ‘not guilty’, or ‘partial’, resulting in a verdict where sentencing is more lenient. This might depend on how well the court takes in the expert’s report and testimony.

Mental condition defences differ from ‘insanity’ as described in Chapter 10 in that they relate to the likely mental state at the time of the offence not at the time of trial. There is the potential for confusion but it is important to be clear, as an expert as to whether you are describing current or previous mental abnormality and if previous, when.

Insanity

Insanity provides a ‘total’ defence. Part 1 of the Article 19 of The Criminal Code in Taiwan provides that ‘an offence is not punishable if it is committed by a person who has a mental disorder or defect and, as a result, is unable to judge his act or lacks the ability to act according to his judgement.’ Despite sounding by its name medical, it is a legal test and is a question expressly left for the court to decide.

Mental disorder is not determined by reference to a category or diagnosis of mental disorder. It can be reasonably assumed that disorders such as schizophrenia or mental retardation are included but it might be that the legal definition incorporates disorders that affect both mind and brain and include epilepsy, cerebro-vascular disease and metabolic diseases (for example thyrotoxicosis or states induced by diabetes) affecting cognitive functioning, which might not, for example, be seen by psychiatrists as amounting to mental disorder. It is important that the psychiatrist recognises that they are not the ultimate ‘decision-maker’ when it comes to deciding on whether mental disorder is present. Mental disorders such as personality disorder might prove controversial.

Inability to judge an act is a concept that again must be identified as a legal judgement that that might be informed by medical evidence. The psychiatrist should consider how the mental disorder that they have described might have affected a person’s ability to judge their act but should not go beyond this. The risk of a psychiatrist giving an ‘ultimate opinion’ on this issue is that they usurp the function of the judge, and therefore may work against, or even defeat the legislative purpose of, Article 19 of the Criminal Code, which authorises and empowers the court to determine the criminal responsibility of the defendant from a “legal” perspective.
Lacking the ability to act according to judgement is again a legal test that might be informed by but not determined by medical evidence. The psychiatrist should usually avoid addressing the test directly but rather provide relevant evidence so that the judge can make the ultimate determination. For example, the psychotic person driven by delusional beliefs might be impaired in their ability to exercise judgement in how they act. The psychiatrist can assist by describing the nature of psychosis, the strength with which delusional beliefs are held and the way in which delusions can impact on decision-making.

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 alleged act but address the defendant’s functional abilities at that time, specifically in terms of the functional limbs of the legal test (see above). Hence, clinical assessment will need specifically to address:

- The defendant’s understanding of their actions per se at the time
- The defendant’s knowledge of their actions at the time;
- The defendant’s explanation for any behaviour

General advice on assessment applies. In particular, however, any mental symptoms present at the time of the offence should be described. Mental symptoms prior, and subsequent to the time of the offence will inform this. 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 clinical state as it may have been known to have been at other times, combined with reference to any evidence in the case which goes to the defendant’s likely mental state at the time of the offence.

An account of the offence 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 offence. However, 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 to establish how, or whether, any mental abnormality that has been assessed as being present relates to the offence.

* Based on Paragraph 1, Art. 156 of the Code of Criminal Procedure, if the defendant’s statements were secured through “undue means” (e.g. duress, threat, fraud, illegal imprisonment, etc.), such evidence shall not be admitted in court. As such, if the expert decides to resort to methods of narcoanalysis (invoking sedatives or other medicines to induce and facilitate history taking) or hypnosis, the legality of such methods as well as the admissibility of the evidence derived therefrom will be questioned or even objected in court.
Neurological disorder

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 have to consider:

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

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?

Diminished responsibility

In the Taiwanese Criminal Code there is provision for reduced sentences when there is considered to be diminished responsibility. Section 2 of Article 19 states: ‘the punishment may be reduced for an offence committed for the reason mentioned in the preceding paragraph [see above] with the result of the obvious reduction in the ability or judgement or to act according to his judgement.’ The obvious contrast being the substitution of the word ‘unable’ with ‘reduction in’. While this will still remain a legal question for the court to determine, the assessment will be as described above.

Amnesia

Amnesia is relevant to offences only where it might suggest that the defendant was in an abnormal mental state at the time of an offence.

Claimed amnesia may also be a way of trying to avoid 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 be relevant to any of the legal tests above.

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

Mental health experts might be instructed on the following issues:

- Is the claimed amnesia genuine?
- Does the amnesia relate to any underlying condition?
- Does the amnesia suggest any mental condition, which might come within the terms of another defence, or partial defences, for example, insanity or diminished responsibility?
- Is there any indication of a more generalised memory disorder?
Clinical issues

All records must be available so that any evidence that the defendant has recalled details at other times or to other people can be considered. The association between any physical trauma and amnesia should be considered. There may be specific memory testing if a more generalised memory disorder is suspected. Previous episodes of amnesia should be discussed (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 on subsequent memory of a dissociative state occurring at the time of an offence (see also above).

