CHAPTER 25

FORENSIC PSYCHIATRY

"Roman law exempted the mad from punishment, in part because they were regarded as not fully responsible for their actions and in part because, as madness was believed to be inflicted by the gods, it would be impious to add to divine punishment"

Paul Mullen, 2001

Introduction

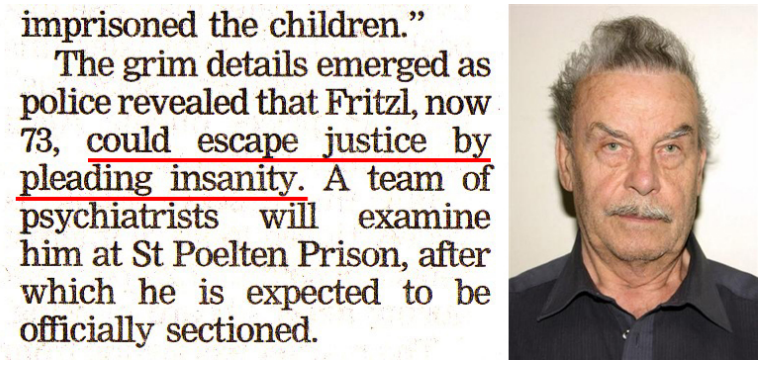
'Forensic' is derived from Latin and comes from the same root as the word forum. The Forum was the public space in ancient Rome where judicial and other public business was debated and decided.

Forensic psychiatry is that part of psychiatry which deals with patients and problems at the interface of the legal and psychiatric systems (Gunn, 2004).

It is reasonable for students to learn some basic principles, as most doctors will be involved, at least peripherally, on occasions.

While the main work of forensic psychiatrists is assessing individuals and presenting evidence in court (which is the focus of this chapter), they are also involved in the care of people incarcerated in forensic psychiatry hospitals (which may be located inside or outside prison walls). Recently, the role of the forensic psychiatrist has widened. They are now being asked to advise on, and sometimes manage, difficult and dangerous patients in civil situations who have not committed offences.

There is frequently public outcry when a criminal act has been performed and the defence raises issues of mental health. There is a feeling that something unfair is happening, a bad person is cheating or tricking the legal system, a guilty person is avoiding punishment (as with the Hinckley and McNaughton cases, on pages 2 & 3).



imprisoned the children."

The grim details emerged as police revealed that Fritzl, now 73, could escape justice by pleading insanity. A team of psychiatrists will examine him at St Poelten Prison, after which he is expected to be officially sectioned.

Illustration. Joseph Fritzl was accused [and found guilty] of imprisoning and raping his daughter over decades, and of contributing to the death of a grandchild. This newspaper clipping exemplifies an all too common tendency to premature judgement and ignorance of the appropriate legal processes. When John Hinckley shot President Reagan (1981) and was found not guilty by reason of insanity (NGI), the public was outraged. This resulted in a new and tougher law governing the insanity defence in the USA: the Comprehensive Crime Control act of 1984.

The law and psychiatry are different disciplines; they serve different purposes and are based on different concepts.

Also, the law deals with concepts in a dichotomous fashion, such as, guilty/not guilty, and sane/insane, while psychiatry (and medicine) operate in a shades of grey fashion, where options about diagnosis, treatment and prognosis are continuously kept open and opinion changes with new developments in the case over time.

Naturally, the interface between psychiatry and the law (which comes under the spotlight when an offence has been committed and the accused person appears to be suffering a mental disorder) is challenging.

A complication is that forensic psychiatrists must frequently balance complex ethical issues. For example, this expert may need to balance conflicting responsibilities – such as, if the he/she learns that a patient represents a danger to another civilian. Not only do the interests of the patient (prisoner) need to be protected, but also those of the wider community - and these may be incompatible (Candilis and Huttenbach 2015).

We are simply touching on principles - laws differ from one jurisdiction to another, and in any location, there may be overlapping laws.

