Chapter 1: An Introduction and General Principles

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Almost all mental health professionals find themselves at some time embroiled in legal issues that affect their patients or even themselves. Usually these are resolved routinely with the submission of a certificate or report. Occasionally these issues initiate panic when the practitioner finds him or herself drawn into unfamiliar and complicated legal quagmires, when they frantically try to access specialized advice or, better still, refer the case to a forensic expert.

But who are these forensic experts? Until 2012, when forensic psychiatry was recognized as a registrable subspecialty of general psychiatry by the Health Professions Council of South Africa, clinicians were only recognized informally as having an interest and experience in forensic practice. Other health practitioners, such as psychologists, occupational therapists, social workers, and professional nurses, are currently not accorded this formal recognition. But what is forensic mental health?

The answer is complicated. Unlike most disciplines forensic practice depends on laws, culture, history, and health infrastructure in specific places. Sometimes there are even subtle but significant differences within countries. Often forensic practice is subsumed within general psychiatry, for example in France offenders who are mentally ill are assessed and treated by general psychiatrists as civilly committed involuntary patients overseen by judges, because there is no formal forensic mental health system. Or, as in the UK and the Netherlands, a diagnosis of personality disorder, including psychopathy, can gain entry into the system even if there is no criminal charge, whereas in others, including South Africa, only serious mental illness or cognitive impairment consequent to a formal criminal charge qualifies for entry into the system.

Therefore, definitions vary, according to how forensic expertise is used in various countries. Most definitions are either for forensic psychiatry or psychology, and do not include other professions who are also involved in forensic work, such as occupational therapy, social work, and nursing. In the USA forensic psychiatry is regarded as a subspecialty of psychiatry “in which scientific and clinical expertise is applied in legal contexts, involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment and

employment" (AAPL, 2002). Most forensic experts in the USA exclusively provide assessments and testimony for the courts, and are not involved in treatment and rehabilitation, even though there are many excellent institutions that undertake the long-term care of mentally ill offenders.

Across the pond, in the UK, forensic practice includes help for victims of crime, abuse, neglect and deprivation, as well as people who are not charged with crime but display aggressive behaviours (Gunn and Taylor, 2014). In South Africa, some forensic units are willing to assess witnesses for competence to testify, whereas the rest vigorously decline to do so. In the narrow sense FMH is concerned primarily with the nexus between serious mental illness and criminal behaviour, but broadly also includes issues that affect civil law proceedings, such as divorce, testamentary capacity, disability claims etc. The former usually are dealt with by specialized state facilities, with occasional involvement of private practitioners, and the latter by generalists who usually are in private practice.

Instead of a definition a list of indispensable skills is offered that the FMH practitioner should possess:

- Clinical expertise that includes not only the ability to make diagnoses but also to understand the contexts and issues that arise from a person's narrative
- An understanding of relevant legislation, especially that which pertains to mental health, and legal concepts. This should be reinforced with a knowledge of important case law
- Skill in writing reports for juridical purposes
- An ability to provide testimony in court
- An understanding of risk assessment, and its measurement
- Clinical expertise in treating chronic disorders, which includes risk management of specific behavioural abnormalities
- An appreciation of ethical issues that arise in forensic practice

The Law-Psychiatry/Psychology Interface

Law and mental health are like a married couple, but with each belonging to a different culture and speaking languages that are almost mutually incomprehensible. Consequently, the assessments and decisions made by either can lead to mutual exasperation and a reciprocal loss of confidence.

Legal processes must lead to definite conclusions, commonly by adversarial mechanisms, whereas mental health practitioners characteristically often can only provide possible diagnoses and descriptions of impairments that the lawyers somehow must use .

Clinicians have a common misunderstanding of legal processes and can be intensely upset when the court does not accept their findings and follow their recommendations. Many cases, in our adversarial system, pit competing experts against each other with the ultimate unedifying rejection of one or both sides. Whatever the expert input the Court decides on the *ultimate issue*. Despite the admonishment to be "ego-less" many experts, who are used to respectful adherence to their opinions, rail against the "stupidity" of lawyers and judges (Gutheil and Simon, 2005). Likewise, the latter are often frustrated at the vague and poorly communicated opinions offered by experts.