Dissociative amnesia is often patchy, is 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:

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

Intoxication

Voluntary intoxication is not usually a defence to any criminal offence, as it is described in Paragraph 3, Art. 19 of the Criminal Code. The expert might consider explaining whether any mental disorder has an impact on the ‘voluntariness’ of the taking of drugs or alcohol.

Conclusion

The courts have a need for psychiatric expert evidence in relation to ‘mental defences’ but it is important to recognise that ultimately, the determination is legal and whilst psychiatric evidence might go towards the ultimate determination it should not address that ‘ultimate issue’. In the circumstances described above psychiatric evidence should address the mental disorder, the relationship between that mental disorder and cognition, the relationship between that mental disorder and behaviour and the way in which it might be considered to relate to responsibility. There should be avoidance of giving an opinion on the ultimate question of responsibility.
CHAPTER TWELVE:
Assessment and reporting for sentencing
Introduction

Writing a report for sentencing is, in most criminal legal situations, 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 ‘binary’, and closely defined, in form, sentencing guidelines in various countries generally tend to much more ‘graded’ in nature, or in their implications. Even in countries where official sentencing guidelines do not exist such as Taiwan, when judges determine sentencing within the legal confinement spelled out by law, they still need to take into consideration certain factors (e.g., factors listed in Articles 57 and/or 59 of the Criminal Code of Taiwan) to justify the sentencing. And, although administration of the discretionary death sentence is, of course, binary, in that it is either imposed or not, the legal tests in regard to whether it should be given, or not, are ‘softer’, and less tightly defined than many of the other legal tests with which a psychiatrist has to deal with. And if we turn attention to the death penalty administration practice in Taiwan, the essential standards created by legal precedents (and which are de facto binding upon lower courts) such as “beyond reformation,” lingers in every corner while not many lawyers, or even judges, really know what this term means, either in law, or in psychology/psychiatry.

A further difference, certainly for the expert, is that writing a report for use in a sentencing hearing involves that expert much more ‘closely’ in determination of punishment than does writing a report for a pre-trial, or trial stage, where their opinion is more ‘remote’ in its implications for punishment, dealing ultimately only with determination of guilt or innocence. And this has major ethical implications, certainly for doctors and other practicing mental professionals, in terms of their proximity to, and influence over the determination of ‘doing harm’, that is, maleficence (see Chapter 14 for discussion of the utilisation of medical evidence directed not just at legal determination of guilt but also punishment).

Mitigation

Aggravating and mitigating factors are taken into account when sentencing convicted offenders. Aggravating factors are those factors taken to indicate a greater degree of culpability and result in more severe sentences. Mitigating factors have the opposite effect. Such factors can include factors relating to mental health and personality. Psychiatric and psychological factors which at trial fell short of laying the foundation for a mental condition defence, or partial defence, as may be scrutinised under Article 19 of the Criminal Code, can take on great significance in terms loosely of ‘mitigation’.

Article 57 of Taiwan’s Criminal Code provides judges with discretion when determining the appropriate sentence based on factors relating to the offender and the circumstances of the offence. Of the ten factors specified, the offender’s mental health is likely to impact on:

- Motive for the offence
- Purpose of the offence
- Provocation at the time of the offence
- Living conditions of the offender
- Conduct of the offender
- General knowledge of the offender
Assessment focused on these areas is likely to particularly assist the court in arriving at a better-informed decision but mental health professionals need to keep in mind the limits of their expertise, as described in Chapters 1 and 2.

In some circumstances there may be no basis for mitigation in regard to mental disorder beyond potentially having an unspecified mitigating effect. Here, information is gathered in the usual clinical fashion, in terms of diagnosis and formulation; however, its relevance to sentencing may be perceived by the court to go beyond solely whether or not there is mental disorder present now, or was so at the point of commission of the offence, and to rely also upon data in the report, adopted and used within a legal and not medical paradigm. An example of the latter 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, yet the court then applies the data in the report, for example, from clinical interviewing, to the court’s own approach to risk assessment. Or, despite the absence of a diagnosable condition per se, mental symptom data might be used to mitigate sentence. This is not uncommon in criminal practice, especially in countries where the court enjoys great discretion on any and all mitigation factors like Taiwan.

Common factors considered potentially relevant as mitigating factors by the court or argued by the defence under Art. 57 and/or Art. 59 of the Criminal Code, may include:

- Abnormal mental state at time of offence
- Abnormal mental state at time of sentence
- Young age at the time of the offence
- Absence of previous offending
- The defendant acted under duress or coercion
- The defendant lacked a measure of ‘reasonable fortitude’ in regard to duress or coercion, or within conviction based upon ‘joint enterprise’, than the normal person
- By way of mental disorder the defendant believed that they were acting reasonably
- The defendant was impaired in their capacity to understand the nature of their actions
- The defendant was impaired such that he was limited in his ability to follow social, moral or legal norms
- The defendant is learning disabled
- The defendant’s character is ‘abnormal’

The role of mental disorder

Article 19 of Taiwan’s Criminal Code prohibits the punishment of a person who is suffering from a mental disorder or defect and, as a result, is unable or less able to judge his or her acts or lacks the ability to act according to his or her judgement.

