# An Introduction to Forensic Psychiatry

## Key Topics in Modern Psychiatry

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**<Opening titles>**

**<Interview with patient (as re-enacted by actor). Patient seated, to camera, speaking hesitantly with pauses>**

It was a habit of mine, when I got up in the morning, to make a cup of tea and to take my wife a cup of tea and a biscuit or a piece of cake upstairs. This particular morning I had…I went to do the same thing. I went downstairs and I lit the fire, let the dog out, then I, I should say, rather it was the dog who brought me round – he was licking my face and I must have gone right out 'cause when I looked up at the clock more than an hour had gone and I didn't understand. And the kettle was boiling, but, anyway, in the end I made the tea and went upstairs and found my wife dead with blood all over her… and I looked and I also noticed there was blood all over me.

**<Professor Gunn to camera>**

You've just been watching a restaged interview with a patient of mine. He's a real patient and the words of the interview are real and we're going to call him Sam for the purposes of this programme, but the part of the patient has been acted, on this occasion, to preserve confidentiality. And what I want to do in this programme is to illustrate some of the key issues and concepts in forensic psychiatry by using Sam's case. But before we get to the details, perhaps, we better just consider at the outset what forensic psychiatry is. Well, the word forensic simply means legal and so forensic psychiatry is that part of psychiatry which deals with legal issues. It's the part of psychiatry that concerns itself with the problems which patients present sometimes by misbehaving, getting in trouble with the law; sometimes other kinds of legal questions are raised. But it's really simply a central part of general psychiatry and I want to emphasise that point right from the very beginning because it's sometimes thought of as a rather different and special part of psychiatry. It's nothing of the kind really because every psychiatrist will have to comment on patients' behaviour from time to time, every psychiatrist will meet occasions when he has to write reports, and every psychiatrist will have to spend a few times when he goes into court to give evidence about patients and on behalf of patients.

Now, to illustrate the way in which forensic psychiatry is a central part of general psychiatry, I want to begin with just a few words about the concept of responsibility. This is a word which tends to raise anxiety in the hearts of many doctors, simply because they think that the concept of responsibility is purely a legal one, it's a special idea which lawyers have and which is alien to their way of thinking. In fact, that's not the case at all because responsibility is part and parcel of everyday life or at least the concept is. We tend to regard one another – our friends, acquaintances, people we come into contact with – as responsible human beings. It's the way we distinguish man from other animals. We think of man as having free will; we think of man as taking blame for things he does wrong; we think of our colleagues as praiseworthy on occasions when they do things well; we think of them, in fact, as responsible for their behaviour and deserving the consequences of that behaviour.

**00:05:02:16**

Now, of course, that concept is modified to some extent under certain circumstances. We don't attribute the same levels of responsibility to everyone. For example, we don't attribute to children the same degrees of responsibility that we attribute to adults. Similarly, we don't attribute to the mentally handicapped and the mentally ill the same degree of responsibility as to other people. If we take someone who develops dementia in later life, we modify their responsibility. Indeed, that may be one of the ways in which a psychiatrist is brought in to consider a question of responsibility. A patient may be becoming – may be getting senile as they get older, and the relatives question whether or not they are now capable of looking after their affairs, and the psychiatrist may be brought in to comment upon that, make a diagnosis and if necessary bring in the Court of Protection to take over the affairs to protect the patient from the consequences of their now failing brain and their lack of responsibility.

Now, the layman understands all these issues and he sets up institutions to deal with them to some extent, and one of those institutions is the psychiatrist. He, as I've just illustrated, is brought in when there are doubts about the mental health of a particular patient. Let's take a classic example: if I go manic and suffer from this very pernicious and severe illness, then I hope that someone will come along to make the diagnosis correctly, and if the illness becomes very severe, take over my affairs on a temporary basis and, indeed, use the powers of the Mental Health Act to admit me to hospital so that I am protected from the worst ravages of the illness – to take over responsibility for my affairs, in fact, for a short period. So all these ideas which are not really unfamiliar to the psychiatrist, or indeed to the layman, are part and parcel of the concept of responsibility. Now, if we take the concept into court, all that happens is that we narrow it a bit. In court, responsibility tends to really mean punishability and the same sorts of issues are brought into play and discussed in the court as some of those that I've mentioned just now. The fact is that if I carry out an antisocial act, one which would normally carry some form of punishment because I break the criminal law, there are ways in which I can be excused the consequences of that act; there are ways in which my responsibility can be regarded as either

lacking or reduced sufficiently to allow complete or partial remission of punishment for my otherwise punishable actions.

