Forensic Psychiatry: an introduction

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Overview

• History
• Development of the ‘Secure Hospital’
• McNaughton’s rules
• What do we do
• Secure Hospitals
• Prison Psychiatry
• MAPPA
• Some medico legal issues
The Act for the Safe Custody of Insane Persons Charged with Offences (39 & 40 Geo III c.94) 1800

Following the trial of Hadfield
- Charged with high treason
- Discharged a pistol at King George III
- h/o head injury
- Episodes of madness
- He ought to die to save the world but not by his own hand

Found ‘not guilty’. Disposal problems.

Admitted to Bethlem. He escaped briefly.

Returned to prison.

Asylum managers expressed concerns
- Private patients
- Additional security
Insanity

- Daniel McNaughton
  - Scottish wood turner who assassinated English civil servant, PM private secretary, Edward Drummond in 1843
  - ‘The Tories in my native city have compelled me to do this. They follow, persecute me wherever I go, and have entirely destroyed my peace of mind... It can be proved by evidence. That is all I have to say’.
  - He was found not guilty on the grounds of insanity.

- At the time of the committing of the act, the party accused was labouring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong
The new building at St Georges Fields opened in 1816
History - Broadmoor

- 1863 - 400 men and 100 women
- By 1903, 760 +
- 1913 - Rampton
- 1922 - Moss Side (Ashworth)
- 1950’s care in community
Establishment of MSU - single case

- Graham Young
  - Committed to Broadmoor ’62 aged 14yrs
  - Attempted poisoning 3 victims
  - ? step mother
  - Discharged after 9 years
  - Murdered 2 workmates within months (antimony, thallium, diary)
  - Intense public outcry
- Butler report 1975
  - Recommendations for mentally ill offenders
  - Secure unit in each regional health authority
What do we do?

• Secure Hospitals
  – Special Hospitals
  – Medium Secure Hospitals
  – Low Secure
• Community Forensic Psychiatry Services
• Prison
• Specialised Forensic Services
  – DSPD
  – SBU
  – Deaf
  – LD
• Expert witness
Secure units

• Forensic inpatient unit increased from 2650 in 1997 to 4000 by 2007

• 2015- Commissioners in England purchased approximately 7719 inpatient beds in secure mental health services.
• Approximately 795 in high secure
• Approximately 3192 in medium security
• Approximately 3732 in low security

• The original expectation that the admission would be for 18 months to 2 years is no longer valid

• Quality Network for Forensic Mental Health Services.
Secure Hospitals

• 3 types of security:
  – physical security;
  – procedural security; and,
  – relational/therapeutic security

• Physical
  – Perimeter fence
  – Locked doors, air lock
  – Escape proof windows

• Procedural
  – Policies like room searches, (high secure: monitoring mail/tel)
  – Rules for escorts and visits

• Relational/ Therapeutic
  – High staff-patient ratio
  – Knowledge of the patient, rapport with the patient
"I used to live in a gated community too. It was called Broadmoor."
Special Hospital

- Mental health services to Mentally disordered individuals with ‘dangerous, violent or criminal propensities, (NHS Act 1977)
- Main criteria for detention is that the patient should present a ‘grave and immediate danger to public at large’.
- Study by Taylor et al:
  - White male between the age of 20 to 50
  - 58% diagnosis of schizophrenia (26% PD)
  - Serious violence against person (homicide) most common precipitant
  - Average length of stay is 8 years (shortage of beds in MSU)
- Follow up study (Buchanan)
  - Over 10 year, 34% reconvicted
  - 15% of a violent offence
Medium Secure Hospital

• MSU
  – Step down from high secure
  – Transfer from Prisons
  – Step up from PICU/General Adult

• MDT process defined roles
  – Psychology, SW, OT, Nurses and Pharmacists
  – Average stay is around 3 years

• Follow Up Studies (Davies 2007) 550 patients over 20 years
  • 10% died (1/3rd by suicide)
  • 50% reconvicted
  • 20% back in secure care
Journey in Secure Care

- **Preadmission**
  - Assessment by MDT
  - Discussion in a bed management panel

- **Acute Phase**
  - Risk management (seclusion, physical intervention)
  - Confirm diagnosis and stabilise
  - Work through CJS

- **Rehabilitation Phase**
  - Psychological treatment (ASRO, Phoenix)
  - OT (community integration, vocation and structured activities)
  - Self medication
  - Accommodation
Community Forensic Psychiatry Services

• Reed report- 1992
• By 2006, there were about 37 in England and Wales
• Most operated parallel model
• All offered risk assessment
• Only half offered therapeutic interventions
• Effectiveness? Two studies naturalistic and not RCT
  • Sahota 2008
    – 20 yr follow up
    – Median time to reconviction was lower in FCS
  • Coid 2007
    – Criminal con, hosp readmissions and deaths
    – Neither services were superior
• More research is needed
Criminal Justice Process

Police - arrested

CPS

Prison - on Remand

Court

Prison Sentenced

Community - released

Section 2/3 informal

Section 35 (report) 36 (Treatment) Section 48

Section 38 (interim) 37/41 (hospital order) Community with req. of Psy 45a (Hybrid)

