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Faculty of Forensic Psychiatry Newsletter
Spring 2023

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Forensic Faculty Newsletter

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In this issue

Welcome

News from the Faculty Chair

by

Dr Josanne Holloway

Chair of the Forensic Psychiatry Faculty

Best wishes for 2023 and I hope to see many of you at the Faculty Conference in Brighton in March. The program looks excellent, and we will have 6 medical students attending as our guests. Please pop into the seminar where these forensic psychiatrists of tomorrow will be presenting their essays and research.

The faculty is saying goodbye to Catherine Langley who is leaving the college for pastures new. She has been an excellent support to the faculty and we would not have been able to function without her. Thank you Catherine and best wishes for the future. Our new faculty is Hayley Shaw. Welcome to Hayley.

A big congratulations to our new President and Faculty member Lade Smith; a worthy winner in a strong field.

At our recent executive committee strategy day, our excellent Carer expert by experience Sheena gave us an excellent insight into what it is like for a carer when their loved one becomes a patient. It was one of the best if not the best strategy days I have attended. Thank you Sheena.

We are hoping to include a piece from our patient and carer representatives in the next edition.

The faculty has been working through the College on a number of initiatives. We have financed the translation of a number of mental health leaflets which would be useful in war torn Ukraine. We are working on a revision of the paper on outcome measures in forensic psychiatry and have drawn up a statement of indeterminant life sentences for public protection. We understand that there will be a question in the House of Lords about this and hope that some positive progress can be made in this regard.

Assisted suicide is another area that the College has been discussing and the faculty will play an active role in discussions and shaping college views on this difficult subject, perhaps a difficult aspect of physical and mental health parity.

Gender identity is another area of discussion and debate in the College which we will also be involved in.

We have also agreed to support a project on trailblazers in Forensic Psychiatry which will involve interviews, podcasts and other content. We hope that some of our trainees will interview some of our eminent colleagues who have shaped our specialty and hopefully have a session at the 2024 conference and content on our web page. Please do contact myself or our new administrator Hayley Shaw with the names of forensic psychiatrists you feel we should interview and the area of forensic psychiatry they have helped to shape.

Josanne Holloway

Legal Update

Dr Richard Latham, Consultant Forensic Psychiatrist, South London and Maudsley NHS Trust

Forensic psychiatrics, as medical specialists, sometimes struggle to reconcile their duties as a doctor, with their duty to third parties, including victims. The General Medical Council and Royal College of Psychiatrists recognise this in their guidance. The most significant risks to other people are often contemplated by forensic psychiatrists. The cases in this update considered legal and ethical duties to third parties in different clinical and legal contexts.

DY v A City Council & Anor [2022] EWCOP 51:

The Deprivation of Liberty Safeguards and risks to others

What was the issue?

DY was diagnosed with generalised anxiety disorder and paedophilia. He is also autistic. His risks to children were considered in the Court of Protection. His mental capacity (to consent to his residence, care, contact, sexual relations, and access to social media) was the focus. Best interests were to be considered with regard to whether preventing harming others (children) was in his best interests.

The question of capacity hinged on his ability to use or weigh information. DY's tendency to give contradictory answers about his need for care and treatment was cited as one of the main reasons for the opinion that he lacked capacity. Other reasons advanced included that he did not think things through and overestimated his abilities.

What was the upshot?

Notwithstanding the reasons noted above, DY was found to have capacity to make the relevant decisions. The principle concerning unwise decisions was emphasised. The deprivation of liberty authorisation was terminated. The risk that might follow from this decision was acknowledged.

M, R (On the Application Of) v First Tier Tribunal (Mental Health) & Ors [2023] EWHC 34 (Admin):

Reasons for conditional discharge provided to victims

What was the issue?

TM's son, K was killed by R W-M. Both perpetrator and victim were living in supported accommodation. Mr W-M was made subject of a restricted hospital order. He was conditionally discharged three and a half years later following a decision of the First-Tier Tribunal. Ms M asked to be provided with reasons for the decision of the Tribunal and this was refused. This case was heard in the High Court and was based on several grounds including that the blanket policy on not providing reasons was unlawful as well as other grounds making a comparison with the rights of victims when the Parole Board sits. It was noted that there was no opportunity for Ms M to make representations to the Tribunal about the impact of the crime on her and her family. There were then several legal stages before this decision.