**<Gunn narrates over slides, interspersed with talk to camera>**

**<Table>**

**Excuses**

**Youth**
**Accident**
**Mistaken Identity**
**Provocation**
**Threat or duress**
**Self-Defence**
**Madness**

Now, I'd like to show you the list of excuses which are use in a criminal court. You'll see that they include such things as the age of responsibility, which I mentioned earlier, which in England is 10 years, and several others which are not of great importance to the psychiatrist, but at the bottom of the list, there is madness, which actually includes a number of psychiatric factors and this is the one which concerns us and it, in fact, concerns us at all stages of the hearing.

**<Table with cascading titles>**

| | |
|---|---|
| **Pre-trial** | **Fitness to plead** |
| **Trial** | **Mens rea (McNaughton rules)** |
| **Sentence** | **Mitigation** |

A criminal trial, as it is commonly called, is actually a hearing and divided into three phases: a pre-trial, a trial and a sentence phase. Now, in the pre-trial phase, the one big issue for the psychiatrist is fitness to plead, and I'll come back to this later on, but

for the moment just note that it means whether or not the defendant is able to go into the trial. Now, if he goes into the trial, the question is was he so mad or lacking in responsibility at the time of the crime that he must be found not guilty. And this one uses the concept of *mens rea* which, I think, is simply translated for our purposes as intent, and to do that we use the McNaughton rules. Again, these will be shown to you in a few minutes. Past the trial stage, we come to sentence. This is where most psychiatric evidence is brought in. It's brought in in mitigation; it can reduce the sentence, the severity of the sentence, or sometimes replace the sentence by a psychiatric disposal.

**00:10:10:02**

**<Gunn to camera>**

Now, as I say, I want to come back to all those point in a moment, but before we do so, I'd like to return to our interview with Sam who will tell us the build-up to the crime that he committed, the killing of his wife, and as we go through the interview, I'd like you to consider the various points I've mentioned so far to see where you think the issues that he brings up can be brought in to the criminal process.

**<Cut to film of Gunn and patient, Sam, seated for interview. Patient speaks hesitantly with pauses>**

**<Sam>**

According to my mother, I did have fits for a bit, but I don't really remember.

**<Gunn>**

That was just after you were born?

**<Sam>**

Yes, up to age of five. I had a brother and sister then, but I think they was alright.

**<Gunn>**

Now, I think you did get into trouble a bit as a boy, is that right?

**<Sam>**

Yes. At about age of twelve, I got into this trouble with the police through stealing. After that it happened a lot.

**<Gunn>**

What sort of things happened?

**<Sam>**

Well, petty things really. I stole money, bikes and a wallet once, things like that, and I was sent to industrial school and borstal. They sent me to prison in the end after I started housebreaking.

**<Gunn>**

That was in 1953?

**<Sam>**

Yes.

**<Gunn>**

Now, I've a note here that you were admitted to Selly Oak Hospital once while you were at industrial school there. Now, what was that for, can you remember?

**<Sam>**

Yes, I woke up in hospital with my mother and father beside me, and they said that according to the doctors I'd had a fit, but I don't remember.

**<Gunn>**

Yes, I see. Now, how old would you have been then?

**<Sam>**

Fifteen, I suppose.

**<Gunn>**

Now, later on these blackouts cropped up again, didn't they? Because I've a record here that you must have been in prison at the time, you were complaining about them. Can you describe what they were like?

**<Sam>**

Well, my head used to shake and I seemed to lose control, and if I was holding anything like a cup of tea, I'd spill it all over me. I did feel weak but I didn't actually go unconscious.

