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ARTICLE

Female filicide perpetrators: challenges facing clinicians and secure services

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SUMMARY

Much exists in the literature on filicide and the characteristics of perpetrators and their victims but there is little in the way of practical advice on how to manage perpetrators of filicide in secure psychiatric wards. Clinically, these patients can rapidly respond to medical treatment, only to be faced with the reality of what they have done. In the authors' experiences, certain aspects of their management are particularly challenging due to the emotive nature of their offence. These include managing the interpersonal dynamics on a ward, the media interest that surrounds the case and rehabilitation back into the community. In this article we outline a brief background to filicide in the context of mental illness and describe our experiences of managing the practical difficulties outlined above. The approaches used, outcomes and the supporting evidence base are discussed and illustrated through examples.

LEARNING OBJECTIVES

After reading this article you will be able to:

- report the proportion of filicide offenders who have a mental disorder and the most common type of mental disorders diagnosed
- show awareness of the interpersonal dynamics that can arise when caring for a mentally disordered offender who is a perpetrator of filicide and how these might be addressed in a clinical setting
- choose which strategies to employ to help deal with challenges posed by the media in relation to in-patients who have carried out filicide.

KEYWORDS

Filicide; forensic mental health services; psychiatry and law; homicide; in-patient treatment.

Filicide is the killing of a child by the father, mother or step-parent. It is a general term that includes neonaticide, the killing of a new-born under 24 h old by its mother, and infanticide, the killing of a baby under 1 year old by its mother while the balance of her mind was disturbed as a result of giving birth (the full legal definition in England and Wales is provided later).

Filicide has historically been considered as a female crime, although numerous studies have found that at least half of filicides were carried out by fathers (Dawson 2018).

In the UK, the most recent figures from the Office for National Statistics (year ending March 2019; Office for National Statistics 2020) (which are based on the cause of deaths determined by a coroner) show that the highest rate of homicide was of babies under the age of 1 (45 per million population) when compared with all homicides (11 per million population), consistent with previous years. Almost one-third of child victims were killed by a parent or step-parent (31%, 21 offences), a similar proportion to the previous year.

There were also key differences identified between filicide offenders and homicide offenders in general: the former were more likely to be employed; less likely to have a previous forensic history; less likely to have antisocial personality disorder; and less likely to be dependent on substances or alcohol. Perpetrators of filicide are therefore also different from the 'typical' patient in forensic secure units, among whom unemployment, criminality, comorbid substance use problems and antisocial personality disorder are common. These differences can stand them apart from other forensic patients, giving rise to a unique set of challenges for the teams treating them.

Filicide, similar to other domestic homicides, is a rare event and many perpetrators do not have a history of criminality or mental illness: therefore, not all filicide perpetrators will be admitted to a secure psychiatric hospital. For those who are admitted to hospital for treatment, there are a number of challenges faced by treating teams, for which, in our experience, there is little guidance available.

This article gives a brief overview of filicide, with particular focus on female mentally disordered perpetrators in hospital in England and Wales and the specific challenges that arise in their care, with emphasis on how to manage the issues where no guidelines currently exist.

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Formulating filicide

Several typologies for classifying filicides have been proposed over the years, added to and adapted by several authors. Resnick (1969) was the first to propose a classification system, the basis of which was the mother's motivation. In his review of the world literature on maternal filicide from 1751 to 1967, he developed a classification system that identified five major motives of the mother:

(a) altruistic, i.e. the mother kills the child out of love as she believes death is in the best interest of the child – Resnick used the example of a mother killing her son, who suffered from an encephalitic illness;
(b) unwanted child, i.e. the mother views the child as a hindrance (Resnick later coined the term 'neonaticide' to describe the murder of a neonate within the first 24 h of life): mothers committing neonaticide were typically younger and unmarried, had unwanted pregnancies and no prenatal care;
(c) acutely psychotic, i.e. severely mentally ill perpetrators with symptoms of psychosis, who killed under the influence of auditory hallucinations and/or delusions;
(d) accidental, i.e. when the mother unintentionally kills the child through neglect, abuse or Munchausen syndrome by proxy; and
(e) spousal revenge, i.e. when the mother wants to cause emotional harm to the father by killing the child – this is the rarest type.

