Handbook of Forensic Psychiatric Practice in Capital Cases

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THE DEATH PENALTY PROJECT

In association with:
ForensicPsychiatryChambers

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Preface

Forensic psychiatry comprises the psychiatry of mental disorder and offending behaviour, that is *clinical forensic psychiatry*, plus law as it relates to all psychiatry, both civil and criminal law, or *legal 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[1] are both 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 also 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 so as to report into the criminal legal process.

This handbook is designed specifically to assist mental health professionals and lawyers engaged in capital trials, sentencing hearings, appeals and mercy hearings. It draws on ordinary principles of forensic psychiatric practice, and much of the text in regard to pre-trial issues and trials is common to all common law jurisdictions, for example in relation to 'mental condition defences'. However, the handbook is 'custom written' specifically in regard to problems that can arise even at the trial and pre-trial stages in countries that both retain the death penalty and may lack the level of mental health services available, for example, in the UK and in regard to the unusual psycho-legal issues that can arise in relation to sentencing hearings, appeals from conviction and sentence, and mercy hearings.

The handbook is limited in its scope and depth in order to make it 'user friendly' within the mental health and legal contexts for which it is written, where usually there will be little in the way of specialist forensic psychiatric training, knowledge or services. However, readers who wish to refer to a more comprehensive text of forensic psychiatric practice, albeit not oriented specifically towards capital cases, may wish to consult Eastman N, Adshead G, Fox S, Latham R and Whyte S (2012) *Oxford Specialist Handbook of Forensic Psychiatry*[2]; and the approach to forensic psychiatry adopted within the current handbook directly reflects that adopted in the *Oxford Handbook*.

As with the *Oxford Handbook*, the abbreviated style of this handbook 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 both thank them all and acknowledge their copyright in their work.

This handbook represents a stand-alone, single-volume practitioners' handbook for the use of psychiatrists and psychologists, solicitors, barristers, prosecuting authorities and the courts, who are required to deal with homicide, and other cases, in jurisdictions and circumstances where the death penalty can apply. It is intended to be relevant to all stages of capital criminal justice process, from arrest and police interviewing, through fitness to plead and trial, to sentencing, appeal and mercy hearings. It therefore deals not only with 'mental condition defences' at trial, but psycho-legal issues that can occur at all stages in capital cases.

[1] The term 'mentally disordered offender' is not restricted to individuals who are mentally disordered and who have also been convicted of a criminal offence, but also includes those facing criminal legal process, as well as those deemed at risk of committing a serious criminal offence.
[2] Eastman N, Adshead G, Fox S, Latham R, Whyte S (2012) *Oxford Specialist Handbook of Forensic Psychiatry*, Oxford University Press, Oxford, UK

Specifically in relation to sentencing, this handbook is intended to be read in close conjunction with The Death Penalty Project's Guide to Sentencing in Capital Cases[3].

As indicated, this handbook will adopt a similar approach to dealing with the interface between psychiatry and law as in the *Oxford Handbook*, specifically in terms of two 'discourses', each with its own constructs and methods of enquiry, derived from their very different social purposes and roles (see Chapter 1), with emphasis on the importance of the relationship between the two being based upon mutual understanding, but always with recognition of the importance of the relationship being a clearly 'boundaried' one.

This handbook is written to be of use to both mental health and legal practitioners, each approaching the 'frontier' between disciplines 'from their own side'. However, although it is similar to the *Oxford Handbook*, in terms of representing the same frontier between psychiatry and law, in order to restrict its size the main focus is upon aiding mental health practitioners more effectively to navigate the frontier between their disciplines and law, although aspects of the book will also be of direct use to legal practitioners.[4] The roles of the forensic psychiatrist and clinical forensic psychologist, together with other clinical professionals, are explained in relation to each stage of the criminal justice system within common law jurisdictions in relation to capital cases. This will include descriptions of how the validity of expert evidence can be assured, or challenged.

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

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 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.

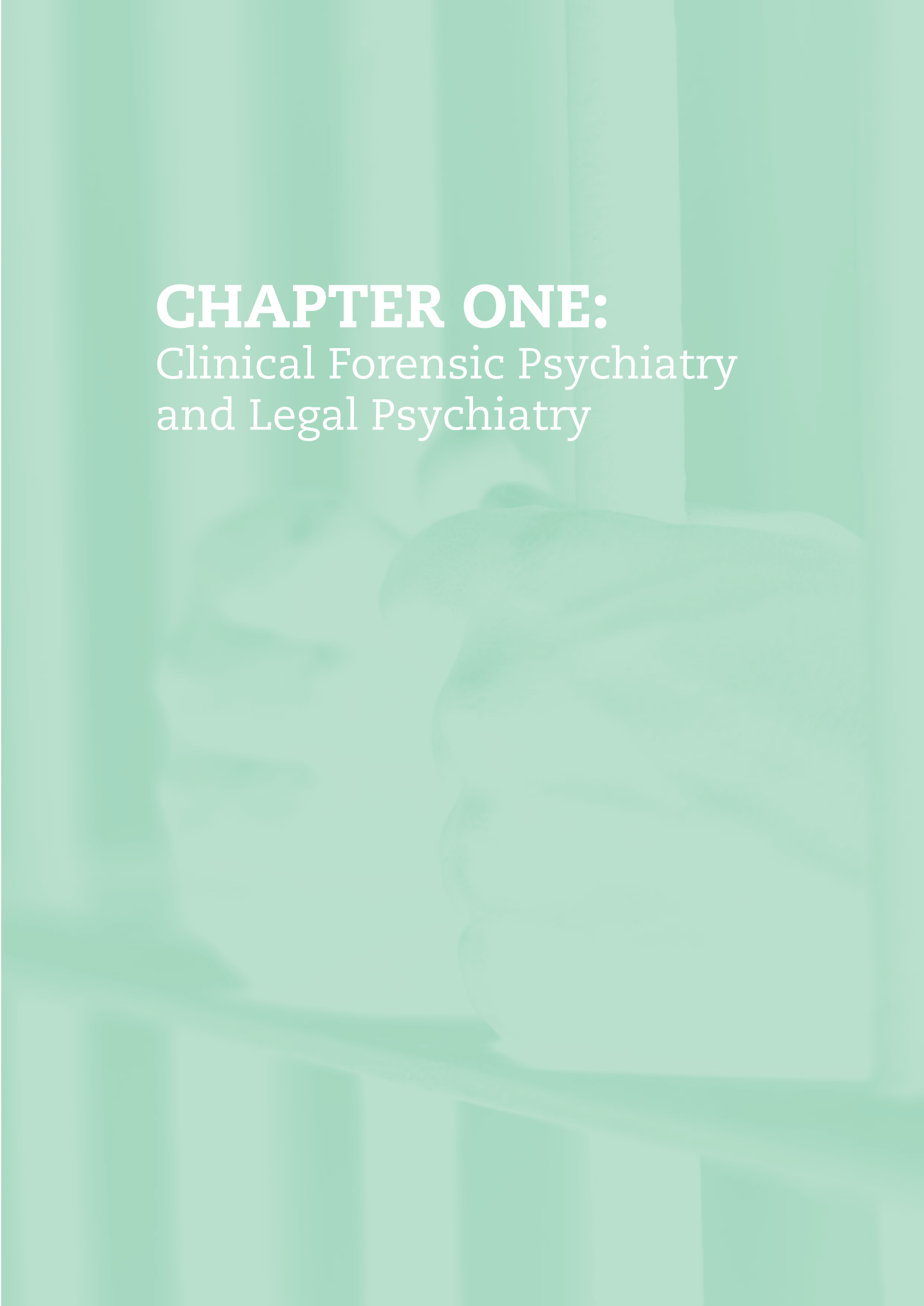
This handbook is not only designed to be read 'on its own', but is also intended to be used in direct relation to education and training events offered by members of Forensic Psychiatry Chambers and the Death Penalty Project. It therefore, effectively, amounts to a 'course book' for such education and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

Professor Nigel Eastman

[3] Fitzgerald E & Starmer K (2007) *A Guide to Sentencing in Capital Cases*. The Death Penalty Project, London.
[4] It is hoped that legal practitioners wishing better to understand psychiatric, and psychological evidence will refer to the *Oxford Specialist Handbook of Forensic Psychiatry.*

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, be 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[5]

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.

[5] 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.

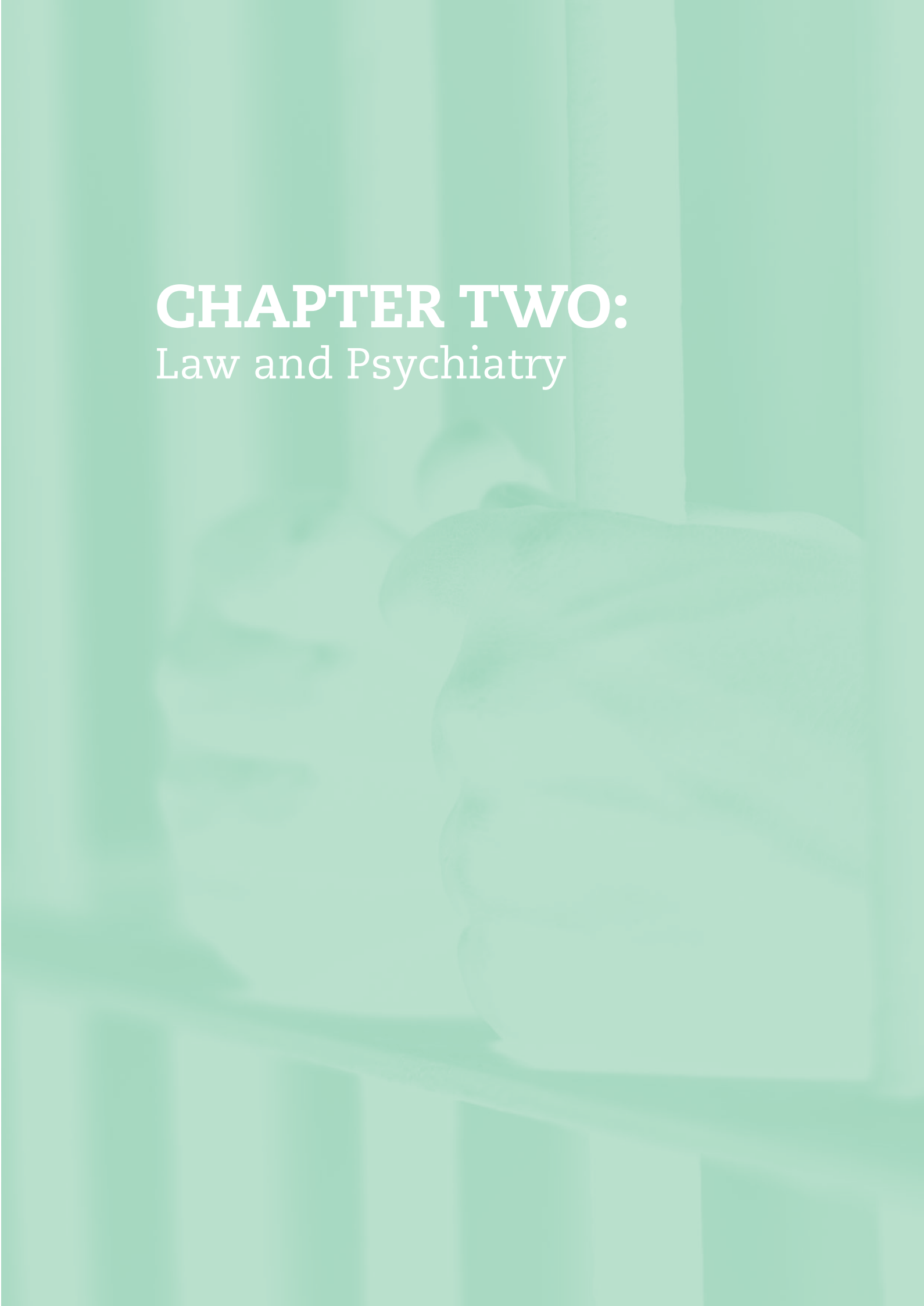
Criminologists study crime and criminals, and do not, in the UK, have direct involvement in the care of mentally disordered offenders. The impact of criminological research is, however, widespread and seen throughout this handbook, since many mentally disordered offenders are driven to offend not only 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.[6]

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.

Autopoesis 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 justice[7] 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 'autopoesis' and 'reflexivity' refer to law's openness, or otherwise, to adopting the concepts used in other disciplines.

[6] 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.

