Legal implications of the increased risk of homicide and serious violence in the first episode of psychotic illness

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There is emerging evidence of a greatly increased risk of homicide, serious violence and suicide during the first episode of psychosis (FEP), which increases if there is a long duration of untreated psychosis. The period before the emergence of frank psychotic illness (the prodrome) has also been shown to be a period of increased risk. The finding of increased danger associated with the FEP has implications for civil, criminal and mental health law. In civil law, it could affect the assessment of the standard of care provided and the perceived duty to warn the patient's close associates. In criminal law, first episode patients may be considered to have a lower level of criminal responsibility, including during the prodrome of illness. The FEP is now known to be a psychiatric emergency for which there should be a lower threshold for involuntary treatment.

INTRODUCTION

Psychosis is a mental condition in which the main feature is the presence of a delusional belief. Psychotic illnesses include the chronic mental illness schizophrenia, severe mood disorders accompanied by delusional beliefs, and a range of other conditions that present with false beliefs, including psychosis arising from medical illnesses affecting the brain, and drug induced states. Delusional beliefs are often secondary to hallucinations, especially hallucinations of voices, and often occur in the presence of severe disturbances in the capacity for logical thinking. Associated symptoms include misinterpretation of everyday events, impaired emotional regulation, loss of volition and impairment in other areas of intellectual function. Psychotic illnesses often cause severe social disability.

The prodrome of psychotic illness is the period between the beginning of a morbid change and the emergence of symptoms of psychosis. The symptoms often observed during the prodrome include anxiety, irritability, depression and attenuated psychotic symptoms such as illogical thinking and irrational suspiciousness.

The period between the onset of definite psychotic symptoms and the initiation of treatment is known as the duration of untreated psychosis (DUP) of what is effectively the first episode of psychosis (FEP). There is a general assumption that the DUP would be quite short because psychotic illness is often so disabling and treatment is readily available; however, for a variety of reasons, the average DUP in developed countries is nearly a year.[1] Patients often do not recognise that they are ill and families may have cultural and other objections to seeking treatment. There are also studies that show that patients and their families make between three and four attempts to obtain treatment before they actually receive care.[2]

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[1] Lieberman JA and Fenton WS, "Delayed Detection of Psychosis: Causes, Consequences, and Effect on Public Health" (2000) 157(11) Am J Psychiatry 1727 at 1727-1730.

[2] Lincoln C, Harrigan S and McGorry PD, "Understanding the Topography of the Early Psychosis Pathways: An Opportunity to Reduce Delays in Treatment" (1998) 172 Br J Psychiatry 21; Cougnard A, Kalmi E, Desage A, Misdrahi D, Abalan F, Brun-Rousseau H, Salmi LR and Verdoux H, "Pathways to Care of First-Admitted Subjects with Psychosis in South-Western France" (2004) 34 Psychol Med 267; Fuchs J and Steinert T, "Patients with a First Episode of Schizophrenia Spectrum

The purpose of this article is first to present the emerging evidence of a greatly increased risk of serious violence during the FEP and, second, to discuss the legal implications of these scientific findings for civil, criminal and mental health law.

EVIDENCE OF AN INCREASED RISK OF SERIOUS HARM IN THE FEP

There is a greatly increased risk of homicide during the FEP compared to subsequent episodes. A recently published study from New South Wales[3] and two recent studies from the United Kingdom[4] show that the risk of a patient committing a homicide during the FEP is in the order of one in 500 new cases.[5] By contrast, the annual risk of homicide by patients who have received treatment is only about one in 10,000 per year. The lethal assault was usually precipitated by frightening delusional beliefs and most of the victims were family members or close associates. Only 15% of victims were strangers.

