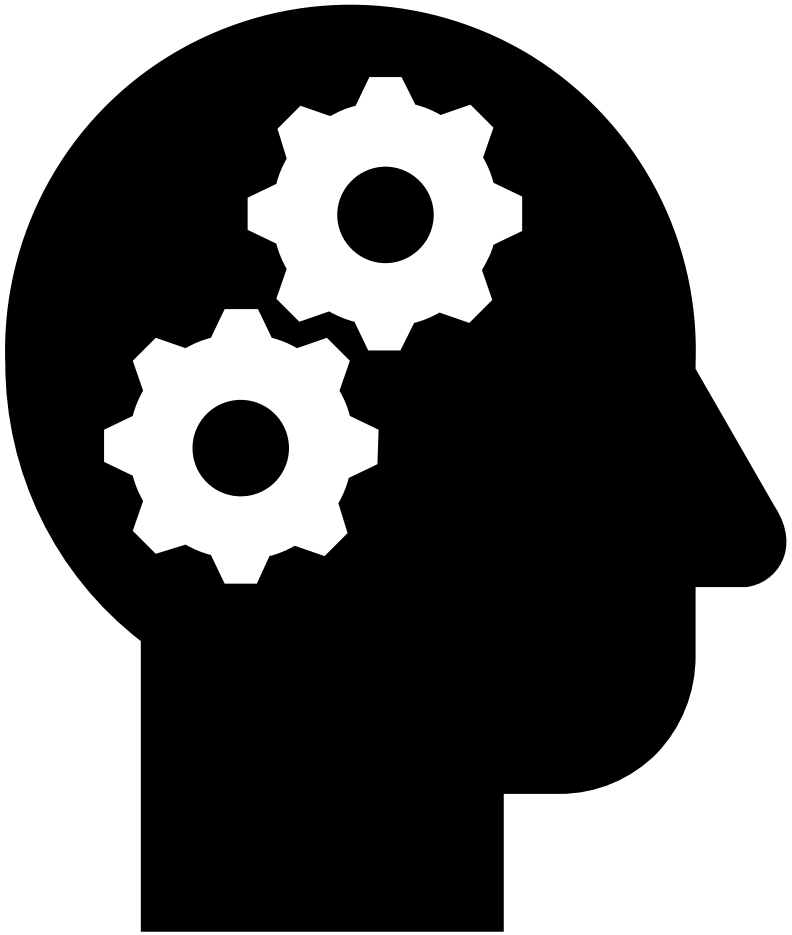


The Diagnosis Debate: Diagnosis in NGI, IST, MDO and SVP Evaluation

MELINDA DICIRO, PSY.D. ABPP

SUSAN NAPOLITANO, PH.D.

BRANDON YAKUSH, PSY.D.

DEPARTMENT OF STATE HOSPITALS

Agenda

Diagnosis: forensic evaluations in general: Melinda DiCiro
- Cautions, controversies, uses and misuses

Diagnosis: California evaluations:
- Definitions, exclusions; use (not use); challenging diagnosis, case application
  - NGI evaluations: Brandon Yakush
  - IST evaluations: Brandon Yakush

Break
  - OMD (FKA MOD) evaluations: Melinda DiCiro
  - SVP evaluations: Susan Napolitano

Exercise: Apply the statutes to a set of facts

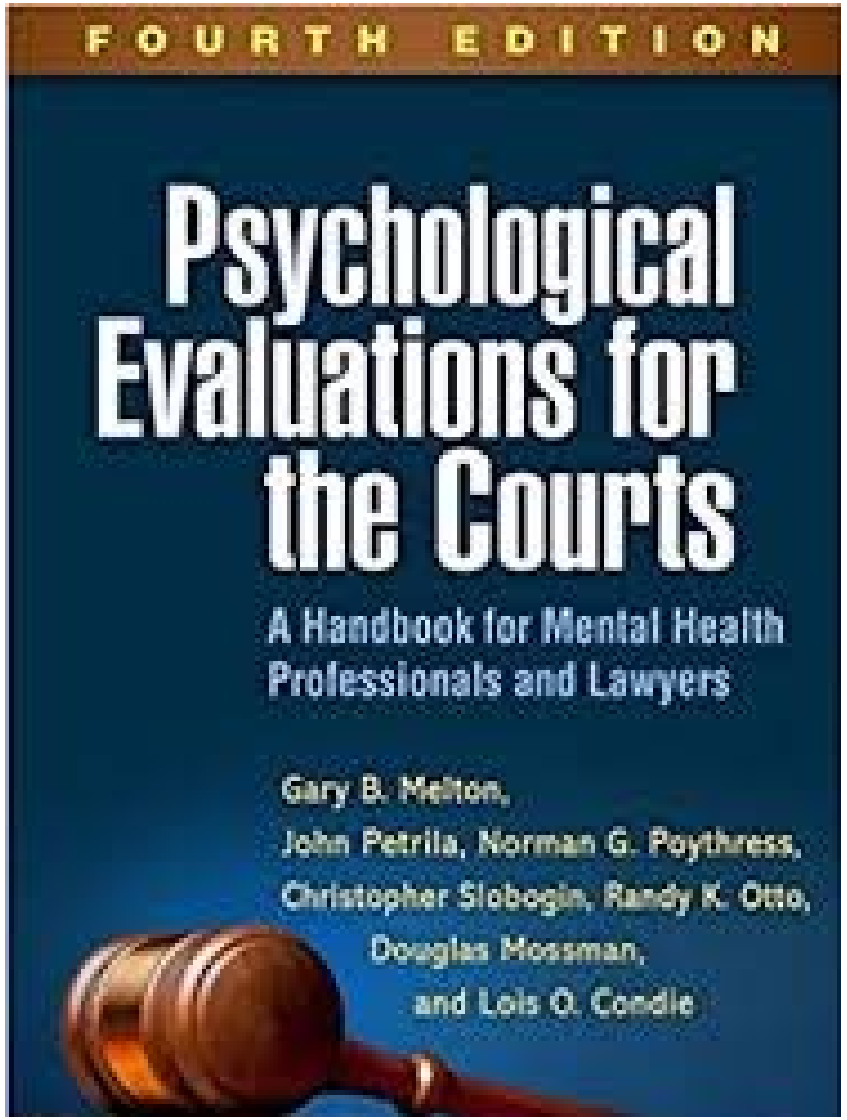
Psychiatric Diagnosis in Forensics Cautions and Controversies

Admonitions

Considerations

Advantages and limitations of (DSM-5) diagnosis

Mitigating limitations



Admonitions

Diagnosis alone is not enough!

---Melton

Guidance and Admonitions

American Psychological Association Specialty Guidelines for Forensic Practice

- **10.01 Focus on Legally Relevant Factors**
  - Help trier of fact **understand evidence**
  - Provide information related to **functional ability, capacity, knowledge**
  - Address **psycho-legal issue** in opinion
  - **Consider problems that may arise with clinical diagnosis in some forensic contexts**
  - **Qualify** opinions, testimony appropriately

Guidance and Admonitions

American Academy of Psychiatry and the Law (AAPL) Specialty Guidelines

- Criminal responsibility
- Competency to stand trial
- Forensic evaluations

Guidance and Admonitions

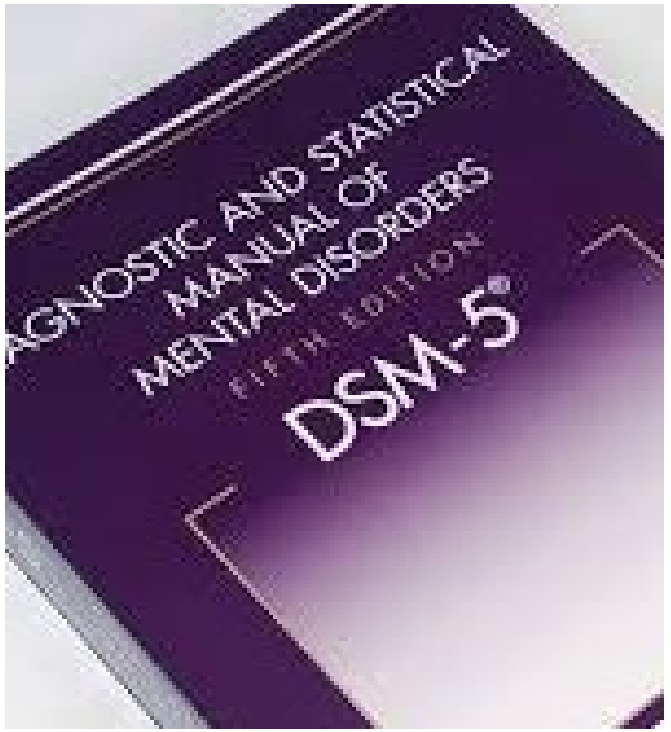
- In some instances, diagnosis is an essential element of legal question
- others not, as with custody.
  - Concern with functioning and capacity
  - Must have adequate reliability, validity
  - Must not be unfairly prejudicial
  - Must relate to individual, not just the diagnostic category

    - **Greenberg et al 2004**

Guidance and Admonitions

The DSM-5 Cautionary Statement

"Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, **DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental disorders.** As a result, it is important to note that the definition of mental disorder included in **DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals**."



Legal Considerations

Sources of information:

the statute; case law; rules of the court; local rules and customs; rules of evidence; regulations

- ✓How is mental disorder defined?
- ✓Is a diagnosis required?
- ✓Is a diagnosis expected?
- ✓Are there exclusions?
- ✓What is the threshold?
- ✓What about relevancy, reliability and sufficiency of the data for the diagnosis and for the threshold?
- ✓What is the relationship of the threshold condition to the ultimate question?
- ✓Will the diagnostic scheme and diagnosis hold up in court?