[7] 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 se*ntencing 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[8].

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.

[8] 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.[9] 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

[9] 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.

- 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

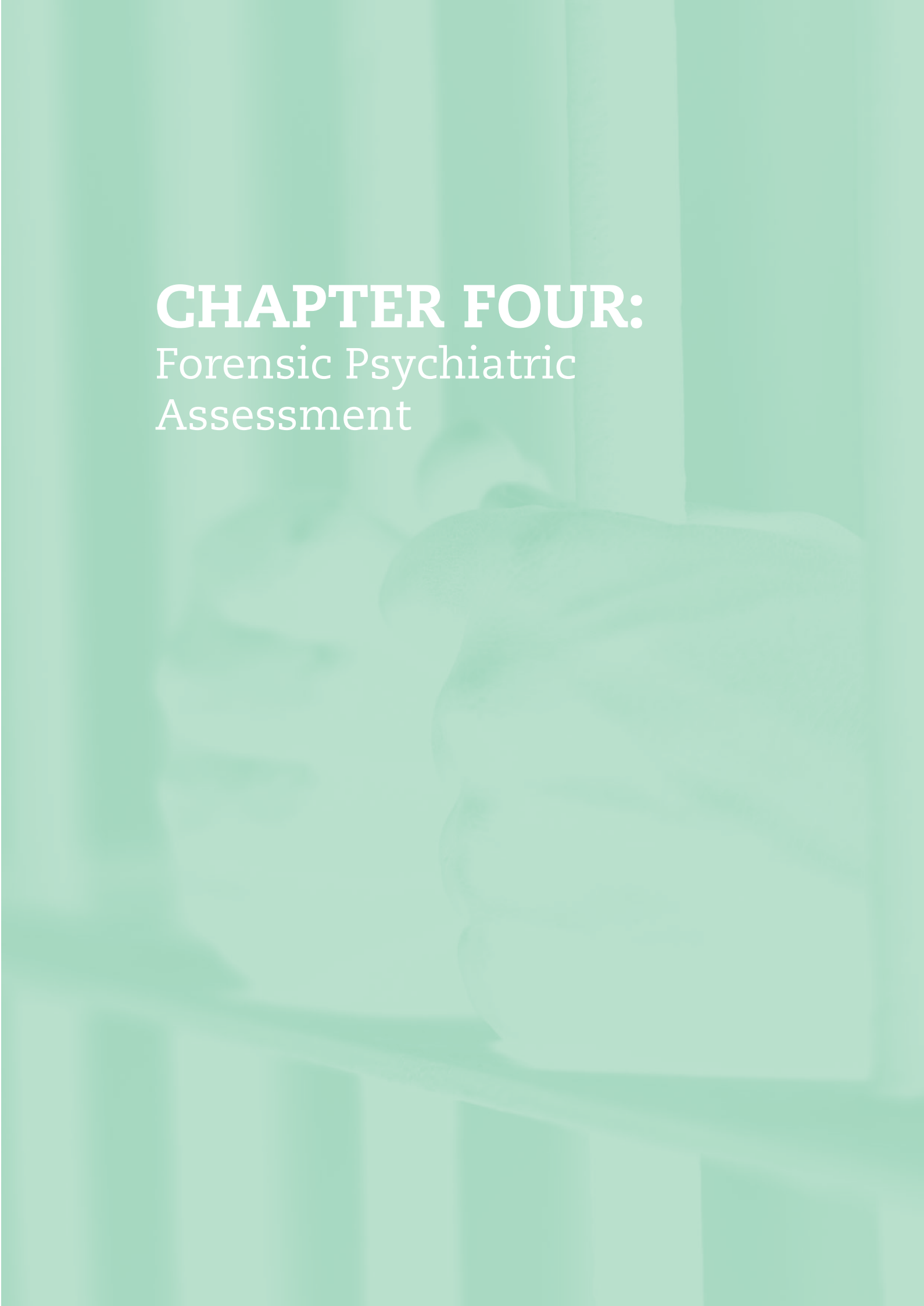
Although rarely associated with serious violence, these disorders can be raised in relation to defences at trial. The following issues can arise:

- 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 effect of difference of purpose

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, incurring 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 functioning 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

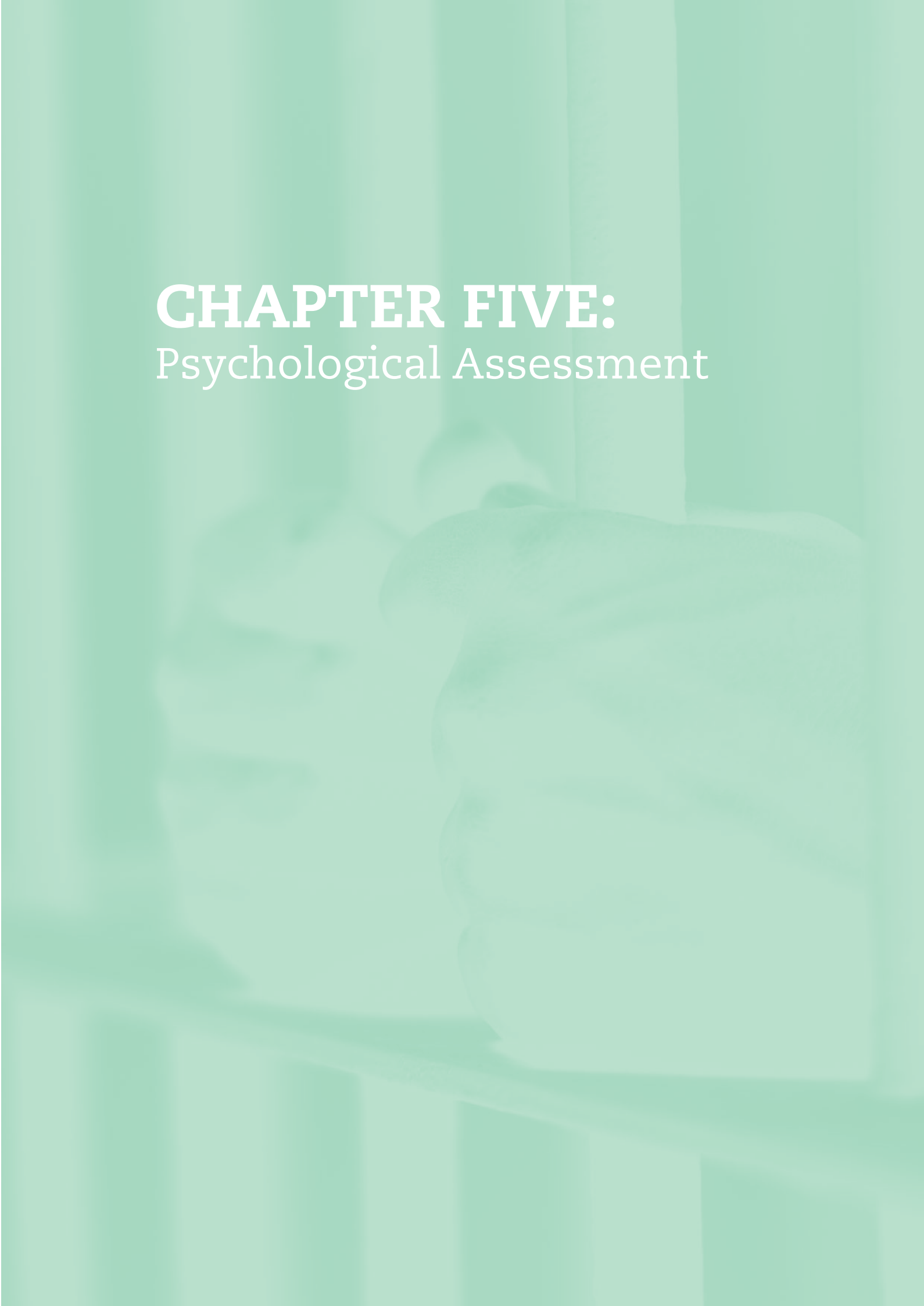
Some have argued that clinicians who undertake assessment in capital cases need to demonstrate a higher standard of professional practice than those engaged in general forensic psychiatric work. Clearly, psychiatrists carrying out such work need to be experienced not only in clinical forensic practice, 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

- 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

- 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.

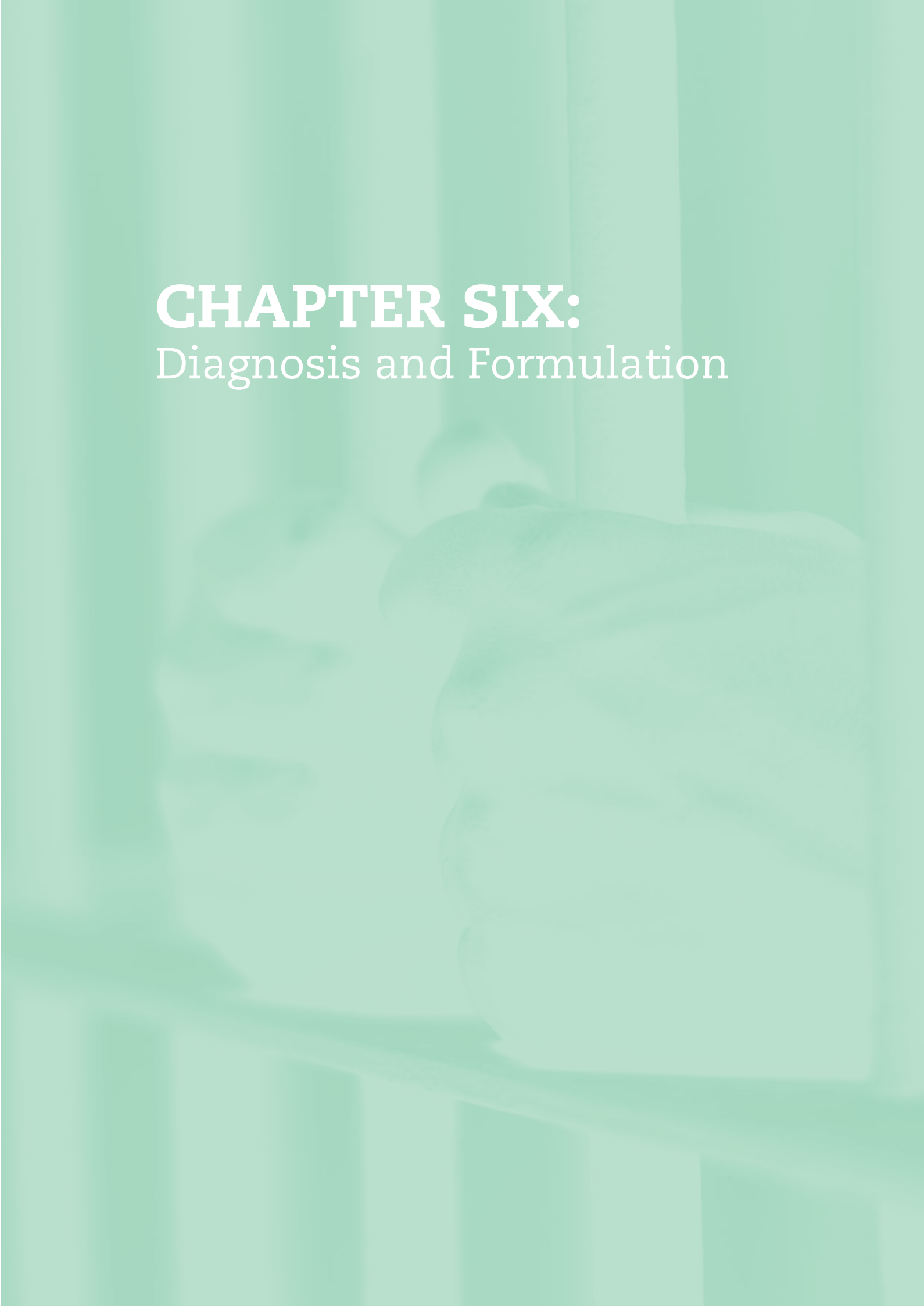
Suggestibility and compliance may enhance the likelihood that an individual has been coerced by others into criminal activity, although the recognised test of suggestibility was developed specifically in relation to 'interrogative' situations, and indeed it is properly referred to as 'interrogative suggestibility'.

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).