There are numerous published studies showing an increased risk of non-lethal violence in the FEP. Three studies of psychotic patients found not guilty by reason of insanity of serious violent offences reported that an average of 49% of patients had not been treated.[6] Five studies of the clinical presentation of FEP reported that, on average, 7.1% (2.5 to 13.7%) patients had committed an assault with a weapon, a sexual assault or an assault causing actual injury,[7] and two demonstrated a fall in the incidence of serious violence in the weeks after initial treatment. A further five studies, including a large international multi-centre study by Volavka,[8] found an average of 17.6% (12 to 31%) of first episode patients committed some form of physical violence prior to treatment.[9]

Psychosis and their Pathways to Psychiatric Hospital Care in South Germany" (2004) 39 Soc Psychiatry Psychiatr Epidemiol 375; Norman RM, Malla AK, Verdi M, Hassall LD and Fazekas C, "Understanding Delay in Treatment for First-Episode Psychosis" (2004) 34 Psychol Med 255; Turner M, Smith-Hamel C and Mulder R, "Pathways to Care in a New Zealand First-Episode of Psychosis Cohort" (2006) 40 A N Z J Psychiatry 421.

[3] Nielssen O, Westmore B, Large M and Hayes R, "Homicide During Psychotic Illness in NSW from 1993 to 2002" (2007) 186 Med J Aust 301.

[4] Appleby L and Shaw J, *Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, University of Manchester (2006), http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths_full_report.pdf viewed September 2007; Meehan J, Flynn S, Hunt IM, Robinson J, Bickley H and Parsons R, "Perpetrators of Homicide with Schizophrenia: A National Clinical Survey in England and Wales" (2006) 57 Psychiatr Serv 57 1648.

[5] Large M and Nielssen O, "Treating the First Episode of Schizophrenia Earlier Will Save Lives" (2007) 92(1)-(3) (May) Schizophr Res 276.

[6] Pasewark RA, Pantle ML and Steadman HJ, "Characteristics and Disposition of Persons Found Not Guilty by Reason of Insanity in New York State 1971-1976" (1979) 136 Am J Psychiatry 655; Lamb HR, Weinberger LE and Gross BH, "Court-Mandated Community Outpatient Treatment for Persons Found Not Guilty by Reason of Insanity: A Five-Year Follow-up" (1998) 145 Am J Psychiatry 450; Zonana HV, Wells JA, Getz MA and Buchanan J, "Part I: The NGRI Registry: Initial Analyses of Data Collected on Connecticut Insanity Acquittees" (1990) 18 Bull Am Acad Psychiatry Law 115.

[7] Humphreys MS, Johnstone EC, MacMillan JF and Taylor PJ, "Dangerous Behaviour Preceding First Admissions for Schizophrenia" (1992) 161 Br J Psychiatry 501; Steinert T and Gebhardt RP, "Aggressive Behavior Against Self and Others Among First-admission Patients with Schizophrenia" (1999) 50 Psychiatr Serv 85; Milton J, Amin S, Singh P, Harrison G, Jones P, Croudace T, Medley I and Brewin J, "Aggressive Incidents in First-Episode Psychosis" (2001) 178 Br J Psychiatry 433; Foley SR, Kelly B, Clarke M, McTigue O, Gervin M, Kamali M, Larkin C, O'Callaghan E and Browne S, "Incidence and Clinical Correlates of Aggression and Violence at Presentation in Patients with First Episode Psychosis" (2005) 72 Schizophr Res 161; Verma S, Poon LY, Subramaniam M, and Chong SA, "Aggression in Asian Patients With First-Episode Psychosis" (2005) 51 Int J Soc Psychiatry 365.

[8] Volavka J, Laska E, Baker S, Meisner M, Czobor P and Krivelevich I, "History of Violent Behaviour and Schizophrenia in Different Cultures: Analyses Based on the WHO Study on Determinants of Outcome of Severe Mental Disorders" (1997) 171 Br J Psychiatry 9.

[9] Bhugra D, Hilwig M, Mallett R, Corridon B, Leff J, Neehall J and Rudge S, "Factors in the Onset of Schizophrenia: A Comparison Between London and Trinadad Samples" (2000) 101 Acta Psychiatr Scand 135; Payne J, Malla A, Norman R, Windell D and Nicole B, "Status of First-Episode Psychosis Patients Presenting for Routine Care in a Defined Catchment Area" (2006) 50 Can J Psychiatry 42; Dean K, Walsh E, Morgan C, Demjaha A, Dazzan P, Morgan K, Lloyd T, Fearon P, Jones PB and Murray RM, "Aggressive Behaviour at First Contact with Services: Findings From the AESOP First Episode Psychosis Study" (2006) 36 Psychol Med 1; Turner et al, n 2.