Fitness to plead

Most would agree, it would be unfair to try (and potentially punish) people who were unable (through mental incapacity) to participate in their own legal defence. Such a person is designated ‘unfit to plead’. Opinions are sought from psychiatrists on fitness to plead (also called competency), but the final decision is made by the court.

While the legal process is complicated, the psychiatric aspects of fitness to plead are straightforward. The important issue is not guilt or innocence, or the nature or severity of any disorder, but the ability of the individual to function in court. The universal features are that the defendant must have the ability, 1) to understand the charge and possible penalties, 2) to understand the court proceedings, and 3) to give instructions to a defence lawyer.

When an individual is unfit to plead, the crime is rarely serious. Such people are highly disorganized and therefore incapable of executing complicated, devious, secret plans. Most often, when the person is unfit to plead, the offences are damage to property or minor assault.

What happens to people who are unfit to plead varies, but this is not a route by which the guilty escape justice. If the defendant is unfit to plead because of a treatable condition, such as schizophrenia, he/she is kept in custody and offered treatment. If and when the ability to plead is gained, the case is heard. This means the patient spends months in a prison hospital before a verdict is reached. Thus, the time spent in custody is usually significantly lengthened by the inability to plead.

Some people who are charged do not regain the ability to plead. Such people may remain in prison or some form of mental health facility indefinitely. In the case of minor offences, the patient may eventually be rehabilitated into the community and the charges are dropped.

Criminal responsibility

For a person to be found guilty, two basic elements must be satisfied. First, a prohibited act must have been performed: this is termed *actus reus* (guilty act). Second, there must have been the necessary state of mind or intention to perform that act: this is termed *mens rea* (guilty mind).

Mens rea is categorized as “specific” and “general” intent. We are now departing into a specialized area, beyond the knowledge needed by most students. Specific intent means that the act was performed to achieve a particular outcome. For example, in murder, the intention must be to kill, not simply to strike in anger. If specific intent cannot be established, the charge becomes a less serious one, such as manslaughter. General intent can be used to argue the defendant should have been aware that the action performed could have undesirable consequences, and was therefore careless, etc.

Insanity defence

This defence is available in most but not all jurisdictions. It is the claim of the absence of a guilty mind. This means that the defendant was not responsible for his/her actions because he/she was ‘insane’ at the time.

If successful, this defence leads to acquittal with the determination being not guilty by reason of insanity (NGI). Importantly, this does not lead to the defendant walking free from court. Instead, the individual is sent to a prison hospital or similar facility for treatment and continuous assessment.

There is no universally accepted definition of legal insanity. One set of principles followed the trial of **Daniel M’Naghten** in England in 1843. He had planned to kill the Prime Minister, Sir Robert Peel. By mistake he shot and killed Sir Robert’s secretary. M’Naghten had acted in response to paranoid delusions. When he was found NGI there was an outcry (similar to that regarding Hinckley). In response, the Chief Justices of England determined rules for the insanity defence.

These became known as the **M’Naghten rules**. The accused must prove the first and at least one of the other two of the following points:

1) there was a disease of the mind,
2) there was a defect of reason, such that the nature of the act was not know, or
3) there was a lack of knowledge that what was being done was wrong.
(Interestingly, M'Naghten would have failed these rules. He knew exactly what he was doing and that what he was doing was legally wrong.)

When the insanity defence is mounted, psychiatrists for the prosecution and the defence assess the patient and give evidence in court. It is difficult to be sure about the mental state of another person at another time. Opinions often differ. It is a matter for the court to decide which evidence is accepted.

Release from custody of an NGI offender occurs only after recommendation is made by a mental health review board of some form. Such boards are always cautious. NGI patients usually spend longer in custody than those found guilty of similar crimes and serve their sentence in the ordinary manner. For this reason, even though there is good evidence of NGI, this avenue may not be taken so that a finite sentence will be given.

Anders Behring Brevik, Norway mass murderer, declared insane

Finding could mean treatment, not prison

BY Christina Boyle NEW YORK DAILY NEWS
Tuesday, November 29 2011, 8:52 AM

Illustration. In 2011, Anders Brevik killed 8 people using a bomb in central Oslo (Norway) then drove to a youth camp on the Island of Utoeya, where he shot dead a further 69 people. He admitted his acts and stated he had done so for political purposes.