What was the upshot?

The failure to give reasons, or the gist of the reason for conditional discharge, to Ms M, was found to have been unlawful. The argument about the right to make representations about the impact of the offence failed, as did emphasis on her right to challenge the decision.

W v Egdell [1989] EWCA Civ 13

Disclosure of a report to treating team by independent expert

What was the issue?

W killed five people and seriously injured two. He was diagnosed with schizophrenia and sentenced to hospital, with restrictions. Several years later, Dr Egdell was instructed by W's solicitor to provide a report for use in the Mental Health Review Tribunal. Dr Egdell included opinions about W's lack of insight and lack of remorse, as well as opinions about W's risk,

particularly in relation to making bombs. He did not recommend a transfer to a lower level of security and emphasised the risks. This opinion was at odds with the clinicians involved in W's care. The report was not served, and W withdrew his application to the Tribunal.

Dr Egdell sought permission from the instructing solicitor to share his report with the treating team. The solicitor declined permission. Dr Egdell subsequently sent a doctor at the hospital, a report which, was almost identical to his original report. The issue - on appeal - was whether W could seek damages against Dr Egdell for breach of confidence.

What was the upshot?

The right to confidentiality was acknowledged as being a qualified right. The ultimate decision balanced the public interest in maintaining professional confidence and the public interest in protecting the public against possible violence. In this case, the balance was felt to be in favour of Dr Egdell's actions. W failed in their appeal.

Working in Prison

by

Dr David Kelsey, Specialist Registrar in Forensic Psychiatry, Forensic Outreach Service, South West London and St George's Mental Health NHS Trust

There are an estimated 85 thousand prisoners in the United Kingdom housed within prisons of decreasing security ranging from the Category A high secure estate, to Category B local remand prisons, Category C prisons, and Category D 'open' prisons. Both Categories C and D usually hold sentenced prisoners. Category A prisons, which number 7 in England and Wales, house offenders who pose the greatest threat to the public or the state.

I am fortunate in that in two and a half years in a non-training post and then a higher trainee in Forensic Psychiatry across London, I have worked in the youth estate, two busy Category B prisons, and in the Category A high secure estate at H.M.P Belmarsh.

Perhaps surprisingly, the extent of the need for mental health services in prisons is not fully described. It is however, anecdotally at least, immense. The more you look, the more you find, and what you find encompasses almost the entirety of the spectrum of mental illness.

In a typical remand prison, you might find those ill but unobtrusive, not coming to attention. The prisoners erupting with violence and proving difficult even in segregation. The cohort clearly unfit to participate in their legal proceedings whose difficulties are unknown to the courts and their legal representatives. The vulnerable presenting with neurodevelopmental impairment. Those on hunger strike, or not eating and drinking due to psychosis. The suicidal on constant watch. In prisons we see all mental health conditions and I would describe it as the best place to see and learn psychiatry. Then there is the trauma and the challenges of illicit substances - the dreaded 'spice' to say the least.

Category B remand prisons come with significant challenges for prison mental health services. Firstly, the trust contracted to provide services in your prison may not be the trust running the local secure unit. Secondly, the volume of prisoners processed at Reception each day can be many. If you have an established relationship with your Liaison and Diversion colleagues in police custody or the magistrates' court, you may be made aware of those arriving presenting with concern. If such prisoners slip through this first screen you may have to rely on a brief screening assessment at Reception, frequently performed by busy nurses who may not have appropriate training, whose job is made harder if the prisoner is

uncooperative. If this fails you might only be made aware of prisoners of concern by prison officers themselves who, though often well-meaning and holding genuine concern, have a myriad of other responsibilities, and following years of budget cuts, supervise a great many prisoners and tend to all the issues arising on a typical wing. If a prisoner is unwell though inconspicuous, this may not occur for some weeks. Finally, you may only be made aware of a prisoner of concern by the prisoner's own legal representative, frequently sourced through the legal aid system who may have had little prior contact with their client. The greater the delay in identification, the less time for assessment.

Anyone who has worked long enough in a busy Category B remand prison will tell you of the frustrations of having to perform a Mental Health Act assessment for a patient imminently due to be released, a so called 'Gate Assessment'. I remember on my first day working in one Category B prison being asked late in the afternoon to perform two. These should not happen, and the scenario represents the end point of often systemic challenges between several agencies.