**<Gunn>**

Now, in 1962, you'd been given a probation sentence and were living at one of the Langley House Hostels for probationers and ex-prisoners and that's where you met your future wife, isn't it?

**<Sam>**

Yes.

**<Gunn>**

And you got married.

**<Sam>**

March 1963, yes.

**<Gunn>**

So during the 3 or 4 months of the marriage, did you in fact have any problems?

**<Sam>**

No problems, at all, no. In fact, if anyone was in love with each other, Trixie and I were.

**<Gunn>**

No difficulties over money?

**<Sam>**

No, no.

**<Gunn>**

Complaints about where you were living or any sort of stress that might happen in any marriage?

**<Sam>**

No, no.

**<Gunn>**

Not as far as you can remember?

**<Sam>**

Not as far as I can remember. In fact, I know there weren't.

**00:14:10:15**

**<Cut to Gunn in studio, to camera>**

Well, we know from the clip at the beginning that Sam killed his wife and I've got a contemporary record of the trial here, which gives us a few details.

**<Gunn referring to and reading from trial record>**

His wife's body was found lying in bed under the coverlet, an eiderdown, hands having been crossed on the chest after death. There were severe injuries to the face and head and defensive injuries to the right arm and hand. Postmortem examination showed that at least 11 blows had been delivered with a 1½ pound claw hammer to the front and side of the head. He, himself, gave the doctors a variable and in some respects a contradictory account of having suffered head injuries, nervous disorders, attacks of dizziness and partial blackouts throughout his life. These phenomena, the records suggest, must have been insignificant for a perusal of prison records shows that in all the years he spent in prison, at no time had such an occurrence been noted by a prison doctor nor had he ever been thought to show signs of mental abnormality. The EEG investigation, however, showed unequivocally that his brain was subject to epileptic activity.

Now, at the trial, his defence was one of diminished responsibility. Dr Hill was called by the defence to give evidence about the EEG findings and his interpretation of them. He said that abnormality of the kind produced by brain damage would be capable of impairing a person's responsibility for his acts, but that since he himself had not examined the patient, he was unable to say what would be the effect in Sam's case. He didn't suggest that he had an epileptic manifestation when he killed his wife.

Two prison doctors were called by the Crown to give evidence in rebuttal. It was their opinion that the EEG evidence of epileptic activity had no bearing on the commission of this defence; the logical sequence of Sam's actions and the absence of any sign of confusion, which would inevitably accompany a state of altered consciousness, made it clear in their view that he had not been suffering from any epileptic condition at the time of the crime. And after a 2½ hour retirement, the jury returned a verdict of manslaughter and Sam was sentenced to life imprisonment.

**<Gunn to camera>**

Well, what were the issues there and how did they come into the hearing? Let's go back to the three stages of the hearing to see where the psychiatric points could have been raised.

**<Gunn narrates over previous slide outlining the three stages of a trial and then to camera>**

First of all: pre-trial. I mentioned that fitness to plead is a rare issue as far as a psychiatrist is concerned and it is rare because it is, in fact, followed by very serious consequences. It can only be raised by the defence and it protects the man from going into a trial which would be unfair to him. Let's look at the criteria which we have to examine to see whether a man is fit to plead.

**<Gunn narrates over slide listing criteria for fitness to plead, interspersed with talk to camera>**

First of all, he should be capable of instructing counsel. He should appreciate the significance of pleading guilty or not guilty. He should be able to challenge a juror, examine witnesses and understand the evidence and the procedure.

Now, this issue is raised in front of a jury in a Crown Court. And if a person's found unfit to plead, the consequence is that they are taken into a hospital indefinitely at the pleasure of the Home Secretary. In other words, they're debarred from the trial, so it's a very serious matter; sometimes if they recover quickly, they can be brought back for trial, but often they're released from hospital some years later without the facts ever being tested. Well, here we're not dealing with that kind of problem – Sam was fit to plead.

So we now move to the trial itself where the question of responsibility is raised in terms of the intentions. Mens rea, as you'll remember from what I said earlier, really can be translated as 'intent'.