One qualitative review of mentally disordered women who had killed their children found that the cases fell into the category either of an extended suicide or an altruistic killing (Stanton 2000).

It is beyond the scope of this article to describe other filicide typologies in detail, except to say that most classifications proposed have similar themes and typically include mental illness as one of the determinants of filicidal acts, but they too have struggled to capture the complex nature of these incidents (Mugavin 2005). In fact, it is likely that mental health problems would affect any of the motivations described and that there are common risk factors between mentally disordered and non-mentally disordered women who kill their children. This generalisation fits with the experience of the authors (P.M., V.B. and L.D.). Notwithstanding the complex psychosocial histories of these women, typical presentations tend to be: of a progressive depressive disorder with increasing suicidal thinking in which the child is either viewed as part of the self or worse-off if left behind; or psychotic episodes in which the child and/or mother is at threat and viewed as better off dead than alive.

Mental illness has therefore long been reported as an important factor in filicide and certain mental disorders have been found to occur more frequently. Resnick's (1969) study highlighted a high frequency of depression (71% in mothers, 33% in fathers) and that 60% were experiencing psychotic episodes. Another commonly cited study (D'Orbán 1979) looked at 89 cases of maternal filicide in a remand prison over 6 years and found that 80% of the sample had a history of psychiatric illness: the most common diagnoses were personality disorder (43%), acute reactive depression (21%) and psychotic illness (16%). Bourget & Gagné (2002) looked at coroner's records for 27 maternal filicide perpetrators over an 8-year period in Quebec. They found a 'psychiatric motivation' in 85% of cases, with most having previous treatment for depressive disorders (67%) or psychosis (15%).

A large UK-based study (Flynn 2013) using data from the annual National Confidential Inquiries into Suicide and Homicide by People with Mental Illness between 1997 and 2006 looked more closely into the relationship with mental illness of parents who killed their children by examining psychiatric court reports of the perpetrators and sending out questionnaires to their mental health teams if they were previously known to services. From a total of 6144 homicides in the UK over that 10-year period there were 297 cases of filicide and 45 cases of filicide–suicide. Over one-third (37%) of parents and step-parents who killed their children had some form of mental illness at the time of the offence. Fathers were significantly more likely than mothers to be the perpetrators (66 *v.* 34%) and significantly less likely to have a mental disorder (66 *v.* 27%). Mothers were significantly more likely than fathers to have psychiatric symptoms at the time of the offence (53 *v.* 23%), with affective disorders predominating (27%), followed by schizophrenia and other delusional disorders (17%) and personality disorder (14%). The overrepresentation of mental illness among filicide perpetrators was the key finding of the study.

Despite this, relatively few women admitted for treatment following a filicide have had previous experience of mental health services. Prior to their admission few of these women have received a diagnosis of a mental illness or personality disorder, although they may have symptoms or traits of such disorders that have not previously been explored. They may have sought assistance for difficulties through primary care, friends and family or other sources of support. A small number have previously sought help and been assessed by mental health services, but for various reasons an outcome of filicide is rarely foreseen and acted on. A study by Stanton *et al* (2000) in New Zealand found that

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women who were psychotic at the time they killed their children typically did so without much planning, compared with those who were depressed, who generally had thought about it for days to weeks. This could be important in considering risk management and identifying potential cases.

In addition, many women convicted of such offences have histories of childhood trauma and adversity and report negative experiences of maternal care in their own upbringing similar to a more 'typical' forensic patient.

