FORENSIC PSYCHIATRY

RC ROUNDS

DR. A JEWETT

Fact witness = no compensation, tell what you **saw/heard**, no opinion, testimony not optional

Expert witness = paid for time, job to give opinion, can choose not to testify but could be compelled/breach of contract

Anytime you are in expert role – you **must inform the evaluee of the limits of confidentiality** as early as possible

Dual duties = doctor/patient but also honesty and objectivity in reporting to court

Court ordered assessments – usually NCR and fitness, **court is employer**

Assessment orders do not allow treatment, can only be used to determine fitness or NCR, determine disposition, challenge credibility of later statements, establish perjury

Duration 5-30 days, can be renewed to max of 60 days

FITNESS TO STAND TRIAL

- Competency
- Guarantee fair trial
- Safeguard accuracy of criminal adjudication
- Preserve integrity and dignity of legal process
- To be certain if the accused found guilty, knows why he is being punished
- Unfit to stand trial:
  - Unable to conduct a defense at any stage of proceedings before a verdict is rendered or to instruct counsel to do so
  - Unable on account of a mental disorder to understand nature of proceedings, understand possible consequences, or communicate with counsel
- Evaluate with McGarry's criteria – 13 criteria

FITNESS TO STAND TRIAL

If unfit – Crown may request person be treated for up to 60 days to restore to fitness, then back to court

Cannot give ECT or psychosurgery

Can treat even if the person is competent to refuse – right to trial trumps right to own body

If not restored, accused comes under the review board's jurisdiction

NOT CRIMINALLY RESPONSIBLE

- On account of mental disorder
- Actus Reus – illegal act committed consciously and voluntarily
- Mens Rea – the guilty mind, guilty act done purposely, knowingly, or recklessly
- Both must be proven by the Crown beyond a reasonable doubt (~90% certainty)
- Canadian standard based on McNaughten Rule
- Section 16 CCC:
  - No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong
  - Every person is presumed not to suffer from a mental disorder, must be proven on a balance of probabilities (>51%)
  - Burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue
- Is there the presence of a mental disorder? Due to the mental disorder, are the incapable of appreciating the nature and quality of the act? Are they incapable of knowing that it was wrong?
- Typically psychotic illnesses, mania with psychosis, psychotic depression

NCR

Nature and quality of the act

Being able to appreciate the material or physical consequences of one's actions

Ie. When you stabbed your neighbor in the heart, did you realize they might die?

Knowing wrongfulness

Being able to apply rational understanding of right and wrong to one's actions

What is the motive?

- Irrational or psychotic
- Rational – profit, revenge/anger, other evidence of rational motive

REVIEW BOARDS

- Goal is to manage risk, not to punish
- Two main questions – does the person pose a significant threat, and if so, how can the threat be reasonably managed?
- If threat – disposition must be necessary and take into consideration need to protect public, mental condition of accused, reintegration of the accused into society, other needs of the accused
- Dispositions:
  - Absolute discharge – not a significant threat
  - Conditional discharge – like probation with conditions – drug tests, appts, living
  - Detained in hospital – like involuntary hospitalization with conditions and privileges (ie. living in community, passes to visit family)
- Bill C-14 clarifies significant risk
  - High risk designation for NCR, can only have detention order, limited community access, extends mandatory hearings to q36 mo vs 12

MENTAL ILLNESS IN CORRECTIONS

- Transinstitutionalisation = closure of mental hospitals leading to rise in incarcerated mentally ill patients (Penrose effect)
- No evidence that deinstitutionalization has led to increased crime and need for more prisons
- Inmates = 97% men, 84% psych dx, **SUDs highest at 75% (85-90%)**, excluding SUD, 43% had a psychiatric disorder, suicide rate 3.7 x higher than gen pop
- 10-14% have mood disorder
- Personality disorder in 50-60%
- **20% of deaths in custody due to suicide**, 3-11 x greater than gen pop
- Mental illness is a risk factor for violence – small but significant, still controversial
- Scz associated but mostly due to concurrent substance abuse
- Paranoid psychosis – more planned violence than disorganized, positive sx>negative
- Threat/control delusions most risky
- Command hallucinations and depression
- **Substances most significant role**
- Impulsive violence – BPD, ASPD, paranoid PD, NPD – anger, impulsivity, hostility
- Planned violence = psychopathy