The authors found three studies linking criminal records to psychiatric case registers that provided information about the relationship between initial treatment and violence. Wessley[10] found that although violent offending was 3.8 times higher in patients with schizophrenia compared with controls, schizophrenia was not a significant predictor of conviction for violent offences once the illness was established. In other words, those patients with schizophrenia who committed violent offences were far more likely to do so prior to the onset of acute symptoms or during their first episode of illness.

Studies by Mullen[11] in combination with data published in a related study by Wallace[12] demonstrate that patients with schizophrenia commit violent crimes at very different rates in different stages of their illnesses. Their results showed violent crime rates in schizophrenic subjects peaked in the four years prior to first admission, during the prodrome and the first episode of psychotic illness. Their findings were consistent with those of Munkner,[13] which found that only one quarter of the total offences committed by males with schizophrenia were committed after the initiation of treatment.

Violence is not the only cause of serious harm in FEP. Three well-conducted studies[14] have demonstrated an increased risk of suicide and suicide attempts in FEP and Melle[15] found an association between suicide attempts and long DUP.

Long DUP is also associated with a worse short-term prognosis and enduring psychological and social disabilities.[16] Worldwide, the mean DUP is more than a year,[17] although it is significantly lower in countries with better mental health services and legislation that makes it easier to admit first episode patients for treatment.

The consequences of violence and suicide invariably lead to the involvement of the legal system in determining responsibility for violence, in inquiries regarding adverse events, in assessing damages for negligence and in confirming and deciding on the conditions of involuntary treatment. Hence, the emerging understanding of the particularly increased risk of adverse events during the FEP has significant implications for the legal system.

IMPLICATIONS FOR MENTAL HEALTH LAW

The two main principles which guide legislation to allow involuntary detention and treatment of the mentally ill are the perceived risk of harm and the need for treatment. The risk of serious harm to self or others is the sole criterion for involuntary treatment of the mentally ill in every State of Australia

[10] Wessley SC, Castle D, Douglas AJ and Taylor PJ, "The Criminal Careers of Incident Cases of Schizophrenia" (1994) 24 Psychol Med 483.

[11] Mullen PE, Burgess P, Wallace C, Palmer S and Ruschena D, "Community Care and Criminal Offending in Schizophrenia" (2000) 355 *Lancet* 614.

[12] Wallace C, Mullen PE and Burgess P, "Criminal Offending in Schizophrenia Over a 25-year Period Marked by Deinstitutionalization and Increasing Prevalence of Comorbid Substance Use Disorders" (2004) 161 Am J Psychiatry 716.

[13] Munkner R, Haastrup S, Joergensen T and Kramp P, "The Temporal Relationship Between Schizophrenia and Crime" (2003) 38 Soc Psychiatry Psychiatr Epidemiol 347.

[14] Altamura AC, Bassetti R, Sassella F, Salvadori D and Mundo E, "Clinical Variables Related to Suicide Attempts in Schizophrenic Patients: A Retrospective Study" (2003) 60 Schizophr Res 47; Clarke M, Whitty P, Browne S, McTigue O, Kinsella A, Waddington JL, Larkin C and O'Callaghan E, "Suicidality in First Episode Psychosis" (2005) 86 Schizophr Res 221; Melle I, Johannesen JO, Friis S, Haahr U, Joa I, Larsen TK, Opjordsmoen S, Rund BR, Simonsen E, Vaglum P and McGlashan T, "Early Detection of the First Episode of Schizophrenia and Suicidal Behaviour" (2006) 163 Am J Psychiatry 768.

[15] Melle et al, n 14.