Challenges posed by maternal filicide

The charge and the defence

Forensic psychiatrists often first encounter a woman accused of killing her child(ren) when instructed to assess and prepare a psychiatric report for the court. Psychiatrists may assist the court where psychiatric defences are put forward. In the UK, the Infanticide Act 1922 (amended 1938) provides that

> 'Where a woman by any wilful act or omission causes the death of her child being a child under the age of twelve months, but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child, then, if the circumstances were such that but for this Act the offence would have amounted to murder or manslaughter, she shall be guilty of felony, to wit of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter of the child' (section 1(1), as amended by section 57 of the Coroners and Justice Act 2009).

This defence is generally viewed as problematic and outdated, not least because the 'lactation' limb is now redundant, given the lack of any evidence that lactation causes mental abnormality. It also does not require a recognised psychiatric diagnosis or a causal link between the mental disturbance and the act of killing, unlike diminished responsibility. According to Office for National Statistics data on homicide in England and Wales, in the 10 years up to March 2019 there were only ten reported infanticide convictions (Office for National Statistics 2020).

More commonly, a woman with mental disorder found guilty of filicide will receive a conviction for manslaughter on the grounds of diminished responsibility. This means that her ability to understand the nature of her conduct, form a rational judgement and/or exercise self-control was substantially impaired. The court will also consider the extent to which the offender's responsibility was diminished by the mental disorder at the time of the offence, with reference to the medical evidence and all the relevant information available to the court.

Challenges in disposal

The issue of disposal is the next challenge. Where infanticide and diminished responsibility are successful defences, a non-custodial outcome (e.g. a hospital order) is usual (although the maximum penalty of life imprisonment could be given).

In England and Wales, the sentencing guidelines for manslaughter by reason of diminished responsibility now outline that, before a hospital order is made under section 37 of the Mental Health Act 1983 (amended 2007) (with or without a restriction order under section 41), judges should consider whether the mental disorder can appropriately be dealt with by custody using a hospital direction and limitation direction under section 45A, thereby adding a penal element whereby the perpetrator is transferred to prison once treatment of the mental disorder is complete. In cases where diminished responsibility has been found, we find it difficult to imagine a situation where a section 45A would be appropriate for a maternal filicide case and we are not aware of any such cases being disposed of in this way, although it is of course a possibility.

In England and Wales, where a hospital order under section 37 of the Mental Health Act 1983 is given, the courts have the option to make an additional restriction order under section 41 of the Act. Restriction orders transfer from the treating clinician to the Secretary of State for Justice power to grant hospital leave or discharge a patient from hospital, the authority to impose conditions on discharge and the power to recall a discharged patient to hospital. The conditions for the court imposing such an order are that these restrictions are necessary to protect the public from serious harm, and must take into consideration the nature of the offence, the antecedents of the offender and the risk that they will commit further offences if set at large. The issue of a restriction order is a matter ultimately for the court, but there is a requirement to hear oral evidence from a doctor, usually a forensic psychiatrist, although it could be from any doctor (who does not have to be approved under section 12).

There is some debate, including among us, as to whether, as with most other homicide cases, a restriction order is indicated.

Some would argue that the nature of the offence, which is unquestionably serious, in itself merits a restriction order as the risks of defaulting on treatment or supervision in the future are too high. In addition, the extra safeguards that the restriction order brings still preside over other types of community supervision, such as community treatment orders. However, the alternative argument is that

filicide offenders typically have no antecedent offending behaviour; they are not usually assessed as posing a risk to the general public other than their own children; they tend not to have significant histories of substance misuse; and they generally engage well with services around their recovery. It could therefore be considered that disposal by way of a Section 37 of the Mental Health Act 1983, with the addition of a Commuity Treatment Order at time of discharge, would adequately manage any future risks, and that the additional conditions imposed by a restriction order (Section 41) are not necessary and do not represent the 'least restrictive option' for management.

Since the case law makes it clear that it is the judge's view of the prognosis and not the doctors' that is determinative, it is arguable that this is an ultimate issue and that the doctors should not be recommending a restriction order or not, but should set out the relevant considerations that fall within their expertise for the sentencing judge to weigh.