CHAPTER SIX:
Diagnosis and Formulation



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 Organisation'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:

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

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

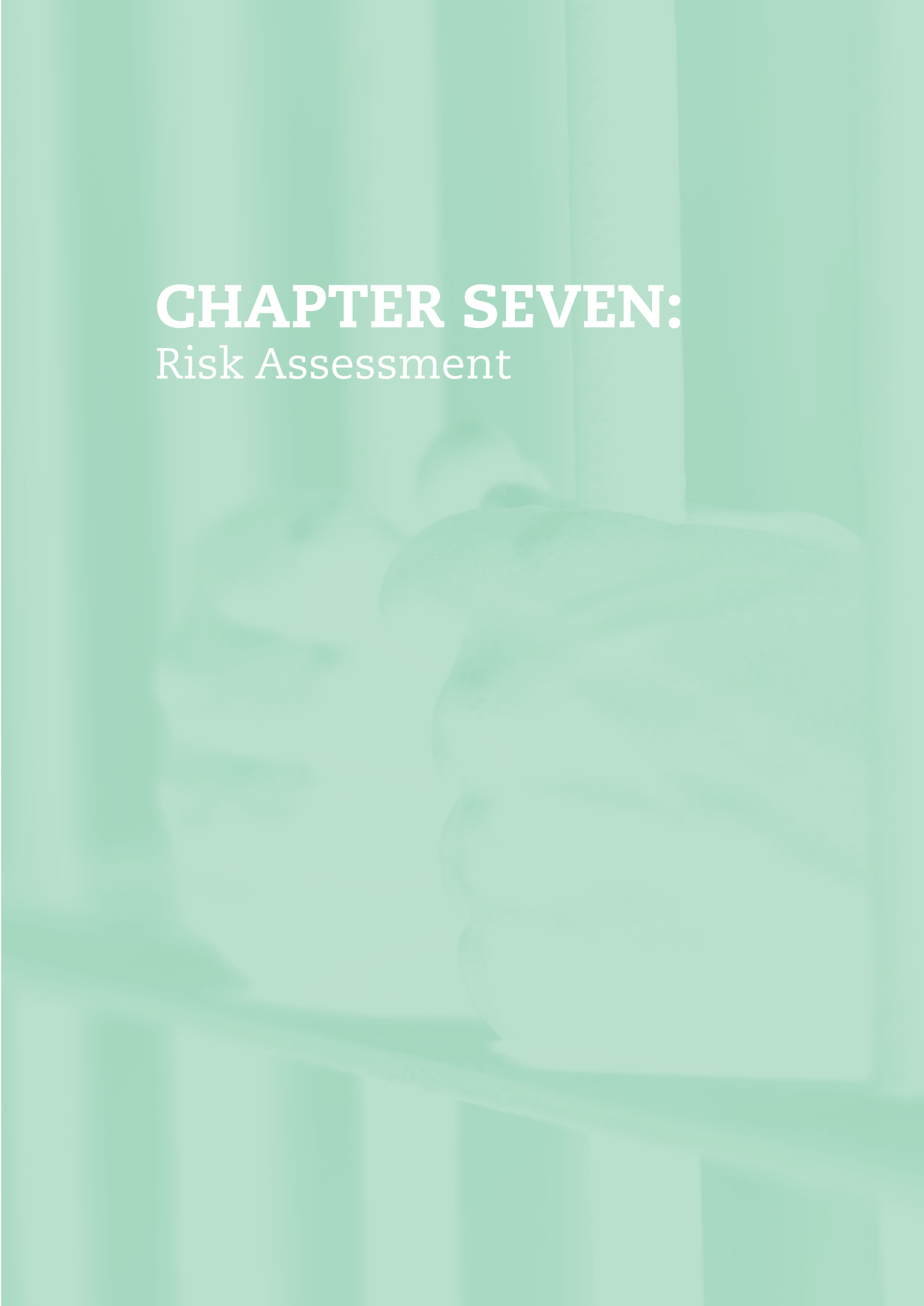
The important factors in considering formulation relating to offending will include:

- 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

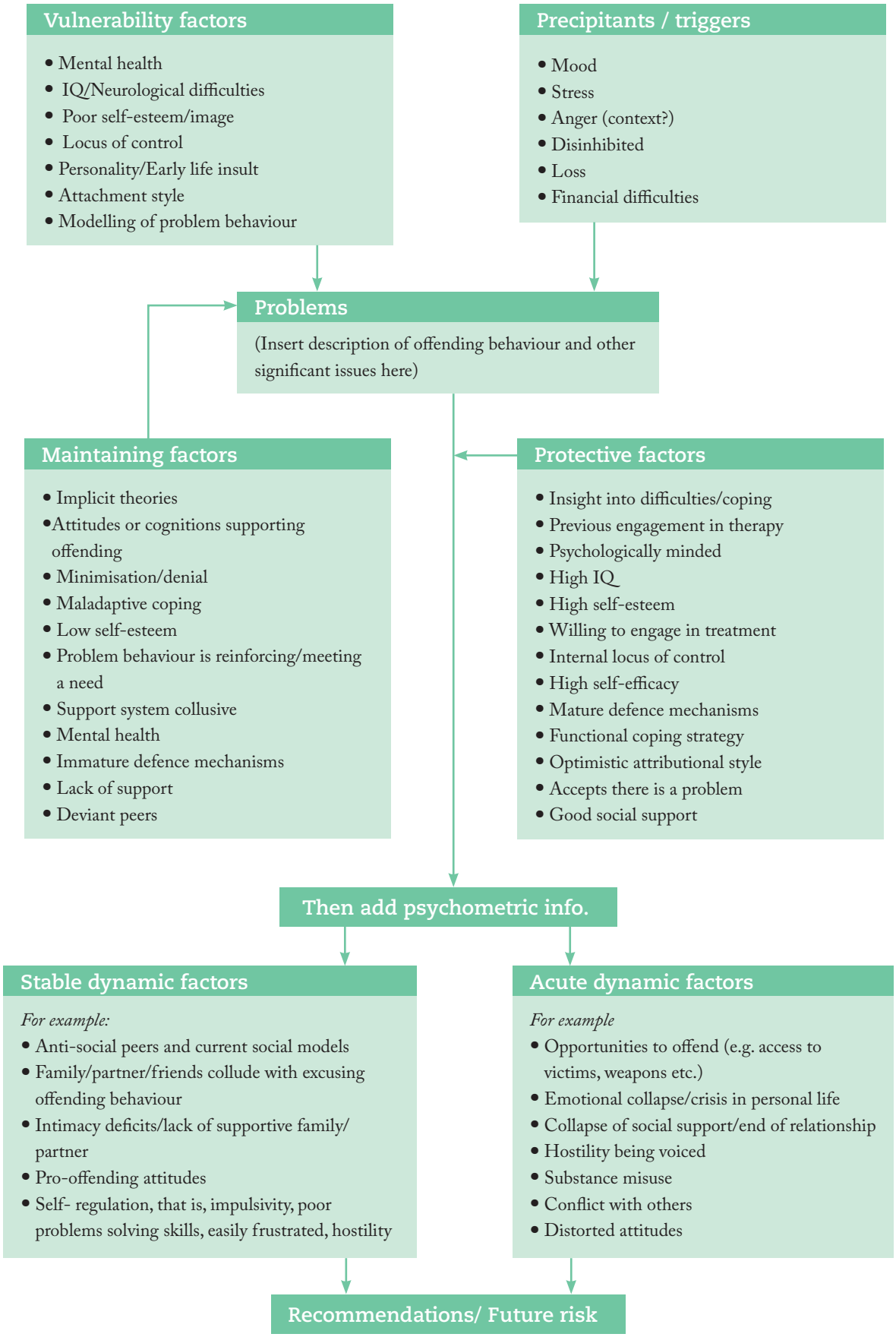
A 'good formulation' will also offer the advantage of drawing on information from clinical interview and psychometric testing, as well as collateral information such as the reports of independent observers or family/friend informants.

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 is 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.

Figure 1: Example Formulation Diagram



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[10]

[10] 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 expessed 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[11]

[11] For more detailed advice on appearing in court the reader is referred to the *Oxford Handbook of Forensic Psychiatry*

If a doctor prepares a written report for court proceedings, then there is an obligation on them to 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.

Timing

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

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

Preparation

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

Giving expert evidence should not be the first time you attend a court. If you have never had an opportunity to shadow another expert, then it should at least be possible to sit in the public gallery and watch proceedings. By doing so you can gain some familiarity with the layout of the court, the 'roles that people play' during a hearing and, perhaps most importantly, the atmosphere 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; the expression of a clear and reasoned conclusion, which takes into account all the material you have been presented with, and which adequately addresses any opposing view, is likely to reduce the chances of having to give oral evidence. However, in some cases attendance at court will still be required, particularly if more than one expert has been instructed and the experts

have arrived at differing conclusions, either clinically or in terms of expression of the relevance of any clinical findings to the legal questions at hand.

The provision of a good written report should 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 laboriously to go through the material again.

The contemporaneous handwritten notes from the interviews conducted with the subject to produce the report need to be kept securely, and then 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.

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 itself, including your own report and the reports of others. Experts are almost always permitted to refer to their report and to their notes whilst giving evidence. 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. In complex cases it may assist to make your own evidential notes, maybe in the form of a 'mind map'; not only can this help you piece together the connections between the different items of evidence you have used, or disregarded, it can also help in thinking through how best to explain your conclusions and, importantly, what those who do not agree with you are likely to see as the weak points in your opinion.

Often, especially in complex cases, it is helpful to both lawyer and doctor to meet before the hearing in order to go through the evidence to be given. 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 barrister will anticipate cross examination points and rehearse them with the doctor in conference.

Perhaps unfairly, it is important for an expert entering a courtroom to give a good first impression. Dress formally – 'one stage more formally than you would 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 probably confuse yourself, use too many words, and so open up more avenues for challenge, and in any event you will be asked to slow down
- As far as possible, simplify your opinion, especially in front of a jury
- Use concrete metaphors in order to get over abstract concepts

- Avoid the use of jargon or, if you have to use it, simplify and explain it
- If you are asked a question implying a dichotomous choice of answers, then use 'Yes, but…' as a response; if you are challenged as being 'self re-examining' then resort to the judge and argue, if true, that to give a simple 'yes or no' reply will have the effect of misleading the court

Before the hearing itself

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

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

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

Check with the lawyer whether you may sit in court to hear other evidence being given, perhaps from another expert or the defendant.

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).

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

You will be 'called' to give evidence by the lawyer who has asked you to prepare the report. 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. Once there, you will be asked to take a religious oath or make the affirmation. This is a good point at which to 'get the measure of the hall', in public speaking terms, 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.

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

Examination in chief

The purpose of giving evidence is to help the judge and jury reach the correct conclusion in a case, not to help the legal representatives who requested your attendance at court; also, questions asked by counsel are asked always 'for the court', even though they may sound partisan. Hence, stand with your feet facing the judge and jury; this helps give the impression that you are talking directly to those who, in the end, have to reach a decision based on the evidence that they hear. The process of giving

evidence does not amount to a conversation with a barrister merely observed by others. 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 so by the court.

Some court rooms will have poor acoustics so it is important to speak loudly and clearly. Judges will often take detailed handwritten notes of the evidence given; and if you speak too fast you will be told to slow down; try to speak at a rate that 'follows the judge's pen'.

The examination in chief, which is conducted by the legal representative who instructed you to prepare your written report, cannot include leading questions.

This part of proceedings will typically start with the expert being invited to describe their experience and qualification.

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

Jargon should be avoided, or if unavoidable – for example, because another expert has used it – it should be explained in simple language. Giving oral evidence can be thought of as akin to teaching; the aim is to allow the jury – people who are very unlikely to have any specialist knowledge of psychiatry – to understand your opinion.

Juries often find it easier to understand a patient's mental condition if this is explained in terms of a narrative bringing together the various strands of evidence to which the expert has had access. The use of analogies and metaphors again can help explain difficult, often abstract concepts.

The examination in chief is a chance fully to describe your conclusions, and your reasoning; and the questions asked should be taken as an opportunity to give a full account of your opinion and the information and reasoning upon which it is based. Remember, however, that all that is said in this part of proceedings can be challenged in cross examination. Choose your words with great care, and avoid too many 'ways of saying the same thing' – since more words imply 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 jury.

Leading questions are allowed.

Keep calm, especially if your competence is questioned. It is perhaps useful to remind yourself that any attack is not personal; the legal representative is merely intellectually 'testing the evidence'.

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 members of the jury and judges, 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.

Be clear where your expertise ends; equally, express your view with confidence. If interrupted, finish your point, if necessary by way of recourse to the judge.