Ideally, you would have identified a patient as being suitable for hospital transfer under a forensic section of the Mental Health Act and referred them to their local psychiatric intensive care unit or regional secure unit. The accepting hospital would identify a bed allowing enough time for a transfer warrant to be applied for, issued, and for secure transfer to be arranged. It is not difficult to imagine that this is less likely when inpatient beds are unavailable, or for those serving short sentences or short recalls. For these prisoners you might be able to keep the possibility of a gate assessment in mind and (to an extent) plan for it. However, they are often unexpected if, say, the prisoner's charges are discontinued, or they are deemed to have done time served at sentencing, but did not appear in person at court. You may not even be aware that the prisoner was due to attend court on that date.

These eventualities might be avoided if established lines of communication existed between prison mental health services and the courts, but this is not always the case and often the prison itself is unaware. If the individual is no longer classed as a prisoner though a Mental Health Act assessment is thought suitable then, with reluctance, the prison may agree to hold them for a brief, finite period. If found detainable under a civil section of the Mental Health Act the clock is ticking to find a bed. No bed, the individual leaves a free citizen but unwell and potentially a risk in the community.

Such a scenario will rarely happen with a Category A offender. By virtue of the gravity of the alleged offence(s), their cases are looked are thoroughly reviewed by the judicial system. Category A offenders are frequently of local if not national interest; at H.M.P Belmarsh they may

also be of interest with respect to national security. Category A offenders at H.M.P Belmarsh for example will likely have their cases dealt with at the Central Criminal Court, otherwise known as the Old Bailey. In my experience, there was greater communication between the prison in-reach service, the judiciary and the court, managed by regular meetings with the Liaison and Diversion Team at the Old Bailey, who would be kept abreast of court dates and legal proceedings including independent psychiatric opinion obtained by the prosecution and defence.

Category A prisons tend to hold smaller populations and a greater staff to prisoner ratio. At H.M.P Belmarsh a strong and collaborative relationship existed between discipline staff and the in-reach service which allowed issues to be addressed in a timely manner at any point during the prisoner's imprisonment. Any significant issues arising during a prisoner's stay, such as a significant change in mental state, admission to the Healthcare wing (Belmarsh has the largest in the U.K), or referral to hospital, would be fed back to the court. The trend of establishing Liaison and Diversion teams at Crown Courts across the country may serve to expand this way of practice across the Category B estate.

Though the large majority of trainees would have stepped inside a prison in a gatekeeping capacity for their respective secure unit, or for medicolegal work, it is in my view far better to be full time. It is unfortunate that not all training schemes offer full-time posts in prisons. Furthermore, given the few Category A prisons nationally, gaining experience in these is more difficult.

Prisons often feel like peripheral sites when compared to secure units, but in fact they are not just the starting point for many forensic patients, providing a positive clinical experience, they are at the interface of the criminal justice and health systems. As such the experience of inter-agency working and exposure to systemic difficulties encountered by each service is invaluable, not simply for our learning, but for future service development.

Similarly, relationships are key. Without a notable presence, it is difficult to establish a working relationship with discipline staff who provide an invaluable perspective of prisoners on the wings. It is difficult to form a full picture when assessing a prisoner if you are unfamiliar with the environment, knowing for example whether any issues exist on their wing, what their engagement (or lack of) with the prison regime is, and whether they present differently to you in clinic than they do on the wing.

Without a relationship with senior officers it may be difficult to have a prisoner moved to or from the inpatient wing. In the absence of a relationship with the courts you may not know which prisoners of concern come in, and which go out, a scenario which can lead to grave safety concerns.

Prisons are also valuable arenas for furthering medicolegal experience. Those who instruct you are often grateful that you are in the building and have the benefit of assessing a prisoner over a greater period and with increased scope than may otherwise be possible in the limited environment and time otherwise available through legal visits.

Working with Category A offenders presents its own challenges. As a trainee, it was especially important to be mindful of neutrality at interview. Consider the consequences of the confession of a serious crime, and always be mindful that your clinical assessment may come under greater scrutiny than it may otherwise do in other settings.

I would recommend that all trainees seek as much and as broad a prison experience as possible. It has truly been invaluable.

