

Forensic aspects of psychiatry

Associations between psychiatric disorders and crime

Possible relationships between crime and mental disorder

1. coincidence
 2. correlation
 3. cause
- among male sentenced prisoners in England and Wales (Gunn *et al.* 1991):
 - 37 % have diagnosable disorder
 - 0.6 % have mental retardation
 - 2 % have psychosis
 - 6 % neurotic disorder
 - 10 % personality disorder
 - 12 % alcohol dependence
 - 12 % drug dependence
 - convicted prisoners:
 - 5.2% major psychological disorder (Cooke 1994)
 - remand prisoners:
 - 2.3% major psychiatric disorder (Davidson *et al.* 1995)
 - 14.1% depression
 - 10.8% anxiety and agitation
 - 22.4% alcohol problem
 - 70% had abused drugs
 - the disorders most likely to be associated with crime are:
 - personality disorders
 - alcohol and drug dependence
 - mental retardation

State Hospital admission

- factors precipitating admission:

• alcohol or drug intoxication	21.2%
• non-compliance with medication and relapse	11.2%
• psychosis	54.8%
• 'normal' aggression	15.4%

Important studies

1. Hafner & Boker, 1982
 - all homicides and attempted homicides in West Germany 1955-64
 - mental disorder was associated with 5% of these
 - the rate of mental disorder in the community was 3-5%
 - homicidal violence rate_{schizophrenia} = 5/10,000
 - schizophrenics were 100x more likely to commit suicide than homicide

- homicidal violence rate_{affective disorder} = 6/100,000
 - affective disorders were 1000x more likely to commit suicide than homicide
- 2. Swanson *et al.* 1990 'Violence and psychiatric disorder in the community: evidence from the epidemiological catchment area survey'
 - violence in last 12 months:
 - non-substance use schizophrenia 8.3%
 - substance abuse 21%
 - substance abuse schizophrenia 30%
 - **active** psychotic symptoms are associated with an increased risk of violence

Patterns of offending

- peak age of offending is:
 - 14 in girls; there is another peak around the menopause
 - 17-18 in boys
- 50% of all indictable crimes are committed by people under the age of 21
- the sex ratio of convicted men to women is approximately 5:1
- by the age of 30, around 30% of men have been convicted of an indictable offence

Specific mental disorders and crime

Psychopathic disorder

- in the Mental Health Act 1983 of England and Wales, the term psychopathic disorder is employed and defined as a 'persistent disorder or disability of mind (whether or not including significant impairment of intelligence), which results in abnormally aggressive or seriously irresponsible conduct'
- if a compulsory order is to be made on the grounds of psychopathy, then the Act requires there to be evidence that treatment 'is likely to alleviate or prevent a deterioration of (the patient's) condition' as well as the requirement 'that it is necessary for the health and safety of the patient, or the protection of other persons'
- there is an increased likelihood of other psychiatric symptoms and disorders
- homicide risk is increased 10x in someone with an antisocial personality disorder

Alcohol dependence

- alcohol and crime are related in 3 important ways:
 1. alcohol intoxication may lead to charges related to public drunkenness or to driving offences
 2. intoxication reduces inhibitions and is strongly associated with crimes of violence, including murder
 3. the neuropsychiatric complications of alcoholism may also be linked with crime

Drug dependence

- offences against property are associated with the need to pay for drugs
- rates of drug abuse are increased among prisoners

Mental retardation

- about 1 % of the prison population are mentally retarded
- most offences committed by those in the borderline to mild ranges of learning disability
- the mentally retarded are more likely to be caught
- they may commit offences because they do not understand the implications of their behaviour, or they are susceptible to exploitation by others
- the closest association between mental retardation and crime is a high incidence of sexual offences, especially indecent exposure by males
 - the exposer is often known to the victim
- there is also said to be an association between MR and arson
- other associations:
 - low socioeconomic status
 - family history of criminality
 - social disadvantage
 - cerebral abnormality
 - history of behavioural disorder as a child
 - minor physical abnormality
 - gullibility

- lack of self control

Depression

- severe illness may lead to homicide
 - the depressed person is usually acting on delusions
 - family member is usually the victim in altruistic homicides
 - the killer often commits suicide afterwards
- sometimes associated with shoplifting

Bipolar Illness

- offending is more common than in depression
- manic patients may spend excessively, hire cars and fail to return them, or steal cars
- may be charged with fraud or false pretences
- prone to irritability and aggression, though any resulting violence is seldom severe