Beware of agreeing too readily with apparently innocuous propositions; 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 to dismantle it via 'a thousand cuts'; where proper, referring to aspects of your evidence, and of facts, which mutually reinforce one another will maintain the integrity of the evidence. The analogy of the building blocks of a structure reinforcing the support of one another is appropriate.

One of the roles of the judge is to ensure that the questioning process is fair and a witness can turn for guidance to the judge if 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.

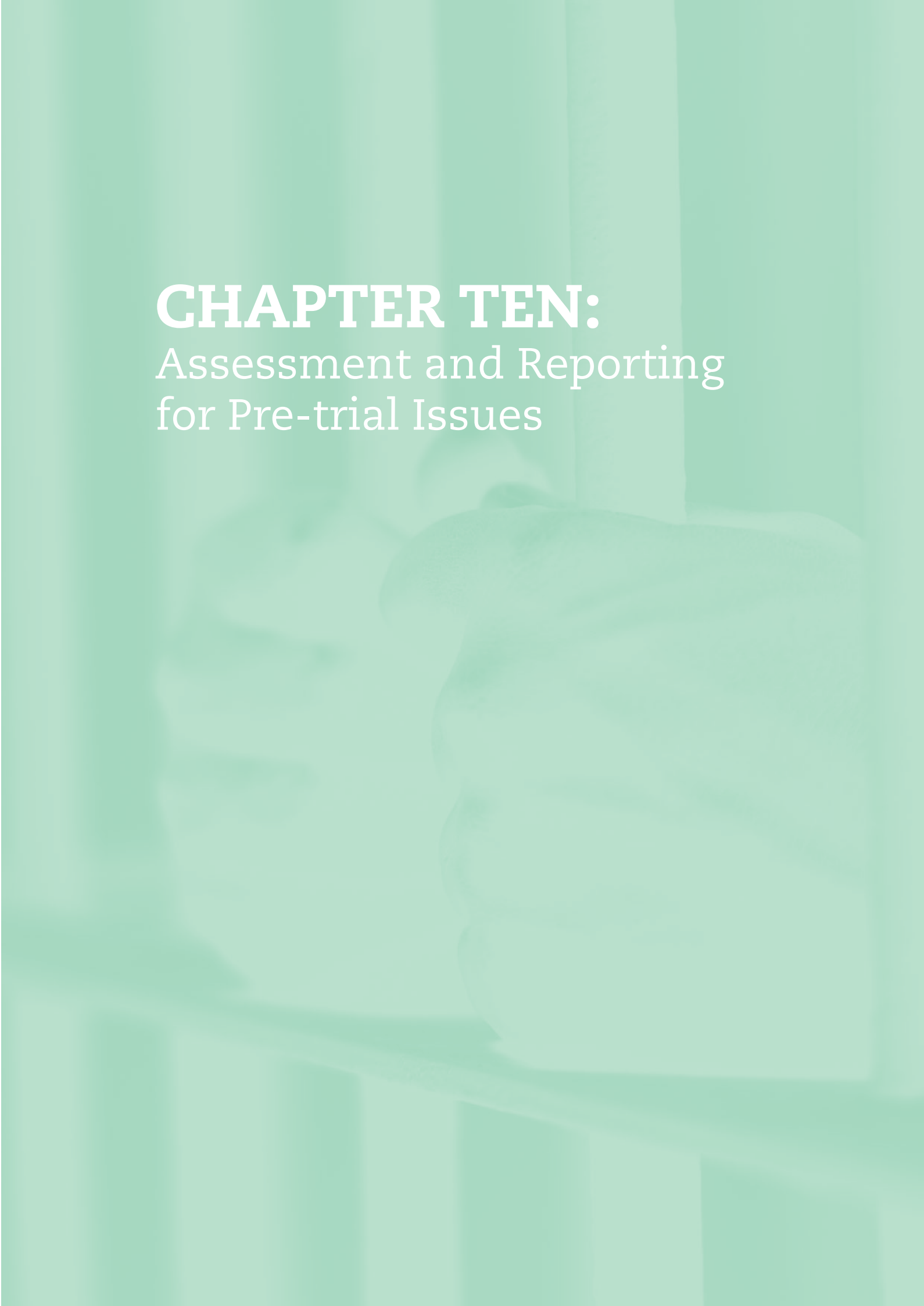
The barrister from your side will subsequently try to repair any damage done in cross examination by way of 're-examination'.

Re-examination

Re-examination is, like the examination in chief, 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. Re-examination is generally short if the process of cross examination has been unsuccessful in undermining the expert's opinion.

At the end of the evidence, and sometimes 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.

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 their having understood a caution, their fitness to be interviewed, or the 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, as well as to psychiatric evidence potentially relevant to non-psychiatric defences such as provocation, or the capacity to have formed the required intention for the offence charged, and these are considered in the next chapter.

Principles of assessing pre-trial issues

General principles of assessment will apply (see earlier chapter):

- Full psychiatric assessment
- Review all available information, specifically that which is 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 the available information in order to attempt to reconstruct the likely mental state at the time a police caution was delivered. This should include any witness statements referring to demeanour or behaviour, descriptions of the defendants' 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, 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:

- Would they have had the ability to understand the words and the meaning of those words?
- If not, why not? Were they likely preoccupied or distracted by psychosis? Did they possess insufficient intellectual capacity to understand?
- Was there intoxication with substances or were they suffering from withdrawal
- Could they consider the impact of the caution in deciding how to proceed?
- Have they confirmed their understanding, or acquiesced in response to direct or forceful questions relating to understanding?
- Has the caution be 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 nature of that participation. It is unlikely you will be asked to assess this at the time of any police interview, since this will usually be done by a Forensic Medical Examiner, commonly a general practitioner. The fact that another doctor thought, even at the time, that the defendant was fit to be interviewed is not necessarily definitive on the point, since they are not likely to have been a consultant psychiatrist, and might not have had had sufficient time to consider the issue in detail, or to have had access to background information about the defendant.

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 susceptible to methods or styles of questioning?

The transcript of the 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?

Reliability of confessions

Here 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 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 characterized by shouting, rudeness or threatening behaviour, combined with asking effectively leading questions, including questions that 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
- 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
- Learning disability impairing the ability to understand the questions 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.

In addition to usual interview recommendations consider the following issues:

- The transcripts of the interview
- Any records of rest or sleep
- Any evidence from transcripts or recordings of confusion or misunderstanding
- Any evidence from transcripts of changing 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 (this may reflect either *suggestibility* or *compliance)*

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, 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 in 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).

Fitness to plead and stand trial

The assessment of a defendant's fitness to plead and stand trial is based upon their mental state or condition at the time of trial. The trial can only proceed if the defendant is fit to plead and stand trial. Psychiatric and/or psychological evidence directed towards the issue is required, but the issue is ultimately determined legally. There might be subtle differences in the legal test for 'unfitness' in different jurisdictions, but in common law jurisdictions all derive from the case of *R v Pritchard:*

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

This is usually interpreted as relating to separate criteria:

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

Assessment should be as close to trial as possible, and if an assessment of fitness to plead is not close to trial then there should be re-assessment.

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

- 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 doing 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 assessment of fitness to plead and stand trial, although no mental disorder automatically confirms someone as unfit to plead, and there is no test that can *diagnose* someone as unfit to plead.

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

Psychosis and learning disability might be assumed to be the most relevant mental disorders, but even delusions about the facts relating to the case do not necessarily amount to unfitness; that is, there is legal distinction between 'unfitness' and 'failure to act in one's own best interest'.

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

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

The following symptoms or impairments might be relevant:

- Impairment in concentration
- Specific delusions or other psychotic symptoms relevant to entering a plea
- Memory impairment – not for the alleged offence, but so as directly to inhibit performance on one of the Pritchard criteria (see above)
- Global cognitive impairment

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 each of the criteria for fitness to plead, and whether or not the symptoms, impairments or disorders described impact on each of these abilities, and if so, in what manner (defendants are required to have all the abilities described, and so a failure on any will result in the opinion that they are unfit to plead). There should then be expression of opinion on
        - Whether they are unfit to plead and stand trial, on the basis of the absence of these abilities; this is unless there is any uncertainty about the way that the psychiatric

evidence relates to the legal test, including through any ambiguity there might be concerning the legal meaning of the test as it might apply to the defendant

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

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

Psychological assessment in fitness to plead

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

- Current intellectual functioning (IQ), for example the Weschler Adult Intelligence Scale (fourth edition). Individuals with low IQ are likely to have greater difficulty in understanding evidence which may either require special measures to assist them at court, or may be such as to imply that the person is not fit to plead. (The correct form to use in former British colonies that retain the English school system is the UK version)
- Language skills, for instance the British Picture Vocabulary Scale (version 2). This offers the assessor information concerning how well the individual understands a discussion, including inferences about how well they may understand discussion with their legal representatives, and how they may be able to manage in Court
- Memory functioning, for example the Weschler Memory Scale, version 4, or for more compromised individuals, the Rivermead Behavioural Memory Test (third edition). 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 which are 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'. However, it is crucial to know 'what is the test' which is at issue, in order to ensure that, in collecting clinical information, interpreting past clinical records and considering relevant legal documents, you act in a manner that can maximally assist legal determination.

Mental condition defences are either 'total', resulting in a finding of 'not guilty', or 'partial', resulting in a verdict of a lesser offence.

Psychiatric evidence can also be relevant to jury consideration of whether the defendant likely formed the *mens rea* (guilty mind) for the offence charged, even though there may be no question of a mental condition defence (though, of course, the expert must not offer an opinion on this 'ultimate issue').

Insanity

Insanity is a complete defence against any crime, and success in raising this defence results in a finding of 'not guilty by reason of insanity'. In most common law jurisdictions this implies very limited 'disposal' options, which are usually directed at treatment. Despite its name sounding medical, it is a legal test, legally defined, and in very narrow terms.

There is a general presumption of sanity and so the defence has to be raised, though in most jurisdictions this can be done not only by the defence side, but also by the prosecution or the judge.

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

- At the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, he did not know what he was doing was wrong

Disease of the mind is not determined by reference to a category or diagnosis of mental disorder but is defined solely legally. It incorporates disorders that affect both mind and brain and can include epilepsy, cerebro-vascular disease and metabolic diseases affecting cognitive functioning, which might not, for example, be seen by psychiatrists as amounting to mental illness.

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

Defect of reason amounts, from a psychiatric perspective, to a very narrow and restrictive disability; that is, a defect of cognition, not of emotion or volition.

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

Not knowing that the act was wrong is both a highly restricted form of 'defect of reason' in itself, and is further limited by being defined, in *R v Windle,* to mean not knowing that it was *legally* wrong, not whether it was *morally* wrong . However, it is a test which can be satisfied by the effects of psychosis having been present at the time of the offence. For example, a person who falsely believed that s/he was licensed by a secret service to kill people, such that, he was not acting unlawfully, would come within the terms of this limb of the test. It *might* also be argued that someone who, though capable of knowing that what he was doing was legally wrong, was, at the time of commission of the offence, so subject to 'psychotic drive' that he was not capable of paying attention to, or did not pay attention to, the legal wrongfulness of what he was doing. However, there is no legal decision in UK jurisdictions as yet which supports this legal contention.

There are variations of this test in different jurisdictions, and any mental health opinion should be considered in light of the test specific to that jurisdiction. Any opinion should include specific reference to the relevant test.

In summary terms, however, the defence of insanity is usually extremely narrowly defined, and therefore is applicable only to a small number of extremely psychotic or brain disordered defendants.

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

Clinical assessment

Any mental health expert addressing a case where insanity might apply must consider the likely mental state of the defendant solely at the time of the alleged offence, and in dissected detail. The assessment must go beyond making a diagnosis and retrospective determination of the likely mental state at the time of commission of the *actus reus* (guilty 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 the legality of their actions at the time; albeit a lack of knowledge now might tend to suggest a lack at the time of commission of the *actus reus* it is clearly not definitive of it
- The defendant's explanation for any behaviour suggesting knowledge of illegality

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

In regard to knowledge, or its lack, of the legality of the defendant's actions, consider whether any of the following apply:

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

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

Automatism

Automatism is a complete defence to any criminal charge. It is not identical to medical concepts of automatism. In law it is defined as the commission of an action that the mind of the defendant did not will. The defendant effectively pleads that their actions were completely involuntary. An impulsive or irresistible response is not an involuntary one. If automatism is argued successfully, then it results in total acquittal. Finally, an automatism can be defined as a sane, or insane automatism, dependent upon whether the cause of the automatism was a legal 'disease of the mind', as defined within the law relating to 'insanity' (see above). Hence, a finding of 'insane automatism' will amount to a finding of 'not guilty by reason of insanity' (see above).