Treatment and rehabilitation

The next challenge faced by clinicians is one of treatment and rehabilitation. Female filicide perpetrators in secure psychiatric hospitals, like other patients in secure units, require treatment of their mental disorder and their offending behaviour in order to rehabilitate them and reintegrate them back into society. What differentiates them from their peers, however, is that they can be treatment responsive, rapidly getting better once treatment is initiated. In contrast, many of their peers will be suffering from a treatment-resistant illness. Treatment-resistant schizophrenia, for example, is relatively common in medium secure units, and has been found to be present in as many as one-third of patients with schizophrenia in this setting (Lopes 2014).

What also separates perpetrators of filicide from other mentally disordered offenders is the reaction that their offence incites in themselves and others. Few other topics ignite the emotive response seen in cases of filicide. The act of filicide defies the basic laws of nature: evolution determines that the parents' role is to protect their children (Klier 2019). The reaction it provokes extends far beyond the evolutionary: notions of good parenting are governed by a multitude of societal expectations and mores (Klier 2019). This is especially the case for mothers, where the breach of the mothering role is considered the most unnatural of acts, the greatest treachery, completely at odds with the loving, nurturing mother that one assumes. It is no wonder then that societal responses to this crime are ones of horror and disbelief.

Once the acute symptoms have resolved, the aftermath of the act therefore awaits: the patient's realisation of what they have done; the grief for the deceased; the guilt; the horror; the trauma; the lifelong consequences to be endured for them and their loved ones. Suicidality is a risk in these patients. Flynn *et al* (2013) found that, of the 297 filicide cases in their sample, 13% of perpetrators subsequently killed themselves; some cite the rate to be as high as 29% (Friedman 2007). Friedman & Resnick (2007) found that in cases of maternal filicide–suicide the women often suffered from depression or psychosis, had altruistic motives and the victims were older children rather than infants (the mean age of the children was 6 years).

Even professionals trained in forensic mental health are susceptible to the societal influences around them and so responses to filicide are not confined to outside the walls of the psychiatric hospital. Each staff member brings with them their own set of core values, beliefs, emotions and experiences. It can be difficult for staff to divorce themselves from their own emotional responses to filicide (let's imagine, for example, the staff member who has a child the same age as the victim). Other patients on the ward, should they find out, can react in a variety of ways, such as anger, sadness, violence, grief, retraumatisation and/or destabilisation of their own mental health. Leakage of newspaper articles and social media reactions can incite a chain of reactions that feel beyond one's control.

Unsurprisingly then, although filicide perpetrators are relatively uncommon on psychiatric units, when they are present they can have a profound impact on the ward.

All of this must be addressed as part of the rehabilitation. Normally, individualised care plans are employed to address the specific needs of the patient. Medical and psychological treatment is based on the best empirical evidence or on standardised guidelines. So, what then, when no guidelines, policies or protocols exist for the specific treatment challenges posed by a patient convicted of filicide? These challenges typically centre around relationships and boundary violations, media and social media, transference and countertransference reactions. Certainly, it is these non-clinical challenges that often prove the most difficult to manage and can raise ethical questions for teams, especially when the extended family and community are hostile and antagonistic.

In some cases, it can be challenging to rehabilitate the patient to the local area (where the offence happened) owing to the high-profile nature of the crime and the negative depiction of the mother by the media. It is not uncommon for mothers to change their names to avoid notoriety.

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Challenges in transference and countertransference

One of the great challenges that persists is managing the difficult feelings that caring for women who have carried out filicidal acts generate. These feelings are not limited to clinicians involved in their treatment, but also to friends, family members and other patients. The dynamics generated have been written about for over a century, but they warrant mention here because of this persistence, their pervasiveness and the degree of challenge and harm they can generate in this particular group of women.

