01 - Chapter 19 Forensic Psychiatry

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Standard of Care and Malpractice 220
Confidentiality 220
Decision Making 221
Emancipated Minors 221
Decisional Capacity 222
Guardians and Conservators 222
Admission to a Psychiatric Hospital 223
Disability 223
Competence to Stand Trial .....223 Not Guilty by Reason of Insanity (NGRI).....224 Risk Assessment 224
Malingering.....225 Child and Family Law.....225
Correctional Psychiatry 225
FORENSIC PSYCHIATRY CHAPTER 19

220 FORENSIC PSYCHIATRY WARDS TIP A wrong prediction or a bad outcome is not necessarily proof of malpractice. ■ Risk assessment. ■ Criminal responsibility. KEY FACT ■ Competence/Decisional capacity. ■ Child custody and visitation. Four Ds of malpractice: Dereliction of Duty that was the Direct cause of Damage. ■ Trauma. ■ Mental disability. ■ Malpractice. ■ Involuntary treatment. WARDS QUESTION Q: What legal case set the precedent that physicians have a duty to report patients who are potentially dangerous to others? A: Tarasoff v. Regents of the University of California which called for the duty to warn. Confidentiality KEY FACT Doctors are required to report child abuse, but lawyers are not. Forensic psychiatry is a medical subspecialty that includes areas in which psychiatry is applied to legal matters. Forensic psychiatrists often conduct evaluations requested by the court or attorneys. While some forensic psychiatrists specialize exclusively in legal issues, almost all psychiatrists have to work within one of the many spheres where the mental health and legal system overlap. These areas include the

following: ■ Correctional psychiatry. Legal issues are considered criminal in nature if someone is being charged with a crime. Civil cases involve other kinds of rights and may result in monetary awards. It is important to note that the specific laws pertaining to the various topics discussed in this chapter may vary by state. Standard of Care and Malpractice ■ The standard of care in psychiatry is generally defined as the skill level and knowledge base of the average, prudent psychiatrist in a given community. ■ Negligence is practicing below the standard of care. ■ Malpractice is the act of being negligent as a doctor. ■ The following four conditions typically must be proven by a preponderance of the evidence in order to sustain a claim of malpractice:

1. The physician had a duty of care (psychiatrist–patient relationship).
2. The physician breached their duty by practice that did not meet the standard of care (negligence).
3. The patient was harmed.
4. The harm was directly caused by the physician's negligence. ■ If a malpractice case is successful, the patient can receive compensatory damages (reimbursement for medical expenses, lost salary, or physical suffering) and punitive damages (money awarded to "punish" the doctor). All information regarding a doctor–patient relationship should be held confidential, except when otherwise exempted by statute, such as: ■ When sharing relevant information with other staff members who are also treating the patient. ■ If subpoenaed—Physician must supply all requested information. ■ If child abuse is suspected—Obligated to report to the proper authorities. ■ If a patient is suicidal—Physician may need to admit the patient, with or without the patient's consent, and share information with the hospital staff. ■ If a patient threatens direct harm to another person—Physician may have a duty to warn the intended victim.

Decision Making ■ Process by which patients knowingly and voluntarily agree to a treatment or procedure. ■ In order to make informed decisions, patients must know the purpose of the treatment, alternative treatments, and the potential risks and benefits of undergoing and of refusing the treatment. ■ The patient should have the opportunity to ask questions. ■ Situations that do not require informed consent: • Lifesaving medical emergency. • Prevention of suicidal or homicidal behavior. • Unemancipated minors (typically require informed consent from the parent or legal guardian). EMANCIPATED MINORS ■ Considered competent to give consent for all medical care without parental input or consent. ■ Minors are considered emancipated if they are: • Self-supporting. • In the military. • Married. • Have children or pregnant. A 74-year-old male with insulin-dependent diabetes mellitus and severe major depressive disorder was admitted to the intensive care unit for treatment of diabetic ketoacidosis. The internal medicine team calls your psychiatry consult-liaison service to evaluate the patient for depression and provide treatment recommendations. When you meet the patient, he is disoriented, confused, and has a waxing and waning level of consciousness. His mini-mental state exam (MMSE) score is 18/30. You identify that the patient is likely delirious, and you are unable to obtain any useful historical information. After interviewing the patient's daughter by phone, you learn that the patient's wife passed away 2 years ago, and in the past he had told family members that he can no longer live without her. One year ago, his daughter found him in the garage taping a hose to his car's exhaust pipe. She said that he broke down crying and admitted that he was going to kill himself by carbon monoxide poisoning. His daughter has been very concerned because he refuses to check his glucose or take his insulin as recommended. She stated, "I think he was trying to kill himself by not taking care of