Soon after the killings, Dr Tarjei Rygnestad, the head of the Norwegian Board of Forensic Medicine stated that he doubted Brevic was psychiatrically ill, because his actions had been so carefully planned and performed. This was also the initial response of the current author. However, after examining Brevic, a group of experts found that he had been psychotic at the time of the crime. They reported that he lives "in his own delusional universe, where his thoughts and actions are governed by these delusions". Nevertheless, when the case went to court, the Judge decided that Brevic was sane, and should bear responsibility for his actions.

TUESDAY, NOVEMBER 1, 2011

Girl's stabber found not guilty by jury

ZARA DAWTREY

A WEST Moonah man was psychotic when he stabbed a teenage neighbour in the stomach and back after charging at her with a large knife in each hand.

Illustration. A psychotic man attacked a female in a city in Australia. She lost a foetus, a kidney and a large piece of bowel. He was found NGI. However, the headlines simply state that the perpetrator was found "not guilty" – this is poor journalism.

Malingering

Malingering is to pretend to be ill to avoid situations such as going to work or jail. It is a concern that individuals may pretend to be mentally ill and thereby avoid appropriate punishment. Malingering in forensic cases was thought to be rare (Enoch M, Ball, 2001).

However, recent empirical research and clinical experience has altered our thinking, and malingering is now recognised as being much more common than previously thought - with reported prevalence rates of 30% or more (Merckelback et al 2009; Scott 2016).

Guilty but mentally ill

Arising out of many difficulties inherent in the NGI defence, in some jurisdictions a new plea was crafted: Guilty But Mentally Ill (GBMI). Unfortunately, GBMI has not significantly improved matters. This plea requires the individual to plead guilty (thus there is no need for lengthy court battles, and teams of psychiatrists giving opposing views). While the verdict suggests that treatment would then be given, this is often not the case, and there is no evidence that GBMI mitigates sentences.

Diminished responsibility

Diminished responsibility may be a defence to the charge of murder. If successful, the accused is found guilty of the lesser charge of manslaughter (The Homicide Act 1957, England).

The important features of diminished responsibility are:
1) at the time of the crime the accused was suffering form “an abnormality of the mind”, and
2) the abnormality of mind substantially impaired mental responsibility.

Many regard diminished responsibility to be a better law than either NGI or GBMI.

Intoxication defence

On first principles, if an individual was so intoxicated as to be unable to form the intent or to not know the nature of his/her actions, one might assume the guilty mind would be absent and the insanity defence could be successfully pleaded. Unlike mental illness and mental retardation, however, intoxication is usually a result of one's own actions, and this is taken as important.

Thus, intoxication is not sufficient for a plea of NGI, but may satisfy the requirement for diminished responsibility.

Automatism

For conviction of a crime there must be the performance of a prohibited physical act (*actus reus*). The performance of this act must have been conscious and volitional.

An act performed by a person's body, independent of the person's mind, is for legal purposes, an automatic act or 'automatism'. This gives rise to the automatism defence. An example would be a person strung by a bee while driving, who involuntarily dries off the road, killing a pedestrian.

This defence is rare. It has been successful with acts which have been performed while sleepwalking, during the post head injury period, and during hypoglycaemia and epileptic seizure.

The future

As stated in the introduction, the legal and psychiatric models are different. They have different roles and their respective practitioners have different ways of thinking. Accordingly, the interface is problematic. The M'Naghten rules have been difficult to apply, and the GBMI legislation, which was ushered in with high expectations, has not improved matters.

Around the world **Mental Health Courts/Diversion from Custody Schemes** are being established. There are differences from one jurisdiction to the next, and legal structures are not yet finalized, but the universal aim is to prevent people who have severe mental illness and commit minor offences from being incarcerated in prisons, and instead, to direct them to comprehensive treatment.

