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## **Managing the many intrusions of death in forensic mental health services**

### **Editorial**

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## **Managing the many intrusions of death in forensic mental health services**

‘My father was a murderer.’

So said a young woman with anorexia nervosa as she responded, with little emotion, to a question about her family during a routine clinical interview with one of us. This was all she knew about her father. He was never otherwise spoken about in the part of the family that had tried to nurture her.

### ***Growing demands on our expertise in the face of death***

Worldwide, many forensic psychiatrists face death mainly as a legal conundrum. Their professional expertise is required on whether mental state could explain or partly explain a homicide committed by a person in custody awaiting trial on a murder charge. For the many who run clinical services for offender-patients, however, death intrudes in many forms and poses special challenges to clinical skills and the well-being of everyone touched by it. For forensic psychiatrists in Europe, services are weighted towards treatment and rehabilitation, with emphasis on prevention of further harms as well as treating mental disorder for those designated as our patients, but are some important aspects insufficiently considered. Should forensic mental health services involved with the father of the young woman described in our opening paragraph have made links with this traumatised daughter? We know little about how to help effectively in such circumstances, which certainly affect a proportion of our patients (Argent et al, 2018). We must be mindful of the needs of a range of others beyond immediate family who are touched by the behaviour of those patients, including ourselves.

We also occasionally face suicide – of patients and, occasionally, a colleague. Among the most threatening set of deaths to us are the rare occurrences of death of a patient by accident or clinical negligence while in the service as these threaten our professional identity. Even deliberate killing occurs. The most prolific serial killer in the UK was, after all, a doctor and, in Germany, was a nurse – both men. These cases alone show the complex web of matters to consider. For the UK case, for

example, there were six resultant inquiry reports – on the victims, coroners’ examination of their deaths and the detailed re-examination of deaths of these, regulation of controlled drugs in the community and a vision of better patient safeguarding (Smith, 2002-2005).

Finally, in developing forensic mental health services we did not much expect to have a role in supporting people through death from natural causes or contemplating assisted dying, but we are increasingly required to do so as we are faced with the physical health toll of long-term mental disorder and its treatment and an aging offender population. In this journal, we have already considered advance care planning ahead of life-altering clinical deterioration (Hurlow, Hurlow, Neil and Pullinger, 2021), but not the question of more actively assisted dying – as euthanasia, as is now possible in a few European countries, or as assisted suicide, that is no longer penalised in some European jurisdictions.

### ***Our learning environment***

In August 2022, we were participants in a residential seminar of about 30 people from several European countries to consider the impact of working in so many ways with death and how to maximise the possibility of influencing outcomes positively. The seminar followed a well-established format of talking and eating together for a week in residence in an out-of-the-way former monastery with few distractions other than the beauty of its surroundings. A small, consistent core of us has worked thus since 2010 with an ever-changing group over the years, including some who are returning after previous seminars and some newcomers. The group bonds over lectures, case material and small group ‘homework’, case discussions and discussions of wider practice, principle and law (Nedopil, Gunn, Thomson, 2012) and in its many iterations contributed substantially to the book *Forensic Psychiatry and Psychology in Europe A Cross-Border Study Guide* (Goethals [Ed], 2018). Consensus but also many outstanding questions emerge.

### ***Clinical roles in ending life***

The question of physician-assisted dying was unresolved but a good indicator of the interpersonal circle of considerations for the good clinician. In the event of ‘unbearable mental suffering’ caused by mental disorder euthanasia is now legal in four European countries: Belgium, Luxemburg, The Netherlands and Spain. Physician assisted suicide has been legalized in other European countries, among them Switzerland (De Hert M, Loos S, Sterckx S, Thys E and Van Assche K, 2022). The German and Austrian Constitutional Courts recently have held that penalization of assisted suicide is unconstitutional as it interferes with the basic right of self-determination. In a bizarre twist, Belgium has a number of long-term prisoners who have requested euthanasia, but in the case of a sexually motivated killer who was initially apparently granted the option (Devolder, 2016), his victim’s sisters objected, in essence, to this way of ending his suffering. Subsequently, an appropriate alternative management plan was drawn up for him, allowing for his clinical needs; doctors withdrew their support for the euthanasia, and he lives on in secure but tolerable conditions. On 23<sup>rd</sup> August 2022, in Spain, a man awaiting trial for shootings was euthanised on grounds of intolerable pain – he too had been shot in the incident([Security guard awaiting trial euthanised by prison authorities in Spain | Spain | The Guardian](#)).

