How Should Forensic Psychiatrists Balance Individual Rights and Public Safety When Managing the Risk of Interpersonal Violence?

There is a worsening climate of fear in the United Kingdom regarding mental illness. New data suggests that more people than ever feel uneasy about the prospect of living next to someone with a mental health condition, and fewer express comfort with mental health services operating in their communities (Ronaldson and Henderson, 2025). Although interpersonal violence associated with mental illness remains statistically rare and contributes far less to overall crime than commonly perceived (Fazel et al., 2014), the visibility of high-profile incidents, amplified by media reporting, has created a narrative that mental illness is unpredictable and inherently dangerous. Public anxieties do not necessarily reflect epidemiology, but they exert considerable influence over political decision-making, resource distribution and the expectations placed on clinicians.

Forensic psychiatry sits at the intersection of medicine, law and public safety. It is the part of the mental health system most directly exposed to societal fears about dangerousness and failure. Within this field, clinicians must navigate a delicate and often uncomfortable relationship between respecting patient rights and preventing potential harm to others. The four pillars of medical ethics – autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress, 2019) provide a moral framework for practice, yet in forensic settings these principles frequently collide rather than complement one another. Autonomy is routinely limited in the name of safety. Beneficence must be balanced against obligations to prevent harm not only to the patient but also to members of the public. Justice becomes more complex when decisions about liberty depend on subjective interpretations of risk. Non-maleficence extends beyond the individual to encompass societal protection. As a result, the equilibrium between rights and safety is rarely stable and often leans in one direction.

This essay argues that the current UK forensic psychiatric system has developed into a culture of excessive risk aversion. While protecting the public from violence is a

legitimate and necessary aim, the system's structural, political and cultural pressures often lead to restrictions that exceed what an individual's actual risk warrants. This essay contends that the most ethically defensible and practically effective way to balance individual rights with public safety is not to intensify restrictive measures, but to embed proportionality in decision-making, strengthen dynamic and person-centred approaches to risk, and invest in robust, well-resourced community forensic services. It argues that long-term public protection increases when patients are supported to rehabilitate, recover and reintegrate rather than being indefinitely contained.

To support this thesis, the essay begins by tracing how historical, legal and societal developments have shaped the current landscape. It then evaluates how the UK presently manages risk and rights, highlighting areas of strength alongside structural and ethical weaknesses. Finally, it proposes how the UK can move towards a model that offers a more balanced, evidence-informed and ethically coherent approach.

1. How the UK Reached a Risk-Averse Forensic Landscape

Secure psychiatric care in the UK has its origins in the mid-19th century, when Broadmoor Hospital opened in 1863 to house individuals described at the time as "criminal lunatics" (Forsyth, 2021). These institutions existed primarily to confine and seclude those considered dangerous, reflecting Victorian views that merged mental illness, moral deficiency and criminality into a single narrative. The institutional role was custodial rather than therapeutic.

The second half of the twentieth century marked a major shift. The Mental Health Act 1959 abolished asylums, accelerated deinstitutionalisation and placed responsibility for decision-making largely in the hands of clinicians (Bartlett, 2011). The move towards community-based care focused on treating mental illness as a medical issue rather than a legal one. The Mental Health Act 1983 formalised the modern legal framework for detaining individuals on the basis of mental illness and its associated risk. Later updated by the 2007 amendments, risk became central to detention criteria, thereby embedding a dual responsibility for forensic psychiatrists: to provide treatment and simultaneously to act as protectors of public safety.

Violence risk assessment also developed significantly during this period. Before the 1980s, clinicians relied on unstructured judgement, which research showed to be highly variable and unreliable (Monahan, 1981). In response, structured tools such as the HCR-20 and START were developed, introducing systematic methods for identifying static and dynamic risk factors. (Webster et al., 2004). These tools formed the basis of the Structured Professional Judgement (SPJ) model, which remains widely used today. While more robust than intuition alone, SPJ tools still cannot reliably predict rare outcomes such as serious interpersonal violence (Large et al., 2011). This limitation becomes highly consequential in a system where liberty is directly tied to professional estimations of risk.

A defining moment in shaping modern forensic psychiatry occurred with the 1992 killing of Jonathan Zito by Christopher Clunis, a man with schizophrenia who had been repeatedly admitted and discharged and ultimately lost to follow-up. The Ritchie Inquiry (1994) documented systemic failures in communication, continuity of care and community follow-up. Public shock and media scrutiny triggered widespread political reform. The Care Programme Approach introduced mandatory care coordination and structured discharge planning. The Mental Health (Patients in the Community) Act 1995 expanded powers for recall. Multi-Agency Public Protection Arrangements (MAPPA), introduced in 2000, formalised interagency responsibility for public protection. The 2007 amendment to the Mental Health Act introduced Community Treatment Orders, extending compulsory treatment into community settings.

These developments reflect what Beck (1992) described as the emergence of the “risk society”, in which governments and institutions become preoccupied with preventing hypothetical future harms. Forensic psychiatry became a focal point for this cultural shift. Clinicians were expected not only to assess and manage present symptoms but also to reliably prevent potential violence, a task that risk science cannot support. The cumulative effect of these pressures has been a steady movement towards precaution, surveillance and control.