[16] Marshall M, Lockwood L, Bradley C, Adams C, Joy C and Fenton M, "Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First Episode Patients" (2005) 62 Arch Gen Psychiatry 975; Perkins DO, Gu H, Boteva K and Lieberman JA, "Schizophrenia: A Critical Review and Meta-Analysis Relationship Between Duration of Untreated Psychosis and Outcome in First-Episode" (2005) 162 Am J Psychiatry 1785.

[17] Large M and Nielssen O, *Methods of Measuring DUP and Access to Treatment for First Episode Psychosis Patients* (2007), Submitted for publication.

and the United States[18] and six countries in the European Union.[19] Patients can be admitted on the basis of an assessed need for hospital treatment and their inability to give consent to treatment in the remaining European countries and in six of 11 provinces of Canada.[20]

Despite the requirement that a patient be dangerous to self or others in order to be detained, predictions of dangerousness are known to be highly unreliable. For example, the best study of the prediction of suicide at the point of admission found that suicide prediction was of no clinical value because of the high rates of both false predictions of suicide and of missed cases.[21]

The prediction of violence following discharge from hospital is somewhat better, probably because violence is more common than suicide. For example, the instrument developed by Monahan et al[22] has an impressive 70% sensitivity and 72% specificity for predicting violence within 20 weeks of discharge. However, such a large number of the subjects were misclassified that it could never been used on its own to make decisions about admission to hospital. Moreover, the main predictor of future violence is past behaviour, which does not apply to first episode patients, who are now known to carry the highest risk of violence. It has been argued that the danger criterion only works at all because accurate risk assessment is not possible and those involved work in the best interests of the patient irrespective of the statutory requirements.[23]

The implication of the emerging evidence of a greatly increased risk of violence in the first episode of mental illness is that mental health legislation should be amended to allow earlier intervention in first episode patients,[24] preferably on the basis of the obvious need for treatment and an inability to give consent for treatment because of the effect of mental illness, rather than the unreliable prediction of future serious harm to self or others. The evidence of a greatly increased risk of violence in the prodromal phase of psychosis suggests that definitions of mental illness should be broadened to include the prodromal phase of psychotic illness.

The other side of such a finding of greatly increased risk of serious violence and self harm in FEP is that the risk of violence by previously treated patients is quite low and that most patients can be managed safely in the community. The reduction in the risk of further violence probably applies to patients who have committed serious violent offences in their first episode of mental illness and who are then detained in secure hospitals for long periods. The rate of serious re-offending for forensic patients is very low[25] and it may be possible to show that patients whose violent conduct occurred in their first episode of illness carry a particularly low risk of further violence once they have received treatment.

IMPLICATIONS FOR CIVIL LITIGATION

The first Tarasoff case and subsequent laws in parts of the United States held that clinicians have a duty to warn people whom they believe may be in danger from patients under their care that over-rides the duty to maintain patient confidentiality.[26] The duty typically arises where it is considered that there is a foreseeable risk to a specific person.

[18] Appelbaum PS, "Law and Psychiatry: Can a Psychiatrist be Held Responsible When a Patient Commits Murder?" (2002) 53 Psychiatr Serv 27.

[19] Dressing H, "A Comparison of Admissions of Mentally Ill Patients in European Union Member States" (2004) 39 Soc Psychiatry Psychiatr Epidemiol 797.

[20] Anfang SA and Appelbaum PS, "Civil Commitment – The American Experience" (2006) 43(3) Isr J Psychiatry Relat Sci 209.

[21] Pokorny AD, "Suicide Prediction Revisited" (1993) 23 Suicide Life Threat Behav 1.

[22] Monahan J, Steadman HJ, Robbins PC, Appelbaum PS, Banks S, Grisso T, Heilbrun K, Mulvey EP, Roth L, and Silver E, "An Actuarial Model of Violence Risk Assessment for Persons with Mental Disorders" (2005) 56 Psychiatr Serv 810.

[23] Warren CAB, *Court of Last Resort: Mental Illness and the Law* (University of Chicago, 1982).