Some judges in the Supreme Court of Taiwan in the case of Chen Kun-Ming ruled that those with mental or intellectual disabilities should not be sentenced to death. However this is not yet a finalised and agreed upon ruling among all judges in the Supreme Court, as certain judges still have doubts on
the interpretation of terms like “mental or intellectual disabilities” and how they should be applied in capital cases.

The presence of mental disorder is therefore vitally important in terms of determining punishment. This principle applies irrespective of whether the mental disorder posited was present at the time of any offence.

Expert mental health evidence is therefore relevant to the determination by the judge of the appropriate sentence.

Any diagnosis of mental disorder at either the time of any offence or at the time of sentence should be clearly described. The presence of mental disorder can be crucial to the non-application of the death penalty and can still be relevant even if the judge has rejected the mental disorder in relation to a mental condition defence at trial. In Taiwan, a defence involving mental condition will typically be subject to a two-tier review: first, as a major factor relevant to criminal responsibility (diminished, or lack thereof) under Art. 19 of the Criminal Code, and second, as a factor relevant in the process of mitigation assessment under Art. 57 and/or Art. 59.

However, a psychiatrist should never give an opinion recommending any penal sentence, or its avoidance, including in regard to capital sentencing, even if invited to do so by a defendant’s lawyers or by the presiding judge. 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, and you should also refrain from excusing or defending the defendant, thereby resorting to moral judgement, which judgement properly resides in the judge.

Any diagnosis present of mental retardation or learning disability is particularly important, as it is likely to be a bar to execution. Low level IQ, even in the absence of mental retardation or frank learning disability, might also be a relevant mitigating factor.

**Assessment for sentencing**

The assessment will follow general principles. However, there should be particularly thorough attention given to individual characteristics, experiences and background, going beyond merely attempting to determine whether any symptoms of personality features are sufficient to make an ICD10 or DSM-V diagnosis.

There should be specific inquiry about sexual abuse, physical abuse, neglect, plus family background and relationships more generally.

The mental health expert might reasonably address the following issues, as examples of factors to mitigation (not an exhaustive list):
• Is there any mental disorder and what were/are the implications for the defendant’s behaviour?
• Are there any psychological factors affecting the judgement or ability to exercise control of the defendant?
• Are there any developmental (social and psychological) factors that have shaped the person’s character, including in response to stress?
• Is there any empirical evidence about the impact on people with similar experiences of trauma or experiences of similar adversity?
• What effect did adverse experiences in their early life (for example, physical or emotional trauma, abuse, neglect) have upon their development and subsequent behavior, including their propensity to commit the crime?
• Whether the person was exposed to risk factors for subsequent violence is a matter that is relevant to ‘risk assessment’, in terms of the ‘beyond reformation’ criterion (see Chapter 7 concerning risk assessment)

Collateral information will be particularly important, both to inform opinion in relation to the interview and to provide objective sources of information. It might also provide information of a type that is not gathered by direct interview.

These records 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, neighbors and friends
• Police records, statements and court transcripts
• Previous probation records

The potential difficulties of using information obtained during police interviews is described in Chapter 10.

Formalised neuropsychological testing and personality testing might also be employed by psychologists, and incorporated within a psychiatric report (see Chapter 5).

**Reporting in relation to 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.
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 terms of their disorder, if there be such. The report might address specific questions in relation to their mental state at the time of any offence, also issues of capacity in relation to their understanding of their conduct.

The following aspects of the mental health assessment are examples of factors that might be considered as mitigating factors:

- Birth complications
- Childhood neglect or abuse
- 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
- 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
- Experience of victimisation as an adult

**Dangerousness and risk**

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

Risk assessment is fraught with methodological difficulties and uncertainties about validity and reliability (see Chapter 7), and this, together with the implications of ‘doing harm’ by way of clinician involvement in capital sentencing, determines that it is something of an ethical minefield. Certainly, for a doctor, the advice would be ‘if there is not diagnosable condition then do not comment upon risk’, since to do so will take the clinician far from ordinary clinical practice. However, clinical psychologists operate based upon a paradigm which does not depend upon, even eschews, ‘diagnosis’, and emphasises ‘understanding (even normal) behaviour’, so that their approach may be more flexible.

Categorisation of someone as ‘high’–‘medium’–‘low’–risk should not be adopted. The process of clinical risk assessment is usually with the purpose of identifying appropriate therapeutic interventions, which is in stark contrast to it being utilised for a determination of whether someone should receive a capital sentence. And, although risk assessment is a core aspect of psychiatric practice, used in clinical practice it is a dynamic concept based upon the risk of a specific type of harm occurring in specified circumstances and within a given time period.
Any assessment where risk assessment is to be included, or where the data gained could be used by the court in that regard in its own terms, should incorporate specific informed consent taking.

Any risk assessment used should only be of a type appropriate for the person you are assessing; also it should only be conducted based upon relevant training and with a clear understanding of the limitations of any assessment.

Any opinion on risk should stay within medical boundaries and not address legal concepts directly.

The sentencer will be concerned about the probability that an individual will act in a way that will be a threat to the public. There is no probability that can be reliably applied to any defendant and so there must be careful consideration and documentation of the limitations of accuracy of individual risk predictions.