As a result, modern forensic psychiatry exists within a complex moral landscape. Clinicians must navigate contradictory expectations: the law demands least-restrictive

practice, yet public and political scrutiny encourage caution. Human rights law requires proportionality, yet services often struggle to apply this consistently. Patients possess fundamental rights, but these rights are variably constrained depending on their forensic status. Understanding this contested landscape is essential before evaluating current practices.

2. How the UK Currently Manages Risk and Rights

The UK's approach to balancing rights and safety rests primarily on legal frameworks, clinical risk assessment tools and institutional structures such as secure hospitals and community forensic services. Each plays an important role, yet each also contains limitations that contribute to an overall pattern of risk aversion.

The Mental Health Act (1983, amended 2007) remains the cornerstone of forensic detention. It allows individuals with a mental disorder to be detained when that disorder threatens to cause harm to them or others. Several sections within the MHA allow for mentally ill offenders to be diverted away from the prison system and towards an NHS facility for treatment. Courts can impose restriction orders under Section 41, giving the Ministry of Justice (MoJ) authority over leave, transfer and discharge. While intended as a safeguard, this system often leads to protracted delays. Research shows that the Ministry of Justice's cautious approach can extend detention far beyond what clinical teams consider necessary (Riordan et al., 2016). Such delays raise questions about fairness and proportionality, particularly when detention exceeds the length of an equivalent custodial sentence.

The Human Rights Act (1998) incorporates the European Convention on Human Rights (ECHR), establishing rights to liberty (Article 5), protection from degrading treatment (Article 3) and respect for private life (Article 8). The law stipulates that although these rights are qualified and may be limited for reasons of public safety, any restriction must be lawful, necessary and proportionate. In theory, the Human Rights Act serves as a counterbalance to the Mental Health Act, ensuring that restrictions are not excessive. In practice, however, rights function differently across patient groups. Civil patients or those without restriction orders can usually be discharged when no longer meeting

detention criteria. Restricted patients, by contrast, face multiple layers of oversight, including tribunals, MAPPA meetings and MoJ approval. The greater the perceived risk, the more complex and prolonged the process becomes, meaning rights are less accessible in practice for those labelled “high risk” (Eastman and Peay, 2010).

Structured Professional Judgement tools form the backbone of contemporary risk assessment. Instruments such as the HCR-20 and START support clinicians in identifying evidence-based risk factors and formulating individualised risk narratives. SPJ enhances transparency and defensibility, reducing the variability associated with unstructured judgement (Douglas et al., 2013). However, SPJ models are fundamentally constrained by the low base rate of serious violence, meaning they inevitably produce false positives (Large et al., 2011). Forensic patients may thus be classified as high risk even when their probability of committing violence is extremely small. Moreover, SPJ assessments can become defensive tools, used to justify restrictive decisions rather than guide therapeutic interventions (O’Shea and Dickens, 2016). Because liberty is closely tied to risk formulations, the process can inadvertently reinforce a system where caution becomes the default.

Secure hospitals remain essential within forensic services. They provide comprehensive multidisciplinary assessment, treatment and rehabilitation. Patients retain access to legal safeguards, including tribunals and advocacy, which aim to preserve rights even within restrictive environments. Yet resource constraints, workforce shortages and political scrutiny all contribute to delays in leave, transfers and discharge. Bed shortages in medium and low-security units mean that patients remain in higher security than clinically appropriate. Lack of community placements further delays progress. Institutionalisation, the gradual reduction of autonomy and social functioning due to long-term hospitalisation, becomes a risk in itself (Snowden, 2014). The result is that patients may remain detained not because their risk requires it, but because the system lacks the resources to support them elsewhere.

Community management strategies, including conditional discharge and MAPPA, form a crucial part of the risk-management pathway. Conditional discharge allows individuals to return to the community under strict supervision, with rapid recall if risk

escalates. MAPPA enables information-sharing between agencies to manage individuals who pose a risk of serious harm. However, these structures operate within an under-resourced landscape. Community forensic teams often carry high caseloads, limiting the frequency and depth of engagement. Supported accommodation is unevenly distributed, creating a postcode lottery in which access depends largely on geography (Buchanan and Grounds, 2011). MAPPA processes can feel adversarial, sometimes discouraging openness from patients. Social determinants such as housing, employment and substance misuse remain inadequately addressed, even though they exert a significant influence on long-term risk (Fazel et al., 2014). Consequently, clinicians may opt for continued detention because community alternatives lack the capacity to manage risk safely.

These structural issues amplify the ethical tensions inherent in forensic psychiatry. Autonomy is constrained by the need to prevent harm. Beneficence towards the patient may conflict with obligations to protect the public. Justice is challenged by evidence of disproportionate representation of ethnic minority groups, particularly Black men, within secure settings (Barnett et al., 2023). Clinicians experience dual loyalty, caught between advocating for the patient and satisfying expectations of public protection. These tensions shape a culture that consistently leans towards risk aversion.