What the patient brings to the dynamic

Admission to hospital has the potential to be provoking for the individual. In any case it is usually a time at which there is increased confrontation of the offence and the circumstances that led to it. For those with early adversity, the experience of in-patient mental health services can in itself be re-traumatising and exacerbate any maladaptive personality traits, associated coping strategies and defences. For some their childhood experiences may need to be explored as part of understanding the offence, potentially heightening their defended position. It is in these defended positions that a patient's reflective capacity can be lost and the potential for problematic relationships with the institution can occur, usually through projections enacted by the patient towards staff (Kelly 2012).

The response of the institution

Although anyone involved in the care of these women has the potential to become a part of a challenging dynamic, in forensic institutions it is commonly nursing staff who are primarily involved, given the frequency and nature of the contact that they have in their day-to-day role (Aiyegbusi 2009). Nursing staff are present on the ward at all times and so do not benefit in ways that other members of the multidisciplinary team may in terms of respite away from the emotions present on the ward; they usually work shifts and have less opportunity for reflection as part of a clinical team, and they are more involved in providing personal care to patients, blurring the boundary between clinician and carer. In combination with a lack of training for managing such complexity, it is therefore not surprising that the first place these dynamics manifest is in the relationship with nursing staff.

The countertransference

An individual clinician's response to what the patient projects can be influenced by a multitude of factors, but in the particular circumstance of working with a woman who has perpetrated filicide these can be particularly emotive influences, including a reaction to the offence, the individual's own experience of parenting a child and of their own parenting.

This response may also be influenced by the stage of recovery the patient is at, and the speed with which this recovery has been achieved. It is often easier to see the offence as a product of an illness when the patient presents as acutely and obviously unwell, usually depressed and 'sorrowful'. We have seen that many of the women who come to hospital having committed offences against their own children have illnesses that are treatment responsive. Consequently, they may quickly appear 'well', forcing staff to see the offence as a result of something other than purely illness and raising the inevitable questions as to how a mother could commit such an act against her child. This can be particularly challenging if the patient is heavily defended against thinking about the offence or is in overt denial.

A common response by clinicians, individually or as a group, is to split the offence from the individual. The result can be identification with the patient by some as 'the victim' of their illness (leading to over-involvement in their distress) and by others as 'the offender' (leading to under-involvement with their needs) (Peternelj-Taylor 2002). Both responses are shifts away from the more desirable position of holding the woman as both victim and offender, thereby enabling her eventually to do the same. Both polarised positions can in themselves be thought of as insidious-type boundary violations (Kelly 2012) that can disrupt the therapeutic relationship, impede recovery and increase risk.

Management of transference and countertransference

Recognising and acknowledging the difficult feelings that women who have harmed their children generate is key to addressing the challenges in their care and treatment. Having appropriate forums in which they can be explored and understood by the clinical team in a non-judgemental manner is essential. Typically, these take the form of group reflective practice. Different models exist, but the general principle is to allow staff to bring challenging experiences with a patient, allow ventilation and acknowledgment of different emotional responses to that experience, and to re-evaluate and reformulate those experiences in light of a new shared understanding of the patient. Although not explicitly a psychodynamic process, in our experience the challenges of these particular cases benefit from the presence of a facilitator with experience in psychotherapy or one with experience in women's secure services.

BOX 1 The 'mad or sad' narrative

Andrea Yates drowned her five children in the bathtub in 2001 at her Houston home, then phoned the police and told them that she had committed the murders because she wanted to save her children from Satan.

There was a transition in the narrative from 'bad' to 'mad' mother, when it became known that she suffered from post-partum depression and psychosis. She was described as a loving mother with strong Christian values. Her former profession as a nurse, and how she had cared for her terminally ill father, were also quoted to portray a more favourable picture. Therefore, it has been suggested that because Yates 'remained a demure, confused, and pitied feminine creature, the media and public took the time to begin to understand the reasons why she committed this cruel crime' (Blanche, *et al.* 2010). She was categorised as mad, and the media emphasised her 'known history of attempted suicides, deep depression and frequent hospitalizations' (Blanche, *et al.* 2010). She was found guilty of murder and sentenced to life, but her appeal against her murder conviction was successful and she was acquitted on the grounds of insanity in her second trial.

