

## The Role of Clinical Psychiatrists in Forensic Evaluations of Legal Sanity

Miazga M<sup>1</sup> and Opio M<sup>2\*</sup>

<sup>1</sup>Medical University of Warsaw, Warsaw, Poland

<sup>2</sup>Department of Forensic Psychiatry, The Institute of Psychiatry and Neurology, Warsaw, Poland

\*Corresponding author: Malgorzata Opio. Department of Forensic Psychiatry, The Institute of Psychiatry and Neurology, Warsaw, Poland, Tel: +216 97 112 062; E-mail: opio.psyche@gmail.com

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### Abstract

The assessment of criminal responsibility is complex and challenging. In the article "Reliability of repeated forensic evaluations of legal sanity" [1] we found that criminal responsibility was changed at least once in subsequent assessment in 32(27.3%) out of 117 cases. One possible explanation is, that the assessments issued by psychiatrists not employed by courts, were placed on an equal footing with opinions issued by forensic experts. These assessments, given by clinical psychiatrists, were often contrary to forensic opinions and led to the uncertainty of the court. Furthermore, due to academic and professional position of these psychiatrists, these opinions were frequently difficult to challenge by forensic experts. It resulted in prolonged proceedings, increases in costs, and especially created a possibility of legal sanity change.

Clinical psychiatrist should be conscious, that every psychiatric certificate can be used for insanity defense in criminal proceeding. Every psychiatrist examining a defendant may potentially influence the final diagnosis and hence the evaluation of the defendant' legal sanity, even if the psychiatrist does not directly participate in court proceeding.

### Introduction

In the article "Reliability of repeated forensic evaluations of legal sanity" [1] we found that criminal responsibility was changed in a subsequent assessment at least once in 32 (27.3%) out of 117 cases. In this article we would like to present one of the possible causes of this issue. Only criminal liability statements issued by forensic psychiatrists were allowed to be taken under consideration by the Judiciary of Poland until 2015 [2]. Nevertheless, since 1989 private psychiatric certificates or opinions issued at the request of defendant have begun to appear [3]. In our practice as forensic experts, we noticed that evaluations issued by psychiatrists not employed by Courts, were placed on an equal footing with those of forensic experts. These evaluations often were contrary to forensic opinions, which led to the uncertainty of the Court. Furthermore, due to academic and/or professional position of these psychiatrists, these opinions were frequently difficult to challenge by forensic experts.

It resulted in prolonged proceedings, increases in costs, and especially created a possibility of legal sanity change. In order to better illustrate this issue we present the following case.

### Case Report

A 55 year old man, with higher education, was accused twice of leading a group of people who committed a number of business frauds. First, he was charged for the acts committed between 1991 and 1993. In this case, the group included 3 people. However, the experts considered him to be insane and he was released.

The second accusation relates to the crimes committed between 1998 and 2000. This time he was leading an organized group of 10 people. In the course of the criminal proceeding he was put on forensic

observation twice with two diagnostically different outcomes. However, in this case, The Lower District Court found the defendant guilty of all the charges and issued a sentence. The convict filed for reinstatement of court proceeding and the proceeding was reopened by The Higher District Court. The assessment of mental health during the incrimination period, as well as the sanity assessment at the time of the criminal act was requested again.

The subject's first psychiatric hospitalization took place in 1978 and he was discharged with diagnosis of "psychopathic personality disorder accompanied with dipsomania causing mild functional dysfunction" / F60.2, F10/. In 1981 he was admitted to mental health unit and diagnosed with depression and symptomatic alcoholism/F32,F10/.In 1993; he attempted to commit suicide by causing a car accident in which he suffered a concussion and multi-organ injury. In the same year he was charged of leading a group of people who committed a number of business frauds for the first time. Six forensic evaluations were issued in connection to the first criminal case /F32/.In March 1997 the inquiry was discontinued as he was proclaimed insane. In 1998 he became a general manager of a new company and a few years later he was arrested in connection with 19 business frauds.

In 1999 he resigned from the company presidency, and co-founded a new company where he held a position of commercial proxy until he was detained.

In April 1999 a forensic opinion was passed on the subject in the second criminal case. He was diagnosed with personality disorder, proneness to alcohol abuse and stated as being sane /F07.0,F10/. He was arrested in June 2001. Forensic opinion, passed while he was detained in custody, stated that he suffered from situational depression syndrome, which was a consequence of unexpected detention/F43/. Experts put forward a motion for observation due to unclear mental

health condition. On the same day, the subject overdosed medical drugs and was hospitalized for that reason. When he recovered from drug overdose, he underwent the planned forensic observation, in which he was diagnosed with depressive neurotic reaction and was found sane. In November 2001 another deliberate drug overdose took place.

In June 2002 the defendant pleaded guilty and was pronounced guilty. In July 2002, after he had left custody, he consulted a professor of psychiatry, who diagnosed a depressive episode and issued a medical certificate supporting this diagnosis.

In August 2002 he had another opinion passed on him for legal purposes. The diagnose was as follows: antisocial personality disorder with complex etiology (co-occurrence of environmental factors and features of organic damage of central nervous system)/F60.2,F10/ accompanied by accumulated symptoms of chronic adjustment disorder related to the subject's legal position, as well as recorded proneness to alcohol abuse". Experts found the defendant sane and capable of participating in judiciary procedures.