Competence and Capacity[1]

Although almost never included in definitions of forensic practice the assessment and restoration, if possible, of competence are essential functions of our practice. In a broad, and unfortunately vague sense, capacity refers to someone's ability to perform certain juristic acts. Therefore, the determination of capacity has two interlocking components; an initial medical/psychological evaluation that is followed by a finding by a juridical body, such as the Court. The Law assumes, by default, that all adults possess full capacity and consequently must take responsibility for their acts. Four types of legal capacity are recognized:

- To have rights and obligations
- To perform juristic acts, such as entering in participating in legal transactions
- To litigate in court
- To incur delictual or criminal responsibility. (Mokgoro et al., 2004)

It is unlikely that a court, or equivalent body, would make a determination without expert opinion, although the SA Law Reform Commission has mooted the possibility that decisions concerning capacity could, in theory, be made without the presence of a diagnosis, mostly because of the difficulties in precisely defining "mental illness" and to avoid discrimination (Mokgoro et al., 2004). The circumstances that could warrant this were not discussed. Nevertheless, currently a

[1] "competence" and "capacity" are usually used interchangeably.

medical/psychological determination would first have to offer a diagnosis then consequently offer an opinion as to whether:

- The person can assimilate relevant facts, and
- The person has an appreciation or understanding of his/her situation as it relates to the facts.
- The ability to make a rational decision based on the facts[2].
- The ability to communicate the decision to others

This is not as straightforward as the wording suggests. Capacity must be judged on decision-specific grounds and not on an all-or-nothing basis. In other words, capacity is both function-specific and function-based. It can be partial or compromised and may even fluctuate in time. For example, someone with Alzheimer's disease can shop for groceries but not draw up a will; yet, during some periods of lucidity (as the severity of the illness can vary) may possess the capacity to draw up a will, sell a house etc. The difficulty is determining, especially in retrospect, if the individual at that time really has sufficient capacity.

Another problem, which is the usual cause of conflict, is determining the threshold of incapacity. Legislation does not regulate this process, especially in requiring that assessments of capacity should be confirmed by cognitive tests, which have their own notorious problems (such as deciding on cut-off scores), taking cultural and education factors into account and whether they actually assess the cognitive skills required for that specific task.

Psychiatric Diagnoses and "Mental Illness"

Virtually all forensic assessments and interventions require a diagnosis. Such a simple requirement hides almost insurmountable difficulties. Two requirements of any diagnosis that are crucial for forensic use are, firstly, it must describe a disorder that undoubtedly exists (i.e., it must have validity), and, secondly, the diagnosis should consistently be made over time and regardless of whoever offers it. Many contemporary academics have bemoaned the questionable validity of psychiatric diagnoses, especially as classified in the various editions of DSM (Frances, 2013, Reznek, 2016). Not only have criteria and diagnostic labels changed over editions of DSM[3] but many

[2] But, what is "rational"?

[3] DSM is the Diagnostic Statistical Manual published by the American Psychiatric Association. DSM provides the criteria used for diagnosing psychiatric disorders. Currently it is in its 5th edition. The World Health Organization publishes its own manual, ICD 11. Although the 2 manuals roughly correspond there are many significant differences.

disorders in the manual have not been adequately ratified by satisfactory research (Jones, 2012)[4]. Worse still, psychiatric diagnoses have extremely poor reliability. Not only do practitioners often disagree about diagnoses, but the diagnoses commonly change over time (Jones, 2012). This is more than just vexing. People's lives, future and liberty depend on diagnoses.

The DSM is primarily a diagnostic guideline for practitioners, and the its authors have explicitly warned that "..the use of DSM5 should be informed by an awareness of the risks and limitations of its use in forensic settings (p.25)" (APA, 2013). They concede that psychiatric language is not precise enough for meticulous legal examinations, and horrifyingly for lawyers, allows for subjective judgements that are meant to aid management and not decide court cases(Frances and Halon, 2013).

The courts and legislation routinely enquire into whether a defendant has a "mental illness," but nowhere have they defined this term. Practitioners that take on these referrals commonly conflate "mental illness" with any psychiatric disorder. Worse still, conferring a psychiatric diagnosis as evidence of a "mental illness" is too often deemed to be sufficient to declare that a person lacks capacity. For example, diagnosing a sexual offender with paedophilia is sometimes regarded as sufficient to persuade the court to direct he undergo treatment rather than incarceration. This clearly is not desirable. Consequently, "mental illness" is considered, in the legal sense, to include serious psychiatric disorders, such as the psychoses, developmental disorders and neurocognitive disorders that are known to significantly impair cognitive functioning and behaviour (Kaliski, 2012).

But diagnoses have to be used, otherwise it would be impossible to motivate conclusions offered in assessments. Frances and Halon (2013) accordingly offer the following guidelines:

- Diagnoses not found in DSM (and presumably ICD) should not be used. There are many so-called diagnoses, such as "Battered Woman Syndrome" and "Catathymic Crisis," that should not be used.
- Differential diagnoses should be considered
- The DSM rules should be followed closely to avoid an impression of being arbitrary and unreliable
- Motivate in detail why the diagnosis is clinically significant for the purposes of the assessment
- Consequently, any diagnosis that is used in forensic settings should satisfy criteria beyond the threshold. *In other words, the diagnosis should be unequivocal*. In South

[4] The compilation of DSM III and DSM III-R seems to have been a haphazard and arbitrary process. This was vividly described by Alix Spiegel in his article, "The Dictionary of Disorder," that was published in the New Yorker magazine in the 3 January 2005

Africa, an obvious example is the promiscuous use of “Bipolar Disorder type 2” diagnosis, when on history the person has only described feeling really good with higher energy levels for about 2-3 days at a time (and often without any sleep disturbance).