Other approaches could include case formulation meetings, where clinical teams meet to agree an understanding and approach to an individual's presentation, or 'positive slant' groups, where the team takes behavioural management approaches to a particular challenge presented by the patient.

At an individual level, training and development are essential, in particular boundaries training that includes case examples specific to the female secure population and reflects the ways in which early trauma may manifest in an in-patient setting. This training should be repeatedly regularly, ideally in workshops attended by the whole clinical team. It is also important to ensure that new members of the team are supported in managing the emotional challenges of the environment.

The importance of supervision for professionals working with this group cannot be overstated. The emotional demands that this type of work places on an individual can be overwhelming, something that each of us has experienced first hand. The patient herself may also benefit from the opportunity of a therapeutic approach to her difficulties that considers dynamic influences, although she may not be immediately amenable to such an approach, in which case 'treating' the clinical team may provide the containment necessary to manage the challenges presented.

Many of the approaches suggested are incorporated within a whole-environment trauma-informed approached to patient care, and this model of care is gaining increasing popularity for offender populations.

Challenges in the media

As previously mentioned, maternal filicide offenders generate a multitude of societal reactions and are typically sensationalised in the media. The advent of social media has also created hospitable platforms for the propagation of these unmoderated views. The reality, of course, is usually very different from what the media portrays. Female offenders are considered 'doubly deviant' (Blanche, *et al.* 2010) because by breaking the law, they defy general societal expectations as well as transgress typical feminine behaviour (Berrington 2002).

How mothers who kill are portrayed in the media

Essentially, the media narrative mostly depicts mothers who kill as 'mad' (and so to be pitied, rather than blamed), 'bad' (set aside from women as a whole) or 'sad' (forced into violence by pressure of life circumstances). 'Mad and sad' mothers (Box 1) are seen as 'victims of their circumstances', with criminal behaviour linked to a medical condition (Barnett 2005). In contrast to the 'bad' women, the narrative for these 'mad' or 'sad' women is more likely to include the offender's feminine appearance (Berrington 2002) and a strong focus on a narrative that their actions were in adherence to traditional female traits and domestic responsibilities (Wilczynski 1991; Berrington 2002; Huckerby 2003; Barnett 2005).

It appears that sympathy for these filicidal mothers is engendered by the media and may lead to the view that such women 'should not be punished for their actions' (Brennan 2009) or should be punished more leniently. We have certainly noted that these 'mad and sad' mothers are more likely to be referred for in-patient psychiatric evaluation and receive a hospital disposal with or without restrictions. By contrast, women portrayed as 'bad' mothers (Box 2) are framed as fully responsible for their deviant actions and therefore as deserving of their punishment (Brennan 2009). These 'bad' mothers often attract headline descriptors such as 'monstrous' and 'evil', without any attempt to understand the context or circumstances. It would be interesting to compare and review how fathers who kill their children are portrayed in the media and if they also attract a similar narrative. Studies suggest that there is in fact less of a dichotomy, fathers being more universally harshly viewed, at least when it comes to punishment by the criminal justice system (Wilczynski 1997).

Managing media challenges on the ward

As previously outlined, the media attention given to filicide cases may not be entirely accurate. Forensic mental health teams will be aware of the potential

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BOX 2 The 'bad mother' narrative

The media's treatment of an Australian woman, Lindy Chamberlain, leading up to and during her trial in 1982 is a prime example of 'trial by media'. This is considered as one of the landmark cases of injustice whereby media treatment contributed to the cloud of prejudice that engulfed the jury.

