Introduction

Mary Davoren and Harry Kennedy

It is a privilege to edit a textbook in the subject to which we devote our professional lives. We were both influenced by Derek Chiswick and Rosemary Cope's text that set out a list of essential topics. Part of the reward for the work of renewing this textbook has been to nudge new topics into the canon of forensic psychiatry.

Forensic psychiatry is the interface between psychiatry and the law. It is a complex and challenging discipline encompassing clinical care and treatment for a highly vulnerable patient group with some of the most complex presentations in psychiatry, legal knowledge and ability, as well as leadership and academic expertise. The forensic psychiatrist must be the experts' expert, a shrewd clinician with serious attention to detail. It is not for the faint-hearted. We hope this book will inspire the brightest and the best to undertake training in this discipline.

Forensic psychiatry is often thought of only in terms of violence risk, and clearly the assessment and management of violence is key to this discipline. 'Risk' is the name of a popular board game in which war and diplomacy are pitched against each other by rolling the dice. Clinical ability in the area of risk assessment is often seen as the defining skill and characteristic of the very best forensic psychiatrists, though actually the best forensic psychiatrists must excel in multiple areas. Forensic psychiatry can also be understood as an uneven distribution of risk in which professional expertise and practice generate means of either regulated redistribution of risk or unregulated accumulation. The risk of violence arising from mental illness, substance misuse and delinquency can only be partly quantified and even more imperfectly regulated. Unregulated, relapses and interactions in these three domains lead to disorder, damage and occasionally death. The risk accumulates non-randomly among the vulnerable – those with mental illnesses, substance misuse issues and personality disorders. The victims are also seldom random: parents, spouses and friends, others with the same vulnerabilities, and sometimes professionals. Most patients in forensic hospital settings are both victims and perpetrators of violence – when the consultant forensic psychiatrist can see only the victim or only the perpetrator, they are unlikely to succeed. A nuanced understanding of both sides is required for excellence in this complex area.

Forensic psychiatry services provide care and treatment to mentally disordered offenders for whom violence linked to mental disorder is also an unmet treatment need. The purpose of these services is to reduce both the probability of violence and the seriousness of violence if it occurs. This is accomplished first through a process of redistribution of risk – placing the high-risk patient in the most therapeutically safe and secure setting, while those who are at a lesser risk, or a less serious risk, can be placed in or moved to medium or lower levels of therapeutic security. Restrictive practices such as seclusion, restraint and

https://doi.org/10.1017/9781911623809.001 Published online by Cambridge University Press

forced medication may be medically necessary to prevent imminent violence while treatments, both pharmacological and psychological, are implemented and take gradual effect. Reducing and eliminating the cycle of violence and providing a safe space for therapeutic engagement and the challenge inherent in good therapy are vital.

There are competing models for how such risks should be managed or regulated. A libertarian approach would hold the mentally disordered to be strictly liable for their acts and would use compulsion under almost no circumstances. Like any unregulated economy, great inequalities in the distribution of risk follow, with prisons becoming the main centres for coping with severe mental illnesses, comorbidities and disadvantages. A bygone era of moral regulation confined the mentally disordered away from civil society in asylums and 'colonies'. A more recent era of risk consciousness and risk aversion also confines but more selectively and with greater attention to selective triage, risk stratification and legally regulated recovery pathways. Modern specialist forensic psychiatry services should provide culturally sensitive services, women's services and specialist services for uniquely vulnerable groups such as children and adolescents and those with intellectual disability.

This second edition of *Seminars in Forensic Psychiatry* aims to find clinical relevance across services and across jurisdictions insofar as this is possible, since we believe that this will reflect the needs of a forensic psychiatry readership. We are confident that this will also benefit forensic psychiatry patients.

Chapters commence with two approaches to the psychiatry of violence in mental disorder (Chapters 1 and 2). Next (Chapter 3) is a chapter on the history of how modern forensic psychiatry services have evolved in Britain, through inquiries and reports that shaped policy. A chapter on psychiatry in prisons follows (Chapter 4). A review of legal issues (Chapter 5) may represent a watershed between psychiatry in the courts and legislation as a gateway or pathway into treatment. A later chapter also addresses questions of medical negligence (Chapter 16). Chapters then deal with structured professional judgement and risk as ways of understanding expertise in forensic psychiatry (Chapter 6); models of care in forensic psychiatry (Chapter 7); the pharmacology of aggression and violence (Chapter 8); the clinical management of in-patient violence (Chapter 9); and community forensic psychiatry (Chapter 10). There are then four chapters covering special subjects such as personality disorder, stalking, sex offenders and terrorism (Chapters 11, 12, 13 and 14, respectively), followed by chapters on psychotherapies and psychological treatments (Chapter 15); forensic child and adolescent psychiatry (Chapter 17); forensic psychiatry and women (Chapter 18); intellectual disability (Chapter 19); cultural psychiatry (Chapter 20); ethnic inequality (Chapter 21); and academic forensic psychiatry (Chapter 22). The book concludes with some no-nonsense guides (Chapter 23) that we hope will be useful prompts and supports as readers set out on their forensic careers.

Forensic psychiatry is much more than medico-legal psychiatry. Dr Katherine Warburton says we must be advocates and educators, as well as treatment providers. An essential aspect of being a consultant forensic psychiatrist is working to attract the very best psychiatry trainees into our discipline; this is what is required to reach the top of this challenging field, and it is what our patients, with their very high levels of vulnerability and complexity, deserve.

https://doi.org/10.1017/9781911623809.001 Published online by Cambridge University Press