his diabetes.” He is followed daily by your consult-liaison team, and his MMSE score improves to 28/30. On hospital day 5, the internal medicine team informs you that he has developed wet gangrene in his right lower extremity and will need to have a below-knee amputation as soon as possible. The team asks you to assess the patient’s capacity to make medical decisions because he is adamantly refusing to consent to this procedure. You meet with the patient to discuss his medical situation. He is alert, lucid, and fully oriented. His affect is euthymic and appropriate. He states, “My doctor told me that I had an ulcer on my foot from poorly controlled diabetes that has become severely infected. I was told that I need to have my right FORENSIC PSYCHIATRY WARDS QUESTION Q: In what situations is informed consent not required? A: In a lifesaving medical emergency, to prevent suicide or homicide, or when treating an unemancipated minor. KEY FACT Elements of informed consent (4 Rs): • Reason for treatment • Risks and benefits • Reasonable alternatives • Refused treatment consequences WARDS QUESTION Q: What is the key difference between capacity and competency? A: Capacity is a clinical term assessed by physicians, while competency is a legal term decided by a judge.

222 FORENSIC PSYCHIATRY WARDS TIP When evaluating for decisionmaking capacity think CURA: Communicate a clear choice Understand the situation, proposed treatment, and treatment alternatives Reason logically through information and decision Appreciate consequences, including risk/benefits of treatment or refusal of treatment WARDS QUESTION Q: What is the standard hierarchy for choosing a surrogate decision maker? A: 1. Durable POA or court-appointed guardian 2. Spouse 3. Adult offspring 4. Parent 5. Sibling 6. Other relative in close contact with patient 7. Close friend DECISIONAL CAPACITY KEY FACT Emancipated minors do not need parental consent to make medical decisions. GUARDIANS AND CONSERVATORS leg amputated very soon or else I could die from the infection.” He maintains that he is not interested in the surgical procedure that has been recommended. He adds, “My daughter is begging me to have the surgery, but I’m already old and I don’t want to have to use a prosthetic leg or a wheelchair. I do not think life would be worth living if I had this amputation.” He denies suicidal thoughts, plan, or intent. Does this patient with history of severe major depressive disorder demonstrate the capacity to refuse a potentially lifesaving procedure? Yes, he demonstrates the capacity to refuse the recommended amputation. Legal standards for decision-making capacity to consent or refuse medical treatment involve the following: the ability to communicate a choice, to understand the relevant information, to appreciate the medical consequences of the situation, and to reason about treatment choices. In this case, the patient demonstrated the ability to discuss all of these topics. Although he was cognitively impaired on admission, his delirium eventually cleared. However, the case is complicated by the fact that the patient may be currently suffering from major depression. This should be further assessed. While a history of current major depression does not preclude having decisional capacity, the patient should be evaluated carefully to ensure that his refusal of treatment does not stem from intent to commit suicide. If it does, then his suicidal intent would be interfering with his ability to reason. Optimally, the consult-liaison team may recommend treating the depression and readdressing the surgical procedure when his depression is in remission, but this may take many weeks and failure to amputate the limb in a timely manner could result in death. Since the patient demonstrates decision-making capacity and does not appear to be suicidal at this time, the medical team must respect the patient’s wishes and treat the condition without surgery Competence and capacity are terms that refer to a patient’s ability to make informed treatment decisions. ■ Capacity is a clinical term and may be assessed by physicians. ■ Competence is a legal term and can be decided only by a judge. ■ Decisional capacity is task

specific and can fluctuate over time. ■ In order for a patient to have decisional capacity, they must be able to: • Understand the relevant information regarding treatment (purpose, risks, benefits). • Appreciate the appropriate weight and impact of the decision. • Logically manipulate the information to make a decision. • Communicate a choice or preference. • Criteria for determining capacity may be more stringent if the consequences of a patient's decision are very serious. ■ If a patient is determined not to have decisional capacity, the decision is typically made by a surrogate decision maker, usually a power of attorney, spouse, or close family member. ■ May be appointed by a judge to make treatment decisions for incompetent patients.

■ Make decisions by "substituted judgment." This means making decisions based on what the patient would most likely have wanted, were the patient competent. ■ Patients can express their wishes for treatment in advance of losing competence or capacity using a mental health advance directive form called "Declaration for Mental Health Treatment." Admission to a Psychiatric Hospital The two main categories of admission to a psychiatric hospital are voluntary and involuntary. ■ Voluntary: • Patient requests or agrees to be admitted to the psychiatric ward. • Voluntary patients often have to meet the same symptom severity criteria as involuntary patients as listed below. • Voluntary patients may not have the right to be discharged immediately upon request. • Patient must have capacity and be competent to be admitted as a voluntary patient to an inpatient facility. ■ Involuntary: • Patient must be found to be imminently at risk of harm to one's self or others or unable to provide for their basic needs. • Involuntary patients have legal rights to a trial to challenge their hospitalization. • Involuntary patients do not automatically lose the right to refuse treatment, including the involuntary administration of nonemergent medication. • Involuntary commitment is supported by legal principles of police power (protecting citizens from each other) and parens patriae (protecting citizens who can't care for themselves). Disability ■ Mental impairment: Any mental or psychological disorder. ■ Mental disability: Alteration of an individual's capacity to meet personal, social, or occupational demands due to a mental impairment. ■ To assess whether an impairment is also a disability, consider four categories: • Activities of daily living. • Social functioning. • Concentration, persistence, and pace. • Deterioration or decompensation in work settings. Competence to Stand Trial ■ Competence is a legal term for the capacity to understand, rationally manipulate, and apply information to make a reasoned decision on a specific issue. This definition varies by state. FORENSIC PSYCHIATRY WARDS QUESTION Q: When can a patient be involuntarily hospitalized on a psychiatric unit? A: When they pose a risk of harm to self, others, or cannot provide for their basic needs. WARDS TIP If a child presents to the emergency department with various bruises, suspicious injuries in various stages of healing, and numerous prior emergency room visits, your next step would most likely be to contact the appropriate authorities. KEY FACT Sixth Amendment: Right to counsel, a speedy trial, and to confront witnesses. KEY FACT Fourteenth Amendment: Right to due process of law.