First issue, however, is: did he do it? What are the facts? In this case, they weren't in dispute. Then the psychiatric issues are raised. Did he, in fact, have a guilty mind – did he intend to do it, did the psychiatric disturbance affect his intent? Now, there's an old common law tradition about this. The defence raises the matter and it's debated in front of the jury. But the common law tradition was fossilised to some extent by a famous trial in 1843. One Daniel McNaughton, who was a Scot, believed that the Tory Party were after him; he had, in fact, a fairly typical paranoid psychosis, and he came down to London to prevent them getting him and he decided that he would get them first by shooting them. And he went into Downing Street with two loaded revolvers and he shot at the leaders of the Tory Party. He managed to kill the Secretary to the Prime Minister, but was stopped from shooting the Prime Minister himself.

**<Gunn narrates over illustration and photograph of McNaughton>**

I think we've got a picture of McNaughton. I'm not quite sure if this shows the before and after effects of psychiatry. One is a woodcut at the time of his trial, another one is several years later when he was in a mental hospital.

**00:19:28:13**

**<Gunn to camera>**

He was acquitted under the common law procedures of the time and sent to a mental hospital because then, as now, the consequences of being found not guilty by reason of insanity are indefinite detention at the pleasure of the Home Secretary. But this not guilty verdict and being sent to hospital in such an infamous case created an outcry. And there were letters to The Times and all sorts of pressures in Parliament. And the judges were asked to formulate some rules showing how they arrived at this type of acquittal and these have been enshrined as the famous McNaughton Rules, which I'll show you briefly.

**<Gunn narrates over slides showing extract from McNaughton Rules>**

You won't need to commit these to memory, but just have a look at them and see how difficult it would be to fit any case into this framework: 'Every man is presumed to be sane until the contrary be proved, and that to establish a defence on the ground of insanity it must be clearly proved that at the time of committing the act, the accused party 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 that what he was doing was wrong.'

**<Gunn to camera>**

I should emphasise that this not guilty by reason of insanity verdict is available for any charge, but because of the difficulty of it and because of the consequences of it, it's almost exclusively reserved in practice for murder. Now, it has many problems as

you can see. And to get round those problems, in 1957, a new Act was introduced to deal with the murderer. This is the Homicide Act and it introduced into England the Scottish concept of diminished responsibility.

**<Gunn narrates over slides showing extract from Homicide Act, 1957>**

The act says that where a person kills or is party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind as substantially reduced his mental responsibility for his acts and omissions in doing or being party to the killing.

**<Gunn to camera>**

Well, he's not to be convicted of murder, but the consequence is that he is convicted of manslaughter. That may not seem much of an advantage, but the point is that it gives to the court a range of sentences; it gives flexibility to the court. Manslaughter like any offence, except murder, has available to it every possible sentence from conditional discharges, fines, probation, all the way through to life imprisonment. And you'll remember that Sam was convicted of manslaughter by reason of diminished responsibility and that he was sentenced to life imprisonment.

So that takes us from the trial stage into the sentencing phase, […]

**<Gunn narrates briefly over previous slide outlining the three stages of a trial and then to camera>**

[…] the third phase of the hearing, where the psychiatrist is more prominently seen. He, in fact, often gives evidence in mitigation. If an offender is found guilty of any offence other than murder, there is a whole range of options available to the court. Firstly, there are ordinary penalties such as Sam suffered. But the ones I want to concentrate on are the ones where a psychiatric component is included, and there are three main ones. The first one is hospital orders, where a patient can be sent to hospital compulsorily; secondly, there are probation orders with conditions of medical

treatment; and thirdly, there's imprisonment with the hope, although this can't be implemented in court, that psychiatric treatment will follow.

