It is my privilege and pleasure to highlight this Special Report on forensic psychiatry. (The first articles in this series appeared in the November issue and are posted on www.psychiatrictimes.com [6].) The respected authors provide us with the most recent thought on subjects that should be of interest to every practicing psychiatrist.

Many forensic psychiatrists are known for never shrinking from a controversial subject. So it is with leading forensic psychiatrists Drs Donna M. Norris and Marilyn Price. In the November issue, they took on a sensitive subject that desperately needs more attention: firearms and mental illness. Much thoughtful work needs to be accomplished here, and Norris and Price are to be commended for bringing this to our attention. Beyond inquiring about firearm possession with our patients, do we have any other roles to play in reducing firearm violence? There is much more to be understood about firearm violence in general before drawing premature conclusions. Yet at this early stage, what we do know will surprise no one—that there are significant associations between threats made against others with a gun and substance use disorders.1

The detection of malingered mental illness is a complex endeavor, and many clinical and conceptual errors may contribute to false attributions of malingering.2,3 Further complicating the matter is that factitious disorder, which may be much more prevalent than is commonly recognized, can easily be misdiagnosed as malingering.4 In the November Special Report, Drs Worley, Feldman, and Hamilton help clear up this challenging diagnostic dilemma and point out that one main difference between malingering and factitious disorder is the location of the patient’s motivation—that is, does it flow from a desire for internal (ie, psychological) or external incentives? The California Supreme Court’s decision in the landmark Tarasoff case over 30 years ago has become a standard part of mental health practice. This case influenced the legal requirements
governing therapists’ duty to protect third parties in nearly every state in the country. Yet even after all this time, the decision is still analyzed and critiqued, for example, in an outstanding Guttmacher Award–winning law review article. In last month’s part 1 of this Special Report, a legal expert in mental health issues and unwavering friend to organized forensic psychiatry, Professor Daniel W. Shuman, JD, reexamined the sociolegal oddity that is Tarasoff. After 33 years of Tarasoff, has this “social science experiment” been successful in terms of what it was meant to accomplish? In the November issue of Psychiatric Times, Shuman gave us his unique insights on why this may be impossible to determine.

Dr Carla Rodgers gives us critical information about the legal regulation of the practice of psychiatry, showing us that such knowledge can be instrumental in avoiding a malpractice suit. In fact, she provides an excellent primer on what Simon and Shuman have termed “clinical risk management,” which they have defined as “the combining of professional expertise and knowledge of the patient with a clinically useful understanding of the legal issues governing psychiatric practice.” This approach stresses good clinical care first while allowing the psychiatrist freedom from destructive fears of litigation.

The doctrine of informed consent has likely been studied most extensively in the United States. In 1972, the term “informed consent” received wide awareness and prominence in public health research as well as in the practice of medicine, in response to the public outcry regarding unethical practices in the Tuskegee syphilis research. Yet even before this, the foundations for informed consent were articulated in the Nuremberg Code after World War II. The right to informed consent, an attribute of personal autonomy, is a fundamental principle of medical ethics.

When assessing a patient’s treatment capacity, it is important to determine whether he or she possesses the following mental abilities: (1) the ability to understand information relevant to the decision, (2) the ability to appreciate the situation and its consequences, (3) the ability to manipulate the relevant information rationally, and (4) the ability to express a stable, voluntary choice. Drs Abigail Dahan and Spencer Eth lead us through the important details of such an examination, with a special focus on patients who have a primary diagnosis of dementia.

The aftermath of any tragic event brings many questions about what could have been done to prevent the tragedy. Drs Webster, Bloom, and Augimeri present the case of a patient with schizophrenia and depression who killed his wife and 2 children. The authors offer 12 principles about risk and risk appraisal that provide practical information to help clinicians understand when a thorough risk assessment is crucial and recommend tools that may help in doing the assessment.

References:

References

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