Clinical-Forensic Considerations

Sources of information:

DSM-5; PDM-2; RDoC; Sims Symptoms of the Mind; Forensic Assessment Books; Manual

- ❑What is the threat of superficial or rigid applications of diagnostic criteria?
- ❑What is the reliability and validity of the diagnostic scheme?
- ❑What is the validity and reliability of the specific diagnosis?
- ❑How does a controversial application fit?
- ❑What is the basis; is it an ipsit dixit diagnosis?
- ❑What are the implications? Pejorative? Stigmatizing?
- ❑How does the diagnosis apply to this individual?
- ❑What do the records say?
- ❑Are there enough facts?

Why a diagnosis, at all if you don't have to?

Diagnosis allows the naming, defining and identification of a singular malady so that it can become an object of consideration, comparison, explanation, and control.

- Sims, *Symptoms of the Mind*

RDoC

DSM-5: "a syndrome characterized **by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning**."[13] ;

ICD-11: final draft definition is similar to DSM 5; Categorical

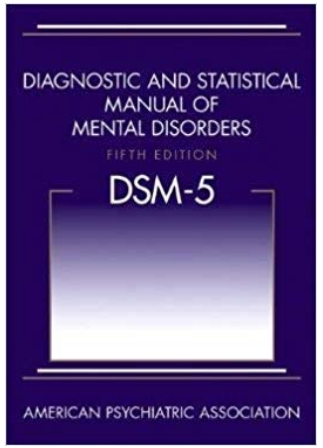
PDM -2: Impairments in functioning as defined in both diagnostic and cross-cutting dimensional categories, including **personality and mental functioning and subjective experience**

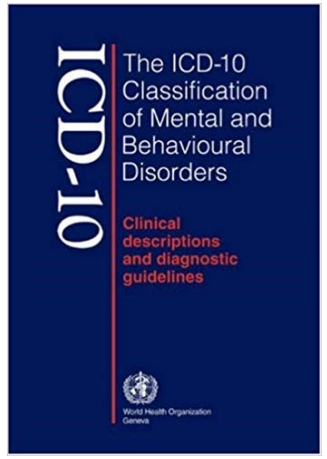
Sims, **Symptoms in the Mind, 6th ed**. Descriptive psychopathology is the **precise description and categorization of abnormal experience** as recounted by the patient and observed in his behavior

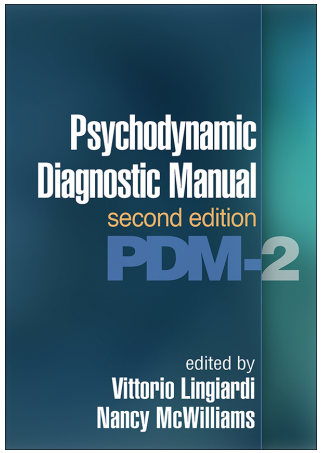
Statutes: Depends on the jurisdiction; threshold condition. and legal question

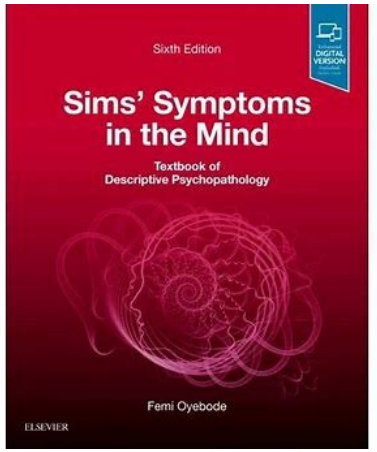
Research Domain Criteria (NIMH RDoC)

Articles and books (emerging diagnoses and syndromes)









Why the DSM-5?

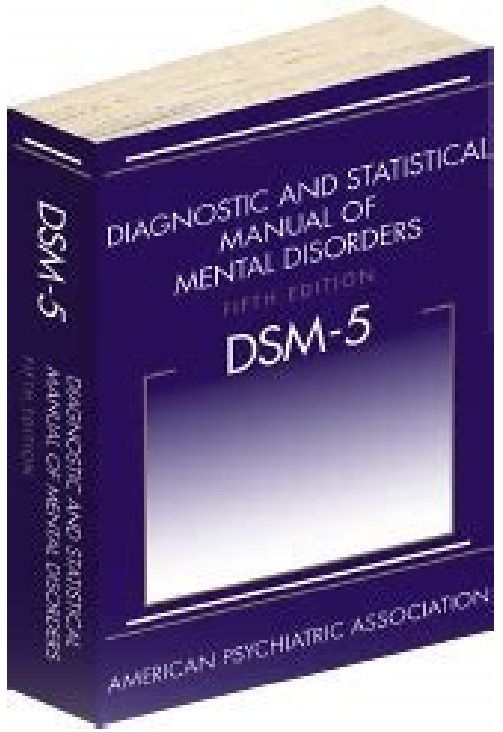
DSM-5 diagnosis expected or required

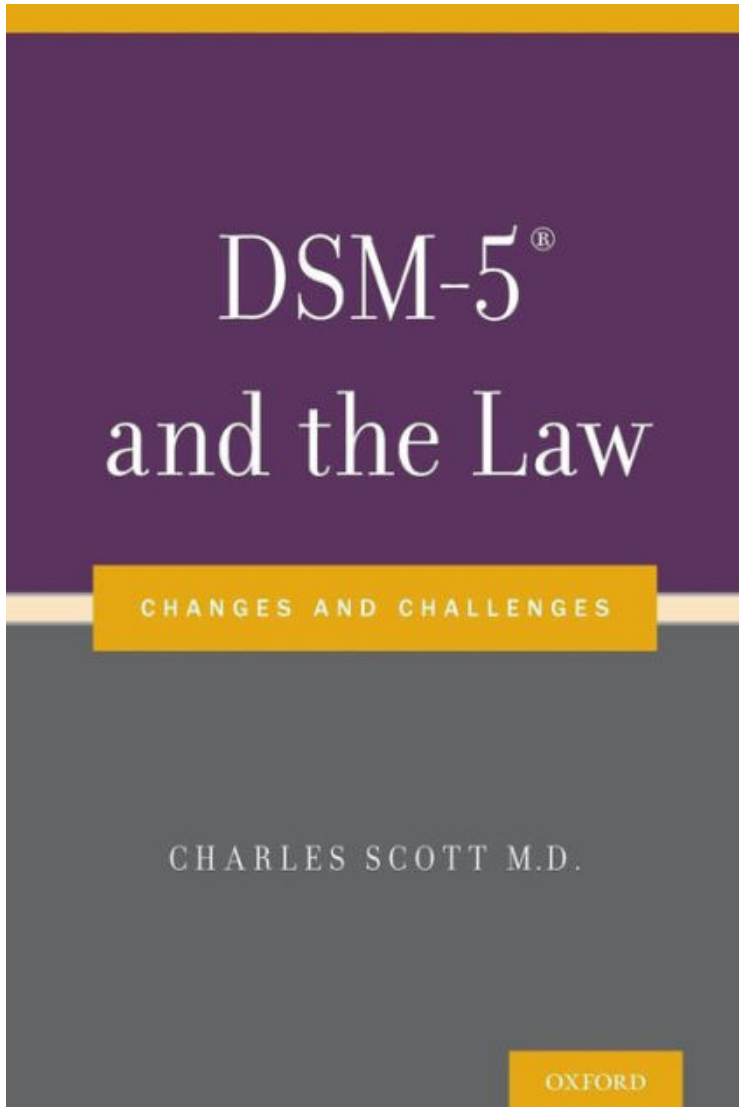
Consensus and research-based

Predominant system of psychiatric classification in the world (NIH; NIMH)

Referenced by and basis of other schemes

- ICD, PDM, Descriptive Psychopathology, etc.





Why the DSM-5?

Court-Friendly Frye/Daubert/Kelly/Sargon

- Generally accepted
- Can be tested; peer reviewed; known error rate, standards, acceptance
- Reliability
- Established diagnosis easier to defend than “ipsit dixit formulation
- DSM 5 cautionary statement now explicitly affirms its use in court
- May use the DSM to define disorder
- Cited in more the 5500 court opinions and 320 time in legislation (Scott, 2015)

DSM-5 Diagnosis better than (most) alternatives

Advantages from the DSM-5 Cautionary Statement

- Diagnostic information can help legal decision makers
- An established system improves (the determination)
  - Value
  - Reliability
- A research-based compendium:
  - DSM-5 improves understanding of mental disorders.
  - Validity and reliability
  - check on ungrounded speculation about
    - mental disorders
    - particular individual.
- Information about longitudinal course relevant
  - Past mental functioning
  - Future mental functioning

Advantages
Using a Diagnosis

Establishes what even qualifies as a mental disorder

Pattern and course of symptoms help with malingering detection

Helps link criteria as “legitimized” symptoms to impairment.

Diagnosis embedded in risk assessment (major mental disorder; personality disorder)

Allows you to explain why odd unusual behavior is or is not a mental disorder

- Culture
- Personality
- Cognitive distortions

Useful for differential diagnosis and exclusion of non qualifying disorders

Bias control (base rates; structured assessment)

Limitations
From DSM 5 Cautionary Statement

Risk of misuse or misunderstanding

Imperfect fit between clinical diagnosis and law

Does not equate to legal criteria for the threshold condition

Diagnostic criteria “met” does not equate to the legal standard being “met”

Does not equate to level of impairment or disability

Does not imply etiology or cause

Does not imply of degree of control over behavior.