Insane or non-insane automatism

The distinction between insane and non-insane automatism is not based on the presence at the time of a medical condition or diagnosis. If the cause is *intrinsic* to the defendant without any 'external blow' (for example, in a post concussion confusional state) then the cause of the automatism will be determined to have been a legal 'disease of the mind', and the automatism to have been an insane automatism. However, since *any* intrinsic factor can determine the presence of a legal disease of the mind, this can lead to incongruence with medical notions of 'disease', in that an epileptic seizure, parasomnia, hyperglycaemia arising from diabetes or cerebral ischaemia can lead to a finding of insane automatism, these not being conditions that psychiatrists would consider 'diseases of the mind'. However, less incongruity is inferred in relation to a state of 'dissociation', if the defendant has an inherent tendency mentally to dissociate.

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

Where the cause of the automatism was 'mental dissociation' (see below), and such dissociation resulted from an 'external blow', be it a physical or a psychological 'blow', the legal determination will be in terms of non-insane automatism. Hence, for example, mental dissociation triggered by

intense fear caused externally, as in battle, will amount to non-insane automatism. However, the presence of personality disorder, for example, 'emotionally unstable personality disorder', which renders the person more likely to dissociate will, if they did dissociate at the time of commission of the a*ctus,* result in a finding of 'insane automatism'. If the defendant was both more vulnerable to dissociation that the ordinary person *and* was subjected to an external blow, mental or physical, then it may be open to argument as to how the causal balance should be struck medically, and interpreted legally.

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

Clinical issues

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

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

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

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

Assessment of functional automatism is particularly difficult and problematic.

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

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

Depersonalisation and derealisation symptoms are suggestive of 'partial dissociation', which would not be sufficient for a finding of a legal automatism.

Capacity to form specific intent

The *mens rea* for an offence is the state of mind necessary for the defendant to be convicted of the offence charged. It is specific to the crime. The issue of whether the defendant had the required *mens rea* for the offence is not a question for expert comment, in that it goes to 'the ultimate issue' of guilt or innocence.

However, whether the defendant had *the capacity to form the required intent* can be commented upon by an expert, albeit determination both of this issue, and of whether the defendant did, in fact, form the required intent, is ultimately for the jury still to determine.

Offences are distinguished into those requiring 'specific intent' and those requiring only 'basic intent'. The distinction is not straightforward and there is little discernable logic underlying the two categories. Hence, any expert instructed should ask to be informed as to what the required intention is for the offence charged and whether the offence is one requiring specific, or only basic intent.

The commonest context of consideration of 'capacity to form specific intent' is that of 'voluntary intoxication', in that the only circumstances where such intoxication can absolve a defendant from responsibility is where they were so intoxicated that they were incapable of forming the required intent for the offence (*R v Majewski*). However, this potential defence is only available where the offence charged is one requiring 'specific', and not merely 'basic', intent.

Psychiatric evidence can also be relevant to jury consideration of whether the defendant, in fact, formed the relevant *mens rea*, beyond just whether s/he was capable of forming the intent, in that s/he may have suffered from a mental disorder which should be seen as affecting the likelihood that, on a particular occasion, s/he formed the relevant intention.

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

Clinical issues

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

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

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

Diminished responsibility

Diminished responsibility is a partial defence and available only in relation to a charge of murder in most common law jurisdictions. Hence, if the victim of a severe attack manages to 'cling onto life', such that the defendant can be charged only with attempted murder, it does not apply. The result of a successful plea is that the defendant is convicted of manslaughter rather than murder. It is a defence which can be raised only by the defence, such that, if the defendant refuses to plead it, he will be convicted of murder. This can cause major difficulties, and injustices, in that a floridly psychotic defendant, for example, may have a very strong defence available to him yet, because of his delusional beliefs, refuse to plead it. And, if he does not come within the very stringent legal terms of being 'unfit to plead' (see Chapter 10), he will be convicted of murder, when in 'natural justice' he should be convicted only of manslaughter. The impact of this injustice in a jurisdiction retaining the death penalty is obvious, in that such a defendant will thereby be vulnerable to such a sentence, albeit his disorder would be likely to result in him not being sentenced to death if the penalty is discretionary in nature.

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

The legal test in regard to 'diminished responsibility' in most common law jurisdictions is that a person shall not be convicted of murder if:

- 'He was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent cause or induced by disease or injury) as *substantially impaired his mental responsibility* for his acts and omissions in doing or being a party to the killing'.[12] [13]

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

There is no psychiatric disorder that automatically qualifies as 'abnormality of mind' and so, whilst mental health evidence is essential to support the determination (*R v Dix*), it is ultimately that which the reasonable man would term 'abnormal'.

Schizophrenia and paranoid psychosis, mood disorders and learning disability might be obvious qualifying disorders; however, personality disorder, pre-menstrual stress. post-natal depression, battered woman syndrome, alcohol dependence syndrome and post-traumatic stress disorder have, been accepted as a diagnosis that forms the foundation of all this defence.

A diagnosis of 'substance dependence syndrome' cannot be used as the relevant 'abnormality of mind' within the defence, unless it was such as to cause 'irresistible impulse to take the first drink (or drug) of the day', such that the intoxication ceases to be viewed as 'voluntary' (*R v Tandy*).[14]

The 'second limb' of the test is not clearly ultimately for expert evidence comment, in that 'mental responsibility' is not a medical concept. However, clearly expert evidence will assist its legal determination. That is, an expert may properly describe the nature of the defendant's likely abnormal mental state at the time of the killing. S/he may also properly describe how that abnormal mental state likely contributed to the 'narrative' of the offence, whilst leaving the jury to determine whether that 'translates' reasonably into substantial impairment of mental responsibility.

A further reason for not commenting upon 'diminished responsibility' per se is that there may be evidence in dispute, concerning likely symptoms (based upon witness evidence) or concerning the 'narrative' of the killing, which the jury will have to determine before deciding upon the relevance of any expertly described likely mental state abnormalities.

The abnormality of mind that has been described should therefore be discussed in terms of emotional state, perception, cognition, consciousness and volition, plus the likely effects on behaviour. For example, if a person was in a state of depression with psychosis, then there may likely have been

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

[13] Reform in England and Wales, under S52, Coroners and Justice Act, 2009, has substituted a much more 'medically based' definition of 'diminished responsibility', written in terms of the defendant having been subject to 'substantially impaired capacity to understand their own actions, or to exercise rational judgment, or to exercise self control', 'arising from a recognised medical condition', which caused ... meaning was a significant contributory factor in causing, the killing', without any reference to 'mental responsibility' per se)

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

an impairment of their ability to appreciate long-term consequences of their actions (individuals who are depressed typically 'see no further than the end of their noses', through preoccupation); or their perception of the actions of others, their perception of their own self-worth or their ability to concentrate or comprehend a situation may have been impaired. Description of the likely impact of any such mental abnormalities on behaviour, including in terms of a narrative of the killing, may then allow a jury to make a decision on the ultimate issue as to whether this was sufficient substantially to impair their mental responsibility.

Clinical issues

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

General advice on assessment applies. In particular, however, any mental symptoms present at the time of the killing should be described. Mental symptoms both prior and subsequent to the time of the offence will inform. However, unless there was a clinical assessment close to that time, what will be required is retrospective reconstruction from clinical interview, aided by additional information about 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 killing.

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

Provocation

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

In broad terms, provocation requires:

- *Sudden and temporary loss of mastery over the mind* (*R v Duffy*) (the 'subjective test')[15]
- Caused by *things said or done* by the victim (sometimes by another)
- The requirement that the things said or done would have caused a loss of self-control in a *reasonable person* (the 'objective test')

[15] Within law in England and Wales, the defence has been abolished, with substitution, by way of S53, Coroners and Justice Act 2009, of a defence of 'loss of control'; this 'need not be sudden', but the required objective level of 'trigger' ('things said or done') has been raised substantially, and 'sexual infidelity' is explicitly excluded as a potential trigger (although it can form 'a trigger with other triggers', see R v Clinton)

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

And expert evidence can be relevant evidence in regard to both the objective and subjective tests.

The subjective test

As regards the subjective test, expert medical evidence of abnormality at the time of the killing, albeit insufficient for 'diminished responsibility', may serve to suggest that there was, in fact, loss of mastery over the mind.

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

Examples include:

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

Where the factor relates specifically to their 'woundability' in response to things said or done (not their general violent 'reactivity'), then it may also be relevant to the objective test (see below).

The objective reasonable person

As regards the objective test, expert evidence in relation to the defendant's particular susceptibility to being 'woundable' by particular things said or done may be relevant to consideration of whether someone with those 'characteristics' of the defendant would reasonably have lost mastery over their mind. Excluded, however, are any characteristics which go merely to his general violent 'reactivity'.

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

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

The defences of 'diminished responsibility' and 'provocation' can be pleaded 'in tandem', and so some aspects of a given body of expert psychiatric evidence can often be applied to both defences, within the terms of different legal relevance.

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 either discussing or acknowledging an offence, or could 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 the defendant lacked the capacity to form the requisite *mens rea* for the alleged offence?
- Does the amnesia suggest any mental condition which might come within the terms of another defence, or partial defences, for example, insanity, diminished responsibility, or provocation?
- Is there any indication of a more generalized 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 generalized 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 a defence to any criminal offence, unless it results in incapacity to form intent where the offence charged is requiring of 'specific intent' (see above).

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

The *mens rea* must be established irrespective of intoxication. If it can be shown that the *mens rea* (usually intent) was formed before the intoxication, then conviction can be based on this. If the criminal behaviour was to some extent predictable upon intoxication, then the doctrine of 'prior fault' applies, and the mental state effects of intoxication are irrelevant (unless the defendant was so intoxicated as to have been incapable of forming the required specific intent for the offence (see above)).

As regards intoxication within other defences, see above.

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

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 generally tend to be much more 'graded' in nature, or in their implications. 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.

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, in terms of their proximity to, and influence over the determination of 'doing harm', that is, maleficence (see Chapter 15 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, and can include factors relating to mental health and personality. Within jurisdictions retaining the discretionary death penalty, psychiatric and psychological factors which at trial fell short of laying the foundation for a mental condition defence, or partial defence, can take on great significance in terms loosely of 'mitigation', or in terms of relevance to one of the recently established legal tests applied within discretionary capital sentencing – those of 'beyond reformation' and 'the worst of the worst' (see below).

The role of mental disorder

The presence of mental disorder is important, arising from the common law principle which prohibits imposition of the death penalty, or execution per se, on anyone with mental disorder (those who are *idiots* or *insane)*. 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, unless there is a mandatory sentence applicable on conviction of the offence per se.

Where sentencing is discretionary, or can be graded, mental health expertise can be relevant to its determination. 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, and 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.

The essence of mitigation legally lies in consideration of either/both the nature of the offence per se, and its severity, or/and in the nature of the defendant; and it is in the latter 'characterological' regard that expert psychiatric and psychological evidence, both in terms of disorder per se, or symptoms, and in terms of risk assessment, that expert evidence may be considered relevant to the discretionary imposition of the death penalty.

There are two legal criteria established in regard to discretionary imposition of the death penalty.

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 (akin to consideration at trial of both the *actus reus a*nd the *mens rea*)

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

Common factors considered generally relevant as mitigating factors include:

- Abnormal mental state at time of offence
- Abnormal mental state at time of sentence
- Young age at time of 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', compared to 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 s/he was limited in her/his ability to follow social, moral or legal norms
- The defendant is learning disabled
- The defendant's character is 'abnormal'

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

current mental state. The presence of mental disorder can be crucial to the non-application of the death penalty, and can still be relevant even if a jury has rejected the mental disorder in relation to a mental condition defence at trial.

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

More generally, there should be care to avoid becoming 'an advocate' for the defendant, whatever your beliefs and personal values about the death penalty, and you should also refrain from excusing or defending the defendant, thereby resorting to moral judgment, which judgment 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 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-IV diagnosis.

There should be specific inquiry about sexual abuse, physical abuse, 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 judgment 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?
- What effect did adverse experiences in their early life (for example, physical or emotional trauma, abuse, neglect) have upon their development?
- 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 and friends
- Police records, statements and court transcripts
- Previous probation records

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, as well as 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 victimization 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 no 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 that does not depend upon, and even eschews, 'diagnosis', and emphasises 'understanding (even normal) behaviour', so that their approach may be more flexible.