224 FORENSIC PSYCHIATRY KEY FACT The fact that someone is mentally ill doesn't mean they aren't competent to stand trial. ■ To stand trial, a defendant must: WARDS TIP After John Hinckley received NGRI for an assassination attempt on President Reagan, there was public outcry against lenient NGRI standards, contributing to the Insanity Defense Reform Act of 1984. Risk Assessment WARDS QUESTION Q: What is the most important factor in assessing a patient's risk of violence? A: The individual's history of violence. TABLE 19-1. Insanity Defense Standards Standard Definition American Law Institute (ALI) Model Penal Code ■ The Sixth and Fourteenth Amendments to the Constitution are the basis for the law that someone cannot be tried if they are not mentally

competent to stand trial. ■ This was established by the legal case Dusky v. United States in 1960. ■ If a defendant has significant mental health problems or behaves irrationally in court, their competency to stand trial should be considered. ■ Competence to stand trial may change over time. • Understand the charges against them. • Be familiar with the courtroom personnel and procedure. • Have the ability to work with an attorney and participate in their trial. • Understand possible consequences. Not Guilty by Reason of Insanity (NGRI) ■ Conviction of a crime requires both an “evil deed” (actus reus) and “evil intent” (mens rea). ■ Insanity is a legal term, and its definition varies by state (see Table 19-1). ■ If someone is declared legally insane, they are not criminally responsible for their act. ■ Some states have a ruling of Guilty but Mentally Ill (GBMI) instead of NGRI, or no criminal insanity defense at all. ■ NGRI is used in less than 1% of criminal cases. ■ It is successful in 26% of cases that continue to use it throughout the trial. ■ Those found NGRI often spend the same amount of time (or more) as involuntary psychiatric patients than they would have spent in prison if they were found guilty. ■ Mental disorders are neither necessary nor sufficient causes of violence. ■ The major risk factors of violence are a history of violence, being young, male, and of lower socioeconomic status. ■ Substance use is a major determinant of violence, whether it occurs in the context of a mental illness or not. M’Naghten ■ Person did not understand what they were doing or its wrongfulness. ■ Most stringent test. Person could neither appreciate the criminality of their conduct nor conform their conduct to the requirements of the law. Irresistible Impulse Person could not appreciate right from wrong or could not control actions. Durham ■ The person’s criminal act has resulted from mental illness. ■ Most lenient test and is rarely used.

■ Predicting dangerousness: • Short term easier than long term. • High false positives because of low base rates (most people are not violent). Malingering ■ Feigning or exaggerating symptoms for “secondary gain,” including: • Financial gain (injury law suit). • Avoiding school, work, or other responsibilities. • Obtaining medications of abuse (opioids, benzodiazepines). • Avoiding legal consequences. ■ Signs for detecting malingering: • Atypical presentation. • “Textbook” description of the illness. • History of working in the medical field. • Symptoms that are present only when the patient knows they are being observed. • History of substance use or antisocial personality disorder. • Reluctant to engage in invasive/in-depth testing or treatment. Child and Family Law Evaluations for which a child forensic psychiatrist may be needed include: ■ Child custody. ■ Termination of parental rights. ■ Child abuse or neglect. Correctional Psychiatry ■ With the closing of state psychiatric hospitals (i.e., deinstitutionalization), many persons with mental illness have moved to correctional institutions. ■ Psychiatrists who practice in jails and prisons must balance treating the inmates as their patients and maintaining safety in the institution. ■ Issues of confidentiality and violence are key. FORENSIC PSYCHIATRY WARDS QUESTION Q: What is the key difference between malingering and factitious disorder? A: The motivation for malingering is for secondary gain (external motivations, such as avoiding work or jail), whereas factitious disorder is primary gain (internal motivations, such as to assume the sick-role). WARDS TIP The contribution of people with mental illness to overall rates of violence is small. Those with mental illness are more likely to be the victims of violence than the perpetrators.

Revision #1
Created 2026-01-04 19:41:09 UTC by Omar Ayman
Updated 2026-01-04 19:41:09 UTC by Omar Ayman