More Limitations

Risk of superficial or rigid application

Abuse of medical system for legal purposes (Appelbaum)

Impairments vary widely within a scheme

Lawyers use the DSM to impeach testimony
- due to changes in the DSM
- cautionary statement
- reliability

Signs and symptoms > relevance to the forensic question than diagnosis
- Prejudicial impact when marginally relevant
- Can be over-generalized
- Opinions; they do not substitute for facts

DSM 5
Clinical Limitations and Advantages

Limitations

Reliability (especially for some)

Change

Already out of date (example SID and personality)

Cross cutting symptoms

Arbitrary cutoffs vs. Dimensions

Strengths

Reliability! (especially for some)

Changes!

Validity

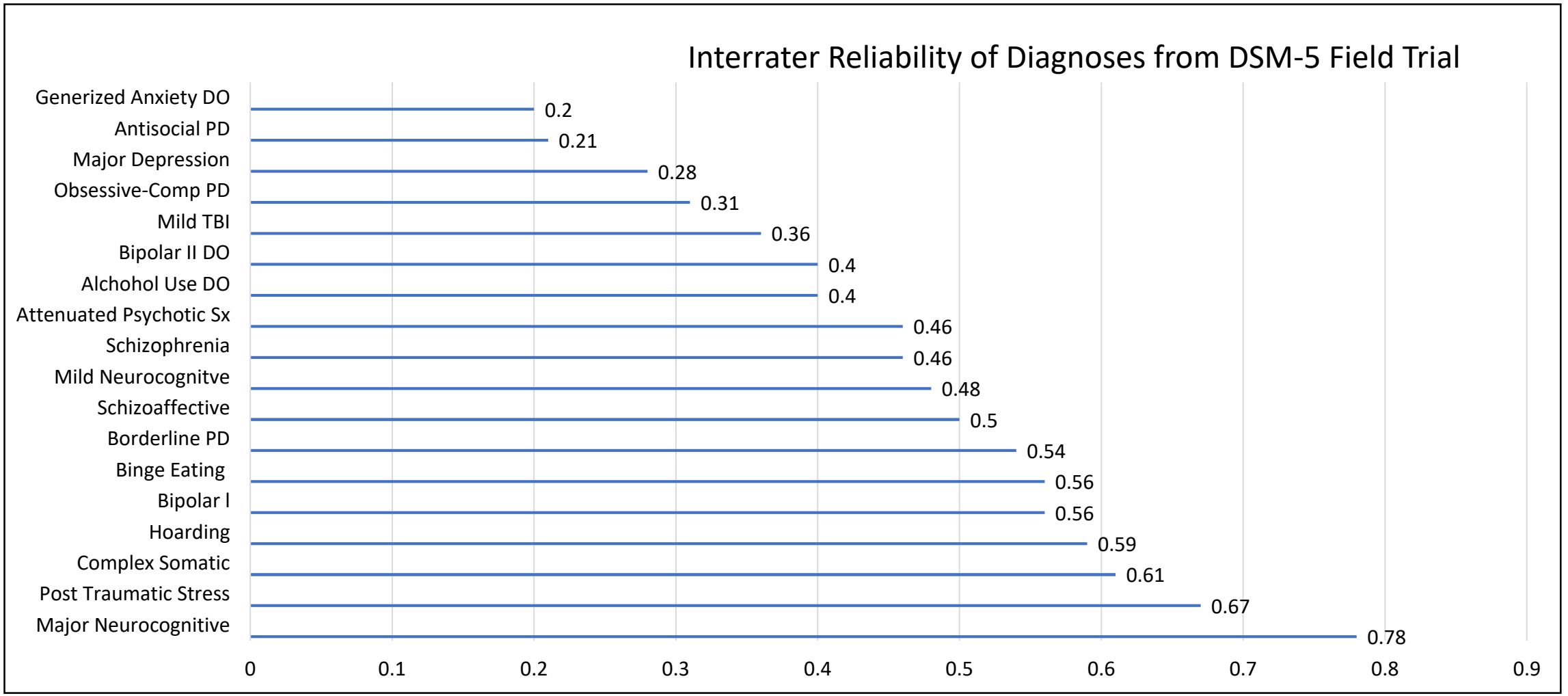
Flexibility

Compendium etiology. associated features; data base

Dimensions considered (assessment measures and personality disorders)

Diagnostic Unreliability

Freedman, R., Lewis, D., Michel, R., Pine, D., Schultz, S., et.al (2013). The initial field trials of the DSM-5: New blooms and old thorns. *American Journal of Psychiatry*. 170:1. 1-5.



Other challenges in diagnosis

Diagnostic momentum

Variability in records

Insufficient records

Documentation not associated with forensic standards

Precision and imprecision

Threshold for diagnosis and for legal definition

Mitigating the Limitations and Challenges

Explicitly link the signs and symptoms to the impairments

Use of Specified, Not Specified (Scott)
- Legitimate cluster within a category
- Unspecified category permits description IAW statute

Counter to challenges
- Purposefully changes (as do medical and physics texts) reflect best science
- DSM-5 explicitly legitimizes use in court

Augment with other schemes and information
- BPRS
- PAANSS
- MMPI

Deep dive your diagnosis

Or Mix Metaphors
Build on the Best

What to do to mitigate failing of or substitutes for for diagnosis?

- ❑Categorize
- ❑Augment
- ❑Use an established category (DSM-ICD/PDM)
- ❑Rate on the DSM-5 Severity Scales
- ❑Place on a dimensions (DSM-5 Emerging Models)
- ❑Describe signs and symptoms (Descriptive Psychopathology)
- ❑Include testing anchors and indices (PANSS; BPRS)

Really know the signs and symptoms of mental disorders, what's an aberration

Key Take-Aways

Know your laws and statutes and local expectations
- Diagnosis required ?
- Expected?

Diagnosis is not enough; It does not equate to
- the threshold condition
- the legal question

Diagnosis can define and distinguish

The DSM-5 is the “generally accepted” source
- Using other schemes might be a heavy lift
- Know the limits and advantages
  - Diagnosis itself
  - DSM
  - Diagnosis you use
- Consider categories, unspecified and other specified

Deep dive your diagnosis (signs and symptoms)

Diagnostic Issues Related to Incompetency to Stand Trial Evaluations

Brandon Yakush, PsyD

PC 1367

Remember:

- PC 1367 – IST criteria
- PC 1369 – Appointment of one or two doctors
- PC 1370 – Commitment as IST
- PC 1372 – Restoration of competency

PC 1367(a):

- A defendant is mentally incompetent for purposes of this chapter if, as a result of mental disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner.

Three criteria

- While there are traditionally two IST criteria (i.e., the Dusky criteria), pragmatically, there are really three:
  - As a result of a mental disorder or developmental disability
  - Inability to understand the nature of the criminal proceedings
  - Inability to assist counsel in the conduct of a defense in a rational manner
- The diagnostic criterion is also a “nexus” criterion:
  - The impairment(s) must be due to the mental disorder or developmental disability (“as a result of”)

IST Diagnostic Criterion

Of all criminal forensic statutes in CA (at least the ones included in this presentation), IST has the broadest diagnostic criteria.

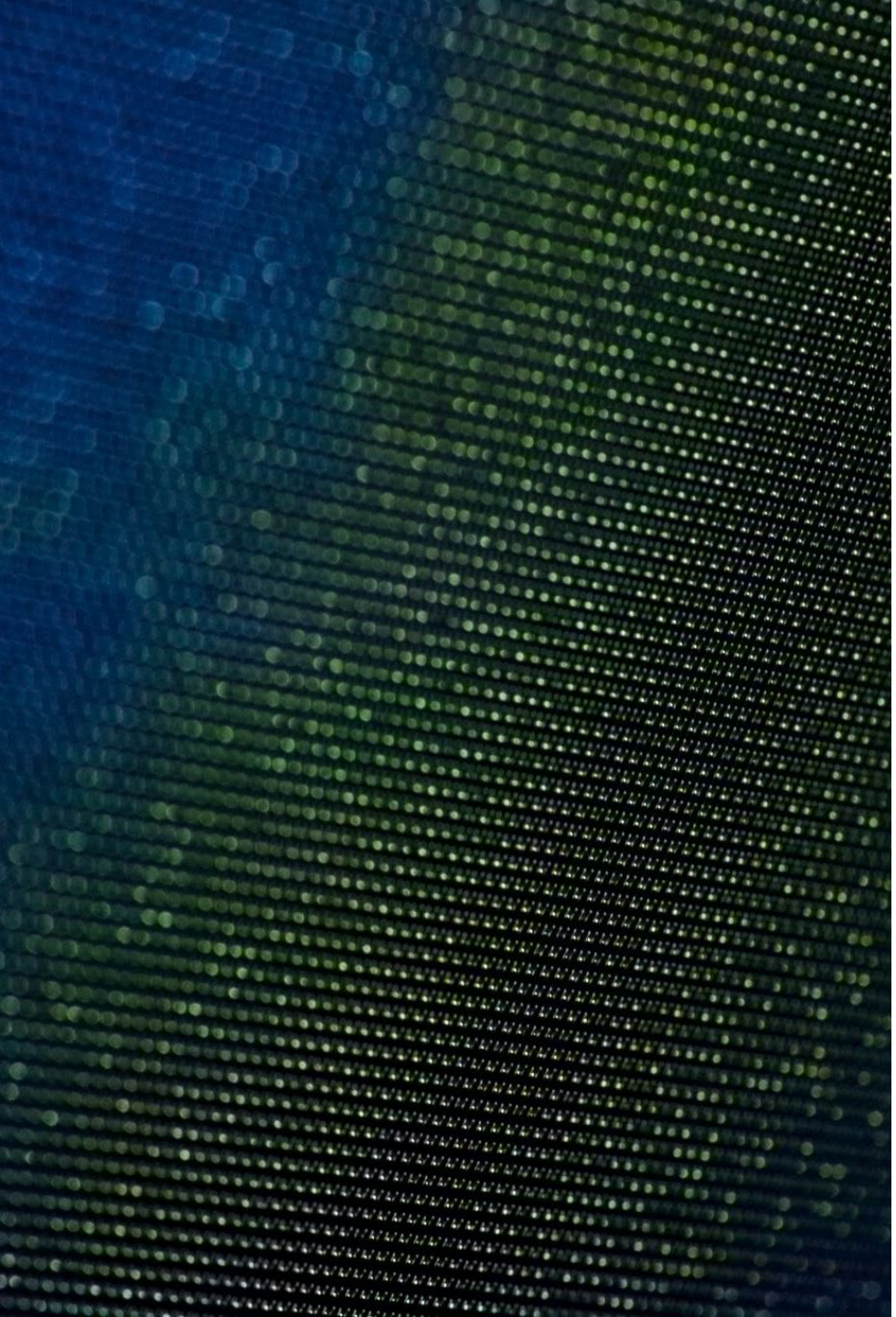
There is no statutory inclusion criteria or description of “mental disorder” or “developmental disability.