ASPD

- Since age 15, at least 18 years old
- Rule violating
- Increased co-morbidity of MDE, ETOH, SUDs, SI, Anxiety
- Etiology:
  - Biology – FAS, birth trauma, early head trauma
  - Genetics – hereditary, ADHD, SUDs, other psych disorders
  - Psychological – modelling of violence, insecure attachment, non-validating environment, failure to develop soothing interjects, lack of sense of mastery of environment
  - Social – master environment through antisocial activity, substances regulate anxiety
- Treatment
  - Pick specific targets – SUD, violence, aggression, impulsivity
  - Treat co-morbidities
  - Aggression – valproic acid, carbamazepine, SSRIs, lithium, antipsychotics, BB

DR. BENASSI – TORONTO REVIEW

Conduct Disorder

Aggression to people and animals

Destruction of property

Deceitfulness or theft

Serious violations of rules

May have limited prosocial emotions

Prevalence 10%, male children more than females, not in adolescence

Risks – parental ASPD, childhood adversity, hypoarousability

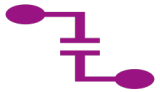
Comorbid with ADHD, SUD, ODD, LD (reading)

Prognosis – less than 50% of severe CD develop ASPD (M>F)

Increased risk of suicide

Tx with psychosocial interventions at parenting and school, CBT, epival, risperidone

Treat ADHD



ASPD

0.2-0.3% prevalence, M>F

Males in prison up to 75%

Risks similar to CD, severe CD and hyperactivity, hypoactive amygdala, decreased 5HT

Comorbid with anxiety, SUD, impulse control disorders, somatization when older

30% improve by 30 years old, 80% remit by 40

Suicide risk 5%, more violent methods

Tx – firm limits, CBT group>individual, carbamazepine/valproate for impulsivity, BB for aggression

Psychopathy (score of 30)

Factor 1 (associated with capacity for rehab)

- Glibness, superficial charm
- Grandiose self worth
- Conning/manipulative
- Lack of remorse or guilt
- Shallow affect
- Callous/lack of empathy
- Failure to accept responsibility for own actions

Factor 2 (assoc. with propensity of violence)

- Need for stimulation, prone to boredom
- Parasitic lifestyle
- Lacks realistic, long-term goals
- Impulsivity
- Irresponsibility
- Poor behavior control
- Early behavior problems
- Juvenile delinquency
- Revocation of conditional release
- Criminal versatility

RISK ASSESSMENT

- Hard to predict violence, suicide
- Better to systemically assess the potential risks
- Reduce or manage risk factor – tx ADHD, mania, psychosis
- Potential violence involves magnitude, likelihood, imminence, frequency
- Alcohol contributes most of SUD

- Look at static and dynamic risk factors
  - Static
    - Previous violence
    - SUD
    - Age – peaks in late teens and early 20s
    - Gender
    - IQ
    - Childhood factors
    - Young age of violence
    - Socioeconomic status
    - Psychopathy
  - Dynamic
    - Current substance abuse/intoxication
    - Agitation
    - Supports
    - Access to weapons
    - Stress (work, finances, relationships)
    - Negative attitude towards treatment
    - Insight
    - Impulsivity
    - Access to victims
    - Current instability of mental illness

CIVIL LAW

- Fiduciary duty – a doctor must act in the patient's best interests
- At risks when personal interests conflict, another fiduciary duty conflicts, profit, benefit or gain from position possible
- Privilege = a patient's right to decide what happens to their personal information, belongs to the patient not to the doctor
- Confidentiality = a clinician's obligation to not disclose information
- Exceptions to confidentiality:
  - Mandatory reporting
    - Child abuse – reasonable grounds to suspect, physical and sexual, some provinces emotional and neglect
    - Occupational hazards – flight crew member or air traffic controller
    - Railway hazard – railway safety act
    - Elder abuse
    - Professional sexual misconduct
    - Driving
    - Communicable diseases
    - Gunshot wounds
    - Health insurance fraud
  - Civil litigation – lawsuit for malpractice or disability, info becomes available to courts, patient consents
  - Court ordered assessments
- Duty to protect – Tarasoff Case
  - Protective privilege ends where the public peril begins
  - Duty to protect, warn, inform if risk to clearly identifiable person or group, when risk includes severe bodily injury, death, or serious psychological harm, when element of imminence and sense of injury
- Informed consent
  - Competence – capacity to understand and act reasonably, legal term
  - Capacity – mental ability to make a rational decision based on understanding and appreciating information, clinical opinion by clinician
  - Lack of consent for touching = battery or assault
  - Failure to obtain informed consent = negligence
  - Valid consent = specific, informed, voluntary, capable, implicit vs. explicit
  - Diagnosis and nature of tx, purpose of tx, risks and benefits of options, alternative treatments and risks
- Substitute consent
  - TSDM
  - Doctor
  - Courts decide tx
  - Based on best interests of patient and what patient would have wanted if they were competent
  - Guardianship – ability to manage one's affairs (personal, property)
  - Financial capacity
  - Capacity to consent or refuse tx