Even without considering the UK’s serial killing doctor, an immediate concern is that law legalizing euthanasia or assisted dying turns us into killers. In January 2020, such concern led to trial for ‘murder by means of poisoning’ for three Belgian physicians after a woman in her 30s, who had been diagnosed with borderline personality disorder and autistic spectrum disorder, was euthanised on 27<sup>th</sup> April 2010 (De Hert et al, 2022). The physicians have been acquitted , but the complexities are evident from the fact that the ramifications of this case are ongoing. Resolution would appear to rest with the extent to which procedural safeguards were followed. This is a sound legal approach, but it hardly takes account of the wider circle of problems and people affected. In particular, in this case, the family of the dead woman appear not to have been involved in the pre-death process at all and,

it seems, took a different view of the likely course of their sister's suffering, assessment and treatment. There is no information about what all this may mean to other, similar patients. The case attracted immense publicity in Belgium, with 1,215 news items in just the one month before the trial of the physicians. Has there been any wider discussion with this specific groups involved? Has anyone asked women who have been diagnosed with borderline personality disorder what they think about this? How do people most closely involved in treating any such individual think and feel about this as a solution? The Belgian prisoner apparently came through the 'unbearable' in his suffering, we will now never know if the woman with such complex mental health problems could have done so – she apparently had before. It will be interesting to see how the rights of other victims in the Spanish pre-trial case will be respected and their probable needs met when no criminal case was established before the alleged perpetrator's death.

### ***Developing victim and survivor rights***

Questions about victims of homicide - and suicide and other sudden deaths – are generally for the plethora of secondary victims, although in a way, even for the person who was killed, homicide is not the end. Men who have survived a miscarriage of justice may be uniquely placed to notice that. In one notorious UK case, such men have repeatedly expressed concern about the reputational damage to a young woman almost invariably defined only as a prostitute in the plethora of press reports about the story. Whether or not the nature of her work at the time was even relevant, she is no longer here to claim her many other characteristics. Our focus, however, was on those who were or are most closely affected by the sudden death.

Victims of crime had little role other than as a possible witness in any criminal case until the turn of the century 1999/2000. Those close to a homicide victim were often deprived even of this limited role when they had not been present at the time of the killing. New rights have now been written into the laws of all European countries for victims of more serious interpersonal crimes. Initially, in many countries, these generally applied to direct and living crime victims, but now such rights are

generally extended to the relatives or significant others of a homicide victim. Among important rights are those of making a victim impact statement before the offender is sentenced, having information about the date and time of any court hearings, about the sentence and any sentence reviews. In many Continental European countries, singly or collectively, a victim may act as an accessory prosecutor with full prosecution rights. People may also receive state compensation for losses incurred from the homicide. In many countries, third sector organisations have grown up, often driven by surviving relatives, determined to turn their loss into something better, on rare occasions, such as the Zito Trust, closing with a sense of mission accomplished ([Jayne Zito: why it's time to end campaign | Voluntary sector | The Guardian](#)). Now, *One Hundred Families* informs, advises and supports not only families but also professional clinicians and criminal justice personnel at the interface (<https://www.hundredfamilies.org>). Ensuring that family and friends as survivors have appropriate, independent support for themselves and not merely as potential longer-term carers for the homicidal patient is vital. The latter may be a risk in forensic mental health services where patients are more likely than others who have killed to have done so within the family (Johnston & Taylor, 2003) and yet family support for the patient is regarded as an asset for rehabilitation.