RCPsych position statement: 'Acute behavioural disturbance' and 'excited delirium' (PS02/22)'

Controversy and working towards multi-agency consensus

by

Dr Matthew Hartley
ST6 Specialist Registrar in Forensic Psychiatry
South London and Maudsley NHS Foundation Trust

In October 2022, RCPsych published a position statement on 'Acute behavioural disturbance' and 'excited delirium' (PS02/22). The expert reference group (ERG) was made up of representatives across a range of RCPsych faculties. My involvement in the ERG came out of working towards a systematic review on so called, 'excited delirium', that had been in progress with Prof Keith Rix. After consultation with colleagues from the race and equality initiative at the RCPsych, we decided that work that had gone into the review should instead go towards contributing to the position statement on this sensitive and complex topic.

By way of brief background, the terms 'excited delirium' (ExD) and 'acute behavioural disturbance' (ABD) have been used to refer to a syndrome said to affect some acutely agitated individuals, characterised by extreme agitation with physiological changes that put them at risk of medical emergency or death. Both concepts are controversial and problematic for a number of reasons. Firstly, 'ExD' arose from case reports from the 1980s, referring to deaths in custody of young men intoxicated with cocaine, often requiring restraint by police, with limited subsequent quality data to support its validity as a construct. While the official use of the term 'excited delirium' has declined in the UK, notably following the 2017 Independent Review of Deaths in Police Custody (Angiolini), 'ABD' has since been taken up as the preferred term by some agencies, including the police and Royal College of Emergency Medicine. Despite the change in terminology, the criteria are similar. Secondly, there has been concern about the use of the terms as a cause of death in cases involving individuals who died following the use of restraint, particularly men from

minority ethnic backgrounds. While not formal diagnoses, the terms have been used by coroners. Thirdly, there is concern that the current criteria describing 'ABD' risk perpetuating racial bias and discrimination, by using subjective terminology with historical racial connotations, such as "unusual strength" and "pain tolerance/impervious to pain" (RCEM guidelines).

The RCPsych published a statement in 2021 raising concern about the use of the terms 'ABD' and 'ExD', highlighting that racial discrimination may be inherent in their current form. While the statement was welcomed by some stakeholders, there was controversy and the Police Federation responded with a strong rebuttal. The initial statement was withdrawn pending further consultation; the response to the statement highlighted the need for the College to publish a more detailed position statement, to contribute to the debate in a systematic and constructive way. Psychiatrists are expert in assessing and safely managing individuals who present with acutely disturbed behaviour, and it has been recognised that pharmacological treatments for agitation and restraint practices in psychiatry have become significantly safer in recent decades. Our consultation indicated the need to be clear about our relevant expertise and to explain to stakeholders why a psychiatric perspective is an important contribution to the discourse.

A series of key recommendations are drawn out of the statement, including the need for clear and neutral definitions, joint protocols, and consistent training materials across agencies to enable true multidisciplinary working (it is worth noting that the Royal College of Emergency Medicine published their updated guidelines on 'ABD' in February 2022, illustrating that the debate is far from over.) The statement emphasises that lessons must be learnt when restraint leads to harm, rather than relying on syndromes with a limited evidence base as an explanation, and those responsible must be held to account. A way forward is suggested, including that a 'red flag' approach might be used to identify agitated and distressed people at particular risk of physical health emergencies, rather than using a categorical concept such as 'ABD'. Further, it is recommended that alternative terminology is sought to replace 'ABD', which has become too entangled with the contested definitions of excited delirium. Consultation with patients and carers indicated that the term 'ABD' can be perceived as dehumanising, and that updated terminology should acknowledge the distressed person at the centre of the situation.

I suggest members of the faculty take time to read the position statement, if you have not done so already, as it is a comprehensive document that explores many live issues surrounding the management of acutely agitated individuals, after consultation with stakeholders, including patients and carers. It has particular significance for those of us who work alongside police in the assessment, diversion, and management of individuals in acute care and custody settings. The bottom line is that all stakeholders want vulnerable and distressed individuals with acute agitation to receive safe, equitable, and effective care, but only through constructive dialogue and openness to compromise can there be a move towards consensus, and better multi-agency working in emergency settings.