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

Categorisation of someone as having 'high-' 'medium-' or '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, 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. So 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 20 or 30 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 than for 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 imply 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 per cent risk of committing an act of serious violence in prison then that does not equate with saying that there is a 40 per cent probability that the defendant under consideration will commit an act of serious violence
- Make clear if your risk assessment is not validated on the population or context you are considering
- Make clear the period of time over which any risk prediction applies; available 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

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

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 both the thinking and mental state of the defendant at the time he committed the offence (see above).

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

However, the ultimate question about whether an offence is sufficiently heinous to be considered 'the worst of the worst' should not be addressed by a mental health expert.

Beyond reformation

Only a defendant who has committed an offence which is 'the worst of the worst' *and* who is considered 'beyond reformation' will be properly sentenced to death. As already described above, psychiatric and psychological data and opinion can be directly applied to this test, both in regard to 'risk assessment' and in regard to 'treatability'. The former is naturally linked to the latter, but risk can be reduced by 'external' measures (such as mode of containment) and therefore without the prospect of successful treatment (which might reasonably imply 'some measure of change within the defendant' operating as a means towards risk management and reduction). (See generally Chapter 7)

Psychological assessment and possibility of reformation

When considering an individual's suitability for psychological treatment, which may then suggest the capacity for 'reform', including via risk reduction, it is particularly important to consider the following questions:

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

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

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

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 Mercy Hearings

The mercy stage will be the only post trial stage at which mental health evidence is considered in mitigation, in jurisdictions where the death penalty is mandatory. The presence of mental disorder will therefore be particularly important to describe in these jurisdictions. Although there is a legal requirement for legal representation at a mercy hearing, there are no legal tests established relevant to the exercise of mercy. Indeed, this is unsurprising given that the hearing is not a court hearing, but a hearing conducted by the executive. The extent or severity of mental disorder 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 that severe mental illnesses such as schizophrenia or mental retardation will result in mercy, but it is less clear whether milder (less than diagnosable) mental retardation, personality disorder or milder forms of mental illness, such as less than psychotic depression, will likely result in the exercise of mercy.

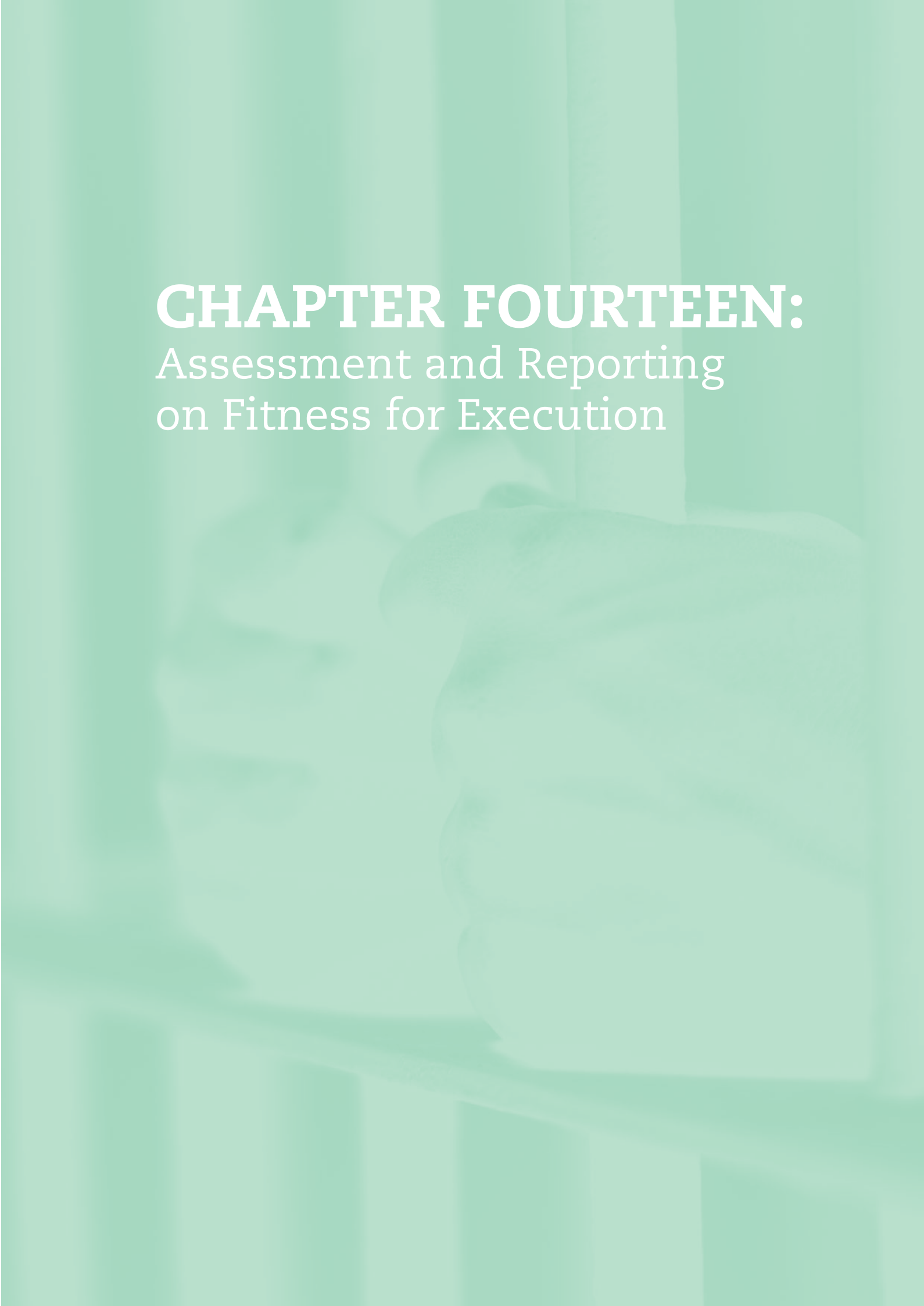
Clinical assessment

Since there are no legally defined criteria for the exercise of mercy – merely an argument that, in natural justice, mercy should be extended to 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



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

Comprehension of execution

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

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

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

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

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

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

Assessment and reporting on fitness for execution

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

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), perhaps the most difficult question to answer. And 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. Also 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 in 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.

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 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 in ensuring that skills are applied fairly, as they would be clinically in a non-litigious situation, and that one is insightful into the risk of bias arising from applying medical ethical principles to an essentially legal context. 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 frequently written in such broad terms as often to be less than fully helpful within the circumstances of an individual case and dilemma. Such codes are also not substitutes for good ethical reasoning.

Each professional will have a set of ethical codes that they are bound to consider. The World Psychiatric Association (WPA), the American Psychiatric Association (APA) and the General Medical Council (GMC) all publish ethical codes. Similar codes exist for psychologists. The American Academy of Psychiatry and the Law publishes ethical guidance for the practice of forensic psychiatry.

Some overall 'national' codes concerned with the practice of forensic psychiatry include within them codes 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 the personal values 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 then 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 on 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 to offer treatment, although you might recommend treatment in some cases. And there is clearly an even greater need for a defendant to be fully informed of all of the foregoing prior to an assessment in a capital case.

Clinician or forensicist

A major ethical debate has been pursued, particularly in the United States for at least two decades, concerning the role of doctors in criminal proceedings, including capital proceedings, specifically in terms of whether they set aside their medical identity – and ethical principles associated with that identity – when they assess a defendant. That is, whether the medical ethical duty of 'non-maleficence' simply does not apply to a doctor assessing a defendant, because, in that context, the doctor's sole duty is to 'justice', and to the court.

In validating this ethical approach, it is suggested that the doctor assessing a defendant is not 'being a doctor'; rather s/he is being 'a 'forensicist', somewhat akin to being a forensic scientist.

However, forensic scientists do not deal directly with individuals to whom they might owe a duty, 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 a suspect in a murder inquiry for his 'competence to be interviewed', or to assess a defendant for his 'fitness to plead', or whether he has available to him a 'mental condition defence', yet be unprepared to be involved in one or more stages that apply after conviction.

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 or her 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 only be, as in regard to sentencing or mercy hearings, by way of finding no relevant disorder

Treatment to restore competence to be executed

The treatment of a mentally disordered prisoner *solely* for the purpose of restoring their competence to be executed is considered by almost all medical bodies to be unethical.

However, where a convict is in extreme mental distress, arising from a treatable mental condition, 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 clinico-legal ethical dilemmas they have encountered, in the hope that open dialogue will serve to enhance ethical practice in this very difficult field.

APPENDICES:

Appendix One: Psychological Assessment Quick Reference Guide

Psychological Factor	Psychometric test
Current general intelligence	• Wechsler Adult Intelligence Scale, fourth edition (WAIS-IV) • Ravens Progressive Matrices
Pre-morbid estimate of intellectual functioning	• National Adult Reading Test (NART) • Schonell Graded Reading Test • Wechsler Test of Adult Reading (WTAR) • Wechsler Test of Pre-morbid Functioning (TOPF)
Memory functioning	• Wechsler Memory Scale, fourth edition (WMS-IV) • Rey-Ostreith Complex Figure Test
Executive functioning	• Behavioural Assessment of Dysexecutive Syndrome (BADS) • Controlled Oral Work Association Test • Reitan Trailmaking test • Haying and Brixton tests • Stroop Neuropsychological Screening Test
Language	• British Picture Vocabulary Scale (version 2) • Graded Naming Test
Suggestibility	Gudjonsson Suggestibility Scale (version 1 or 2)
Compliance	Gudjonsson Compliance Scale (Form D for the individual or Form E for an informant)
Mood	• Beck Anxiety Inventory (BAI) • Beck Depression Inventory version two (BDI-II) • Hospital Anxiety and Depression Scale (HADS) • State/Trait Anger inventory (STAXI)
Personality functioning	• Millon Clinical Multi-axial Inventory – third edition (MCMI-III) • Minnesota Multiphasic Personality Inventory (MMPI) • Personality Assessment Inventory (PAI)
Substance misuse	• Leeds Dependency Questionnaire (LDQ) • Sensation Seeking Scale (SSS)
Dissociation	Dissociative Experiences Scale (DES)
Sub-optimal effort/ malingering	• Test of Memory Malingering (TOMM) • Ravens Standard Progressive Matrices • Millar Forensic Assessment of Symptoms (MFAST) • Structured interview of Reported Symptoms (SIRS) • Structured Inventory of Malingered Symptomatology (SIMS) • Paulhus Deception Scale

NB: *This is not an exhaustive list, but represents some of the most commonly used measures with robust psychometric properties.*

Appendix 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.

ICD10 code	DSM code	Diagnosis
F00-09		*Organic mental disorders*
F00.0	290.10	Dementia in Alzheimer's disease with early onset
F00.1	290.0	Dementia in Alzheimer's disease with late onset
F00.2	294.1	Dementia in Alzheimer's disease, atypical or mixed type
F00.9	294.1	Dementia in Alzheimer's disease, unspecified
F01.0	290.40	Vascular dementia of acute onset
F01.1	290.40	Multi-infarct dementia
F01.2	290.40	Subcortical vascular dementia
F01.3	290.40	Mixed cortical and subcortical vascular dementia
F01.8	290.40	Other vascular dementia
F01.9	290.40	Vascular dementia, unspecified
F02.0	290.10	Dementia in Pick's disease
F02.1	290.10	Dementia in Creutzfeldt-Jakob disease
F02.2	294.1	Dementia in Huntington's disease
F02.3	294.1	Dementia in Parkinson's disease
F02.4	294.1	Dementia in human immunodeficiency virus [HIV] disease
F02.8	294.1	Dementia in other specified diseases classified elsewhere
F03	294.8	Unspecified dementia
A fifth character may be added to F00–F03, as follows:		
.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

F05.0	293.0	Delirium, not superimposed on dementia, so described
F05.1	293.0	Delirium, superimposed on dementia
F05.8	293.0	Other delirium
F05.9	780.09	Delirium, unspecified
F06.0	293.82	Organic hallucinosis
F06.1	293.89	Organic catatonic disorder
F06.2	293.81	Organic delusional [schizophrenia-like] disorder
F06.3	293.83	Organic mood [affective] disorders
F06.30	293.83	Organic manic disorder
F06.31	293.83	Organic bipolar affective disorder
F06.32	293.83	Organic depressive disorder
F06.33	293.83	Organic mixed affective disorder
F06.4	293.84	Organic anxiety disorder
F06.5	293.9	Organic dissociative disorder
F06.6	293.9	Organic emotionally labile [asthenic] disorder
F06.7	294.9	Mild cognitive disorder
F06.8	293.9	Other specified mental disorders due to brain damage etc.
F06.9	293.9	Unspecified mental disorder due to brain damage etc.
F07.0	310.1	Organic personality disorder
F07.1	310.1	Postencephalitic syndrome
F07.2	310.1	Postconcussional syndrome
F07.8	310.1	Other organic personality and behavioural disorder
F09	293.9	Unspecified organic or symptomatic mental disorder