There is no statutory exclusion criteria.

In theory, any diagnosis could apply.

Why so broad?

- Why did the legislature choose to include such a vague diagnostic definition for IST?
  - It allows for broad judicial interpretation/application.
    - Ultimately, the judge or jury will decide if a “disorder” or condition qualifies.
  - It lowers the likelihood of false-negative findings.
    - Sending an incompetent defendant on to trial or plea bargain is the worst possible outcome.



Four Diagnostic Issues in IST Evaluations

- Borderline Intellectual Functioning
- Substance abuse/intoxication /withdrawal
- Personality Disorders
- Sub-delusional beliefs

DSM-5

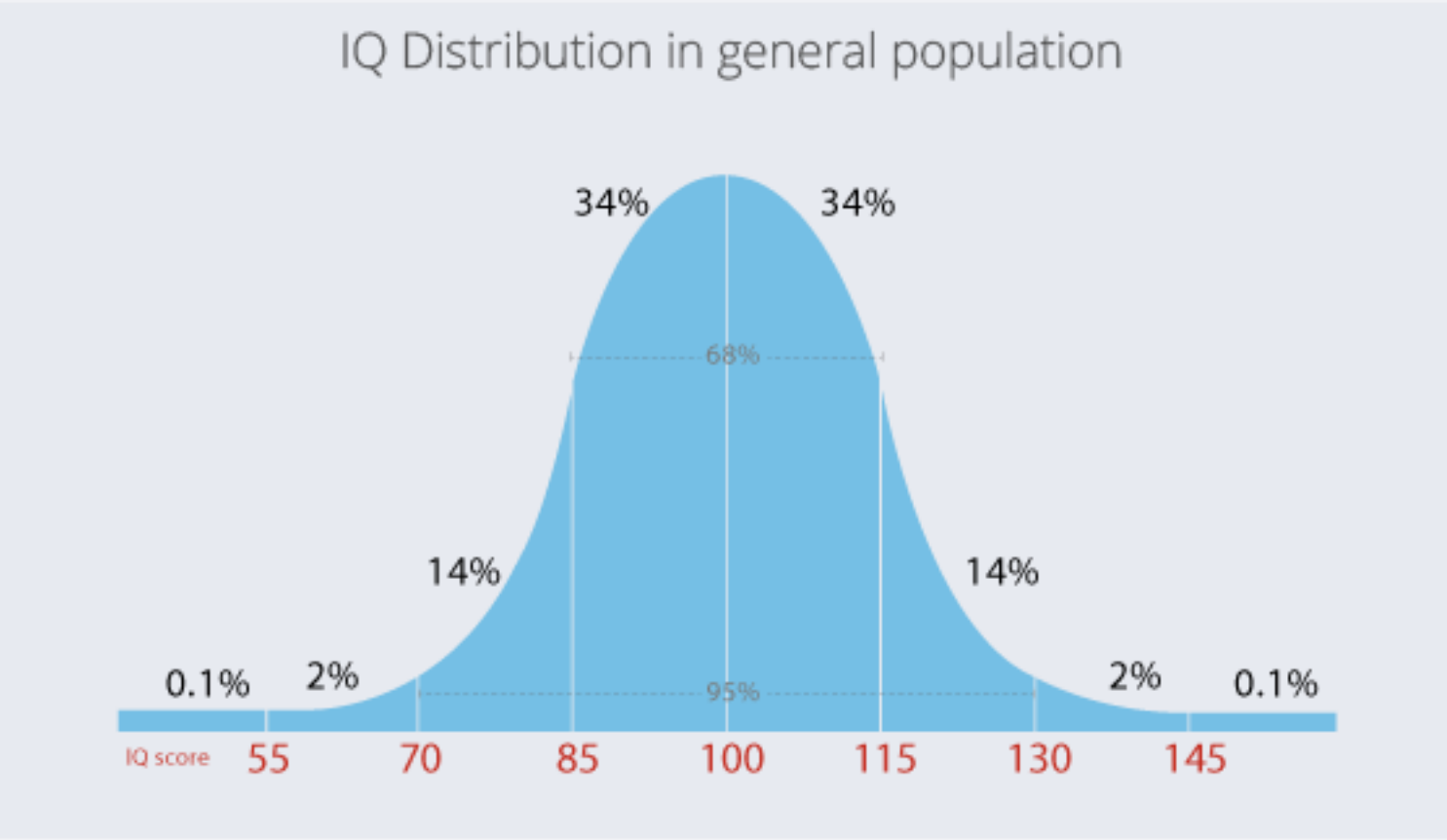
- If PC 1367 includes the broad criterion of “mental disorder or developmental disability,” can any condition in the DSM-5 count towards a finding of incompetency?
  - Yes and no
- Any mental disorder or developmental disability in the DSM-5 could qualify, except for any condition that is not a “mental disorder” or “developmental disability.”

DSM-5 (cont.)

- V/Z Codes
- “Other Conditions that May Be a Focus of Clinical Attention”
- Per the DSM-5:
  - “The conditions and problems listed in this chapter are not mental disorders.”
- Thus, while it may be in the DSM, it is not a mental disorder or developmental disability.

One potential V-Code problem

- While is it highly unlikely an evaluator or court would give a second thought to the vast majority of Z-codes (e.g., abuse, relationship problems, employment issues) as qualifying for IST, there is one exception…
- Borderline Intellectual Functioning (BIF)
  - Classified as a V-Code on p. 272 of DSM-V in the "Other Conditions that May Be a Focus of Clinical Attention" section
  - IQ scores roughly 70 to 85
    - Between one and two standard deviations below the mean
  - Above the impaired range, but below low-average



One potential V-Code problem (cont.)

- While evaluators or attorneys might argue for the applicability of BIF to PC 1367, it is not a mental disorder or developmental disability in the DSM-5.
- Further, while IDD covers roughly 2% of the population, BIF is found in roughly 14%.
- However, BIF can be a very relevant comorbid diagnosis.

What about substance abuse?

- Unlike OMD and NGI, there is no substance intoxication/substance addiction exclusion for IST.
- It is quite common for defendants to come into custody intoxicated or withdrawing from substances.
- Their presentation at arraignment can appear very impaired.
- Seasoned defense attorneys often continue the proceedings for a few weeks to see if their client improves prior to declaring a doubt (especially when the criminal record shows drug-related cases).

Substance Abuse (cont.)

- If an evaluator determines a defendant meets one or both IST criteria, but suspects drug withdrawal is the etiology of the presentation, what is the evaluator to do?
- What not to do…
  - Don’t find the defendant competent because the source is probably substances.
  - There is no legal basis for such an opinion.
- Therefore, either:
  - Find the defendant incompetent but note the etiology is probably substance-related, or
  - Ask for more time to see the defendant again, after a few weeks have passed.

A common question

Can someone be found IST for a personality disorder?

As we saw before, if we consider personality disorders to be “mental disorder,” than yes!

Unlike OMD and NGI, PDs are not excluded in the IST statute.

Personality Disorders

While personality disorders would appear to qualify for a finding of IST, the likelihood that someone with a PD would meet the other criteria for IST is rather low.

IST is about ability and capacity, not willingness or attitude.

Individuals with PDs most likely can rationally assist counsel whether they want to do so or not.

Personality Disorders (cont.)

- However, personality disorders are not all created equal!
- Some are highly unlikely to result in IST:
  - Antisocial, Narcissistic, Histrionic, Dependent, Obsessive-Compulsive, Avoidant, Schizoid
- Others are unlikely (but more likely than the ones listed above):
  - Borderline, Paranoid, Schizotypal
  - These three disorders are psychotic-like.

Paranoid PD v. Delusional D/o v. Schizophrenia

- Great article on comparing the paranoia in Paranoid Personality Disorder with paranoia in Delusional Disorder, Persecutory-Type and Schizophrenia
- Noonan, J. R. (1999). Competency to stand trial and the paranoid spectrum. *American Journal of Forensic Psychology*, 17(5), 5-26.