Schizophrenia

- more likely to commit non-violent as well as violent crimes
- minor offences more likely than serious offences
- most criminal behaviour followed the onset of schizophrenia, although crime is frequently a result of personality difficulties and social incompetence
- risk of homicide is moderately increased in schizophrenia compared to the general population
- violence in schizophrenics may be associated with any of:
 - great fear and loss of self control associated with non-systematized delusions
 - systematized paranoid delusions of persecution
 - irresistible urges
 - instructions from hallucinatory voices
 - unaccountable frenzy
- risk of violence is greatest where delusions are accompanied by strong affect, and when the person has made efforts to try to confirm the truth of the delusions

Dementia

- 44% are mildly aggressive
- 10% severely aggressive
- association between offending and dyspraxia

Episodic dyscontrol syndrome (Bach-y-Rita *et al.* 1971)

- repeated unprovoked episodes of violence
- excluded epilepsy, schizophrenia, pathological intoxication, drug intoxication
- unexplained violence preceded by a sequence of aura, headache, and drowsiness
- 50 % reported amnesia for the episode
- 50 % have EEG abnormalities, usually in the temporal lobes

Psychiatric issues in the assessment of offenders

Fitness to be interviewed

- factors to be considered include:
 1. Does the detainee understand the police caution after it has been explained to him or her?
 2. Is the detainee fully oriented in time, place, and person and does he or she recognize the key persons present during the police interview?
 3. Is the detainee likely to give answers that can be seriously misconstrued by the court? i.e. are they able to understand the consequences of their answers

The appropriate adult

- used when the detainee is found fit to be interviewed, but does not have a mental illness or learning disability
- an appropriate adult is:
 1. a relative, guardian, or other person responsible for the care or custody of the subject, or
 2. someone with experience in dealing with mentally ill or handicapped people, or
 3. some other responsible person who is not a police officer or someone who is employed by the police

Mental state at the time of the offence

- before anyone can be convicted of a crime, the prosecution must prove the following:
 1. he carried out an unlawful act (*actus reus*)
 2. he had at the time the state of mind necessary to commit a crime (*mens rea*)
- traffic offences only require *actus reus*
- the categories of *mens rea* (loosely translated as meaning a 'guilty mind') are:
 1. **Intent** - the person perceives and intends that his act of omission will produce unlawful consequences
 2. **Recklessness** - 'is the deliberate taking of an unjustifiable risk'. A man is reckless with respect to the consequences of his act, when he foresees it may occur but does not desire it (e.g. pulling the trigger of a gun that you do not know whether it is loaded or not)
 3. **Negligence** - 'a man acts negligently when he brings about a consequence which a reasonable and prudent man would have foreseen and avoided' (Smith & Hogan 1988)
 4. **Blameless inadvertence** - 'a man may reasonably fail to foresee the consequence of his act, as when a slight slap causes the death of an apparently healthy person: or reasonably fail to consider the possibility of the existence of a circumstance, as when goods, which are in fact stolen, are bought in the normal course of business from a trader of high repute' (Smith & Hogan 1988)

Criminal responsibility

- in England and Wales, it starts at the age of 10 - children under 10 are excluded because they are deemed incapable of criminal intent
- in Scotland, it begins at the age of 8
- children between 10 and 14 do not have *mens rea* unless it can be proved otherwise – this is termed *Dolci incapax* and means that criminal responsibility is partial
- after the age of 14, an individual is legally responsible for their actions unless caused by:
 - a mistake
 - an accident
 - duress
 - necessity
 - mental disorder

Homicide

- in England and Wales, it may be:
 - lawful and justifiable (e.g. killing on behalf of the state)
 - lawful and excusable
 - unlawful – this is ‘the unlawful killing of any reasonable creature in being and under the Queen’s peace, the death following within a year and a day’
 - causing death by dangerous driving

Insanity in bar of trial

Fitness to plead

- English law requires that the defendant must be in a fit condition to defend himself
- the issue can only be decided by a jury
- if the accused is found unfit to plead and the charge is murder, an order is made committing him to any hospital specified by the Home Secretary where he may be detained without limit of time and can be discharged only at the discretion of the Home Secretary
- in determining fitness to plead, it is necessary to determine how far the defendant can:
 1. understand the nature of the charge
 2. understand the difference between pleading guilty and not guilty
 3. **instruct counsel**
 4. challenge jurors
 5. examine a witness
 6. **follow the proceedings in court**

Disposal of those deemed insane in bar of trial

- three stage process:
 1. Determine whether or not insane in bar of trial (evidence from two doctors, one approved)
 2. Examination of facts:

- as near as possible to an ordinary trial, but held in the presence of a sheriff or judge alone
 - if not satisfied beyond reasonable doubt, then acquitted
 - if satisfied, then disposal
3. Disposal of insanity cases:
- hospital order +/- restrictions
 - guardianship order
 - new supervision and treatment order
 - discharge with no order
 - for murder, there is mandatory hospital and restriction orders