Dual Training in Forensic Psychotherapy

by

Dr Katy Mason, Consultant Forensic Psychiatrist and Medical Psychotherapist, West Strand House
Dr Abigail Manjunath, Consultant Forensic Psychiatrist and Medical Psychotherapist, Avon and Wiltshire Mental Health Partnership NHS Trust

As part of writing this article we talked about our first experiences of meeting a forensic psychotherapists, both remembering specific individuals, such as the late Gabriel Kirtchuk. There was something about the way he saw the world, the way that he understood people, and the way which he held onto compassion but never seemed to underestimate or forget about the serious risks posed by his patients. We had both felt drawn to this way of practicing psychiatry, and had started to look into what the training route to being a forensic psychotherapist would be. We know that this is a popular training route, and are asked on a regular basis about dual training pathways combining both forensic psychiatry and medical psychotherapy.

Psychiatrists who work as forensic psychotherapists, are trained in forensic psychiatry and have a psychotherapy training. Psychotherapy training can be gained through the Medical Psychotherapy route or through an external self-funded pathway as a group analyst or psychoanalyst. Currently there are five dual training (Forensic Psychiatry and Medical Psychotherapy) posts across the UK; Birmingham, Exeter, Leeds and two in London. When an individual is appointed to a dual training scheme, they remain in the post for the duration of their training, which is at least five years, the length of time depending on the amount of disruptions higher training and life throws at the trainee in question. Therefore, it is vital to be in the right place, at the right time, or to make sure that you are.

As a dual training peer group we have reflected on challenges of obtaining these posts, reflecting on the cost in terms of time, money, sometimes professional relationships and geographical relocations. Idealisation is a wonderful thing. Idealising the training, the people in it, the vision of how you will practice professionally and see the world when you get there. Here is the bad news, idealisation is not possible without denigration.

Denigration. Defined in the dictionary as “the act of unfairly criticising”. It sounds relatively straightforward, we’ve all felt somewhat piqued by critical feedback at points. Dual training absolutely sets someone up for

denigration, the maths is pretty straightforward. If someone gives 70% to two specialities, they're giving 140% but to each speciality they're giving 30% less than other trainees. Psychotherapy training is not a good pair with forensic psychiatry. To be a good forensic psychiatrist you need to be agile with your time, responsive and available. The length of time psychotherapy cases take means that psychotherapy cases bleed unyieldingly into forensic time, limiting your flexibility and availability. It's virtually impossible to take placements out of area because you are tied to your therapists couch at various points throughout the week. Adding in travel out of area is an impossibility. You are now no longer ideal, you are demanding special treatment. Within psychotherapy you also don't quite fit. There are times when you need to be more pragmatic about holding the frame. I remember in the midpoint of my group therapy case, an important forensic meeting was regularly scheduled between 14:00 and 15:00. My analytic group started at 15:30. The only way to manage this without leaving my three year group case half way through, was to madly dash across the city, skidding into the group room at 15:29, much to the chagrin of my co-facilitator. Dual trainees may have a lot of flair and ambition, but they are an absolute logistical nightmare. This is fed back to you by multidisciplinary colleagues, seniors, and other trainees. For a trainee who has put so much into getting the post, and unconsciously idealised what it will be like to get there, and considered the post to be a unique opportunity leading to excellence, this is incredibly painful. To hope to offer something unique, but to find yourself in the position of being more of a nuisance. There's the intellectual knowledge that this will happen, you're told it will be painful, but the idealisation doesn't allow the reality of how it will actually feel.

As dual forensic psychotherapy trainees, we started to meet regularly and formed a cohort, realising that we shared these experiences, and the experience of being "other" and feeling unwelcome and an inconvenience was common. We wondered as a group whether how much of this was actually a reality in the mind of the other, and how much was a result of our own internal tendency to the defences of idealisation which also leads to denigration.

Professional loneliness. This was another theme that emerged for each of us during our training. As trainees and consultants in this specialty, you often wonder where you fit. The training in each geographic region is constructed slightly differently, but the majority of us commenced in one specialty, before moving on to the next and then eventually combing the two. This meant local specialty peer groups were lost along the way and although you could identify as "a forensic trainee" or a "medical psychotherapy trainee" each was only for a limited time. Making the move between the two disciplines and then trying to combine them reminded us

of the lonely space we inhabited. With very few consultant posts in forensic psychotherapy outside London, it was unlikely that we all would get to work in this clear role. Would we therefore have to choose which specialty we felt more aligned with, whilst suffering the loss of part of our identity? In reality, you cannot unlearn what you know and we would still continue to inhabit a dual identity, so would still not quite fit in either space, and this is something we have all had to work through.