**Assessment**

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. 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 can validly and reliably give an 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 is the question ‘In what circumstance?’ Hence, in regard to the test of ‘beyond reformation’, it may be that the defendant is considered 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.

Since risk assessment in clinical practice is always context specific ask ‘in relation to what circumstance(s) do you wish risk to be assessed?’ If there is a question about ‘risk after release’ then that should be addressed within that specific context (although this might be extremely difficult given the vast uncertainty about risk factors potentially relevant twenty or thirty years into the future).

Actuarially (see Chapter 7), there are generally equivocal or low rates of serious violence by people convicted of capital offences. And the rate is lower for prisoners whose sentences have been commuted (compared to those in prison awaiting execution). 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’ factors for future violence; and this will include both static and dynamic factors (see Chapter 7 generally on risk assessment techniques).

**Reporting**

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

- Record clearly the exact nature of the risk questions that have been posed
- Explain clearly the limits of any risk assessment
- If any actuarial data is presented then 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 who have a 40% risk of committing an act of serious violence in prison then that does not equate with saying that there is a 40% 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 data will often be gathered over a limited follow-up period.
- Do not use terms like ‘high risk’ or ‘low risk’, at least without significant qualification and emphasis that risk assessment is concerned with ‘description of factors and circumstances relevant to the individual defendant’.
- Emphasise uncertainty

**The ‘Worst of the Worst’ and ‘Beyond Reformation’**

These legal concepts have been widely accepted in international jurisprudence, including in the USA and Eastern Caribbean, as providing a basis for sentencing in capital cases (see ‘A Guide to Sentencing in Capital Cases’ by Edward Fitzgerald & Keir Starmer, The Death Penalty Project, 2007; www.deathpenaltyproject.org/legal-resources/research-publications/guide-to-sentencing-in-capital-cases/).

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 courts): 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.
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.

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 expert evidence can be relevant, albeit alongside other evidence as to his ‘character’. The presence of mitigating factors, including those within the remit of the mental health expert, are highly likely to rule this out to the extent that consideration within the test includes consideration of the thinking, and mental state of the defendant at the time he committed the offence (see above).

These tests, in particular ‘beyond reformation’ have been adopted by a portion of judges in the Supreme Court and lower courts in capital sentencing in Taiwan in regard to the discretionary imposition of the death penalty. However, there are no clear legal standards for such concepts in Taiwan and mental health practitioners therefore need to approach any consideration of them with care.

**Remorse**

Remorse is complex and very difficult for a mental health expert to comment upon directly. There can be reporting of a defendant’s views on their offending but the interpretation of whether this amounts to any, or what degree of remorse is a complex moral issue. There can however be comment on related concepts such as blame attribution.

**Conclusion**

The carrying out by mental health professionals of assessments to be directed at capital sentencing hearings, and the reporting of those assessments to courts, is necessary, given the nature of the legal rules which determine discretionary capital sentencing. Defendants facing the possibility of imposition of the death penalty have a right to such assessments. However, the process is fraught with technical and ethical bear traps for the professional concerned, and should be approached by any psychiatrist or psychologist with extreme care and caution.
CHAPTER THIRTEEN:
Assessment and reporting for pardons
Article 40 of the Taiwanese constitution gives the President the power to grant amnesties, pardons, the remission of sentences and the restitution of citizen’s rights. The details of the process are not fully described and no clear rules of procedure have been established. The Amnesty Law makes plain that the power to grant a pardon or mercy is entirely discretionary.

There are no established legal tests relevant to the exercise of mercy or the granting of a pardon. 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 that will carry weight in determining the exercise of mercy is therefore uncertain. However, the following issues might arise and may be relevant.

**The nature of mental disorder**

There is relatively clear legal authority in other jurisdictions, such as the USA and the Eastern Caribbean, 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 (see ‘A Guide to Sentencing in Capital Cases’ by Edward Fitzgerald & Keir Starmer, Death Penalty Project, 2007; [www.deathpenaltyproject.org/legal-resources/research-publications/guide-to-sentencing-in-capital-cases/](http://www.deathpenaltyproject.org/legal-resources/research-publications/guide-to-sentencing-in-capital-cases/)).

**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 some suffering from mental disorder, there can be no detailed advice on clinical assessment. Rather, the reader might reasonably cull advice from foregoing chapters as seems likely to be useful.

**Reporting for a mercy hearing**

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 FOURTEEN:
Assessment and reporting on fitness for execution
If insanity develops after conviction, Article 465 of the Taiwanese Code of Criminal Procedure states that execution of the death penalty should be suspended until the offender recovers. Based on similar reasoning, Article 467 of the Code of Criminal Procedure makes clear that the execution of imprisonment or criminal detention should be suspended if the inmate is found suffering from insanity and is yet to recover.

Guidance as to what this means in practice is lacking but clearly psychiatric evidence will be crucial in establishing ‘insanity’, in particular an assessment of the offender’s current mental state. A detailed mental state examination will be required. Collateral information, particularly from the prison and also hospital if the offender has received medical treatment is likely to be helpful. Any symptoms of mental disorder should be carefully documented.

