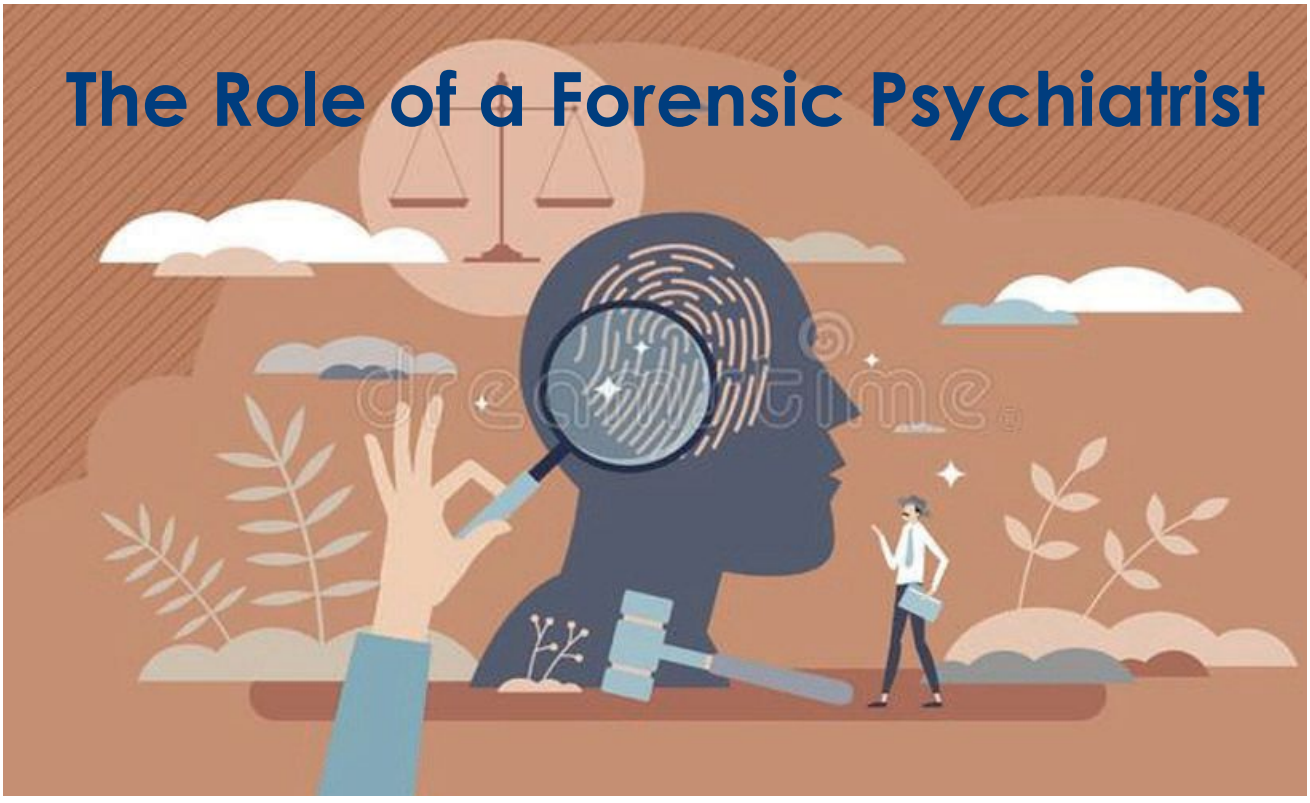
The Role of a Forensic Psychiatrist



by Christine Martone, MD

The proliferation of headline grabbing cases, accompanied by extensive media coverage, has generated interest in the role of psychiatry in the courtroom. Additionally, with the recognition of damage to emotional and mental wellbeing, the psychiatrist has become a more frequent presence in civil court.

"My name is Dr. Martone. I am here to complete a psychiatric evaluation of you which has been ordered by the court. The report of this evaluation will go to the judge. Therefore, if there are things you do not want the court to know, you should not reveal them to me." I began interviews with these or similar words at least two days a week for 40 years.

What is Forensic Psychiatry?