Delusional, or not?

- Defendants undergoing IST evaluation can often present with extreme, firmly-held beliefs.
  - "The court is part of a conspiracy to silence me."
  - "My attorney is an undercover agent for the prosecutors."
- These beliefs often directly impact their ability to rationally assist counsel.
- But are these beliefs always delusions?
- Are they necessarily the product of a mental disorder?

Overvalued Ideas

- Were first discussed by Carl Wernicke in 1892.
- Are more recognized in British psychiatry/psychology than in the United States.
- Can be seen in other mental disorders, such as anorexia and hypochondriasis.
- Are distinct from delusions.

Overvalued Ideas (cont.)

- Recent articles on the topic:
  - Rahman, T., Meloy, J. R., & Bauer, R. (2019). Extreme overvalued belief and the legacy of Carl Wernicke. *Journal of the Academy of Psychiatry and the Law,* 47, 180-187.
  - Rahman, T., Resnick, P. J., & Harry, B. (2016). Anders Breivik: Extreme beliefs mistaken for psychosis. *Journal of the Academy of Psychiatry and the Law,* 44, 28-53.
  - Cunningham, M. D. (2018). Differentiating Delusional Disorder from the radicalization of extreme beliefs: A 17-factor model. *Journal of Threat Assessment and Management*, 5(3), 137-154.

Overvalued Ideas in IST Evaluations

- If a defendant has a delusion that directly impacts his or her ability to rationally assist counsel, then a finding of incompetency is extremely likely.
  - The defendant cannot rationally assist counsel due to a mental disorder (e.g., Delusional Disorder, Schizophrenia, etc.).
- But what if the belief is an *overvalued idea* and not a delusion?
  - While the belief likely does impact rational assistance of counsel, is it due to a mental disorder?

Overvalued Ideas versus Delusions

- One common feature of overvalued ideas is that the beliefs are not idiosyncratic to the individual.
- The beliefs are typically held by others.
- Quite often, the defendant will cite sources of the beliefs (usually from the internet) that are verifiable.
- Cunningham (2018) provided 17 factors to consider in this differential.

Overvalued Ideas & Sovereign Citizens

- Every now and then, an IST evaluation gives you the opportunity to interview a sovereign citizen.
- A common example of overvalued ideas
- Great article on the topic:
  - Parker, G. F. (2014). Competent to stand trial evaluations of sovereign citizens: A case series and primer of odd political and legal beliefs. *Journal of the Academy of Psychiatry and the Law,* 42-338-349.
- Be sure to consider any possible “comorbid” diagnoses that might explain the person’s vulnerability to the extreme belief system.

Other Examples of Overvalued Ideas

Extreme religious views

Extreme political views

Other examples?

Diagnostic Issues Related to Insanity Evaluations

Brandon Yakush, PsyD

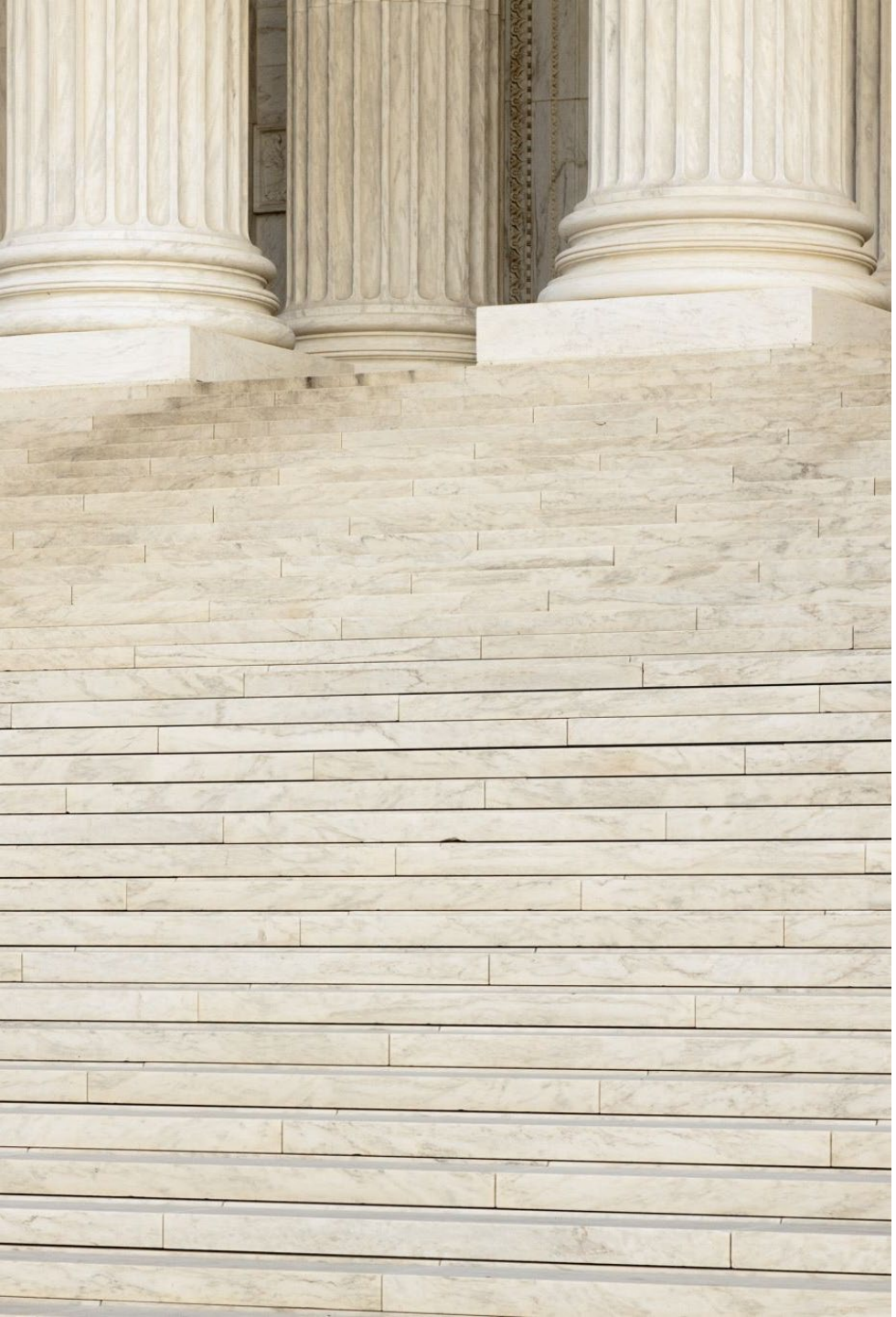
PC 1026

Remember:

- PC 1026 – Commitment as NGI
- PC 1026.5 – Extension of NGI commitment
- PC 1027 – Selection of two doctors
- PC 25(b) – Criteria for NGI

PC 25(b)

- In any criminal proceeding, including any juvenile court proceedings, in which a plea of not guilty by reason of insanity is entered, this defense shall be found by the trier of fact only when the accused person proves by a preponderance of the evidence that he or she was incapable of knowing or understanding the nature and quality of his or her act and of distinguishing right from wrong at the time of the commission of the offense.



PC 25(b)

- In any criminal proceeding, including any juvenile court proceedings, in which a plea of not guilty by reason of insanity is entered, this defense shall be found by the trier of fact only when the accused person proves by a preponderance of the evidence that he or she was incapable of knowing or understanding the nature and quality of his or her act *and* of distinguishing right from wrong at the time of the commission of the offense.
- This definition passed in 1982 as Proposition 8 and was in response to Hinckley's attempted assassination of Reagan.
- This mistake was fixed in *People v. Skinner* (1985) by changing *and* to *or*.

PC 29.8

- PC 25(b), the definition of insanity, does not include any statement about diagnosis.
- However, such information is contained in PC 29.8:
  - In any criminal proceeding in which a plea of not guilty by reason of insanity is entered, this defense shall not be found by the trier of fact solely on the basis of a personality or adjustment disorder, a seizure disorder, or an addiction to, or abuse of, intoxicating substances.
- Notice that the exclusion criteria in PC 29.8 are the same as in the OMD law under PC 2962(a)(2), except that PC 29.8 does not exclude “intellectual disability or other developmental disorder.”

Let’s be practical

- With the exceptions of personality disorders, adjustment disorders, seizure disorders, and substance abuse/intoxication, any mental disorder could legally justify a finding of insanity.
- However, the other M'Naghten criteria in CA – “was not able to understand the nature or quality of the act or was unable to distinguish right from wrong” – denote a state of severe impairment not seen with most mental disorders.
- Thus, the overwhelming majority of true insanity findings will be for psychotic disorders.
- Severe mania and PTSD are two other less common possibilities, though usually only when psychotic symptoms are present.