The notion of insanity is not well developed in Taiwanese law (see Chapter 10), and there seemingly is a discrepancy in the legislation of the Criminal Code (e.g. Article 19 in which criminal responsibility is discussed) and the Code of Criminal Procedure Act (e.g., Article 294 in which the competence to stand trial is referred to) with respect to the concept of “insanity” in criminal legal contexts. But the core concept described in Article 465 seems to be that the offender’s mental state has deteriorated after sentencing and it is this ‘change’ then that will need to be the focus of assessment. It would be unsurprising if many offenders on receiving the death sentence become somewhat depressed, fearing for the future. The degree of change would seem to need to be substantial to qualify as a ‘loss of sanity’, however. It appears unlikely that the offender needs to be completely free from symptoms of mental disorder; for some offenders, for example, those suffering with enduring personality disorder, this is highly unlikely. For others, with relapsing and remitting mental disorders, the ‘window’ of sanity might be relatively brief and brought about by medical treatment, including treatment in hospital, raising difficult ethical issues for the treating doctor.

The lack of a clear legal test makes it important that clinical findings are clearly described.

**Recommendations concerning treatment ‘to make fit’**

Where the cause of unfitness for execution is potentially reversible, such as where the condition is a severe psychosis, the ‘impossible 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 treatment will result in his execution. This is, amongst a range of profound ethical dilemmas posed to doctors who are in any way involved in capital trials (see Chapter 15), The answer can be determined only by the individual doctor in the individual case. The dilemma brings into direct conflict the duty to treat a patient in medical need with the duty not to do harm, however, that harm might arise; plus there may be a perceived conflict between the duty to do no harm to one’s patient, again however that might arise from your actions, with the societal duty upon the doctor as citizen to facilitate the lawful exercise of justice.
CHAPTER FIFTEEN: Ethical Issues in Forensic Psychiatry in 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, and 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 recognition of what is a normative, or ethical question, 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 which makes clear the nature of the justification. Put otherwise, it is ‘biting the ethical bullet’, and doing so with ethical insight into what form of ethical justification you are applying, and into why you have decided to choose one course of action over another competing course.

Hence, 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.

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, but with added frequency and difficulty in forensic mental health care; 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. Hence, 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; 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 both 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 into 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 s/he assesses.

Principles

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

The ethical principles which are most commonly considered to underpin most medical practice (‘the four principles’) include autonomy, beneficence, non-maleficence and a duty to respect justice. And, amongst these, it is the duty to respect patient autonomy, which 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 exercise formally 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 s/he might appear to all but abandon ‘respect for autonomy’ in favour of a duty to assist the State in the exercise of justice. Hence, 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 as they are usually balanced by doctors.

And 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 injunction 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 ‘doing no harm’.

One ‘partial solution’ to such a 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. The only escape from such a danger lies 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. That is, 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. Hence, 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; whilst 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 a duty to acquire and maintain specific medico-legal 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’. Remaining within the limits of your expertise is paramount, and this may require you to refuse involvement in a case. 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 to do so.

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 substitute 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 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.

Values, bias and objectivity

There should be no personal interest in any case. It is however very difficult to detach yourself completely from your personal values and beliefs, and perhaps particularly so in capital cases.

Acknowledgment of your personal values and beliefs is to be encouraged, in that good ethical reasoning should include insight into personal values which you inevitably bring to such reasoning.
Pretending that you are ‘unbiased’ is ethically more dangerous than acknowledging your likely sources of bias, and attempting to be as honest as you can, alongside such ‘insight’ into ‘your ethical self’.

Objectivity is an impossible goal; however, the attempt to achieve objectivity, and the pursuit of honesty, are crucially important goals within good clinical ethical practice. And again, clarity in defining the ethical question at hand, and in defining and acknowledging a given form or reflective process, will offer the best protection against the ‘unseen’ operation of personal bias.

More simply, consider the following factors:

- Have you considered your own values and beliefs and considered whether your opinion is unduly influenced by these?
- Have you given thought to alternative opinions and 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’?

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, ‘telling’ a defendant that your role is not that of a doctor assessing and treating a patient, though crucial and necessary, may well not, indeed likely will not, result in persistence of understanding of the distinction on the part of 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, which 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 be at least 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 whether to co-operate 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 (albeit 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, other than one 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 that, in utilising medical techniques, a doctor necessarily utilises techniques of communication which 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 which are designed for, and originate in the pursuit of human welfare by way of treatment. That is, s/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 greatest ethical protection.

**Proximity to execution**

As suggested (above) some doctors adopt an approach to involvement in capital trials based upon ‘how proximate’ to execution per se is their posited involvement, in terms of legal stage.

Hence, a doctor may be prepared to assess 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.

**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; however, 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, in terms of the test of ‘beyond reformation’, or perhaps also in terms of the test of ‘the worst of the worst’ (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. That is, 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 be only, as in regard to sentencing or mercy hearings, be 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, there may be thought also to be an ethical imperative to treat the condition.