3. How the UK Can Improve Balancing Risk and Rights

To create a more balanced system, the UK must move beyond a model that relies heavily on prediction and containment. A system that focuses on forecasting rare violent events inevitably leans towards restriction, because uncertainty is often interpreted as risk and risk becomes justification for limiting rights. Preventive approaches enhance safety not by imposing further constraints, but by reducing the underlying factors that increase vulnerability and instability.

Early intervention in psychosis illustrates this well. Evidence consistently shows that early treatment reduces relapse rates, improves social functioning and lowers the likelihood of violence (Kirkbride et al., 2012). Importantly, these reductions are achieved through support, not restriction. Expanding early intervention teams,

particularly in socioeconomically deprived areas where incidence is higher, represents both a public safety strategy and a commitment to health equity.

Trauma-informed care is equally essential. Many forensic patients have significant histories of childhood adversity or abuse, which shape emotional regulation and behaviour throughout adulthood. Trauma-informed practice fosters safety and trust, helping to reduce agitation and aggression (Sweeney et al., 2016). It shifts the focus away from controlling behaviour and towards understanding what drives it, thereby supporting therapeutic engagement and reducing future risk.

Substance misuse must also be central to prevention. Substance use disorders are among the strongest predictors of violence, often more influential than mental illness itself (Fazel et al., 2014). Yet access to dual-diagnosis services remains inconsistent. Investing in integrated substance misuse support would reduce risk more effectively than prolonged detention.

Finally, prevention requires recognising the role of social determinants. Stable housing, financial security and meaningful occupation significantly buffer risk. Integrating forensic services with housing providers, welfare organisations and employment support ensures that individuals transition into conditions that promote safety, autonomy and long-term recovery.

The second priority is strengthening dynamic, person-centred risk assessment. The 2024 guidance highlights the importance of considering protective factors, such as supportive relationships, coping strategies and engagement with services. These factors offer a more balanced and holistic view of risk than a focus solely on deficits. Improving national consistency through standardised training and supervision would reduce variability across clinicians. Digital tools such as OxRec can support consistency but must be used cautiously due to potential biases. Transparency with patients about how risk is conceptualised can promote trust and autonomy, encouraging collaboration rather than compliance.

The third area concerns community forensic services. International evidence provides compelling examples of how robust community infrastructure can safely support individuals with complex needs. The Netherlands, for instance, operates highly structured step-down systems that include intensive community residence, graduated freedoms and long-term follow-up, allowing earlier discharge without compromising safety (van der Wolf et al., 2016). Germany's approach to proportionality, limiting the length of forensic detention to roughly the equivalent of a prison sentence unless strict criteria are met, encourages investment in community provision rather than reliance on containment. Scandinavian countries integrate mental health, social care and housing services to create comprehensive, recovery-oriented pathways. These models demonstrate that strong community support reduces readmission rates, enhances rehabilitation and enables a rights-based approach that maintains public safety.

A fourth key area is embedding proportionality into legal and clinical decision-making. Detention should be no longer or more restrictive than necessary. Proportionality assessments should be required for all restricted patients, ensuring that decisions are justified and transparent. Tribunal processes should occur at regular, non-negotiable intervals to prevent unnecessary delays. The MoJ must adopt more transparent timelines and decision-making processes. Importantly, resource scarcity should never be used as a justification for restricting liberty.

Enhancing autonomy is also crucial. Shared decision-making empowers patients, reduces conflict and improves adherence (Slade, 2017). Psychiatric advance directives allow patients to express treatment preferences during periods of stability, supporting autonomy during relapse. Recovery-oriented practice, which emphasises hope, meaning and agency, counters the pessimism that can arise from risk-focused environments.

Addressing systemic inequalities requires deliberate action. The disproportionate representation of minoritised groups in secure services raises ethical concerns about fairness and discrimination (Barnett et al., 2023). Cultural competence training, diverse staffing, community engagement and transparent monitoring are essential for building trust and reducing disparities.

Finally, improving resource allocation is fundamental. Without sufficient community placements, specialist staff and forensic outreach teams, clinicians have little choice but to adopt cautious approaches. Investment in prevention, step-down services, community forensic outreach and supported accommodation is therefore both an ethical requirement and a public safety strategy.

Taken together, these reforms support the creation of a national ethical framework grounded in proportionality, transparency, reciprocity and recovery. Such a framework would promote fairer, more consistent decision-making, reassure the public and strengthen patient trust.

Conclusion

Balancing individual rights and public safety in forensic psychiatry is one of the most ethically and practically challenging tasks in modern medicine. Although the UK's current system is grounded in structured assessment tools, legal oversight and therapeutic intentions, it operates within a broader sociopolitical environment that prioritises safety at the expense of proportionality. This essay has argued that relying heavily on prediction and containment undermines both patient rights and long-term public protection. A more effective approach involves shifting towards prevention, strengthening dynamic and person-centred assessments, investing in community services and embedding proportionality into all stages of care. International evidence demonstrates that respecting rights enhances, rather than compromises, public safety. Ultimately, the safest forensic psychiatric system is not the one that restricts most, but the one that rehabilitates most effectively, supporting individuals to reintegrate safely and meaningfully into society.

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