

Introduction to Forensic Psychiatry

Stephen A. Montgomery, M.D.

Definition

- Interface of mental health and the law
- Subspecialty requiring one year fellowship and written exam
- Expertise in explaining human behavior

Topics

- The Insanity Defense
- Civil Commitment
- Duty to Protect/Violence Risk Assessment

Daniel M'Naughten (cont)

- Daniel M'Naughten – paranoid schiz
- Was trying to kill the prime minister Sir Robert Peel Killed but shot Edward Drummond his secretary by mistake
- Found NGRI
- Queen and public outraged
- Decision appealed

The M'Naughten Rules

- “...labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong...”

Insanity Defense Reform Act (1984)

- Burden of proof – affirmative defense
- Standard of proof – clear and convincing
- “...as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts.”
- Majority of states changed their laws
- Utah, Montana, and Idaho abolish the plea

Tennessee NGRI Statute

- Tennessee Code 39-11-501
 - (a) “An affirmative defense to the prosecution that at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature or wrongfulness of such defendant’s acts. Mental disease or defect does not otherwise constitute a defense. The defendant has the burden of proving the defense of insanity by clear and convincing evidence.”

What happens to NGRI Acquittees?

- Maximum prison term
- Indefinite commitment
- In general, the more serious the offense, the longer the institutionalization
- Jones v. US (1983)
 - Burden of proof on acquittee to prove no longer mentally ill or dangerous
 - Can be held longer than would have if incarcerated
- Foucha v. Louisiana (1992)
 - Confinement requires both dangerousness and mental illness

Insanity Defense Myths

- Frequency
 - Raised in 1% of felony cases, only about ¼ of those are successful
- Debate of Experts
 - Most NGRI cases are plea bargained 70-80%
- Only used for murder cases
 - Actually only 14-20% NGRI's are murder

History of Involuntary Hospitalization

- **Parens patriae** “Father of the country” state takes responsibility for those unable to care for themselves
- **Police power**: state has authority to prevent harm to the community
- Decisions to admit were traditionally made by physicians and patients’ families

The Case of Mrs. E.P.W. Packard (1864)

- Under Illinois statute husbands could commit their wives “without evidence of insanity or distraction required in other cases.”
- She did have some symptoms such as believing she was the mother of Christ
- Put on a train to the hospital and kept 3 years hence the term “railroading”

Lake v. Cameron

(D.C. Court of Appeals 1966)

- Catherine Lake was an elderly senile “bag lady” committed to St. Elizabeth’s in 1962
- “Deprivation of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection”
- Least restrictive alternative for treatment

O'Connor v. Donaldson

(U.S. Supreme Court 1975)

- Mr. Donaldson kept in Chattahoochie State Hospital almost 15 years
- Christian Scientist who refused meds
- “The state cannot constitutionally confine without more, a non-dangerous, mentally ill person who is capable of surviving safely in freedom by himself or with the help of family or friends.”

Addington v. Texas

(U.S. Supreme Court 1979)

- “One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma...it cannot be said, therefore, that it is much better for a mentally ill person to “go free” than for a mentally normal person to be committed.”
- Clear and Convincing evidence

Tennessee Statutes

Who can commit?

- Physicians
- Psychologists
- Psychological examiners
- Social workers (Masters degree and 2 years of mental health experience)
- Licensed Clinical Social Workers
- Marital and Family Therapists
- Psychiatric nurse practitioners
- Professional counselors

TN Criteria for Commitment

- (1) a person has a mental illness or serious emotional disturbance, AND
- (2) the person poses an immediate substantial likelihood of serious harm, under § [33-6-501](#), because of the mental illness or serious emotional disturbance, AND
- (3) the person needs care, training, or treatment because of the mental illness or serious emotional disturbance, AND
- (4) all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person

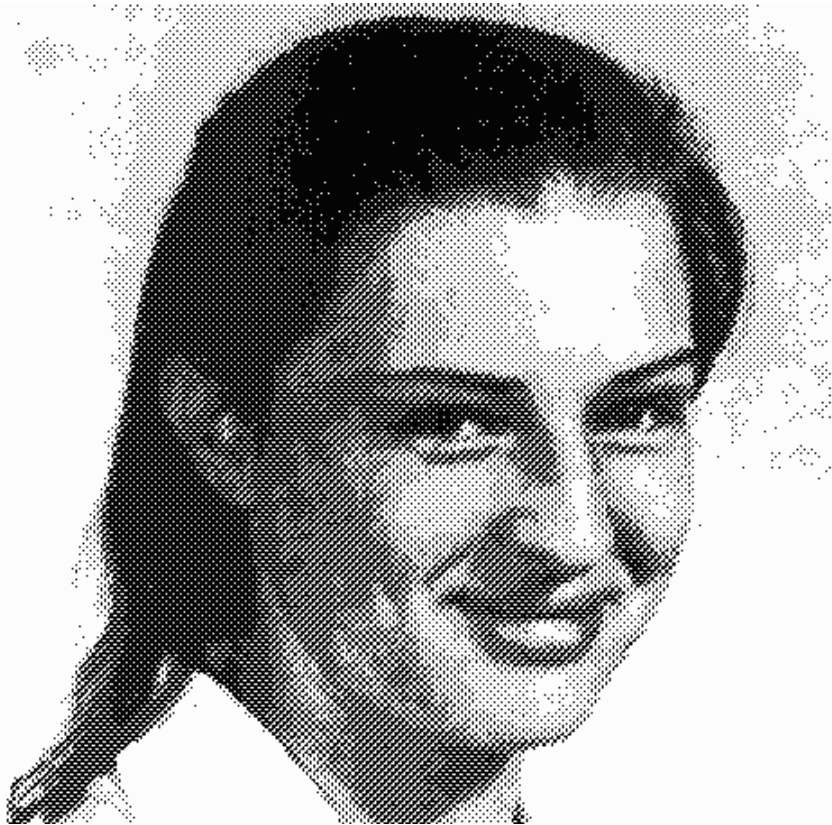
“Substantial likelihood of serious harm”