### ***Clinician risks by association***

An uncommon but devastating event for clinicians is when a person kills while in or recently in their care. There are parallels with suffering other patient losses, for example by suicide, when there is at least some recognition that affected clinicians may need urgent and confidential help ([Psychiatrists' Support Service \(PSS\) | Royal College of Psychiatrists \(rcpsych.ac.uk\)](#)). Sudden, unexpected deaths of any kind relating to a person in psychiatric care are, effectively, regarded as 'never events' and thus, almost anywhere subject to a range of inquiries, from the special courts to determine cause of death that may also recommend further actions, including prosecution, through a range of inquiries. Across Europe the latter are generally internal to the healthcare provider organisation, but, for a

homicide, the UK has an additional layer of inquiry if the perpetrator had been in contact with services within six months of the killing that is independent of the healthcare provider, police and any legal proceedings (Holliday & Taylor, 2016). Its stated purpose is to review care and treatment so that the NHS can:

- Be clear about what – if anything – went wrong with the care of the patient
- Minimise the possibility of a reoccurrence of similar events
- Make recommendations for the delivery of health services in the future.

[NHS England » Independent investigation reports](#)

Over time, such inquiry has become more systematic and standardised, but still the bias inherent in a retrospective review and the counterfactuals involved leave everyone vulnerable to missing ‘the truth’. In this context, counterfactual thoughts express a past that is possible but not necessarily true, capturing events that are more available in the history – such as actions and exceptions rather than inactions or norms (Reiss, 2001). Regardless of the system of information seeking, the clinicians most directly involved are likely to need professional support, even treatment, and, certainly, legal advice (Mezey et al, 2021).

### ***Preventing homicides***

Whatever the stresses involved, we are committed to learning and feeding any valid new knowledge into prevention of harm strategies. The rate of homicide by people with mental disorder is low; the rate of homicide recidivism is very small indeed. It is thus hardly surprising that, in a survey of findings from all the individual homicide inquiries to the date of their review, reporting with all the benefit of hindsight, counterfactuals or no, Munro and Rungay (2000) observed that only just over one quarter of the homicides could have been predicted, but two-thirds of them could have been prevented, with some overlap. In no less than 17 of the 26 cases considered preventable ‘this was



not through better risk assessment but through a better level of psychiatric care in general’ – in other words, by more timely or appropriate treatment.

From another perspective, Mossman (2009), after intensive work on refining prediction algorithms observed:

- We know that behaviors and conditions, such as smoking and obesity, are clearly associated with poorer health. Though medicine responds to diseases ... that are linked to smoking and obesity and makes efforts to monitor and detect them, the optimal approach is to adopt a ‘population strategy of prevention’ ... rather than try to detect who will die prematurely.
- Preventing violence is not really different. .... A society sincerely concerned about reducing violence will seek broad measures that address known risks for violence among persons both with and without mental health problems.

Few of us have taken up this challenge – but Scottish recognition of the particular dangers of the sharp pointed knives, so easily bought in ordinary household stores and supermarkets, led to production and promotion of round-ended knives. This is a good example of where clinicians can promote primary prevention of harms through public health modelling (Kidd et al, 2014).

### ***Surviving and learning***

Many more distinct and troubling areas were discussed in our seminar, including the peculiarly toxic intrusiveness of death as an adjunct to sexual gratification. The strongest theme of all, however, was the eagerness to work with each other, to share experiences and learn how the slightly different laws and cultures in another European country create opportunities for reconsidering our own assumptions and practices. Working in isolation is not an option for good forensic mental health practice. Not everything that we do can be as evidence based as we would wish – randomisation of patients to formally risk-assessed management strategies versus ‘treatment as usual’ would not survive sound ethical review. We need our teams, our partnerships with relevant non-clinical

agencies and, as we did in this week, to be able to test among critical friends those practices that we have perhaps learned to treasure despite fragile evidence for them.

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