I am a retired forensic psychiatrist. Forensic psychiatry is the subspecialty that encompasses the interface of psychiatry and the law. The requirements for practice include a yearlong fellowship following the successful completion of a psychiatric residency. Board certification is necessary given the scrutiny exercised by the court and legal community. A clinical practice must also be maintained.

The implications of the words quoted above illustrate the fundamental difference between the role of a psychiatrist/physician and the forensic psychiatrist. The doctor-patient relationship inherent in the usual treatment setting does not exist in the forensic setting. The individual being evaluated is not referenced as the patient. He/she is identified as the defendant, the claimant, or the evaluee. Payment for services is provided by the requesting party. These requests do

not originate with the evaluee, since receiving payment from the evaluee creates the potential for bias. Since the contracting party is not the individual being evaluated but a third party, all reports belong to someone other than the physician or the evaluee. Specifically, they belong to the requesting party, whether that be the court or an officer of the court such as an attorney, or to the requesting agency such as an insurance company or an employer. While the forensic psychiatrist serves as expert witness to the court, often, particularly in civil cases, the forensic report is sufficient for the needs of the requesting party; and appearance in court does not occur. While the requirements and parameters have been outlined, the actual practice of forensic psychiatry encompasses many issues and arenas.

Much of my career as a forensic psychiatrist was spent fulfilling the requests of the criminal division of Allegheny County Court of Common Pleas. The image created by the media and entertainment industry is far from the reality. The request for an evaluation for the insanity defense is not a frequent one. The insanity defense is raised in less than 1% of felony cases. Of these, fewer than 26% are successful, and most of these occur during a bench trial (a trial whose outcome is decided by a judge rather than by a jury).[1] Despite the infrequency, I, in my role, have evaluated individuals involved in such headline grabbing cases as a mass murderer and extreme school violence. Given that the insanity defense captures the interest of the American public and raises questions for the psychiatric field at large, a brief discussion of the two most common insanity defenses used in the United States follows.

The Insanity Defense

First, it must be understood that, while the forensic psychiatrist reports on her findings regarding very weighty matters in criminal court, she does not decide; she opines. It is for the judge and the jury to decide. These are known as the 'fact finders'. It must also be understood that a person is presumed to be 'whole' unless the court states otherwise. In other words, he/she is presumed to be competent and sane. This means that the burden of proof for a not guilty by reason of insanity defense rests with the defense. Therefore, most, but certainly not all, requests for insanity evaluations originate with the defense.

When responding to such a request, the evaluator must use the standards established by the court. The traditional definition used in most states is the M'Naghten definition which derives from the famous case of Daniel M'Naghten in the Victorian England of 1843. Briefly, it states: *if an individual, "because of disease of mind or defect of reason, did not know the nature and quality of his act; or, if he did know it, he did not know the wrongfulness of it," he is not guilty by reason of insanity.*[2] The exact wording varies from state to state but the elements of disease or defect, nature and quality, and wrongfulness are present in all. There are fine points such as legal wrongfulness and moral wrongfulness which vary from state to state. It should be stressed that the criminal codes are referring to legal insanity and not psychiatric insanity. Additional parameters of the definition and examples of its merits are beyond the scope of this discussion and should be left for a more detailed review.

The second most common definition of legal insanity is the American Law Institute Standard (ALI) which states: *"If an individual, as a result of mental disease or defect, lacks the substantial capacity either to appreciate the wrongfulness of his conduct or the substantial capacity to conform his conduct to the requirements of the law," he is not guilty by reason of insanity.*[3] It can readily be seen that this is an easier standard to meet due to the conduct clause and the words "appreciate" and "substantial". Before 1984, roughly half of the states and Federal Court used the ALI defense and the other half M'Naghten. Since 1984, and the successful insanity defense of John Hinkley, who shot President Reagan, only 18 states still use the ALI standard and the Federal Court has abandoned it for a rule that more closely resembles the M'Naghten definition.[4]

There are two other legal insanity definitions (Irresistible Impulse and the Durham Standard), but they are rarely used.[5] Additionally, a guilty but mentally ill plea is available in several states. Likewise, a discussion of this defense is beyond the scope of this discourse.