- Avoid “NOS,” now called “Other specified” or “Unspecified” as qualifiers, because these terms are inherently unreliable and often are based on “free floating clinical impressions” (p.341).
- Diagnostic labels should not be used as weapons, especially in civil cases, such as child custody battles, as a means of denigrating the character of one of the parties to the dispute.

Pathways: Some common denominators

Surprisingly, when requesting it, many practitioners have, at best, a vague notion of the consequences of a forensic assessment. There is a common misconception that entry into the FMH system allows one to escape ordinary sanctions, such as a prison sentence, without appreciating that sometimes it results in a lifetime of limitations of personal liberties.

For most contact with a forensic specialist is cursory, such as a request for support for an application for benefits or sick leave. Many may find themselves drawn into an involved assessment process that launches them into a rehabilitation system that can take years (sometimes a lifetime) to traverse. Some find themselves obliged to return regularly for ongoing assessments to ensure the continuation of benefits or treatment.

Commonly experts provide recommendations in their assessments that cannot be followed, either because of resource constraints or lack of a service. A disheartening example in South Africa is the legislative requirement that offenders aged 12-14 years old undergo an assessment under the Child Justice Act to determine if they possess criminal capacity. There are virtually no child and adolescent forensic mental health services in the country. Therefore, very few recommendations can be followed, and many are now being referred to primary health care facilities for further management where not only are there no resources for their care, but where the potential for incurring greater harm exists. Similarly, experts have testified in court that child sex offenders would benefit from a court mandated intervention, only to find out later that, apart from some expensive short-term programmes in the private sector, none exists in our general forensic services.

The solution clearly is that the state should be lobbied to increase investment in forensic mental health services so that a broader section of the community can benefit.

Assessment and Recovery

Assessments always lead somewhere. When this means into a treatment facility there is an expectation that either the person will be successfully treated and discharged home or contained in a secure hospital environment indefinitely. Forensic patients, called 'state patients" in South Africa, almost always were charged with violent offences and diagnosed with serious mental illnesses. Consequently, few are discharged, and even then, reluctantly. As the numbers entering the system are overwhelmingly higher than those leaving, this situation is not sustainable.

Historically there are several reasons for this seemingly endless expansion of the forensic mental health service. Beds in the general psychiatric service have been drastically reduced and those with chronic serious psychiatric illnesses whose behaviour is deemed problematic are now being reinstitutionalized via the forensic system(Kaliski, 2017, Kaliski, 2013). But equally important is the conventional requirement that the state patient must no longer be mentally ill to qualify for a discharge. This requirement has been challenged primarily by proponents of the Recovery Model, who insist that practitioners accept that it is more important to focus on how to optimise patients' lives given their symptoms and functional impairments. How this model can be inserted into the forensic mental health service continues to be explored (Kaliski and De Clercq, 2012, Drennan and Alred, 2012)

Some Controversies

Every forensic mental health practitioner should be uneasy about what they are they doing, unless, of course, they enjoy working in dictatorial regimes. They are constantly being confronted by the clash of their values and the facts (or reality) that are presented to them, what Fulford (2011) called the "squeaky wheel" which plunges the practitioner into the "hurly burly" arena (Hughes and Fulford, 2005). Below are some of the numerous "hurly burly" areas to contemplate (and hopefully will be addressed by this book):

- *Dual Agency*: unlike other areas in mental health the patient/client/user does not enjoy the practitioner's undivided loyalty
- *The Insanity Defence*: is it legitimately useful to declare someone "not guilty by reason of insanity"?
- *Risk Assessment:* It is not possible to determine overwhelmingly whether any individual will act violently, especially in the distant future. Is it fair to restrict liberty on such flimsy grounds?

- *Coerced treatment and the UN Convention on People with Disabilities*: A proper reading of this convention, especially Article 12, prohibits coerced treatment of someone with a disability (which includes a psychiatric disorder). Most countries have signed the convention but still disregard this injunction.
- *Indefinite hospitalization*: surely it is an abuse of human rights to restrict someone's right to liberty without limits?

As the reader traverses these pages other pressing controversies and "squeaky wheels" will ambush their comfortable value systems. Therefore, read this book with scepticism and empathy for those we assess and assist.

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