- a person has threatened or attempted suicide or to inflict serious bodily harm on the person, OR
- the person has threatened or attempted homicide or other violent behavior, OR
- the person has placed others in reasonable fear of violent behavior and serious physical harm to them, OR
- the person is unable to avoid severe impairment or injury from specific risks, AND
- there is a substantial likelihood that the harm will occur unless the person is placed under involuntary treatment

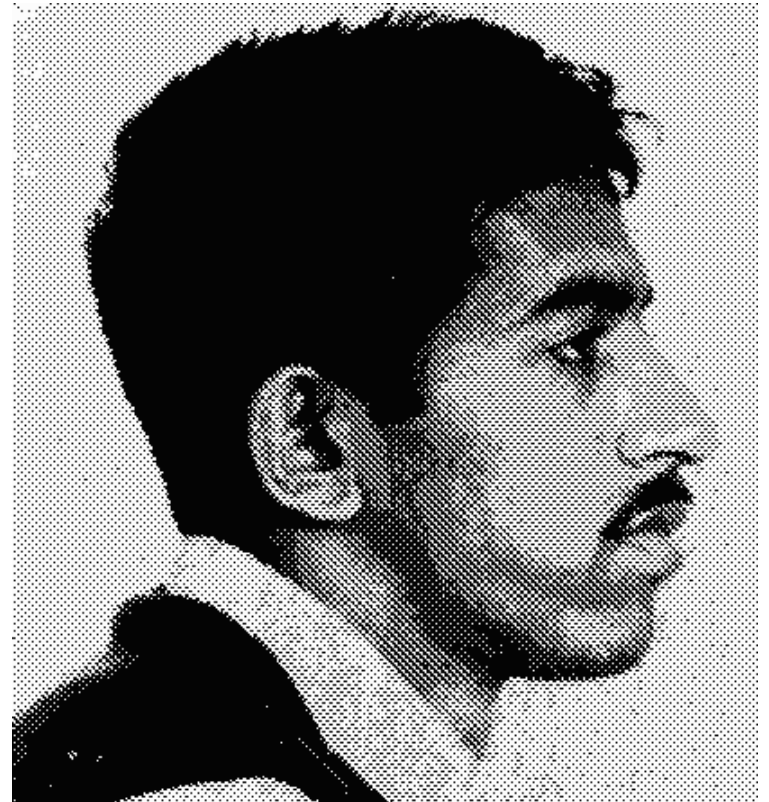
“Severe impairment”

- (1)** As a result of a mental illness or serious emotional disturbance:
 - (A)** Is in danger of serious physical harm resulting from the person's failure to provide for the person's essential human needs of health or safety; or
 - (B)** Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over the person's actions; and
- (2)** Is not receiving care that is essential for the person's health or safety.

Duty to Protect (The Tarasoff case)



Tatiana Tarasoff



Prosenjit Poddar

“The protective privilege ends where the public peril begins.”

“The discharge of the duty may require the therapist to take one or more various steps, depending on the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.”

33-3-206. Duty to predict, warn or take precautions to provide protection

IF AND ONLY IF

- (1) a service recipient has communicated to a qualified mental health professional or behavior analyst **an actual threat of bodily harm against a clearly identified victim**, AND
- (2) the professional, using the reasonable skill, knowledge, and care ordinarily possessed and exercised by the professional's specialty under similar circumstances, has determined or reasonably should have determined that the service recipient has the apparent ability to commit such an act and is likely to carry out the threat unless prevented from doing so,

THEN

- (3) the professional shall take reasonable care to **predict, warn of, or take precautions to protect** the identified victim from the service recipient's violent behavior.

33-3-207. Discharge of duty.

- The duty imposed by § [33-3-206](#) may be discharged by the professional or service provider by:
 - (1) [Informing the clearly identified victim](#) of the threat;
 - (2) Having the service recipient [admitted](#) on a voluntary basis to a hospital;
 - (3) Taking steps to seek [admission](#) of the service recipient to a hospital or treatment resource on an involuntary basis pursuant to chapter 6 of this title; or
 - (4) [Pursuing a course of action consistent with current professional standards that will discharge the duty.](#)

Violence Assessments

- Fitness for duty
- School
- Release of insanity acquittees
- Pre-sentencing hearings
- Emergency room
- Release of involuntary patients
- Outpatient settings

Predictors of future violence

- History of past violence (#1)
- Substance abuse
- Antisocial personality disorder (esp psychopaths)
- Access/knowledge/history of weapon use
- Acute agitation
- Young age, male gender