Psychiatric defences

- a defence can be made that the person is not culpable because he did not have a sufficient degree of *mens rea* due to:
 1. not guilty by reason of insanity
 2. diminished responsibility (not guilty of murder, but guilty of manslaughter, which requires a lesser degree of criminal intent)
 3. incapacity to form an intent because of an automatism
 4. if a mother kills her child in the first year of life, she is not usually held legally responsible for murder, but for the lesser charge of infanticide

Not guilty by reason of insanity

- embodied in the McNaghten rules (in 1842 Daniel McNaghten, a wood turner from Glasgow, shot and killed Edward Drummond, private secretary to the Prime Minister, Sir Robert Peel)
 - To establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know what he was doing was wrong
- the McNaghten rules do not apply in Scotland
- the burden of proof lies with the defence
- based on the opinions of 2 psychiatrists 'on the balance of probability'
- it counts as an acquittal, but the disposal is as Insanity in bar of trial

Diminished responsibility

- the defence of diminished responsibility for murder was introduced in 1957
- the Homicide Act 1957 (Section 2) states:
 - where a person kills or is party to a killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being party to the killing

- if the plea is acceptable to the judge and prosecution, there is no trial but a hearing and a sentence of manslaughter (culpable homicide) is passed
- it refers only to sentencing, not responsibility for the act in terms of guilt
- “degrees of mental illness produce degrees of culpability”
- personality disorder is not sufficient in Scottish Law

Culpable homicide

- there is a lack of specific or evil intent to kill
- **Involuntary culpable homicide** – an unintended death occurs as a result of an assault or other criminal act or as a result of culpable negligence
- **Voluntary culpable homicide** – death results from an intentional reckless act but because of provocation or diminished responsibility, the offence is reduced from murder to culpable homicide

Intoxication

- **involuntary intoxication** (as when someone unwittingly takes a drink to which a drug has been added) or automatism occurring as a side-effect to medical treatment, constitutes a valid defence
- **self-induced intoxication** is not a defence unless:
 1. it is itself evidence of ‘disease of the mind’ under the McNaghten rules or
 2. it is evidence of lack of intent in relation to those crimes for which ‘specific intent’ must be proved (e.g. murder, theft, and burglary)
- intoxication has been accepted as a reason for diminished responsibility (Dingwall 1857) and for reducing murder charge to culpable homicide

Automatism

- if a person has no control over an act, he cannot be held responsible for it – the concept is similar to being ‘briefly insane’
- it is a legal term, and has no connection with epileptic automatisms
- verdicts of not guilty have been returned when acts of violence were judged to have been committed as ‘sane automatisms’
- **sane automatism:**
 - leads to a full acquittal
 - seen to be due to an ‘external cause’
 - includes:
 - absent-mindedness (in association with depression)
- **insane automatism:**
 - automatism thought to arise from a ‘disease of the mind’ – the appropriate defence is then insanity and the McNaghten rules apply
 - are due to an ‘internal cause’ because the conditions may reoccur
 - includes:
 - epileptic automatism
 - hypoglycaemia, hyperglycaemia
 - sleep-walking

- arteriosclerosis

Amnesia

- in the absence of organic disease, the presence of amnesia is unlikely to carry any legal implications

Specific Crimes

Violent Offences

The Offence

- offence type does not accurately predict future offence category
 - about 15 % of sexual offences are re-convicted, but re-conviction is just as likely to be a non-sexual offence

Degree of violence

- degree increases with:
 - low IQ
 - mental illness
 - intoxication
 - low victim resistance
 - family killings
 - multiple killings
 - when women killed

Quality of violence

- better indication of mental illness than quantity
- bizarre quality equates with mental illness or severe personality disorder

Disinhibiting factors

1. alcohol and drugs
 - 86 % of victims assaulted are intoxicated at time of injury
 - 63 % of offenders are intoxicated at time of offence
 - 60 % of murderers have drunk alcohol prior to their offence
2. companions and groups
 - e.g. football match
3. stress and fatigue
4. blood sugar

Criminal record

- *the best predictor of future behaviour is past behaviour*
- 1. predictors of repetition for dangerous offences include:
 - a) a juvenile record
 - b) number of previous offences
 - c) convictions for violence
 - i) one previous violent offence predicts 14 % chance of re-conviction
 - ii) four previous violent offence predicts 60 % chance of re-conviction
 - iii) the exception is over-controlled murder, where a 'mild-mannered' person is 'pushed over the edge'
 - d) severity of last offence