MEDICAL MALPRACTICE

- Tort = civil suit involving one person wronging another, penalty is money, can be intentional (battery, assault), unintentional (negligence)
- Negligence
  - Duty
    - Usually evident – saw patient
    - Could extend to hallway consultation, on-call coverage, duty to protect 3rd person
  - Dereliction
    - Must exercise a reasonable degree of knowledge and skill exercised by other members of the profession in similar circumstances
  - Damages
    - Physical or psychological harm (PTSD, depression), compensation is money for suffering
    - Punitive – court wants to make an example
  - Direct cause
    - Mistake must cause the negative outcome
    - Cause in fact = but for the psychiatrist's act or omission, the negative outcome would not have occurred
    - Proximate cause = act or omission was a substantial factor in bringing about the outcome
    - Foreseeable = flukes don't count, only reasonably foreseeable outcomes
- Malpractice in Canada = failure to undertake an appropriate and thorough suicide or homicide risk assessment, wrongful confinement, problems arising from prescription of medication, sexual impropriety, failure to meet the expected standard of care

PARAPHILIAS

- Paraphilias alone not disorder, must cause distress/impairment or entail personal harm or risk of harm to others
- In controlled environment and in remission specifiers
- Recurrent, intense, sexually arousing fantasies, sexual urges or behaviors generally involving non human objects, suffering or humiliation of oneself or partner, or children or other non-consenting persons
- Cause distress and dysfunction or interfere with rights of others
- Occur over a period of at least 6 mo
- Sex crimes common – 1/6 women, 1/1000 children per year
- Comorbidity is the rule (tend to have more than one)
- Pedophilia, frotteurism, voyeurism, exhibitionism, fetishism, sexual masochism, sexual sadism, transvestic fetishism, paraphilia NOS
- Much higher in men, onset usually late teens, early adulthood
- High fantasies in non-offenders, up to 21% had sexual attraction to children
- Many sex offenders do not have paraphilias – SUD, mental illness, ID, impulse control disorders
- Paraphilias very common, most do not come to clinical or legal attention

- Pedophilia
  - Most men
  - Less than 3% population
  - Most heterosexual
  - 50% consumed alcohol at time of offence
  - Often feel more accepted by kids – low SE, body image issues
  - High comorbidity
  - Treatment
    - External control
      - Incarceration
      - Release conditions – sex offender registration, community notification, castration
      - Civil commitment (not in Canada yet)
    - Reduce sex drive
      - Partial reduction – SSRIs, cyproterone, medroxyprogresterone
      - Ablation of testosterone – Lupron, goserelin
      - Inhibit peripheral testosterone – finasteride
    - Tx comorbid conditions (not manopause)
    - Psychotherapy
      - CBT, covert sensitization (imagine consequence whenever thought occurs), satiation (masturbate to non-bad fantasies, talk about bad ones without getting aroused), olfactory aversion, relapse prevention group, social skills group
    - Treatment works – overall 5 yr recidivism 13%, incest the lowest
    - 39% rapists 25 yrs, 53% extrafamilial child molesters 25 yrs
    - Compared to >60% for other offenses

K AND S PEARLS

- Split treatment = psychiatrist provides meds, nonmedical therapist does therapy; psychiatrist must retain full responsibility and spend sufficient time to ensure proper care given – ie. Must periodically discuss with therapist
- In making a will (testamentary capacity) = must know nature and extent of bounty (property), the fact that they are making a bequest, and the identities of their beneficiaries (spouse, kids, etc)
- Contractual capacity = ie marriage or contract = can be invalid if unable to comprehend the nature and effect of their act

RESOURCES

- Dr. Joel Watts – Ottawa Review Course
- Dr. Paul Benassi – Toronto Review Course
- K and S