**<Gunn refers to charts on display board next to him and narrates over these. To camera in between>**

Now, what I want to do is to try to illustrate some of these diagrammatically for you. Now, first of all, I have here a chart showing the trial phase and showing what happens if a man has committed an antisocial act. The first verdict, at the top here, <*indicates words, 'non-insane automatism: acquitted'*> is a rare one and not one to concentrate upon. This is something which is hardly ever used and is only ever used if someone is found unconscious, say, sleepwalking. But I want to dwell upon a little more on this important verdict here: this is the one where a man is found insane, is thought to have no responsibility and therefore no guilt. You'll remember the McNaughton Rules apply here. This is the one where the patient is sent off to hospital compulsorily, indefinitely, and he often goes to a special hospital, special hospitals being Broadmoor, Rampton, Moss Side and Park Lane, but he can go to an ordinary hospital but, in any case, he stays there until the Home Secretary releases him. And that's rather like the consequence which can occur in the pre-trial phase where he's found unfit to plead; he is also sent to hospital indefinitely and compulsorily although, on that occasion, very rarely he can be brought back to the court for trial.

**00:24:32:00**

Well, that was the trial and pre-trial phase. I'd like now to turn to the sentencing phase. And here we are dealing with a man who has been found guilty of a crime, and in the first option you'll see, he can be sent, as we found, to prison or to inpatient care, either National Health Service Hospital or a special hospital. This is under the hospital order arrangements of the Mental Health Act 1959 in England. Two psychiatrists can make the recommendation and the court can agree to send the patient there for compulsory inpatient care. Usually they can be discharged at the behest of the doctor, but sometimes they can be put on a restriction order so that

only the Home Secretary can discharge them. Now, I've mentioned that in the case of murder, that option is not available for a person found guilty because there is a mandatory life imprisonment sentence for a murderer, but if the person is found guilty by reason of diminished responsibility under a murder charge, they are then convicted of manslaughter and the options are the same. In other words, they can go to prison or they can go to inpatients care, either special hospital or inpatient treatment under the Mental Health Act in exactly the same way as all other guilty persons.

Now, the third and interesting option available, on this chart, is the probation order with provision of medical treatment. Here, the court makes a probation order for 1, 2 or 3 years and a doctor has to agree to take the patient into inpatient or outpatient treatment, this time only in a National Health Service hospital, and it is timed in as much it can only last up to 3 years. It's very flexible: the patient can be moved from inpatients to outpatients according to clinical need.

But I also mentioned earlier that if a person is sent to prison then there is the possibility when he gets there that psychiatry may follow even so. There are three types of psychiatric treatment I've illustrated here. First of all, there's the very special therapeutic community at Grendon. This is quite unique; it takes the psychopathic and neurotic prisoner and deals with them with group treatment in a therapeutic community, a very rare option, I'm afraid, because there are so few places. Secondly, there is the possibility of bringing the psychotherapist to the prisoner and having sessions, either individually or group sessions. Thirdly, there's perfectly ordinary psychiatric treatment in a prison hospital: drugs, ECT, other options which would we available in any hospital. The prison medical department don't really like this option very much; they feel that prison is not the place to give ordinary psychiatric treatment and they would much prefer to operate the powers of the Mental Health Act section 72 to get a person from that position <*indicates prison hospital*> to an ordinary NHS or special hospital. Unfortunately, that's all too rare because of difficulties in transferring prisoners out to the National Health Service, but the option does exist.

**<Gunn to camera>**

So those are the facilities which are theoretically available, but you'll remember that Sam went to prison, and I think we should now go back to his interview to see what happened to him there.

**<Cut to film of Gunn and patient seated for interview as before. Patient speaks hesitantly with pauses>**

**<Sam>**

Well, I was at Winchester for a bit and then they sent me to the Moor, Dartmoor.

**<Gunn>**

So what happened to you?

**<Sam>**

Well, they eventually sent me to be investigated by Dr Crow at the Burden Institute, Bristol, and I did all sorts of examinations and X-rays and things, and they definitely agreed I was epileptic.

**<Gunn>**

And that was in 1968?

**<Sam>**

Yes.

**<Gunn>**

So how long after that, did you stay in prison?

**<Sam>**

Another 8 years.

**<Gunn>**

That's a long time.

**<Sam>**

Yes. And on this sentence, 13½ years, even though I'd only been convicted of manslaughter, not murder.

**<Gunn>**

Do you know the reason it was such a long time?