Competency To Stand Trial

While these definitions and their aftermath are of interest, the most common question put to the forensic psychiatrist by the criminal court is the question of competency to stand trial. The Dusky standard is used to evaluate an individual for competency. It derives from a 1960 case which holds that the defendant being evaluated must have the capacity to understand the nature of the proceedings against him and to assist in his own defense to be considered competent to stand trial.[6]

Clearly there are many factors that have to be considered to reach an opinion regarding this capacity. The defendant must demonstrate the capacity to appreciate the seriousness of the charges being brought against him, to understand the possible outcomes/penalties, to define

the role of the various courtroom personal, to assess legal strategies, to cooperate with his attorney in presenting his defense, and to conduct himself appropriately in a court of law. If the court finds an individual incompetent to stand trial, the court requires that, if possible, competency be restored. This usually results in a criminal commitment to a forensic unit for further assessment and treatment.

Since the individual before the court is assumed to be whole/competent, the burden of the proof rests with the defense. The court, in its effort to preserve the integrity of the trial and to avoid grounds for appeal, requests competency evaluations as often, if not more often, than the defense. In our court and in most major counties, a court clinic is maintained for these evaluations. It was this court clinic (the Behavior Assessment Unit of the Court of Common Pleas of Allegheny County, Criminal Division) where I served on staff and as medical director for 40 years.

Additional questions regarding criminal competence include competence to waive the Miranda Warnings, to provide testimony in court, and to be executed. The parameters of these evaluations are left to a more detailed discussion.

Aid in Sentencing Evaluation

The second most common request made by the criminal court is a request for "an aid in sentencing" evaluation. This usually is a request to provide requirements or safeguards necessary for success in the community should the defendant be sentenced to probation rather than incarceration. While these evaluations can involve risk assessments, the actual decision to incarcerate is the responsibility of the court.

Involuntary Hospitalization

In actual practice, appropriateness for involuntary commitment is the most common assessment performed by a psychiatrist that entails legal consequences. Most often this is completed by a treating or ER psychiatrist and does not require forensic training or experience. If testimony becomes necessary, it is usually before a hearing officer assigned to the hospital rather than a formal proceeding in court. The criteria varies from state to state; but the assessment for dangerous behavior to self (including inability to care for oneself) or others is the key issue in all states. The danger can arise from a decision to do harm or poor judgment which would result in harm. No longer is psychosis enough. Threat is the issue under consideration, and the least restrictive form of treatment is the standard. [7]

Civil Issues Evaluations

The criminal justice system is not the only arena of law where forensic psychiatric consultation is requested. Very often, civil competence is evaluated. The capacity to make medical decisions such as treatment or placement is the most frequent question encountered by almost all specialties. The parameters to be considered are the ability to receive information, the ability to manipulate information, the ability to make a rational decision, and the ability to communicate the decision. These assessments are often completed in hospital by the liaison psychiatrist. Legally, these can be performed by any physician, but, in practice, are usually deferred to the psychiatrist. When there are objections and ensuing conflict, the matter is frequently referred to court where the services of a forensic psychiatrist are often requested.

Competency to handle funds, make a will, and enter a contract are other sources of referrals. The criteria for these assessments are beyond the scope of this discussion. It is important to again note that the person is considered whole until proven otherwise; therefore, the burden of proof rests with the party questioning the individual's capacity. The court decides if the individual is competent or incompetent; the psychiatrist assesses the compacity to perform the criteria necessary for the competence in question and serves as an expert witness.

Most medical and surgical specialties are consulted regarding the civil issues of tort, disability and worker's compensation cases depending on the injury claimed. Rarely is the treating physician's opinion accepted as there is concern regarding bias. An independent medical evaluation (IME) is sought. In today's environment with the focus on mental health coupled with less objective testing available for psychiatric diagnosis and causation, the forensic psychiatrist is frequently consulted.

Like all physicians, forensic psychiatrists are consulted in tort cases; these cases can range from malpractice to psychic damages from injury secondary to negligence or injury. When providing an opinion on a malpractice case, the forensic psychiatrist is asked to consider the four Ds which are the essential elements in all tort cases. Simply stated the four Ds refer to four essential questions: Did a duty exist? Was there a dereliction in that duty? Did damage occur to the plaintiff? Were the damages the direct result of the dereliction?