F10-19		*Mental/behavioural disorders due to substance use*
F10.00	303.00	Acute alcohol intoxication – uncomplicated
F10.01	303.00	Acute alcohol intoxication – with bodily trauma or injury
F10.02	303.00	Acute alcohol intoxication – with other medical complications
F10.03	291.0	Acute alcohol intoxication – with delirium
F10.04	303.00	Acute alcohol intoxication – with perceptual distortions
F10.05	303.00	Acute alcohol intoxication – with coma
F10.06	303.00	Acute alcohol intoxication – with convulsions
F10.07	303.00	Acute alcohol intoxication – pathological intoxication
F10.1	305.00	Harmful alcohol use
F10.20	303.90	Alcohol dependence – currently abstinent
F10.21	303.90	Alcohol dependence – abstinent in a protected environment
F10.22	303.90	Alcohol dependence – on a maintenance/replacement regime
F10.23	303.90	Alcohol dependence – abstinent, receiving drug treatment
F10.24	303.90	Alcohol dependence – currently using alcohol
F10.25	303.90	Alcohol dependence – continuous use

F10.26	303.90	Alcohol dependence – episodic use (dipsomania)
F10.30	291.81	Alcohol withdrawal – uncomplicated
F10.31	291.81	Alcohol withdrawal – with convulsions
F10.40	291.0	Alcohol withdrawal – with delirium but without convulsions
F10.41	291.0	Alcohol withdrawal – with delirium and convulsions
F10.50	291.9	Alcohol-induced psychosis schizophrenia-like
F10.51	291.9	Alcohol-induced psychosis, predominantly delusional
F10.52	291.9	Alcohol-induced psychosis, predominantly hallucinatory
F10.53	291.9	Alcohol-induced psychosis, predominantly polymorphic
F10.54	291.9	Alcohol-induced psychosis, predominantly depressive
F10.55	291.9	Alcohol-induced psychosis, predominantly manic
F10.56	291.9	Alcohol-induced psychosis, mixed
F10.60	291.1	Alcohol-induced amnesic syndrome
F10.70	291.9	Alcohol-induced residual disorder- flashbacks
F10.71	291.9	…residual disorder – personality or behaviour disorder
F10.72	291.9	… residual disorder – residual affective disorder
F10.73	291.2	… residual disorder – dementia
F10.74	291.9	… residual disorder – other persisting cognitive impairment
F10.75	291.9	… residual disorder – late-onset psychotic disorder
F10.80	291.9	Other mental/behavioural disorder related to alcohol use
F10.90	291.9	Unspecified mental /behavioural disorder related to alcohol use

Conditions related to use of substances other than alcohol follow the same general pattern. Each has a different DSM code for harmful use (abuse) and for dependence (all subtypes). The digit shown as 'x' in the ICD codes indicates the substance concerned, as follows:

	Abuse	Dependence	Substance
x=1	305.50	304.00	Opioids
x=2	305.20	304.30	Cannabinoids
x=3	305.40	304.10	Sedatives or hypnotics
x=4	305.60	304.20	Cocaine
x=5	305.90	304.90	Other stimulants, including caffeine
x=6	305.30	304.50	Hallucinogens
x=7	305.90	305.10	Tobacco
x=8	305.90	304.60	Volatile solvents
x=9	305.90	304.90	Multiple drugs or other substances

F1x.00	292.89	Acute intoxication – uncomplicated
F1x.01	292.89	Acute intoxication – with trauma or other bodily injury
F1x.02	292.89	Acute intoxication – with other medical complications
F1x.03	292.89	Acute intoxication – with delirium
F1x.04	292.89	Acute intoxication – with perceptual distortions
F1x.05	292.89	Acute intoxication – with coma
F1x.06	292.89	Acute intoxication – with convulsions

F1x.07	292.89	Acute intoxication - pathological intoxication
F1x.1	above	Harmful use
F1x.20	above	Dependence – currently abstinent
F1x.21	above	Dependence – abstinent in a protected environment
F1x.22	above	Dependence – on a maintenance/replacement regime
F1x.23	above	Dependence – abstinent, receiving drug treatment
F1x.24	above	Dependence – currently using the substance
F1x.25	above	Dependence – continuous use
F1x.26	above	Dependence – episodic use
F1x.30	292.0	Withdrawal state – uncomplicated
F1x.31	292.0	Withdrawal state – with convulsions
F1x.40	292.0	Withdrawal state – with delirium but without convulsions
F1x.41	292.0	Withdrawal state – with delirium and convulsions
F1x.50	292.9	Substance-induced psychosis, schizophrenia-like
F1x.51	292.9	Substance-induced psychosis, predominantly delusional
F1x.52	292.9	Substance-induced psychosis, predominantly hallucinatory
F1x.53	292.9	Substance-induced psychosis, predominantly polymorphic
F1x.54	292.9	Substance-induced psychosis, predominantly depressive
F1x.55	292.9	Substance-induced psychosis, predominantly manic
F1x.56	292.9	Substance-induced psychosis, mixed
F1x.6	292.83	Substance-induced amnesic syndrome
F1x.70	292.9	Substance-induced residual disorder- flashbacks
F1x.71	292.9	… residual disorder – personality or behaviour disorder
F1x.72	292.9	… residual disorder – residual affective disorder
F1x.73	292.82	… residual disorder – dementia
F1x.74	292.9	… residual disorder – other persisting cognitive impairment
F1x.75	292.9	… residual disorder – late-onset psychotic disorder
F1x.8	292.9	Other substance-related mental/behavioural disorders
F1x.9	292.9	Unspecified substance-related mental/behavioural disorder

F20-29		*Schizophrenia, schizotypal and delusional disorders*
F20.0	295.30	Paranoid schizophrenia
F20.1	295.10	Hebephrenic schizophrenia
F20.2	295.20	Catatonic schizophrenia
F20.3	295.90	Undifferentiated schizophrenia
F20.4	311	Post-schizophrenic depression
F20.5	295.60	Residual schizophrenia
F20.6	295.90	Simple schizophrenia
F20.8	295.90	Other schizophrenia
F20.9	295.90	Schizophrenia, unspecified

A fifth character may be used to classify course:	
.x0	Continuous
.x1	Episodic with progressive deficit
.x2	Episodic with stable deficit
.x3	Episodic remittent
.x4	Incomplete remission
.x5	Complete remission
.x6	Other
.x9	Course uncertain, period of observation too short

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

F30-39		*Mood [affective] disorders*
F30.0	296.00	Hypomania
F30.1	296.03	Mania without psychotic symptoms
F30.2	296.04	Mania with psychotic symptoms
F30.8	296.00	Other manic episodes
F30.9	296.00	Manic episode, unspecified
F31.0	296.40	Bipolar disorder, current episode hypomanic
F31.1	296.43	Bipolar disorder, manic without psychotic symptoms
F31.2	296.44	Bipolar disorder, manic with psychotic symptoms
F31.30	296.52	Bipolar disorder, mild or moderate non-somatic depression
F31.31	296.52	Bipolar disorder, mild or moderate somatic depression

F31.4	296.53	Bipolar disorder, severe non-psychotic depression
F31.5	296.54	Bipolar disorder, severe psychotic depression
F31.6	296.60	Bipolar disorder, current episode mixed
F31.7	296.66	Bipolar disorder, currently in remission
F31.8	296.7	Other bipolar affective disorders
F31.9	296.7	Bipolar affective disorder, unspecified
F32.00	296.21	Mild depressive episode without somatic syndrome
F32.01	296.21	Mild depressive episode with somatic syndrome
F32.10	296.22	Moderate depressive episode without somatic syndrome
F32.11	296.22	Moderate depressive episode with somatic syndrome
F32.2	296.23	Severe depressive episode without psychotic symptoms
F32.3	296.24	Severe depressive episode with psychotic symptoms
F32.8	311	Other depressive episodes
F32.9	311	Depressive episode, unspecified
F33.00	296.31	Recurrent depression, mild without somatic syndrome
F33.01	296.31	Recurrent depression, mild with somatic syndrome
F33.10	296.32	Recurrent depression, moderate without somatic syndrome
F33.11	296.32	Recurrent depression, moderate with somatic syndrome
F33.2	296.33	Recurrent depression, current episode severe non-psychotic
F33.3	296.34	Recurrent depression, current episode severe psychotic
F33.4	296.36	Recurrent depression, currently in remission
F33.8	296.30	Other recurrent depressive disorders
F33.9	296.30	Recurrent depressive disorder, unspecified
F34.0	301.13	Cyclothymia
F34.1	300.4	Dysthymia
F34.8	296.90	Other persistent mood [affective] disorders
F34.9	296.90	Persistent mood [affective] disorder, unspecified
F38.0	296.90	Mixed affective episode
F38.1	296.90	Recurrent brief depressive disorder
F38.8	296.90	Other specified mood [affective] disorders
F39	296.90	Unspecified mood [affective] disorder

F40-49		*Neurotic, stress-related and somatoform disorders*
F40.00	300.22	Agoraphobia without panic disorder
F40.01	300.21	Agoraphobia with panic disorder
F40.1	300.23	Social phobias
F40.2	300.29	Specific (isolated) phobias
F40.8	300.29	Other phobic anxiety disorders
F40.9	300.29	Phobic anxiety disorder, unspecified
F41.0	300.01	Panic disorder [episodic paroxysmal anxiety]

F41.1	300.02	Generalized anxiety disorder
F41.2	300.00	Mixed anxiety and depressive disorder
F41.3	300.00	Other mixed anxiety disorders
F41.8	300.00	Other specified anxiety disorders
F41.9	300.00	Anxiety disorder, unspecified
F42.0	300.3	Predominantly obsessional thoughts or ruminations
F42.1	300.3	Predominantly compulsive acts [obsessional rituals]
F42.2	300.3	Mixed obsessional thoughts and acts
F42.8	300.3	Other obsessive – compulsive disorders
F42.9	300.3	Obsessive – compulsive disorder, unspecified
F43.0	308.3	Acute stress reaction
F43.1	309.81	Post-traumatic stress disorder
F43.20	309.9	Brief depressive reaction
F43.21	309.9	Prolonged depressive reaction
F43.22	309.9	Mixed anxiety and depressive reaction
F43.23	309.9	With predominant disturbance of other emotions
F43.24	309.9	With predominant disturbance of conduct
F43.25	309.9	With mixed disturbance of emotions and conduct
F43.28	309.9	With other specified predominant symptoms
F43.8	308.3	Other reactions to severe stress
F43.9	308.3	Reaction to severe stress, unspecified
F44.0	300.12	Dissociative amnesia
F44.1	300.13	Dissociative fugue
F44.2	300.15	Dissociative stupor
F44.3	300.15	Trance and possession disorders
F44.4	300.15	Dissociative motor disorders
F44.5	300.15	Dissociative convulsions
F44.6	300.15	Dissociative anaesthesia and sensory loss
F44.7	300.15	Mixed dissociative [conversion] disorders
F44.80	300.11	Ganser's syndrome
F44.81	300.14	Multiple personality disorder
F44.82	300.11	Transient childhood/adolescent dissociative disorders
F44.88	300.11	Other specified dissociative [conversion] disorders
F44.9	300.15	Dissociative [conversion] disorder, unspecified
F45.0	300.81	Somatisation disorder
F45.1	300.82	Undifferentiated somatoform disorder
F45.2	300.7	Hypochondriacal disorder
F45.30	300.82	Somatoform autonomic dysfunction – cardiovascular system
F45.31	300.82	Somatoform autonomic dysfunction – upper GI tract
F45.32	300.82	Somatoform autonomic dysfunction – lower GI tract
F45.33	300.82	Somatoform autonomic dysfunction – respiratory system

F45.34	300.82	Somatoform autonomic dysfunction – genitourinary system
F45.38	300.82	Somatoform autonomic dysfunction – other organ or system
F45.4	307.80	Persistent somatoform pain disorder
F45.8	300.82	Other somatoform disorders
F45.9	300.82	Somatoform disorder, unspecified
F48.0	300.82	Neurasthenia
F48.1	300.6	Depersonalization – derealisation syndrome
F48.8	300.9	Other specified neurotic disorders
F48.9	300.9	Neurotic disorder, unspecified