[24] Hayes R, Nielsson O, Sullivan D, Large M and Bayliff K, "Evidence Based Mental Health Law: The Case for Legislative Change to Allow Earlier Intervention in Psychotic Illness" (2007) 14(1) *Psychiatry, Psychology & Law* 35.

[25] Simpson AI, Jones RM, Evans C and McKenna B, "Outcome of Patients Rehabilitated Through a New Zealand Forensic Patient Service: A 7.5 Year Retrospective Study" (2006) 24 Behav Sci Law 833.

[26] Herbert PB, "The Duty to Warn: A Reconsideration and Critique" (2002) 30 J Am Acad Psychiatry Law 417.

The emerging evidence of a greatly increased risk of serious and lethal assault on family members and close associates by patients in the FEP creates a duty for clinicians not only to intervene and initiate treatment, but also to alert family members (and others involved in the patient's care) of the increased risk of violence arising from frightening symptoms. Once the patient's condition is known, any subsequent violence would be "reasonably foreseeable" and failure to have taken reasonable steps to intervene would be seen to have been negligent.

The patient is also subject to a duty of care, as illustrated in a case reported by Appelbaum[27] of a recently diagnosed patient who stopped taking antipsychotic medication after an initial period of treatment and subsequently killed two strangers. The patient was initially successful in an action against his psychiatrist for his failure to fully describe the serious and persistent nature of his psychosis, although the case was overturned when a higher court found the homicides were not foreseeable. The final outcome seems reasonable given the risk of an FEP patient killing a stranger is probably lower than one in 5,000 new cases of psychosis. However, in light of the recent studies, the homicide of a family member who is the subject of a frightening delusional belief held by an FEP patient would be held to be reasonably foreseeable.

Given the controversial nature of many common law claims for damages arising from a failure to treat, legal principles have been devised to limit the patient's rights to claim for damages arising from his or her behaviour while mentally ill. In the case of *Hunter Area Health v Presland*,[28] an FEP patient who killed his brother's fiancée soon after premature discharge won damages from the health authority for the consequences of the failure to treat. The Court of Appeal overturned the decision on public policy grounds, and the opportunity for other patients to sue in a similar way was blocked by changes to the *Civil Liability Act 2000* (NSW). There had been a number of similar actions in less contentious circumstances with more obvious negligence, but it is not known how many of those cases have been settled in favour of the patient.

The authors have found significant differences in the proportion of homicides during FEP between countries, which in turn appears to be directly related to the DUP.[29] This finding could expose those health services that could not demonstrate that they had taken reasonable steps to reduce DUP, or provide the means for timely treatment, to a liability at common law for damages to injured, bereaved and financially disadvantaged relatives after homicides by FEP patients. But again, changes to the common law by civil liability acts will severely limit such exposure to suit.

Ordinary people in Australia who suffer the consequences of negligence by a large range of insured persons and organisations, such as motor vehicle drivers, employers, professionals such as psychiatrists, and public authorities such as psychiatric hospitals, are only just beginning to experience the consequences of the success of the insurance lobby in persuading governments to curtail common law rights to compensation in return for the promise of reduced insurance premiums. Limitations on liability and assessment of damages contained in civil liability acts significantly reduce the legal exposure of professionals, public authorities, and individuals exercising statutory discretions, such as that of a psychiatrist to admit a person assessed as mentally ill under a mental health act. The authors believe the new data about the risks in FEP support claims for a capacity to sue for damages for the consequences of lack of care and the winding back of the recent tort law reforms.

IMPLICATIONS FOR CRIMINAL RESPONSIBILITY

Cases arising from violence by the mentally ill are common in criminal courts. Criminal behaviour, especially interpersonal violence, can be a direct consequence of symptoms of psychosis, but may also be due to the loss of emotional regulation and capacity for logical thinking that accompanies both acute psychotic illness and the prodrome of illness.

[27] Appelbaum, n 18.

[28] *Hunter Area Health Service v Presland* (2005) 63 NSWLR 22.

[29] Large and Nielssen, n 17.