Mental disorder and violence

Patients suffering mental disorders are more often convicted for crimes than the general population (Walsh et al, 2002). However, this difference is not as great as some members of the public and the media appear to believe. Somewhat distorting the figures, of course, is that mentally ill offenders are more easily caught than healthy persons (Robertson, 1988).

A recent, Dutch study (Vinkers et al, 2011) found this was an across the board issue, that is, all types of mental disorder had a somewhat increased association with all types of criminal charge. However, mental disorder was most strongly associated with arson, assault and homicidal attempts or threats.

People with personality disorders, and people with IQs lower than 85 are more likely to perform sexual crimes. People with personality disorder are also more likely to commit homicide than people with other disorders.

Manic illness is associated with disinhibition and there may be financial and sexual indiscretion. While people with mania may be annoying and belligerent, they rarely resort to violence.

Schizophrenia is erroneously considered to be a condition frequently leading to violence. The rate of violence may be 2 to 5 times higher than among the general population, but this needs to be taken in context, that is, the rate at which members of the general population perform violence is low. Mullen (2001) places the problem in perspective, “violent behaviour in people with schizophrenia is at the same frequency as in young men”. Young men of the general population tend to grow out of violent behaviour, and some schizophrenic people do not. But, we don’t lock up all the young men of the general population because they have a somewhat greater tendency to violence than the rest of the general population.

For people with schizophrenia, the risk is greater for family members and friends than for strangers. The risk of suicide by the individual is very much greater than the risk of any serious injury to others.

The risk of violence increase about four times when there is drug or alcohol abuse, and the patient is not receiving treatment (Dr Hadrian Ball, personal communication, 2017).

While people with schizophrenia can be violent as a direct response to hallucinations and delusions, this is rarely the case. Minor offences are the most common, and these are usually secondary to deterioration in personality and social functioning, and sometimes alcohol and drug use. Thought disorder and negative symptoms are common complications of the disorder; in the same way that these may prevent functioning in activities of daily life, they prevent patients planning and conducting premeditated crimes.

Pathological (or morbid) jealousy is the morbid belief that the spouse is being unfaithful. This disorder may arise from chronic alcohol abuse and psychotic illness. This disorder represents a significant risk to the spouse and calls for specialist assistance.

Risk Management

Dangerousness refers to potential, and is a matter of opinion. The term implies an all-or-none phenomenon, a static characteristics of an individual. Dangerousness has been assessed using an “actuarial” approach, i.e., demographic variables of age,

gender and socio-economic status have been linked with violent criminality. Age at which criminal acts were first performed and the nature of past acts are other static/actuarial facts which are correlated with the potential for future violence.

The term 'risk' is now used in preference to dangerousness. Risk takes into account not only the static characteristics of the individual, but personality (e.g., level of irritability) and environmental factors (e.g., presence of intoxicating substances and weapons) which may be modifiable. Accordingly, modifications can be expected to reduce risk. Whether this language change from dangerousness to risk has advanced the field is a matter for discussion (Philipse et al, 2006).

The prediction of violence remains an area of uncertainty (Heilbrun, 1999; Craig et al, 2006).

Risk management has become an area of intense research and clinical activity in forensic psychiatry. Drug and alcohol use and compliance with treatment have emerged as major risk factors which may be modified through professional assistance.

Case report 1

In 1983 human body parts were found in a sewage processing plant in Hobart, Tasmania, Australia. Subsequently, Dr Rory Jack Thompson, an American-born research oceanographer, aged 41 years, employed by the Commonwealth Scientific and Industrial Research Organization (CSIRO) was charged with the murder of his estranged American-born wife, Maureen.

Dr Thompson had come to Australia in 1974 at the age of 32 years, and pursued a distinguished research career.