Personal data

1. Sex
 - women less likely to seek violent solutions
 - but when women do become violent, they can display the same level of violence
 - the most common offence committed by women is stealing
2. Age
 - high rates of offending in youths
 - sex crimes may decline with increasing age if offence is linked to orgasm
 - exhibitionism may persist to later age
3. Marital status
 - persistent failure to achieve sexual relationship and one or more violent assaults on a woman is ominous
 - of adult female victims of murder, 40 % were killed by their husband
4. Social circumstances
 - association between homelessness and violence

Personality

- two broad types:
 - *over-controlled* - feelings inhibited
 - *under-controlled* - easily exhibits feelings and resorts to violence
- Helman's triangle (in childhood) is a good predictor of future violence:
 1. bedwetting
 2. firesetting
 3. cruelty to animals
- paranoid / suspicious
 - suspicious is more likely to resort to verbal or physical aggression

Family and personal history

- violent behaviour is associated with:
 - childhood deprivation
 - poor parent / child relationships
 - childhood beatings
 - alcoholic fathers
 - dominant mother
 - isolation from peers
 - deep hostility to authority
- childhood physical abuse is associated with:
 - marital conflict and violence
 - single parent families
 - low socio-economic status

Past psychiatric history

- schizophrenia (esp. paranoid) is most likely diagnostic group to commit crimes of violence
- mentally ill are more likely to be assaultative, and risk is increased if:
 - male

- young
- low socio-economic status
- substance abusing
- rates of violent offending:
 - schizophrenia = 5 in 10,000
 - affective psychoses = 6 in 100,000

Predictors of repetition

1. **History:**
 - a) one or more previous episodes of violence
 - b) repeated impulsive behaviour
 - c) evidence of difficulty in coping with stress
 - d) previous unwillingness to delay gratification
 - e) sadistic or paranoid traits
2. **The offence:**
 - a) bizarre violence
 - b) lack of provocation
 - c) lack of remorse
 - d) continuing major denial
 - e) severity of violence
3. **Mental State:**
 - a) morbid jealousy
 - b) paranoid beliefs plus a wish to harm others
 - c) sadistic fantasy life
 - d) deceptiveness
 - e) lack of self control
 - f) threats to repeat violence
 - g) attitude to treatment/ lack of insight or willingness to comply
4. **Circumstances:**
 - a) provocation or precipitant is likely to reoccur
 - b) alcohol or drug abuse
 - c) social difficulties and lack of support

Shoplifting

- peak age = 10-18
- majority offend once and are not re-convicted
- in middle-aged women, depression is present in up to 30%
- associated with:
 - phobic anxiety states
 - chronically stressed
 - personality disorder, in association with low mood
 - chronic physical illness
 - organic states

Arson

- M:F = 1:2.5
- more common in:
 - subnormality
 - alcoholism
- recurrence more likely if:
 - multiple attempts
 - psychotic
 - demented
 - mentally retarded
 - alcoholic
 - sexual excitement derived from the act

Stalking

- usually due to:
 - personality disorder
 - paranoid illnesses

Juvenile delinquency

- is law breaking behaviour by 10- to 20-year-olds
- associated with:
 - unsatisfactory child rearing
 - low IQ
 - conduct disorder in childhood
 - parental criminality
 - large family size

Kleptomania

- refers to the recurrent failure to resist irresistible impulses to steal objects not needed for personal use nor for their monetary value
- it is classified under ICD-10 F63 'Habit and impulse disorders'
- it is rare – with less than 5% of shoplifters giving a history consistent with kleptomania
- the average age of onset is 20 years
- the diagnosis is usually made 1-2 decades after the average age of onset
- stealing is impulsive, and done without the assistance of others

Risk assessment

Risk assessment tools

- HCR-20 History, Clinical, Risk; 20 items
- VRAG Violence Risk Appraisal Guide (Quinsey *at al.* 1998)
- RRASOR

The Criminal Procedures (Scotland) Act 1995

CPA 52 (65)	Remand to hospital before trial (High Court – 110 days)
CPA 52 (147)	Remand to hospital before trial (Sheriff Court – 40 days)
CPA 53	Interim hospital order
CPA 54	Not fit to stand trial or acquitted
CPA 54 & 57(2)a	Insanity in bar of trial with Hospital Order
CPA 54 & 57(2)b	Insanity in bar of trial with Restriction Order
CPA 58 & 59	Hospital Order with Restriction Order/ Direction
	CPA 58: Hospital Order without Restriction Order
	CPA 59: Hospital Order with Restriction Order
	MHA 60: Hospital Order without restriction order
	MHA 62: Hospital Order with restriction order
CPA 65	Remand to hospital
CPA 200	Remand Order (patient convicted but not sentenced)
CPA 230	Informal treatment as a condition of a probation order