As trainees, we often experienced a lack of understanding by our medical psychotherapy colleagues for the time and effort we were putting into honing our forensic skills, or an indifference to our need to attend our personal and other therapy sessions by our forensic psychiatry colleagues. This indifference or lack of acknowledgement felt attacking and painful. We understood it was not personal as each of us experienced it across the country in exactly the same way in all but the detail. With time, as a group we understood this was actually a valuable part of our training. We were the object of projections as we were seen as different or "the other". It was also important to work through the part of ourselves that had set up this dynamic, by choosing this "other" training pathway, so that we learnt to not only tolerate these projections, but also to understand and make sense of them, and also develop our abilities to have more insight in what we were doing to be aligned to that role.

This became the new hot topic of our forensic psychotherapy peer group discussions. How to manage the projections, sit with them, and understand them, and not to act out in response. It seemed to us the best solution was to integrate. This would mean creating a clear curriculum for forensic psychotherapy training where the competencies of six years of training could be met in 5 years and where everyone would understand our role. We considered this further with more experienced forensic psychotherapy colleagues and sought there advice and perspectives. Despite this integration seems to be an ongoing struggle.

Why does this struggle exist? We started to see parallels between the way we felt, and the way emotions were treated in the forensic setting, and the way pragmatic issues such as risk were seen in a psychotherapy setting. Something we have begun to wonder about is whether there is a need for us to sit between the two specialties. Perhaps our role is to tolerate the feeling, understand it, and help the other in doing so. This would enable us all in our work with very complicated, often violent patients. The next article in this series focusses on a high profile case where it is really important that we understand and think about dynamics, projections and roles within institutions as a vital part of psychiatric care that we provide.

A psychodynamic approach to risk assessment and management

by

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Managing and minimising the risk of further violence is central to care planning in forensic services, which both treat high risk patients and protect the public. Risk assessment involves a 'measure' of an individual's risk, which indicates the likelihood that some unwanted and harmful event will happen. We argue here that using a psychodynamic approach can help with taking this measurement.

Risk assessment is a complex task and is the subject of extensive academic and professional study. This is not just the case in medicine, but also in the corporate sector, including petrochemical industries, ground transportation and airlines. However, many commentators have highlighted that the relationship between mental disorder and the risk of violence is especially complex: partly because human violence is driven by many factors, (few of which relate to mental health care), and partly because accurate risk assessment is known to be hard for incidents like homicide or suicide which are low frequency, high impact events. Put another way, the denominator of people with severe mental illness is much greater than the numerator of people who commit acts of serious violence.

There is professional consensus that it is important to focus on a range of factors when considering violence risk and its prevention. Numerous risk assessment tools exist to take these factors into account, and have become big business. However, such approaches, often actuarial in nature, rely on quantifying factors that are dimensional e.g. the intensity of a delusional belief (see Doctor, 2004). Other factors are so general as to be largely irrelevant: for example, most violence perpetrators are male, but most males are not violent. Maleness on its own is obviously unhelpful when assessing risk in female offenders where violence is extremely unusual. Substance misuse and intoxication are stronger risk factors, especially in those who have been violent before: but many individuals who misuse substances don't act violently. Simply totting up the known risk factors may be misleading, whether in terms of overestimating or underestimating risk.

A psychodynamic approach assumes that risk levels are dynamic, and respond to different dimensional risk factors interacting together. It is therefore vital to keep in mind all the potential factors that may be at play, especially relational risk factors. The absence of the usual risk factors and the (apparently) pleasant nature of the patient do not neutralise the possibility that a significant change in an important relationship with another person may generate disturbing and dangerous emotions, which can exacerbate risk.

The following clinical vignette illustrates the difficulty in predicting serious violence:

Mr T, a 45-year-old man suddenly kills his long-term partner and their pets, then hands himself in to the police. He has no previous history of criminality and no obvious mental health history apart from recent treatment for depression by his GP. It emerges that this man's partner wanted to end the relationship and had asked him to leave the family home while they both sought legal advice and divided their assets. There was no history of violence between them and both Mr T's solicitor and GP said that they were not aware of any anger issues or threat towards his partner.