In 1984 Dr Thompson told the court he had killed his wife to "stop her stealing" their children. Dr and Mrs Thompson were living apart at the time of the murder and their two children, aged 5 and 8 years were staying with Dr Thompson. He told the court that one night before the murder he had rehearsed his actions by dressing in disguise and driving to his wife's house to check the timing of his plan. On the night of the

murder he put the children to bed, then dressed in a wig and skirt, so that he could not be identified, and drove across the city to his wife's home. He killed her with a club he had made from the leg of a table and dismembered her body with a meat clever and hacksaw which he had taken with him for this purpose. He said he had flushed 90% of her body pieces down the toilet and buried the remainder, including her head, in a shallow grave in nearby bush-land. (He later retold the story in an autobiography; Thompson, 1993.)

Dr Thompson pleaded not guilty to murder, saying that he had been mentally ill, he had not been aware that his actions were wrong and that he was acting under an irresistible impulse. He was found NGI and committed to a prison hospital under a mental health act.

It was difficult for those not engaged in the court proceeding to accept this decision. Dr Thompson had take care to escape detection and has disposed of his wife's body - there appeared to be ample evidence that he knew what he was doing was wrong, at least in the eyes of the public and the law. He had planned and even rehearsed the murder, thus there appeared to be little evidence that the murder was the result of an irresistible impulse. He was a successful scientist, had never been treated for a psychiatric disorder and did not appear to be suffering mental disorder at the time of capture.

Whether or not NGI was the most appropriate verdict, this was the verdict achieved. He was found not guilty, thus he was not in need of punishment. However, he was found insane and dangerous, which indicated he was in need of treatment.
Dr Thompson's release from custody, therefore, would depend not on the expiration of a finite sentence, but on a Mental Health Review Tribunal forming the opinion that he was no longer insane and no longer a danger to the public, followed by the acceptance of this opinion by the Tasmanian Government of the day.

In 1990, after 7 years of incarceration Dr Thompson applied for release to the Tribunal. Release was recommended. The Government of the day refused. In 1992, Dr Thompson made another application for release. Release was again recommended and again denied by the Government of the day. He made further appeals for release in 1993 and 1994 but these were denied.

In 1999 (now aged 57 years) Dr Thompson escaped from captivity but was recaptured within hours. Later that year he hung himself in prison.

This case illustrates some of the problems with the NGI option, in particular, the difference between the legal definition of insanity and the medical definition of mental disorder, and the difficulty securing release even when no mental disorder is (or ever was) present.

Case report 2

Illustration. The only details available on this case, on the other side of the world (to Australia), come from two brief newspaper reports.

In 2001, in Houston, Texas, Andrea Yates (37 years) drowned her five children (Mary 0.5 years, Luke, 2; Paul, 3; John, 5; and Noah, 7) in the bath, one by one. Noah was afraid and Ms Yates had to chase him through the house to catch him. After each child was dead she carried the body to its bed and covered it with a sheet. Ms Yates was married to Russell, who worked with computers for NASSA.

Mr Yates told that Ms Yates had suffered post-natal depression (and attempted suicide) after the birth of their 4th child. With treatment, she had made a good recovery. However, she became depressed again after the birth of the 5th child, and 3 months before the murders, her father had died.

Ms Yates told that at the time she killed her children, she believed she was saving them from Satan.

In July, 2006 Ms Yates was found NGI. It appears Ms Yates had been in a forensic facility for 5 years, and that she would now be transferred to a state mental hospital. A prosecution psychiatrist described Ms Yates' condition as having been "well managed". And, it was anticipated that she would soon be released from the mental hospital back into the community.

Although the information is limited, this appears to be a classic case of murder for which the perpetrator is NGI. It is noted that 5 years passed from apprehension to court hearing. We do not know why the process took 5 years, it may have been that Ms Yates was initially not fit to plead. In any case, this was not a hasty process.

Case report 3

In 2009 Phillip Garrido (58 years; California, USA) was charged with abducting a female child and keeping her as a sex slave for 18 years. In 2011 he was convicted and sentenced to 431 years jail.

In 1975 (24 years of age) he was convicted of a brutal rape. On that occasion Garrido was examined by a forensic psychiatrist who found that, the defendant "did not lack substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law". The case is mentioned here because the 1975 assessment is an example of the application of as the 'McNaughton rules'.

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