Complexities of NGI Evaluations

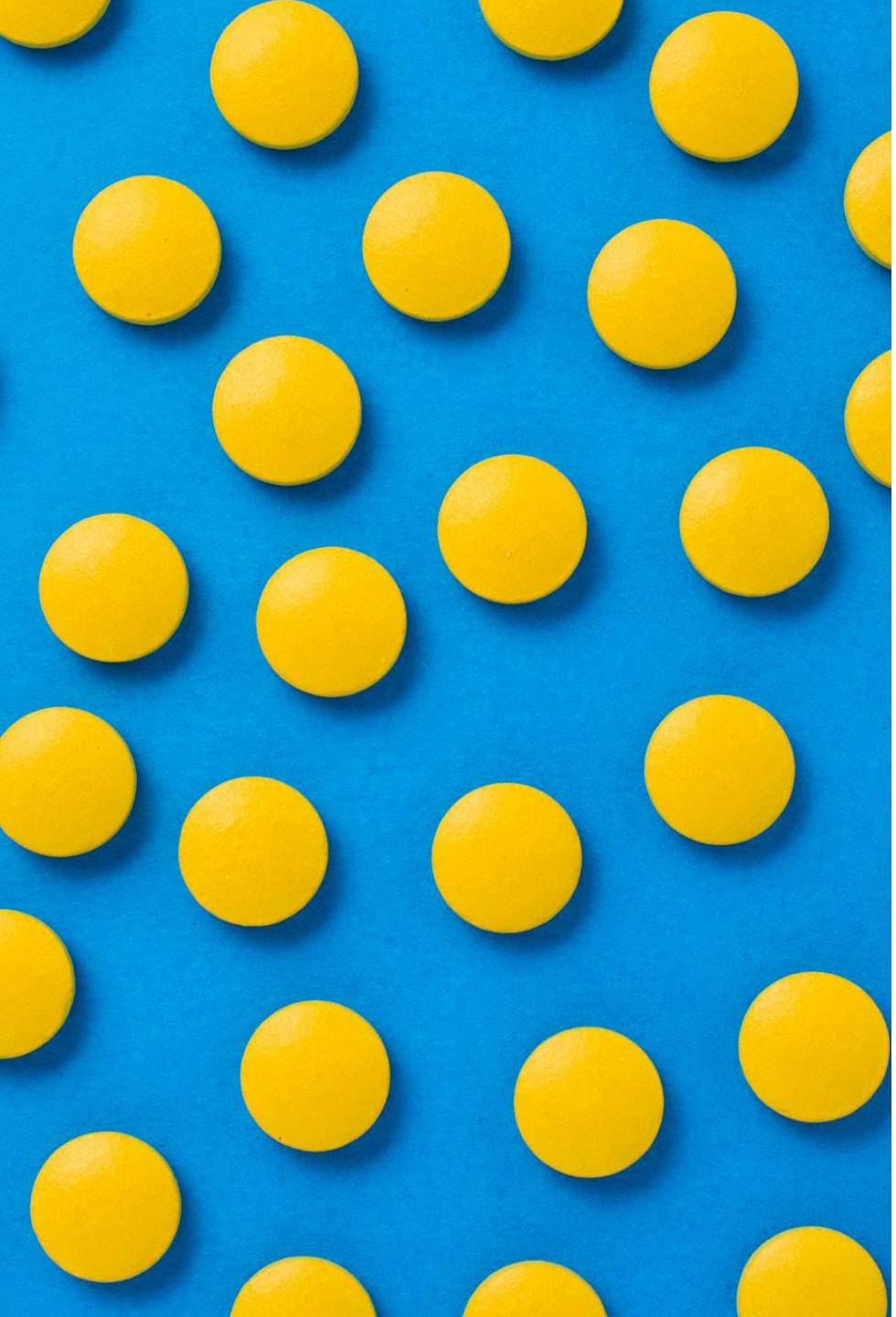
- Admittedly, diagnostic issues are usually not the hard part of NGI evaluations.
  - "Distinguishing the wrongfulness" of the act is usually the crux of a hard evaluation.
- Rarely, the diagnosis can be at issue.
- I will explore three such diagnostic issues here:
  - Substance-induced psychosis
  - Overvalued ideas
  - Personality disorder versus psychotic disorder

CALCRIMS 3450

- The issue of substance use is further delineated in the jury instructions related to insanity, CALCRIMS 3450:
  - Special rules apply to an insanity defense involving drugs or alcohol. Addiction to or abuse of drugs or intoxicants, by itself, does not qualify as legal insanity. This is true even if the intoxicants cause organic brain damage or a settled mental disease or defect that lasts after the immediate effects of the intoxicants have worn off. Likewise, a temporary mental condition caused by the recent use of drugs or intoxicants is not legal insanity.
  - If the defendant suffered from a settled mental disease or defect caused by the long-term use of drugs or intoxicants, that settled mental disease or defect combined with another mental disease or defect may qualify as legal insanity. A settled mental disease or defect is one that remains after the effect of the drugs or intoxicants has worn off.

Substance Use and Insanity

- The second part of CALCRIMS 3450 is confusing to me:
  - If the defendant suffered from a settled mental disease or defect caused by the long-term use of drugs or intoxicants, that settled mental disease or defect combined with another mental disease or defect may qualify as legal insanity. A settled mental disease or defect is one that remains after the effect of the drugs or intoxicants has worn off.
- Does this mean that if the defendant has a substance-persisting psychosis, he also must have schizophrenia to qualify for NGI?
- What about a settled mental disease alone?
- Wouldn't a settled psychosis and schizophrenia be mutually exclusive?



Substance Use and Insanity (cont.)

- Different possibilities lead to different conclusions:
  - If the symptoms were caused by substance intoxication or withdrawal alone, with no persisting issues, then NGI is precluded.
  - If the symptoms were originally caused by chronic drug use, but there was no drug use in proximity to the offense (i.e., the symptoms were persisting), then it would seem NGI is allowed.
    - Though CALCRIM 3450 seems to contradict this conclusion.
  - If the defendant has a long history of psychosis without drug use, but was intoxicated at the time of the crime, then it would seem NGI is permissible.
    - However, be sure the symptoms are not due only to the intoxication, though the intoxication could exacerbate his symptoms.

Practical Thoughts on Intoxication at the Time of the Offense

- Unfortunately, it seems to be rare that drug testing is done after an arrest.
- If the defendant was taken to a hospital for medical clearance prior to being booked into jail, assuming the arrest was made soon after the crime, make sure to review those records for possible information about signs of intoxication and/or testing.
- Remember, acute drug intoxication usually includes physical signs in addition to psychiatric ones.
- Police usually have a “11550” form they use to document signs of drug intoxication.

Overvalued Ideas

- Like with IST evaluations, overvalued ideas can be a differential “diagnosis” in NGI evaluations.
- If a defendant claims his crime was morally permissible due to a belief, is that belief a delusion or an overvalued idea?
- Think of crimes committed by cults or religious fanatics.
  - Holoyda, B. & Newman, W. (2016). Between belief and delusion: Cult members and the insanity plea. *Journal of the Academy of Psychiatry and the Law*, 44, 53-62.

Personality Disorder vs. Psychotic Disorder

- The diagnostic differential between a personality disorder and a psychotic disorder is not all that uncommon.
- Individuals with Borderline Personality Disorder, for example, can experience transient psychosis.
- If the psychosis is purely secondary to the PD, it would not qualify under PC 29.8 for insanity.
- But when is the psychosis more than just a PD?
- Just a differential could make the difference between a positive and negative insanity evaluation.

Case Example

In order to elaborate on this issue, I am going to present a case example.

This case has some real facts and some modifications.

The diagnostic issues will be emphasized.

Background Information

- At the time of the homicide, the defendant was in his late 30s.
- His problems began in his early 20s after he appeared to have a mental breakdown while in college.
- He had a history of sporadic mental health treatment throughout adulthood, including antipsychotic medication.
- He was hospitalized at least once in a severely psychotic state.

Clinical Presentation

- The defendant's most salient historical symptom was how he would have brief episodes where he believed himself to be intertwined in major world events.
- However, the beliefs were transient, short-lived, and with some discussion, he could be reasoned out of his thinking.
- During inter-episodes, he had no abnormal thought content
- Understandably, some clinicians called the beliefs *delusions*.
- The fact that with some dialogue, he could realize he was wrong was not entirely consistent with delusional ideation, however.
- Per DSM-5, delusions are "fixed beliefs that are not amenable to change…"

Clinical Presentation (cont.)

- The nature of his beliefs were better described as *ideas of reference*.
  - Per DSM-5, “The feeling that causal incidents and external events have a particular and unusual meaning to that specific individual.”
  - While ideas of reference can rise to *delusions of reference*, such beliefs would be strongly held and thus not consistent with the defendant.
- Typically, ideas of reference are not part of Schizophrenia, but are a primary symptom of Schizotypal Personality Disorder.

Schizotypal Personality Disorder

- In looking at this diagnosis, it fit the defendant exceedingly well.
- He presented with clear evidence of:
  - A1: Ideas of reference
  - A5: Suspicious or paranoid ideation
  - A6: Inappropriate or constricted affect
  - A8: Lack of close friendships or confidants other than first-degree relatives
  - A9: Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.

Schizotypal Personality Disorder (cont.)

- The defendant also showed some limited evidence of the other four criteria (but only five of nine were needed for the diagnosis):
  - A2: Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or “sixth sense”)
  - A3: Unusual perceptual experiences, including bodily illusions
  - A4: Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborative, or stereotyped)
  - A7: Behavior or appearance that is odd, eccentric, or peculiar

Schizotypal Personality Disorder (cont.)