The high rates of violence in FEP are probably due to the combination of frightening symptoms and a lack of awareness of illness.[30] FEP patients usually have no prior experience of remission of symptoms after treatment and have received no medical explanation for their symptoms. In recently published studies on this topic, the most common reason given for lethal assault is the frightening delusional belief that the victim is about to attack.[31]

Both the effect of a defect of reason depriving a person of the knowledge that their actions are morally wrong, and the effect of gross disorganisation of thinking associated with acute mental illness are recognised in Australian jurisdictions in the mental illness defences and the partial defences of substantial impairment and diminished responsibility.

Case linkage data showing an increased rate of violent offences by people who develop schizophrenia prior to the emergence of symptoms of psychosis, or before the symptoms are detected,[32] suggests that the prodrome of mental illness is also associated with an increased predisposition to irrational violence. However, prodromal symptoms may not be sufficient to meet the criminal law definitions of mental illness and mental abnormality.

Post-sentence developments which reflect upon the appropriateness of the conviction or sentence of a person are considered under the common law system of government and criminal justice to be peculiarly the province of the Executive. However, where the development is in the mental state of the convicted person, as where the offender has moved from the prodrome at the time of the offence to a frank mental illness following sentence to prison, the criminal justice system has been prepared, to a degree, to accommodate therapeutic values. For example, various jurisdictions in Australia, including New South Wales, allow mentally ill prisoners to be transferred from prison to psychiatric hospitals and, if appropriate, released under community care, prior to the expiry of their sentences. But where, as in New South Wales, diversion from the criminal justice to the mental health care system is controlled by the Executive, the therapeutic value of the process is generally made secondary to populist notions of law and order. It is no longer possible in New South Wales to secure the conditional or unconditional release, even by the Executive, of a transferee forensic patient who is serving a life sentence.[33]

Evidence that an offence occurred during the prodrome of a mental illness may be relevant to sentencing. While the statement by the Victorian Court of Appeal of the relevance of mental illness to sentencing requires only that "the evidence shows the nature, extent and effect of the mental impairment experienced by offender at the relevant time",[34] the statement of the New South Wales Court of Criminal Appeal requires the particular classification of the mental state as a "significant mental disorder".[35]

Existing sentencing guidelines need to be developed to facilitate appropriate placements and services for long-term prisoners who are first and foremost chronically mentally ill, taking into account the low risk of further violence in psychotic episodes subsequent to that in which the homicide occurred.

Individual deterrence is clearly relevant to whether a life sentence should be imposed under s 61 of the *Crimes (Sentencing Procedure) Act 1999* (NSW). Thus, the limited relevance of punishment, as opposed to treatment, to the prevention of further violence from prodrome and first episode offenders should render a sentence to life for murder a seldom-used option. And current guidelines make it relevant that the prodrome and first episode offender typically has had no experience of, and limited capacity to cope with, violent, stressful environments, whether they be psychiatric hospitals or prisons.

[30] Bjorkly S, "Empirical Evidence of a Relationship Between Insight and Risk of Violence in the Mentally Ill – A Review of the Literature" (2006) 11 *Aggression and Violent Behaviour* 414.

[31] Large and Nielssen, n 5.

[32] Fazel S and Grann M, "Psychiatric Morbidity among Homicide Offenders: A Swedish Population Study" (2004) 161 Am J Psychiatry 2129.

[33] *Mental Health Act 1990* (NSW), ss 82(5), 106.

[34] *R v Verdins* [2007] VSCA 102 at [8] (Maxwell P, Buchanan JA and Vincent JA agreeing).

[35] *R v Henry* [2007] NSWCCA 90 at [28] (Howie J, Simpson and Hislop JJ agreeing); *Clay v The Queen* [2007] NSWCCA 106.