Section 47/49 Prisoner transfer

MAPPA
Prison Psychiatry

- Historically provision of health care was responsibility of HO
- The Government’s policy for prison health is enshrined in the principle of ‘equivalence of care’.
- Primary and Secondary services
- Suicide prevention- a major target.
DSPD

Michael Stone

Lin & Megan Russell & Josie Russell

- b. 7th June 1960
- In care, temp 1967, perm 1972
- 1st Offence 1972
- All adolescence in care or custody
- 1st psychiatric admission 1980
- Mostly in prison 18-32
- 1992 CMHT paranoid personality schizophrenia
- 1994 personality disorder
- Substance misuse disorders
- April 1996 probation order ended
- 4th July 1996 CPN concerned
- 9th July 1996 Russell attacks
- 23rd July admitted to MSU for detox
- 12th November 1996 discharged
- 23rd January 1997 brief readmission
- July 1997 Arrest
- 23rd October 1998 first convicted
DSPD

• DSPD intended to address: The challenge to public safety presented by the minority of people with severe personality disorder, who because of their disorder pose a risk of serious offending”

• 4 male (2 in prison and 2 hospital) and

• 1 female (prison)

• Some research findings:
  – DSPD requires the detention of six people to prevent one crime
  – DSPD started badly, but may have a use
  – DSPD needs to be cost-effective

• PIPE (psychologically-informed planned environments)
MCQ

- 43 yr old male patient with diagnosis of delusional disorder reveals he intends to ‘rip-off’ his neighbour, with whom he believes his wife is having an affair. Which is correct in his management
  - No one needs to be informed to protect confidentiality
  - Inform wife as she is the carer
  - Only inform the neighbour
  - Inform police, wife and neighbour
Tarasoff v. Regents of the U of California,

- Case in which the Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient.
- 1968 - Prosenjit Poddar and Tatiana Tarasoff.
- Emotional crisis. Improvement after TT left
- Prosenjit Poddar was a patient of Dr. Moore, a psychologist at UC
- He confided his intent to kill Tarasoff.
- Dr. Moore requested that the campus police detain Poddar, writing that, in his opinion, Poddar was suffering from schizophrenia.
- Poddar was detained but shortly thereafter released, as he appeared rational. Dr. Moore's supervisor, Dr. Harvey Powelson, then ordered that Poddar not be subject to further detention.
- 1969 - TT returned, Poddar carried out the plan. Parents of TT sued UC - The Tarasoff Rule - Duty to warn and duty to protect.
MAPPA

- 3 categories of offenders 1, 2, and 3.
- After a meeting, level of risk is decided:
  - Level 1: normal interagency liaison with 1 taking the lead
  - Level 2: MAPPs will be held
  - Level 3: senior people to attend the MAPP

- Criticisms
  - No extra funding
  - No adequate training
  - Mental health problems with patient confidentiality and public protection
  - Level 2 ignored
Fitness to be interviewed

• **Legal Context for court**
  - Under Section 78 of the Police and Criminal Evidence Act 1984, the court may exclude evidence on the grounds that, because of the way in which it was obtained or for any other reason, the admission of the evidence would have such an adverse effect on the fairness of the proceedings that the court ought not to admit it.

• **Detainee may be at risk in an interview if it is considered:**
  - It could **significantly harm** the detainee’s physical or mental state
  - Anything the detainee says in the interview about their involvement or suspected involvement in the offence about which they are being interviewed might be considered **unreliable in subsequent court proceedings** because of their physical or mental state
Fitness to plead and stand trial

• Criteria
  • The defendant must have capacity to
    – Understand the charge
    – Instruct a lawyer
    – Challenge a juror
    – Plead the charge
    – Understand the evidence
    – Follow evidence in court
  • The person found unfit may improve and return to court for trial.
  • Disposal options who are found unfit / acquitted under insanity after trial of facts
    – Admission order
    – Guardianship/ Supervision treatment order
    – Absolute discharge
Expert witness

- Psychiatric defenses to murder
  - Diminished responsibility
  - Automatism
  - Infanticide
  - Not guilty by reason of insanity
- Fitness to plead
- Intent
- Risk assessment or ‘dangerous’ assessment
- Need for future psychiatric support
- Sentencing options
Diminished responsibility

- Only to murder
- Murder = mandatory life sentence
- Manslaughter = judge’s discretion
- ‘where a person kills...he shall not be convicted of murder if ..
  – he was suffering from such an abnormality of mind
    • (where arising from a condition of arrested or delayed development of the mind or)
    • any inherent cause as induced by disease or injury
  – as substantially impaired his mental responsibility for his acts

- Abnormality of mind : broader than mental disorder
- substantially impaired : not total, not minimal or trivial
- Examples:
Legally accepted clinical examples under DR

- Psychosis (most obviously)
- ‘Reactive depression’ (Seers [1984]; Reynolds [1988])
- ‘Pre-menstrual syndrome’ (Craddock [1981])
- Elements of ‘battered woman syndrome’
- ‘Chronic post traumatic stress disorder’, severe anxiety symptoms
- Learning disability
- Personality disorder (Byrne [1960])
- ‘Substance dependence syndrome’, but must have been ‘brain damage’ or ‘irresistible craving’ if intoxicated (Tandy, Stewart, Wood)
Any questions?