- From Dr. Million's handbook on personality disorders, he fit following descriptions of this disorder :
  - "Emotionally impoverished social life"
  - "Distancing from close interpersonal relationships"
  - "Confused or autistic… way of thinking"
  - "Meaningless, idle, ineffectual existence, drifting from one aimless activity to another"
  - "On (the) periphery of societal life"
  - "Rarely developing intimate attachments or accepting enduring responsibilities"
  - "Withdrawn and isolated existence"
  - "Aloof and isolated and behave in a bland and apathetic manner because they experience few pleasures and have a need to avoid few discomforts"
  - "Attribute unusual and special significant to peripheral and incidental events, construing what transpires between persons in a manner that signifies a fundamental lack of social comprehension and logic"
  - "Unable to grasp or resonate to the everyday elements of human behavior and thought"

Schizotypal Personality Disorder, but…

- A Schizotypal PD diagnosis fit the defendant exceedingly well.
  - It was as if Dr. Millon interviewed him for the handbook description.
- But the diagnosis did not fully explain his history.
- The defendant had experienced psychotic episodes that were way beyond what one would expect from his PD alone (which can include transient psychosis).
  - E.g., hospitalized for severe psychosis, another time he presented as psychotically paranoid consistently for several months

How to Augment the Schizotypal Diagnosis?

- Schizophrenia
  - He did not meet Criterion A
  - Even if the beliefs were delusions, he still only met one symptom of Criterion A
- Delusional Disorder
  - The beliefs were too inconsistent and transient
- Brief Psychotic Disorder
  - Episodes must be less than one month in duration – not the case here
  - Seems to imply the person only has one episode ever, not a reoccurring thing
- Attenuated Psychotic Disorder
  - DSM-5 Conditions for Further Study
  - Sub-threshold psychotic symptoms
  - During the acute episodes, the defendant exhibited *threshold* psychotic symptoms
- Acute and Transient Psychotic Disorder
  - Not in DSM-5 but is in ICD-10
  - Involves sudden onset (less than two weeks)

Psychotic Spectrum

- DSM-5 recognizes a psychotic spectrum.
  - Schizotypal Personality Disorder is now actually listed in the section *Schizophrenia Spectrum and Other Psychotic Disorders*.
  - But the criteria are still under *Personality Disorders*.
- So, the final diagnostic conclusion was the the defendant's baseline diagnosis was Schizotypal Personality Disorder,
- And he had experienced episodes on the psychotic continuum,
- But he did not have Schizophrenia.

Psycholegal Complexity

- As for the psycholegal issue:
  - “This diagnostic conclusion leads to an additional psycholegal complexity. If Mr. X has Schizophrenia, he clearly has a PC 25(b)/29.8-defined mental disorder. If he only has Schizotypal Personality Disorder, such a condition is excluded for a finding of insanity by PC 29.8, as it is a personality disorder. But, what if, as I opined, he is somewhere in the middle?”
- It does not seem that the law (which is dichotomous) recognizes the continuum nature of mental illness.

In Conclusion

- Therefore:
  - “While such a determination is, in the end, a legal issue for the trier of fact, I would posit the following observation: When at baseline, and only showing symptoms of Schizotypal Personality Disorder, Mr. X’s pathology would not qualify under PC 25(b), CALCRIMS 3450, and PC 29.8. However, when in a discrete psychotic episode, his pathology is quite in line with the intentions of a mental disorder under PC 25(b), CALCRIMS 3450, and PC 29.8, and thus would qualify for a finding of insanity.”
- Thus, the final opinion on insanity could be contingent on what state of pathology the defendant was in when he committed the crime.

MELINDA DICIRO,
PSY.D., ABPP

Diagnosis in PC 2962 Evaluations

PC 2962 Post- Prison Civil Commitment

Diagnosis: Do it right

- “an individual’s right to liberty is too sacred a premise of our ordered democracy…to have it rendered also meaningless by a cursory interview, brief review of medical records, and an inconclusive, tentative conclusion”
- In re MH, Arizona Court of Appeals,2008, Cited in People v Bendovid Cal 2nd Court of Appeals, 2018.

PC 2962
FKA MDO
NKA OMD
or OMHD

Prisoners

- With violent crimes
- In mental health system
- Are evaluated on six PC 2962 Criteria

If criteria are met

- are treated at the state hospital
- as a condition of parole upon release

The Six Criteria

1. Severe mental health disorder (**SMHD**)
2. Violent crime
3. **The SMHD** is cause or aggravator in the crime
4. **The SMHD** is not in remission/cannot be keep in remission
5. 90 days of post sentencing treatment for **the SMHD**
6. By reason of **the SMHD**, substantial danger to others

The term “**severe** mental health disorder” means

1. an illness or disease or condition that

2. a. substantially impairs the person’s
thought,
perception of reality,
emotional process, or
judgment;

or which

b. grossly impairs behavior;

or

that demonstrates evidence of an acute brain syndrome for which prompt remission, in the absence of treatment, is unlikely.”

Definitions

Substantially

Black's Law dictionary defines "substantially" as:

"Essentially; without material qualification; in the main; in substance, materially; in a substantial manner. About, actually, competently, and essentially."

Oxford Dictionary defines "substantially" as:

"1. to a great or significant extent,

2. for the most part; essentially:" and

Grossly as:

"Great; culpable; general; absolute. A thing in gross exists in its own right, and not as an appendage to another thing. Before or without diminution or deduction. Whole; entire; total; as in the gross sum, amount, weight—as opposed to net. Not adjusted or reduced by deductions or subtractions."

PC 2962 Statutory Exclusions

The term “severe mental health disorder,” as used in this section, does not include

- a personality disorder,
- adjustment disorder,
- epilepsy,
- intellectual or other developmental disabilities, or
- addiction to or abuse of intoxicating substances

Case Law in PC 2962 Diagnosis

People v. Starr (2003)

- Pedophilic disorder qualifies

People v. Bendovid (2018)

- C-5 (90 days of treatment) focused
- Treatment for “unspecified mood disorder and personality disorder” is not treatment for “delusional disorder”
- Cites the DSM-5 definitions of these disorders; DSM-5 assertion: diagnosis determines treatment received.
- Cites **Cuccia v Superior Court (2007)** the MDO act requires the DA to accept the diagnosis .. of [the] treating facility.”
- Cites **People v Sheek (2004)** must prove he was diagnosed during the relevant treatment period
- Cites **Sheek** and **People v Garcia (2005)** disorder not diagnosed means not treated
- Decried “speculation” about treatment-disorder relationship
- Cites **Garcia (2005)** the treatment must be for ***the*** mental disorder not ***a*** mental disorder.

People v. Pierre (2019)

- Clarifies **Bendovid**
- Cites the DSM-5, including acknowledgement of the differential in this case
- Rejects the argument that the treatment and disorders must match word for word
- Concludes **no** evidence that treatment for schizophrenia and schizoaffective disorder is not substantially the same

Key Errors

1. Disorder

Equating PC 2962 SMHD and
- **a “Coleman 10” diagnosis**
- **a “serious and persistent mental illness” or “major mental illness”**
- **any diagnosis for that matter (loc meds)**

Not enough facts
- **Over-relying on the conclusions of others**
- **Over-relying on conclusory statements and self report**

Misdiagnosing a paraphilic disorder

2. Exclusions
- **Not identifying**
- **Note distinguishing excluded conditions**

3. Impairments
- **Not identifying (assuming!)**
- **Low threshold (not severe; not substantial or gross)**
- **Not linking them to the disorder**

Challenges:

Records

- Diagnostic variability
- Diagnostic momentum
- Data vs. inferences

Level of Care

- Motivations
- Variable standards for placement

Threshold

- Severe
- Substantially
- Grossly

Making Challenges Steeper

1. High prevalence of excluded conditions in prison
2. High overlap
3. High co-morbidity of excluded conditions
   - no either or distinction
4. Inadequate documentation
   - objective signs
   - discrete episodes/changes from baseline
5. Superficial diagnoses and expedient use of medication

PC 2962: Diagnosis: to use or not to use?

Pros

Mitigates key errors and challenges

- It's "a thing"
- Diminishes diagnostic momentum
- Avoids imprecise, biased, and idiosyncratic application
- Eases cross criterion application
- Eases differential
- Encourages reliability and factual basis (by structured examination of criteria)
- Congruent with standard practice for CDCR and ASH
- Frye, Daubert, Sargon
- Bendovid expectations
- Severity specifiers and domain ratings

Cons

Perpetuates key errors and challenges

- High risk of equating diagnosis with SMHD
- High risk of precluding potentially qualifying conditions
- Excessive precision in an imprecise world
- Use of the "f" word
- Out of date on key differentials
- Misapplication of essentially equivalent diagnoses on C5 (90 days of treatment)
  - People v Bendovid 2018 and People v Pierre 2019