One month later the subject was admitted to psychiatric ward for treatment. Affective bipolar disease and organic brain damage were diagnosed /F31,F07.0/. During hospitalization another opinion was passed on him in-patient clinic regarding his capacity to serve a prison sentence. The diagnosis was as follows: "organic personality disorder as well as depression and alcohol addiction"/F07.0, F43, F10/. Reactive factors and central nervous system damage were identified as underlying causes for those disorders. Differences in diagnoses had been noted and recommendation forensic observation was put forward.

After leaving hospital the defendant consulted an out-patient clinic and was issued certificates of incapability to participate in judicial proceedings. In April 2004 he was put on the requested observation, while he was diagnosed with alcohol dependency syndrome in abstinence period, organic personality disorder and recurring depressive episodes of reactive character/F10.20,F07.0,F43/. When the observation was completed he repeatedly consulted the Mental Health Out-patient Clinic. In October 2004 the Court proceedings were instituted de novo on the motion of the defendant's defense council. At the end of 2004 he started trading in cars trade, however he incurred losses.

In December 2004 he became a patient of yet another professor of psychiatry. Since then he was hospitalized in his clinic three times, with affective bipolar disease diagnosed /F31/, as well as alcohol dependency syndrome of symptomatic character in abstinence period /F10.20/ and frontal lobe disorder/F07.0/. After those hospitalizations an opinion was passed with regard to his capability to participate in a suit to reinstitute the trial de novo. The opinion stated that in his current mental condition, which was described as stable, he was capable to participate in court proceedings.

Another opinion was passed by a team of experts (independent of the above mentioned clinic) with regard to his sanity tempore criminis (at the time of the criminal act). However, the subject's condition due to pharmacological treatment made it impossible to complete the examination. A motion was put forward to carry out another forensic observation. The Court requested a forensic evaluation by The Institute of Psychiatry and Neurology in Warsaw. The defendant was diagnosed with bipolar affective disorder with residual symptoms of depression of a complex etiology with organic personality disorder, addicted to

benzodiazepines and to alcohol. The conclusion about his sanity was that he was fully criminally responsible/F31,F07.0,F19/.

## Discussion

Criminal responsibility evaluation is a very complex and controversial issue [4-6]. The case described above illustrates the fact that forensic experts have to confront different diagnoses and different opinions. This articles expressing concern about this recurring issue which also began to appear in polish forensic journals since 1989 [7-9]. Hajdukiewicz [10], in her first publication regarding this topic, stated that psychiatrists, being involved in treating patients, were influenced by their patients (who were simultaneously defendants), what resulted in changes of diagnosis or in exceeding the competences of clinical psychiatrists. Content of medical certificates frequently wasn't verifiable in medical records.

Furthermore, as indicated in the case above, the difference in psychiatric diagnosis may depend on many other factors, such as difference in information given by patient (inadequate or unreliable history), changes in symptoms with time and treatment, development of diseases' classifications or psychiatrist's personal agents (e.g. disposition, relation to the patient or the length of examination).

Validity and reliability of forensic evaluation have been criticized for many years also in foreign literature [11]. In Poland, the law requires the legal sanity to be stated by forensic psychiatrist. In contrast, there are countries which allow psychologists to issue that statement.

However there is still no clear standards for criminal responsibility evaluation.

The sanity evaluator should reach confirmation of their opinion in all available sources to minimize the risk of reaching the wrong conclusion. However, Morris at al found that, in more than half of the cases, the evaluators offered their opinion on the basis of incomplete data [12]. When the opinion is obtained from a private doctor it is even more likely that the doctor had not obtained all information regarding alleged offense, patient's criminal history and statements of witnesses.

It is known that assessors are prone to bias [13-14] which might be increased when an assessor is a clinician responsible for the patient's medical care. Dąbrowski recommended that, a medical doctor should not act as a forensic expert in cases where they have therapeutic relationship with the defendant [15]. This emotional therapeutic relationship between patient and doctor was also pointed out by Kocur, who analysed the abnormalities found in forensic assessments [16]. This author indicated the positive example of the Court, which excluded a psychiatrist from criminal proceeding because of therapeutic relationship with a defendant.

Although forensic psychiatrists in Poland notice the problem caused by the improper conduct of clinical psychiatrists, no actions were implemented to try to resolve it. Furthermore, in July 2015 The Polish Code of Penal Procedure has been changed [17]. The current system allows the parties themselves to appoint the experts. It may result in deepening of the problem.

## Conclusion

The role of forensic psychiatric assessments cannot be overemphasized; therefore doctors issuing such assessment should have appropriate training and high ethical standards. Reliability,

insightfulness, carefulness and criticism during psychiatric examination and evaluation of mental state are required. Clinical psychiatrists should take under consideration facts, that every psychiatric certificate can be used for insanity defense in criminal proceeding. Every psychiatrist examining a defendant may influence the final diagnosis and evaluation of the defendant's legal sanity, even if they do not participate in court proceeding. This applies especially to opinion leaders in the field of psychiatry, as their assessments may influence other psychiatrists. In consequence, these outcomes have impact on final forensic evaluation of legal sanity.

We hope that this article will contribute to better reciprocal understanding of attitude of clinical and forensic psychiatrists and further facilitate improvement in the fulfilment of their duties.

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