Lindy was wrongfully convicted of the murder of her 9-week-old daughter Azaria at Ayers Rock, but the conviction was quashed in 1987 and she was declared innocent. She was portrayed as a freak of nature, a witch, a mother who had lost her natural ability to mother and there was great focus on her dress and personal style. This was shown by her unfeminine stoicism (Creed 1996, p. 119). The media joked about her frantic words, 'A dingo ate my baby!'. There was a great motivation to preserve tourism at Ayers Rock and idea of man-eating dingoes taking babies was not in anyone's interests. This case was famously adapted in a movie called *Evil Angels*, with Meryl Streep played the role of Lindy Chamberlain.

BOX 3 Case vignette

M was a 33-year-old woman detained on an unrestricted hospital order following her conviction for a filicide offence. She was placed in a secure unit away from her home and the location of the offence owing to a lack of appropriate services in that area. M's case was reported in both local and national media at the time of the offence and had continued local media reporting in her home area subsequently.

M was having increasing periods of unescorted leave with a view to stepping down from her current placement. While on leave M and her family were approached by a journalist asking for comment about her offence. An article was subsequently published in local and national media commenting on her 'release'. The article featured comments from other family members and neighbours, and attracted a mixture of comments from the public, some of which were threatening in nature.

Subsequently, M's family reported further contact from media organisations asking for comment. A number of calls were received on the ward payphone from unknown individuals asking to speak to M or other patients and asking questions about M's offence and current mental state. In addition, calls were received to the ward office from people reporting to be family, friends or solicitors, but who then declined to leave contact details.

A scripted response to formal media enquiries was prepared by the trust's communications department and distributed to all relevant staff. Regular reminders about checking identification of callers and maintaining confidentiality were provided.

Meetings were held with M and her family giving similar advice on dealing with media contact, and on planning and taking leave. They were also helped to access independent legal advice regarding the article and issues of privacy. M's case was brought to a multi-agency public protection arrangements (MAPPA) meeting for discussion and advice, which resulted in local police placing flags on M's name and addresses in the event of further unwanted approaches or threats.

With M's agreement a discussion took place with other patients at the ward community meeting to explain the concerns and M's wish for privacy and requesting other patients not to disclose information about her or her leave arrangements to their own friends, family or others.

impact on both the offender and other patients on the unit should they become aware of the media reporting. There is often no policy to guide the team as to how best to manage these situations and teams have to balance patient safety with issues of confidentiality and least restrictive principles.

Most secure units have a policy regarding mobile phones, and the risks of these being available to patients have to be weighed against the least restrictive practice narrative. In the medium secure unit in which one of us works, patients are individually risk assessed before being allowed to have access to a basic mobile phone, which they can purchase to use in the privacy of their own bedrooms. The threshold for this to be allowed is low, given the need for patients to be able to keep in touch with their loved ones and carers. These phones do not have internet access and therefore the user cannot access the news or social media online. However, on the same unit, patients are allowed to use their smart phone with access to the internet and social media while on leave.

As regards print publications, most secure units purchase daily newspapers and often host coffee mornings or current affairs sessions where patients discuss the news of the day as part of ward-based therapeutic programmes. Units have to be mindful of news stories in the tabloid press or other papers relating to the offence of an in-patient filicide offender, and they may choose to remove the papers in advance so as to 'protect' the individual from the frequently skewed and inaccurate profile portrayed by the media. This serves to reduce the risk to the patient from both themselves and other patients on the unit. On the other hand, other patients may offer support to a filicide offender if they know details of her case. This is particularly important given that media reporting is likely to occur at a time of significant vulnerability, such as when the offender has faced a court appearance or has been sentenced. Nevertheless, removing the newspapers also protects the confidentiality of the offender.

However, our experience is that filicide offenders themselves may share their offence with others and word may spread quickly on the ward. In addition,

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some patients would have access to personal television and radio, and it would be practically impossible to prevent them accessing news broadcasts. It would be interesting to review whether this degree of 'overprotection' is offered to male offenders and whether it actually prevents these women from facing the reality of their offending.

Institutional policies and procedures

Most forensic in-patient units will involve their communications team if the media approach services for a view, and staff are reminded to direct any journalist to these teams, who will tend to respond with a generic statement about the need to maintain confidentiality.