In tort matters other than malpractice such as accident or work injury, the clinician does not opine on duty or dereliction but rather focuses on damage and causation. For the forensic psychiatrist the psychic damage often involves Post Traumatic Stress Disorder (PTSD) or exacerbation

of a previous condition. An example might clarify. A mother and her older daughter witness the death of her younger daughter when a hose dislodges from a fire truck while speeding to a call, striking the child which results in her death. Both witnesses claim PTSD. Both require forensic evaluations.

Workplace Evaluations

The most frequent noncriminal referrals for evaluation by a forensic psychiatrist are requests for disability and worker's compensation evaluations. The issue in disability evaluation is the evaluee's ability to return to fulfill the duties of his most current job description or other employment, depending on the insurance policy. The issue of malingering is a frequent concern. While malingering is a concern for all specialties, it presents a greater challenge when a psychiatric disability is claimed as there are no concrete lab and radiologic studies available. Most often, the specialized training of a forensic psychiatrist is sought for clarification. Recommendations regarding the conditions necessary that would enable the worker to maintain his/her current employment are frequently requested. The issues are very similar in worker's compensation cases, with the addition of an opinion on the causation regarding workplace conditions.

Finally, fitness for duty is another frequent source of referral. This can take the form of routine screening for certain dangerous and high stress careers such as police work. These are usually completed by psychologists who administer screening tools such as the MMPI. More often the forensic psychiatrist is consulted when a worker is asked to leave employment because of mental illness and now seeks a return to his former duties. The problem can be an illness such as depression that prevents the worker from completing his or her tasks such as a teacher who, because of reoccurring episodes of depression, frequently misses work or cannot maintain adequate classroom instruction or complete grading on schedule.

More often, the forensic psychiatrist is asked to provide an opinion on an employee who is perceived as a threat on the job site. Frequently recommendations are required for the employee's safe return. The evaluation must include risk assessment. An example will help to clarify: the case of a crane operator for a steel plant who is diagnosed with alcohol use disorder and bipolar illness type II has demonstrated angry outbursts on the work site. The concerns are his judgment and impulse control compounded by the circumstance that he operates heavy equipment in a hazardous environment. The employee is evaluated after treatment has been instituted and his symptoms are controlled with medication. He is no longer abusing alcohol. The recommendations would consist of the following: no swing shift assignment as such scheduling is known to be associated with exacerbation of manic behavior, compliance with treatment including therapy and medication demonstrated, if available, with therapeutic blood levels, alcohol treatment and abstinence as demonstrated by random blood alcohol testing. It should be specified that the treating psychiatrist need only provide verification of compliance and not the content of therapy sessions. Lastly, regarding fitness for duty is that the requesting source is entitled only to the answer to the question of whether the defendant can or cannot return to duty and the recommendations. Past history of treatment or diagnosis are not part of the report.

Conclusion

Like many clinicians, I, as a forensic psychiatrist, have witnessed tragedy and triumph, the worst of humanity and the best. There have been sad yet humorous cases such as a mentally ill bank robber whose get-away plan was public transportation. The tragic cases involve the death of another (usually a loved one) caused by actions of a mentally ill individual who was not actively engaged in treatment at the time of the offense. There have been glimmers of hope when treatment is followed by a mentally ill individual confiding the damage that they were planning during their psychosis demonstrating that treatment does have the potential for preventing tragedy. Sadly, these are too few.

My career has been enormously interesting and professionally satisfying. I hope physicians-in-training might consider forensic psychiatry as a career and in-practice physicians will understand the capabilities and appropriateness of a forensic psychiatry consultation.

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Christine Martone, MD, is the former medical director of the Behavior Assessment Unit, Allegheny County Court of Common Pleas Criminal Division; Director of the Forensic Psychiatric Fellowship at University of Pittsburg Medical Center/Western Psychiatric Institute and Clinic, and a past president of the Pittsburgh Psychiatry Society.