Where such treatment is likely to restore competence for execution, an ‘almost impossible’ ethical dilemma is posed, in terms of balancing harms.

If the convict remains competent to consent to, or refuse treatment, then he should make the decision. However, mental disorder which 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 legal 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 death penalty cases towards achieving such deliberation and reflection, in the knowledge that 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 clinic-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 One: Psychological Assessment Quick Reference Guide

<table>
<thead>
<tr>
<th>Psychological Factor</th>
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<td>• Wechsler Adult Intelligence Scale, fourth edition (WAIS-IV)</td>
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<td>• Ravens Progressive Matrices</td>
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<td>• Rey-Ostreith Complex Figure Test</td>
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<td>• Behavioural Assessment of Dysexecutive Syndrome (BADS)</td>
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<td>• Controlled Oral Work Association Test</td>
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<td>• Reitan Trailmaking test</td>
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<td>• Hayling and Brixton tests</td>
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<td>• Stroop Neuropsychological Screening Test</td>
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<tr>
<td>• Graded Naming Test</td>
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<td>• Beck Anxiety Inventory (BAI)</td>
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<td>• Hospital Anxiety and Depression Scale (HADS)</td>
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<td>• State/Trait Anger inventory (STAXI)</td>
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<td>• Personality Assessment Inventory (PAI)</td>
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<td>• Leeds Dependency Questionnaire (LDQ)</td>
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<td>• Sensation Seeking Scale (SSS)</td>
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<td>• Test of Memory Malingering (TOMM)</td>
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<td>• Millar Forensic Assessment of Symptoms (MFAST)</td>
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<td>• Structured interview of Reported Symptoms (SIRS)</td>
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<td>• Structured Inventory of Malingered Symptomatology (SIMS)</td>
<td></td>
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<tr>
<td>• Paulhus Deception Scale</td>
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**NB:** This is not an exhaustive list, but represents some of the most commonly used measures with robust psychometric properties.
Appendix Two: 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 set. 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 is actually very easy, and is a test which 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.

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 a subject’s ability to shift their attention and problem solving abilities, as well as assessing their visuo-spatial 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, then 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
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 – the test assesses the effort that the individual is making.

Test of Memory Malingering (TOMM)
The TOMM is a 50-item recognition test for adults, which 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 suggestions 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 which 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. 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 Three: Diagnostic Classifications: DSM & ICD

The following table lists the diagnoses and diagnostic codes from the International Classification of Diseases, 10th edition (ICD10) and the APA Diagnostic and Statistical Manual, 4th edition, text revision (DSM-IV-TR).

There are many more specific diagnoses in ICD-10 than in DSM-IV-TR; the diagnostic terms listed are therefore those of the ICD-10.

The new version of DSM is due in 2013.

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<th>ICD10 code</th>
<th>DSM code</th>
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<td>Organic mental disorders</td>
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<td>Dementia in Alzheimer's disease with early onset</td>
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<td>Vascular dementia of acute onset</td>
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<td>Dementia in human immunodeficiency virus [HIV] disease</td>
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<td>F02.8</td>
<td>294.1</td>
<td>Dementia in other specified diseases classified elsewhere</td>
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<tr>
<td>F03</td>
<td>294.8</td>
<td>Unspecified dementia</td>
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*A fifth character may be added to F00-F03, as follows:*

<p>| .x0         | Without additional symptoms |
| .x1         | Other symptoms, predominantly delusional |
| .x2         | Other symptoms, predominantly hallucinatory |
| .x3         | Other symptoms, predominantly depressive |
| .x4         | Other mixed symptoms |
| F04         | 294.0    | Organic amnesic syndrome, not substance-induced |</p>
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<td>F05.0</td>
<td>293.0 Delirium, not superimposed on dementia, so described</td>
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<td>293.9 Other specified mental disorders due to brain damage etc.</td>
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<td>293.9 Unspecified organic or symptomatic mental disorder</td>
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### F20-29 (ICD-10)

#### Schizophrenia, schizotypal and delusional disorders

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<td>311 Post-schizophrenic depression</td>
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A fifth character may be used to classify course:

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F21  301.22  Schizotypal disorder
F22.0  297.1  Delusional disorder
F22.8  297.1  Other persistent delusional disorders
F22.9  297.1  Persistent delusional disorder, unspecified
F23.0  298.9  Acute non-schizophreniform polymorphic psychotic disorder
F23.1  295.40 Acute schizophreniform polymorphic psychotic disorder
F23.2  295.40 Acute schizophrenia-like psychotic disorder
F23.3  297.1  Other acute predominantly delusional psychotic disorders
F23.8  298.8  Other acute and transient psychotic disorders
F23.90  298.8  Acute/transient psychotic disorder with acute stress
F23.91  298.8  Acute/transient psychotic disorder without acute stress
F24    297.3  Induced delusional disorder
F25.0  295.70 Schizoaffective disorder, manic type
F25.1  295.70 Schizoaffective disorder, depressive type
F25.2  295.70 Schizoaffective disorder, mixed type
F25.8  295.70 Other schizoaffective disorders
F25.9  295.70 Schizoaffective disorder, unspecified
F28    298.9  Other nonorganic psychotic disorders
F29    298.9  Unspecified nonorganic psychosis