The experience of those who routinely provide representation and expert evidence in the criminal courts is that there is a constant stream of cases in which people have committed homicides in bizarre circumstances that raised the suspicion of mental illness, but are dealt with by the courts as though they are mentally normal, only to develop frank mental illness in the years after being sentenced. No Australian jurisdiction has a specialist mental health court that can develop a general expertise through concentration exclusively on the appropriate judging, sentencing and disposition of mentally ill offenders. In any event, the development by judges of specialist expertise, which they then use to inform their decision-making, is against the common law tradition. Nevertheless, in criminal cases involving mentally ill accused, judges do need in many instances to be better informed not only about the science of mental illness and its treatment and management, but also about the limitations and dangers of the environments to which the mentally ill offender will be consigned in order for judges to be able to elaborate further, and sensibly apply, the sentencing principles relating to mentally ill offenders.

The emergence of a clear FEP soon after a person is convicted may be grounds for an appeal, if it can be established that the offence was committed after a morbid change that was present at the time of crime. However, it would have to be determined whether the emergence of frank mental illness constitutes "fresh evidence" justifying an appeal. In *R v Ashton*,[36] the court held:

> There is a firmly established principle that this Court will allow evidence to be introduced of events subsequent to the imposition of sentence concerning the physical or mental condition of the applicant where the existence or effect of that condition was unknown or not fully appreciated at the time sentence was passed.[37]

Ashton involved a re-determination of sentence based on fresh evidence in the form of psychiatric reports made subsequently to the date of sentence.

Fresh evidence is relevant at the second of the two stages of a sentencing appeal. The first question requires a determination whether the sentence imposed was appropriate. The second question is a re-determination of the sentence if it has been found that the sentence imposed was inappropriate. The general rule is that fresh evidence cannot be taken into account in the first stage. However, this is subject to the *Ashton* exception that allows the appellate court to re-sentence in light of a significant development of the applicant's mental state.

The high risk of serious violence in FEP when compared to subsequent episodes of psychotic illness has a bearing on the assessment of future dangerousness. There is a 20-fold decline in the risk of homicide after treatment and patients who commit serious violence in their first episodes of illness and respond to treatment can generally be managed in lower security settings. There needs to be a more complete understanding of the effect of the phase of illness and the pattern of symptoms associated with violence which better informs sentencing and decisions regarding transfer to lower security settings and to community care.

STATUTORY BODIES TO INVESTIGATE PSYCHOTIC HOMICIDE

Individual homicides are subjected to intensive investigation by coroners and by criminal courts. However, the findings of individual cases may not take into account all of the scientific knowledge or be able to consider trends in psychotic homicides in a way that could allow recommendations to reduce the danger to the public. In Finland and in England and Wales, statutory bodies have been set up to investigate homicides committed by the mentally ill. Without the findings of those bodies, the true relationship between FEP homicide and its relationship to delays in initial treatment might still be unknown.

The authors recommend the establishment of similar independent authorities to investigate all homicides and incidents of serious violence committed by the mentally ill. The findings of an independent statutory body could support the introduction of measures that could save lives.

[36] *R v Ashton* (2002) 137 A Crim R 73.

[37] *R v Ashton* (2002) 137 A Crim R 73 at [10] (Howie J, Buddin J agreeing).

CONCLUSIONS

The emerging scientific evidence of an increased risk of violence and serious harm during the first episode of psychotic illness has significant implications in civil, criminal and mental health law, as well as affecting clinicians and treating agencies.

Mental health law should be amended to make it easier to provide treatment earlier, either by a special provision to allow the assessment and treatment of patients in the FEP or the prodrome of mental illness, or by the return to provisions allowing treatment on the basis of need and an inability to recognise or give consent to involuntary care.

The greatly increased risk of adverse consequences for patients and those around them during the FEP also has serious implications for clinicians and health services, who may be liable for failing to treat patients or take reasonable measures to provide earlier treatment of first episode patients.

The implications for criminal law arise from the fact that: (a) first episode patients have a lower level of criminal responsibility because of their lack of experience in recognising symptoms; (b) there needs to be a reassessment of the risk of further violence by patients who committed violent acts in their first episode of illness; and (c) difficulties associated with basing an appeal on the emergence of mental illness after sentencing which confirms that the person's conduct was affected by the prodromal phase of mental illness.

The findings of the recently published studies support the establishment of a statutory body to investigate serious violence by the mentally ill, which could provide further data to inform the courts.