F50-59		*Behavioural syndromes associated with physical factors*
F50.0	307.1	Anorexia nervosa
F50.1	307.1	Atypical anorexia nervosa
F50.2	307.51	Bulimia nervosa
F50.3	307.51	Atypical bulimia nervosa
F50.4	307.50	Overeating associated with other psychological disturbances
F50.5	307.50	Vomiting associated with other psychological disturbances
F50.8	307.50	Other eating disorders
F50.9	307.50	Eating disorder, unspecified
F51.0	307.42	Nonorganic insomnia
F51.1	307.44	Nonorganic hypersomnia
F51.2	307.45	Nonorganic disorder of the sleep-wake schedule
F51.3	307.46	Sleepwalking [somnambulism]
F51.4	307.46	Sleep terrors [night terrors]
F51.5	307.47	Nightmares
F51.8	307.47	Other nonorganic sleep disorders
F51.9	307.47	Nonorganic sleep disorder, unspecified
F52.0	302.71	Lack or loss of sexual desire
F52.10	302.79	Sexual aversion
F52.11	302.79	Lack of sexual enjoyment
F52.2	302.72	Failure of genital response
F52.3	302.70	Orgasmic dysfunction
F52.4	302.75	Premature ejaculation
F52.5	306.51	Nonorganic vaginismus
F52.6	302.76	Nonorganic dyspareunia
F52.7	302.9	Excessive sexual drive
F52.8	302.70	Other sexual dysfunction, not caused by organic disorders
F52.9	302.70	Unspecified non-organic sexual dysfunction
F53.0	293.9	Mild puerperal mental and behavioural disorders
F53.1	293.9	Severe puerperal mental and behavioural disorders

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

F60-69		*Disorders of adult personality and behaviour*
F60.0	301.0	Paranoid personality disorder
F60.1	301.20	Schizoid personality disorder
F60.2	301.7	Dissocial personality disorder
F60.30	301.9	Emotionally unstable personality disorder, impulsive type
F60.31	301.83	Emotionally unstable personality disorder, borderline type
F60.4	301.50	Histrionic personality disorder
F60.5	301.4	Anankastic [obsessive-compulsive] personality disorder
F60.6	301.82	Anxious [avoidant] personality disorder
F60.7	301.6	Dependent personality disorder
F60.8	301.81	Narcissistic personality disorder
F60.8	301.9	Other specific personality disorders
F60.9	301.9	Personality disorder, unspecified
F61.0	301.9	Mixed personality disorders
F61.1	301.9	Troublesome personality changes
F62.0	301.9	Enduring personality change after catastrophic experience
F62.1	301.9	Enduring personality change after psychiatric illness
F62.8	301.9	Other enduring personality changes
F62.9	301.9	Enduring personality change, unspecified
F63.0	312.31	Pathological gambling
F63.1	312.33	Pathological fire-setting [pyromania]
F63.2	312.32	Pathological stealing [kleptomania]
F63.3	312.39	Trichotillomania
F63.8	312.30	Other habit and impulse disorders
F63.9	312.30	Habit and impulse disorder, unspecified
F64.0	302.85	Transsexualism

F64.1	302.85	Dual-role transvestism
F64.2	302.6	Gender identity disorder of childhood
F64.8	302.6	Other gender identity disorders
F64.9	302.6	Gender identity disorder, unspecified
F65.0	302.81	Fetishism
F65.1	302.3	Fetishistic transvestism
F65.2	302.4	Exhibitionism
F65.3	302.82	Voyeurism
F65.4	302.2	Paedophilia
F65.5	302.9	Sadomasochism
F65.6	302.9	Multiple disorders of sexual preference
F65.8	302.9	Other disorders of sexual preference
F65.9	302.9	Disorder of sexual preference, unspecified
F66.0	302.6	Sexual maturation disorder
F66.1	302.6	Egodystonic sexual orientation
F66.2	302.6	Sexual relationship disorder
F66.8	302.6	Other psychosexual development disorders
F66.9	302.6	Psychosexual development disorder, unspecified
F66.90	302.6	Psychosexual development disorder, heterosexual
F66.91	302.6	Psychosexual development disorder, homosexual
F66.92	302.6	Psychosexual development disorder, bisexual
F66.98	302.6	Psychosexual development disorder, other incl. prepubertal
F68.0	300.9	Elaboration of physical symptoms for psychological reasons
F68.1	300.19	Factitious disorder
F68.8	301.9	Other specified disorders of adult personality and behaviour
F69	301.9	Unspecified disorder of adult personality and behaviour

F70-79		*Mental retardation [learning disability]*
F70	317	Mild mental retardation
F71	318.0	Moderate mental retardation
F72	318.1	Severe mental retardation
F73	318.2	Profound mental retardation
F78	319	Other mental retardation
F79	319	Unspecified mental retardation

A fourth character may be used for behavioural impairment	
F7x.0	No, or minimal, impairment of behaviour
F7x.1	Significant behavioural impairment requiring treatment
F7x.8	Other impairments of behaviour
F7x.9	Without mention of impairment of behaviour

F80-89		*Disorders of psychological development*
F80.0	315.39	Specific speech articulation disorder
F80.1	315.31	Expressive language disorder
F80.2	315.32	Receptive language disorder
F80.3	307.9	Acquired aphasia with epilepsy [Landau-Kleffner syndrome]
F80.8	307.9	Other developmental disorders of speech and language
F80.9	307.9	Developmental disorder of speech and language, unspecified
F81.0	315.00	Specific reading disorder
F81.1	315.2	Specific spelling disorder
F81.2	315.1	Specific disorder of arithmetical skills
F81.3	315.9	Mixed disorder of scholastic skills
F81.8	315.9	Other developmental disorders of scholastic skills
F81.9	315.9	Developmental disorder of scholastic skills, unspecified
F82	315.4	Specific developmental disorder of motor function
F83	315.4	Mixed specific developmental disorders
F84.0	299.00	Childhood autism
F84.1	299.80	Atypical autism
F84.2	299.80	Rett's syndrome
F84.3	299.10	Other childhood disintegrative disorder
F84.4	299.80	Overactive disorder of MR [LD], with stereotyped movements
F84.5	299.80	Asperger's syndrome
F84.8	299.80	Other pervasive developmental disorders
F84.9	299.80	Pervasive developmental disorder, unspecified
F88	299.80	Other disorders of psychological development
F89	299.80	Unspecified disorder of psychological development

F90-98		*Childhood/adolescent behavioural and emotional disorders*
F90.0	314.9	Disturbance of activity and attention
F90.1	312.81	Hyperkinetic conduct disorder
F90.8	314.9	Other hyperkinetic disorders
F90.9	314.9	Hyperkinetic disorder, unspecified
F91.0	312.89	Conduct disorder confined to the family context
F91.1	312.89	Unsocialised conduct disorder
F91.2	312.89	Socialized conduct disorder
F91.3	313.81	Oppositional defiant disorder
F91.8	312.89	Other conduct disorders
F91.9	312.89	Conduct disorder, unspecified
F92.0	312.89	Depressive conduct disorder
F92.8	312.89	Other mixed disorders of conduct and emotions

F92.9	312.89	Mixed disorder of conduct and emotions, unspecified
F93.0	309.21	Separation anxiety disorder of childhood
F93.1	300.29	Phobic anxiety disorder of childhood
F93.2	300.23	Social anxiety disorder of childhood
F93.3	V61.8	Sibling rivalry disorder
F93.8	313.9	Other childhood emotional disorders
F93.9	313.9	Childhood emotional disorder, unspecified
F94.0	313.23	Elective mutism
F94.1	313.89	Reactive attachment disorder of childhood
F94.2	313.89	Disinhibited attachment disorder of childhood
F94.8	313.9	Other childhood disorders of social functioning
F94.9	313.9	Childhood disorder of social functioning, unspecified
F95.0	307.21	Transient tic disorder
F95.1	307.22	Chronic motor or vocal tic disorder
F95.2	307.23	de la Tourette's syndrome
F95.8	307.20	Other tic disorders
F95.9	307.20	Tic disorder, unspecified
F98.0	307.6	Nonorganic enuresis
F98.1	307.7	Nonorganic encopresis
F98.2	307.59	Feeding disorder of infancy and childhood
F98.3	307.52	Pica of infancy and childhood
F98.4	307.3	Stereotyped movement disorders
F98.5	307.0	Stuttering [stammering]
F98.6	307.9	Cluttering
F98.8	313.9	Other specified childhood/adolescent disorders
F98.9	313.9	Unspecified childhood/adolescent disorders

F99		*Unspecified mental disorder*
F99	293.9	Mental disorder, not otherwise specified

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 evaluees 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 in the University of London and an Honorary Consultant Forensic Psychiatrist in the National Health Service. 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, whilst also having nearly 30 years experience of clinical forensic psychiatry. He has extensive experience of acting as an expert witness in both 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 and, 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 of 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 in preparing reports for a number of different Courts, both civil and criminal, including experience offering oral testimony and 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.

Richard Latham is a Consultant Forensic Psychiatrist in the National Health Service. He works with offenders with both mental illness and learning disability. In addition to his medical training he holds a Masters degree in Mental Health Law, and his thesis focused on the use of mental health expert evidence. He has substantial experience of acting as an expert witness in criminal and civil proceedings, including preparing reports in capital cases in East Africa and the Caribbean. He is a founder member of Forensic Psychiatry Chambers.

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About Forensic Psychiatry Chambers: Forensic Psychiatry Chambers comprises 10 consultant forensic psychiatrists, all working otherwise within the NHS, and 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. It 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 which utilise the Judicial Committee of the Privy Council.

About the Death Penalty Project

For more than 20 years, The Death Penalty Project has worked to protect the human rights of those facing the death penalty. Although the Project operates in all jurisdictions where the death penalty remains an enforceable punishment, its actions are concentrated in those countries which retain the Judicial Committee of the Privy Council in London and in other Commonwealth countries, principally in the Caribbean, Africa and Asia.

The Project's main objectives are to promote the restriction of the death penalty in line with international minimum legal requirements; to uphold and develop human rights standards and the criminal law; to provide free and effective legal representation and assistance for those individuals who are facing the death penalty; and to create increased awareness and encourage greater dialogue with key stakeholders on the death penalty.

The provision of free legal representation to men and women on death row has been critical in identifying and redressing a significant number of miscarriages of justice, promoting minimum fair trial guarantees, and establishing violations of domestic and international human rights. In many cases, forensic psychiatrists and clinical psychologists have been instructed *pro bono*, to assess prisoners and provide reports on their mental state. Many individuals facing execution have been found to be mentally disordered or mentally impaired impacting on pre-trial issues, mental condition defences, sentencing and the mercy process.

Some of the Project's landmark cases which have restricted the implementation of the death penalty in the Caribbean include *Pratt & Morgan v the Attorney General of Jamaica* [1994] 2 AC 1, *Lewis v the Attorney General of Jamaica* [2001] 2 AC 50, *Reyes v the Queen* [2002] 2 AC 235, *The Queen v Hughes* [2002] 2 AC 259, *Fox v the Queen* [2002] 2 AC 284 and *Bowe & Davis v the Queen* [2006] 1 WLR 1623. Other landmark cases include *Mutiso v Republic*, judgment of the Court of Appeal at Mombasa, 30th July 2010 (abolition of the mandatory death penalty for murder in Kenya); *Attorney General v Kigula et al.,* judgment of the Supreme Court of Uganda, 21st January 2009 (abolition of the mandatory death penalty and delay on death row in Uganda); *Kafantayeni et al. v Attorney General* 46 ILM 564 (2007) (abolition of the mandatory death penalty in Malawi); *Boyce et al. v Barbados,* decision of the Inter-American Court, 20th November 2007 (savings clause, mandatory death penalty and prison conditions found to be in violation of the American Convention on Human Rights) and *Cadogan v Barbados*, decision of the Inter-American Court, 24th September 2009 (mandatory death penalty and lack of psychiatric evidence at trial).

Perspective

Saul Lehrfreund MBE and Parvais Jabbar MBE
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 who recommended that UN member 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 convictions and their sentences. 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 will also need to have the necessary skills to enable them to do so.

This unique handbook, the first of its kind, 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. It will be of practical relevance in all serious criminal cases, not just those concerning the death penalty.

THE DEATH PENALTY PROJECT

In association with:

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