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<td>296.00  Other manic episodes</td>
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<td>F30.9</td>
<td>296.00  Manic episode, unspecified</td>
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<td>F31.1</td>
<td>296.43  Bipolar disorder, manic without psychotic symptoms</td>
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<td>F31.2</td>
<td>296.44  Bipolar disorder, manic with psychotic symptoms</td>
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<td>296.52  Bipolar disorder, mild or moderate non-somatic depression</td>
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<td>F31.31</td>
<td>296.52  Bipolar disorder, mild or moderate somatic depression</td>
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**F40-49 Neurotic, stress-related and somatoform disorders**

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### F50-59 Behavioural syndromes associated with physical factors

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<td>307.46 Sleep terrors [night terrors]</td>
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### F53.8 293.9 Other puerperal mental and behavioural disorders
### F53.9 293.9 Puerperal mental disorder, unspecified
### F54 316 Psychological /behavioural factors of other disorders
### F55.0 305.90 Abuse of non-dependence-producing antidepressants
### F55.1 305.90 Abuse of non-dependence-producing laxatives
### F55.2 305.90 Abuse of non-dependence-producing analgesics
### F55.3 305.90 Abuse of non-dependence-producing antacids
### F55.4 305.90 Abuse of non-dependence-producing vitamins
### F55.5 305.90 Abuse of non-dependence-producing steroids or hormones
### F55.6 305.90 Abuse of non-dependence-producing herbal or folk remedies
### F55.8 305.90 Abuse of other non-dependence-producing substances
### F55.9 305.90 Abuse of unspecified non-dependence-producing substances
### F59 300.9 Unspecified behaviour syndromes with physiological disturbances

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*A fourth character may be used for behavioural impairment*

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### Childhood/adolescent behavioural and emotional disorders

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**Appendix**
Appendix Four: Legal Cases

Bratty v Attorney-General for Northern Ireland [1963] AC 386

R v Byrne [1960] 2 QB 396

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, 477 U.S. 399 (1986),

DPP v Majewski [1976] UKHL 2

R v McNaughten (1843) 10 CI & F 200

R v Quick [1973] 3 WLR 26

R v Pritchard [1836] 7 CP 303

R v Tandy [1989] 1 WLR 350

R v Windle [1952] 2 QB 826
Appendix Five: 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 co-operate 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 evaluee's understanding of medical confidentiality. A forensic evaluation requires notice to the evaluee 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 evaluee that the psychiatrist is not the evaluee's ‘doctor’. Psychiatrists have a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluee 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 evaluee 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 evaluee 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 evaluee that if the evaluee refuses to participate in the evaluation, this fact may be included in any report or testimony. If the evaluee 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.

Without 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 practising 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…
Authors

Nigel Eastman is professor emeritus of law and ethics in psychiatry at the University of London and an honorary consultant forensic psychiatrist in the National Health Service (NHS). Alongside his medical training, he was called to the Bar, in Gray’s Inn, in 1976. He has carried out research and published widely on the relationship between law and psychiatry, while also having nearly 30 years’ experience of clinical forensic psychiatry. He has extensive experience of acting as an expert witness in criminal and civil proceedings in England and Wales, and in the jurisdictions of other countries. This includes 20 years’ experience of assessing ‘death row’ cases for the Judicial Committee of the Privy Council. Much of his work has been concerned with matters of public policy; for example, he has given evidence to Parliamentary Select Committees on law and psychiatry. He advised the Law Commission during its work towards reforming the partial defence to murder of ‘diminished responsibility’ and later lectured to all ‘murder ticket’ judges on the new statutory provisions, for the Judicial Studies Board. Professor Eastman is an expert member of the Foreign Secretary’s International Death Penalty Panel. He is a founder member of Forensic Psychiatry Chambers.

Tim Green is a chartered clinical psychologist, employed as head of psychological and talking therapies in forensic services at the South London and Maudsley NHS Foundation Trust. He is also an honorary researcher in the psychology department at the Institute of Psychiatry in London. He has extensive experience of preparing reports for a number of different courts, both civil and criminal, including offering oral testimony. He also has experience of offering opinion in murder trials, including assessments of inmates on death row in the Caribbean, in cases of appeal before the Privy Council.

Leon Huang is a practising attorney at Lionheart Attorneys-at-Law in Taiwan. He was educated at New York University in psychology and politics, and holds a LLM degree from Soochow University. His legal career of nearly 20 years has been closely focused on intellectual property, international law, human rights, mental health law and criminal defence. While frequently consulted by legal practitioners in the defence of major crimes involving issues of forensic psychology/psychiatry in Taiwan, he also trains attorneys in the field of trial advocacy and examining forensic psychologists and psychiatrists, among other experts. He is currently a doctorate student in the psychology department of National Taiwan University, with a research focus on forensic psychology. He is also one of the founders of the Forensic Science and Evidence Committee at the Taipei Bar.