**<Sam>**

Well, they did tell me, the doctor in charge of me at Parkhurst, he told me that one of the reasons was that they didn't have nowhere for me to go.

**<Gunn>**

But you're alright now in the hostel?

**<Sam>**

Very satisfactory, yes.

**<Gunn>**

But you still get fits.

**<Sam>**

Not as bad now, but I do get them, yes.

**<Gunn>**

Can you describe them?

**<Sam>**

Generally, probably first thing in the morning when I don't seem to get the warnings before I go out sometimes for a day or 2 days, but the people in the hostel generally know when they're coming and generally get me to bed in time before I go out.

**<Gunn>**

I bet you go unconscious.

**<Sam>**

Oh yes.

**<Gunn>**

Then what's it like when you wake up?

**<Sam>**

Well, it's hard to explain. It's a semi-twilight. You know something has gone wrong, but you don't think about epilepsy for a bit because you know what it is, and it gradually comes to that you've had another fit.

**<Gunn>**

But if my recollection's right, you can get very frightened during that phase?

**<Sam>**

Yes, I can, yes. The last one I had, I thought I was back in Langley, where… that's the hostel where I met my wife. And Jane, that's the woman who's in charge of me nowadays, I thought she was going to send me back into prison and I cried my eyes out. It's not always her, I think people are trying to harm me, especially by sending me to prison.

**<Gunn>**

So you do get a bit confused and frightened?

**<Sam>**

Yes, confused and frightened.

**00:31:47:09**

**<Cut to studio. Gunn to camera>**

Well, that was Sam's account of what happened to him in prison. And to put it in medical terms, the investigations he mentioned discovered that he did indeed suffer from temporal lobe epilepsy, and they noticed after each attack, a very prolonged period of postictal confusion. And during those confusional episodes, he developed

severe paranoid delusions and sometimes became quite aggressive in a paranoid way. And indeed, we've seen such postictal paranoid delusional states since he's been released from prison.

Now, I think, with hindsight, we can speculate that the murder itself took place during one of these confusional episodes. And also using the privilege of hindsight, I think, it's possible to see that a stronger plea in mitigation could perhaps have been mounted at the time of the sentence and could have resulted in either a special hospital disposal for this man or maybe a definite sentence or, at the very least, a shorter number of years spent behind bars, which illustrates, in itself, the importance of the accurate diagnosis and the detail which is necessary when making a clinical judgement at a trial because, on the day of the trial, a great will hang upon the report given by the psychiatrists attending.

Well, this leads me then to the final aspect of forensic psychiatry, an aspect which we really haven't got time to deal with in this particular tape, but one which I don't want to omit entirely because it is so central. You may have gained the impression from what's been shown you so far that forensic psychiatry is simply about the legal process, about going to court, about disposal in prison, special hospital and so on, but if you think about that final piece of interview, you'll realise that it's a lot more than that: it's about the long-term care of the mentally abnormal offender. Very often patients with this kind of problem have lifelong problems and they need lifelong care. It was, after all, the lack of accommodation which prevented Sam from being released until he'd spent 13 years in prison. And as part of this process, we have set up a special hostel for epileptic offenders in London and that's the hostel which Sam has gone to. And I think that's an important component of forensic work.

So, if I do nothing else in this tape, I want to emphasise to you that one central aspect of forensic psychiatry is long-term care and rehabilitation of the mentally abnormal offender, but what I hope also the tape will have done will raise two issues in addition to that – three issues altogether for your consideration and discussion after you've seen it. The first is the question of responsibility: what is the concept, how does it play a role in general psychiatry, how indeed does it play a role in

ordinary life? Where does it fit into our thinking about the offender? Secondly, the role of the psychiatrist in court. We'll all be going to court, we'll all be making judgements about patients' mental states and recommending disposals. How can we do this to the best advantage of both the court and the patient? And then, thirdly, this very important issue which I haven't had time to tackle in this programme, but which bears a great resemblance to the ordinary psychiatry, which is called general psychiatry – the special problems of long-term care and rehabilitation.

**<End credits>**