Mr T was assessed as being mentally unwell with depression at the material time, and received a diminished responsibility verdict. He was sent to hospital where he developed a profound affective psychosis with somatic and suicidal features. As he recovered from this, he was offered time to talk about his life story before he met his partner. Gradually it emerged that Mr T's mother died when he was just 10 years old and he was sent away to live with relatives in a foreign country, where he was very unhappy. When he met his partner (who was about 10 years older than he), he made a strong attachment to her, and it became clear that her decision to end the relationship provoked a level of unresolved pain, fear and rage in him that overwhelmed him, and may even have taken him by surprise, leading to the destruction of everyone he loved.

Prior to the murder, Mr T had no actuarial risk factors for violence (although a study in 2009 by Elbogen et al did suggest that loss of a close relationship in the previous twelve months can be a contributory factor to violence risk). This fatal violence could not have been predicted, but understanding its emotional meaning may remind those who are assessing Mr T's risk for future management to pay special attention to his attachments to women. His story would also suggest that he needs therapy that will help him address complex unresolved grief, not only with respect to his mother but also the partner he killed, and getting that therapy may contribute to future risk management in less secure conditions.

A psychodynamic approach to risk assessment is a clinical approach. It centres on the patient's internal world, specifically looking at factors that might make violence meaningful to them. Human violence is considered in the context of the relationship between perpetrator and victim: this relationship may be actual (the most common scenario, when both know each other) or perceptual and even delusional (when the perpetrator 'sees' something in the victim that they think they know). Violent thoughts and acts can be explored with patients alongside their historical experiences, relationships, difficulties and traumas. Putting the patient at the centre of the assessment in this way ensures that risk assessments are not simply reduced to a tick box exercise at team meetings, but add real clinical value. Lucas (2009) warns mental health professionals against believing that they have assessed risk just by completing the relevant form. This is especially true if they have not discussed risk with the patient, or based their assessment of the patient's mental state only on what they say, not how they present relationally on the ward.

However, a psychodynamic approach does not just take a patient's individual psychopathology and narrative into account. It also invites professionals to consider their emotional responses to the patient and their offence and reflect on whether that response (which may be both conscious and unconscious) affects how the patient's risk is 'seen' and assessed. Eastman & Rix (2022) argue that professionals may be at risk of all kinds of bias, including unconscious bias in relation to factors such as the patient's offence history. For example, if a patient has done something high profile and/or particularly abhorrent, it is not unusual for forensic professionals to see such patients as higher risk, although neither publicity nor feelings of abhorrence are known risk factors for violence. This can lead to unnecessary, punitive or hostile treatment. In contrast, when we consider boundary violations by professionals in secure settings, what we often see are professionals who are consciously focussing on their positive assessment of the patient, and unconsciously ignoring all the evidence of risk. Using a psychodynamic framework gives treating teams the opportunity to share their own experiences of a patient (which may be strikingly different), building a fuller picture of the individual and the risk that they may pose: avoiding clinical 'blind spots' that might precede serious untoward incidents.

Although many (if not most) violent acts can seem senseless, psychodynamic theory argues that the violence may seem rational to the patient. Furthermore, given that most fatal or near fatal violence is relational, it can be hypothesised that the violence is a type of communication directed from the perpetrator to the victim. The nature of the communication may be hard to understand, but the roots of this means of communicating may be traced back to individual difficulties in early

relationships which were often traumatic in some way. Memories of such trauma may be activated in a patient's mind by interactions with others that might seem completely innocuous to bystanders. Psychodynamic approaches to risk assessment seek to integrate these past experiences together with other risk factors into the dynamic present for consideration and evaluation in a team setting. Exploring a patient's history in this way with a multidisciplinary team has the added benefit of helping to humanise them, particularly when their crimes are highly disturbing. This in turn can help forensic professionals to treat individuals with compassion and moderate our responses to them. For all of these reasons we conclude that a psychodynamic approach to risk assessment is a task for all forensic professionals, not just those called 'psychotherapists'.

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Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by Friday 23rd June 2023.

The newsletter is a means to keep you informed and updated on relevant topics and the Faculty of Forensic psychiatry's work.

If you would like to share your experiences in your area or write in the newsletter, please contact the iForensic Newsletter team:

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