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**About Forensic Psychiatry Chambers:** Forensic Psychiatry Chambers comprises 10 consultant forensic psychiatrists, all otherwise working within the NHS. It was formed to pursue legally informed and ethical forensic psychiatric practice in the provision of legal services to the courts. It attempts to achieve this through a ‘collegiate’ approach to practice, including through rigorous peer review of past cases. The Chambers is committed to enhancing the quality of practice both ‘within itself’ and through offering tailor-made training programmes. It is also committed to provision of *pro bono* services for humanitarian purposes, and several members of Chambers have undertaken assessments of ‘death row’ cases in jurisdictions that use the Judicial Committee of the Privy Council.

**About Taiwan Alliance to End the Death Penalty:** The Taiwan Alliance to End the Death Penalty (TAEDP) is a coalition of Taiwanese abolitionist, non-governmental organisations and research institutes. The Alliance, formed in 2003, is the first coalition in Taiwan that advocates for the abolition of the death penalty and promotes reform of Taiwan’s penal system. TAEDP undertakes its work through the use of several different approaches. It works on individual death penalty cases and monitors the trial procedure to ensure every defendant receives a fair trial. Training programmes and seminars on specific topics for criminal defence attorneys are held constantly. In 2014, The Death Penalty Project published *The Death Penalty in Taiwan: A Report on Taiwan’s Legal Obligations under the International Covenant on Civil and Political Rights* in collaboration with TAEDP and Professor Wen-chen Chang. The *Handbook of Forensic Psychiatric Practice for Capital Cases in Taiwan* is the second collaborative work between The Death Penalty Project and TAEDP.
About the Death Penalty Project

The Death Penalty Project works to protect the human rights of those facing the death penalty. It operates in all countries by providing free legal representation, advice and assistance. For more than 20 years, its work has played a critical role in identifying a significant number of miscarriages of justice, promoting minimum fair trial guarantees in capital cases, and in establishing violations of domestic and international law.

Through its legal work, the application of the death penalty has been restricted in many countries, in line with international human rights standards. Its training programmes and research projects create awareness of the issues surrounding the death penalty, encourage greater dialogue and provide a platform to engage with experts and key stakeholders.

Since 2000, The Death Penalty Project has been involved in a broad range of activities in Asia, in terms of capacity building, legal advice and direct legal assistance to prisoners under sentence of death.

Between 2013-2015, The Death Penalty Project has published a number of reports focusing on capital punishment in Asia:

- *The Death Penalty in Malaysia: Public Opinion on the Mandatory Death Penalty for Drug Trafficking, Murder and Firearms Offences*, by Professor Roger Hood;
- *The Death Penalty in Japan: A Report on Japan's legal obligations under the International Covenant on Civil and Political Rights and an Assessment of Public Attitudes to Capital Punishment*, co-authored with Maiko Tagusari, Professor David Johnson and Dr Mai Sato;
- *The Inevitability of Error: the Administration of Justice in Death Penalty Cases*;
- *The Death Penalty in Taiwan: A Report on Taiwan's legal obligations under the International Covenant on Civil and Political Rights*, co-authored with Professor Wen-Chen Chang and Professor David Johnson.

These reports and other publications by The Death Penalty Project are available to view or download at [www.deathpenaltyproject.org](http://www.deathpenaltyproject.org)
Perspective

Saul Lehrfreund and Parvais Jabbar
Executive Directors, The Death Penalty Project

Safeguard 3 of the Safeguards Guaranteeing the Protection of the Rights of those Facing the Death Penalty (‘The Safeguards’), adopted by the UN Economic and Social Council in 1984, states: “Persons below 18 years of age at the time of the commission of the crime shall not be sentenced to death, nor should the death penalty be carried out on pregnant women, or on new mothers, or on persons who have become insane.” In 1989, these standards were further developed by the Council, which recommended that states eliminate the death penalty “for persons suffering from mental retardation or extremely limited mental competence, whether at the stage of sentence or execution”. In 2005, the UN Commission on Human Rights urged all states that maintain the death penalty “not to impose the death penalty on a person suffering from any mental or intellectual disabilities, or to execute any such person.”

The Safeguards establish minimum standards to be applied in countries that still impose capital punishment and all states are bound by these standards pending abolition. They should be considered the general law applicable to the death penalty and clearly prohibit the imposition of capital punishment or the execution of persons suffering from any mental illness or intellectual disability. In our experience, however, it is clear this international norm is not being applied as it should. This is especially so in countries that may lack the level of mental health services, training and the necessary expertise within the criminal justice system.

We have instructed many forensic psychiatrists and clinical psychologists to assess prisoners and provide reports to the courts. In far too many cases, individuals who have been sentenced to death are found to be suffering from mental illness and/or an intellectual disability, thus impacting on the safety of their conviction and the lawfulness of the sentence. For Safeguard 3 to be consistently applied in capital cases, medical experts will not only need to participate actively in the criminal justice process, but also have the necessary skills to enable them to do so.

This unique handbook, adapted specifically for Taiwan, responds to these problems and will be a vital resource to mental health professionals, lawyers, prosecuting authorities and the courts, being relevant at all stages of the criminal justice process.