Most secure services will have a policy on mobile phone access, but none of the units in which we work have policies relating to social media. Access to such sites is restricted on ward computers used for general access during internet sessions. Forensic psychiatrists may have specific concerns relating to a patient accessing social media. Cases of patients finding staff on social media are a recognised problem that needs to be individually risk assessed. Clinicians may choose to amend their name or choose an alias on social media to prevent them being identified by their patients. However, when considering social media and the filicide offender, the open and extensive reach of these platforms may present unique challenges. Social media are not officially regulated (although some practise a degree of self-regulation) and their content is available to all. Newspapers report a snapshot of a particular news item, whereas social media articles may 'snowball'.

Anybody can comment or give a view, often without any means of being challenged should they say something abusive, offensive or untrue. Trolls may seek to abuse the filicide offender or 'out them' to wider society. Although social media can have huge benefits in relation to strengthening connections, these again must be carefully balanced against the potential effect on the filicide offender's mental health.

Cyber bullying is a recognised phenomenon on social media, which can lead to or worsen anxiety and depression. However, this is more often associated with younger people and society is voicing increasing concerns about the amount of time young people spend on social media. For the filicide offender, the impact of this type of exposure may be particularly harmful. This is something that forensic mental health teams will have to manage on an individual basis and it might need to be incorporated into the individual's care plans and treatment.

The fictitious case vignette in Box 3 illustrates an example of the media challenges a patient and a team might encounter and how these might be addressed.

Conclusions

Female filicide offenders are not all that commonly encountered on forensic psychiatric wards, but when they are they pose a unique set of challenges that clinical teams have to manage. To manage these challenges, it is important that teams recognise the psychodynamic processes underpinning the various different relationships the filicide offender holds. This includes the relationships they have with: their view of the offence and themselves as the offender; their family; their peers; the clinical team; the media; and the wider community. Each of these relationships brings with it a different set of challenges that need to be navigated.

While each individual case will merit its own specific interventions and approaches, clinical teams can be well prepared for supporting the patient, their peers and the staff by employing strategies and techniques routinely used in forensic settings but with some adaptation to allow for the sensitive nature of filicide.

Training for staff is key and needs to be embedded within the team, regularly being rolled out to all staff. Topics should include relational boundaries, the gender-specific needs of women, and understanding the role of trauma and adverse life experiences. Only by nurturing and supporting such a culture can the team begin to deal with the hugely complex issues that will arise when caring for patients who have committed filicide.

Author contributions

All authors contributed equally to the literature review and writing of the paper. P.M. took lead and was responsible for the majority of the editing.

Declaration of interest

None.

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MCQs

Select the single best option for each question stem

1 Infanticide is the killing of:
- a a new-born child within the first 24 h of life
- b a child under 12 years by its mother
- c a child by his or her parents
- d a child under 12 months old by its mother while the balance of her mind was disturbed as a result of giving birth
- e a child by its mother.

2 Compared with homicide offenders, filicide offenders are more likely to:
- a be unemployed
- b have no forensic history
- c have dissocial personality disorder
- d be dependent on substances or alcohol
- e be women.

3 The most common mental disorder in filicide cases is:
- a emotionally unstable personality disorder
- b obsessive–compulsive disorder
- c dissocial personality disorder
- d schizophrenia
- e depressive disorder.

4 Forensic mental health services with filicide offenders can manage the transference and countertransference by:
- a ignoring difficult feelings
- b concluding that the offence was caused by mental illness
- c seeing the patient as a victim
- d conducting case formulations with the multidisciplinary team
- e having fewer boundaries with filicide offenders.

5 If a mental health professional is approached by the media enquiring about a filicide offender, they should:
- a tell them about the details of the case
- b tell them to mind their own business
- c direct them to the trust's communications team
- d tell them only about the patient's treatment
- e give them a dirty look and walk off.