Mitigating the “cons” and challenges

Read the statute—keep it front and center

1. Diagnosis/disorder

Don’t equate diagnosis or LOC with SMHD

Rely on facts, not inferences

Favor objective indicators

Use deep diagnosis: read the criteria; know the disorder; don’t be rigid

Augment with measures, research and other systems

Use Other specified; Unspecified within classifications

2. Explicitly consider and rule out excluded disorders

3. Link facts to criteria and to impairments

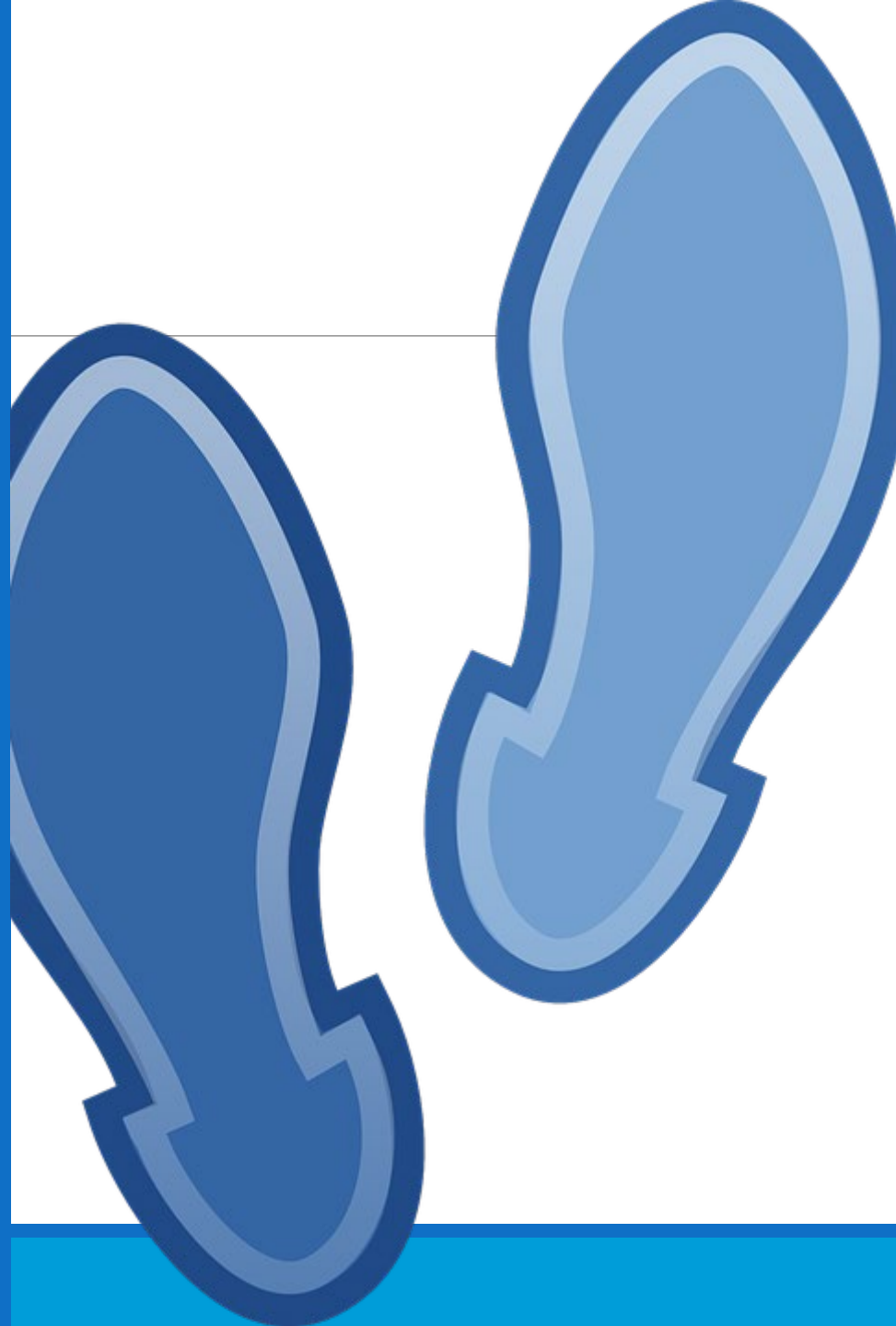
Apply the same disorder across criteria and dual track (when indicated)

Three (Overlapping) Steps

1 . Identify the illness, disease or condition
- Identify indicators
  - Illness
  - Impairment

2. Distinguish from exclusions

3. Link the illness disease or condition to impairments



Step 1

Identify indicators illness disease or condition and impairment

Objective, descriptive, relevant, sufficient

Key to

Illness disease or condition indicators

Impairment indicators

Gather your facts: Identify inferences

Facts: (Records and MSE)	Inferences (Records mostly, be alert)
Thinks CIA read his mail; writes to the Warden	Delusional
Reports that he was a famous rap star	Grandiose
Pacing in cell continuously X 7 days	Manic
Rants and gesticulates at unseen others	Auditory Hallucinations
Intentional overdose; on ventilator X 4 days	Suicide attempt
Direct quotations of disordered speech	Thought disorder
Food and garbage strewn in cell	Cell is unkempt

Ferret the SMHD from the trashcan

Excluded conditions

- Substance use
- Adjustment disorders
- Personality disorders
- Developmental disability

Recognize

Malingering

Prison behavior

- IEX
- Auditory hallucinations
- Suicidal ideas & acts
- Prison paranoia

Challenging Disorders: PC 2962

Substance Use and Induced Disorders

"Settled conditions"

Personality Disorders

Normal variants

Malingering

Paraphilias

Settled-Condition Substance Induced Psychosis

Does not appear to be excluded

- Not necessarily use of
- Not necessarily addiction to

Can **substantially impair** the person's

- thought,
- perception of reality,
- emotional process, or
- judgment;

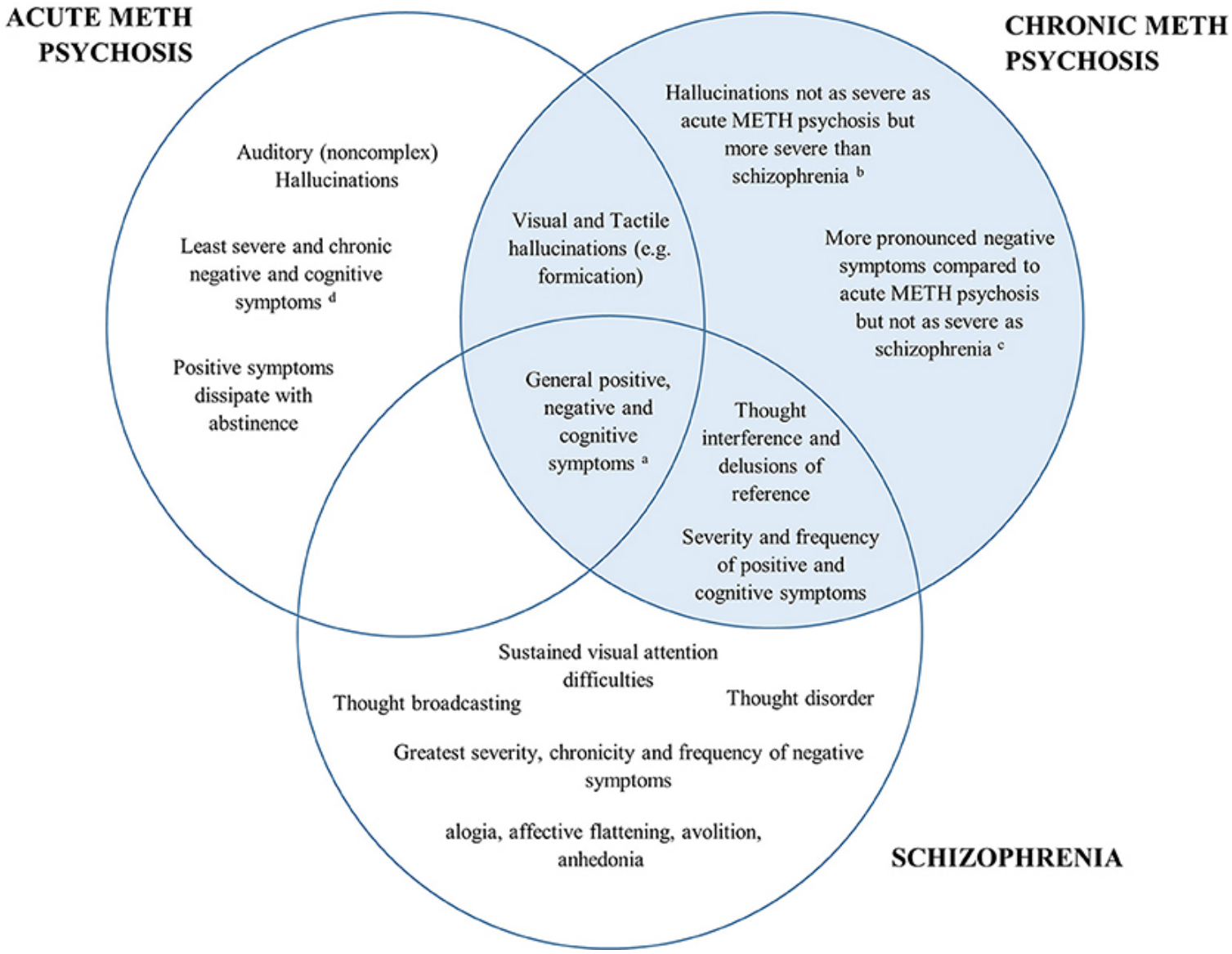
or which **grossly impairs** behavior;

Addiction and Intoxication v Substance Induced disorders

Mood, anxiety, psychotic

Acute Meth v Chronic Meth v Primary Psychosis

Wearne T. and Cornish, J (2018) A Comparison of Methamphetamine Induced Psychosis and Schizophrenia. A review of positive, negative, and cognitive symptomology. Frontiers in Psychiatry, 9.491. With permission from the authors Feb 8 2020



Personality Disorder

Excluded

Personality disorder can look like

- Psychosis
- Bipolar disorder

Normal variations and adjustments

Excluded

Can be mistaken for

- Psychosis, is it really
  - Paranoia?
  - Grandiosity?
  - Abnormal perception?
- Depression

Even normal adjustment

Can look like schizophrenia

People are spitting in my food
Officers are setting me up
They don't want me to parole
Retaliation for grievances "602"
They stole my property
Bona fide threat

"Paranoia is an illness I contracted in institutions. It is not the reason for my sentences to reform school and prison. It is the effect, not the cause."

Jack Henry Abbott

Malingering

Not a mental disorder

Excluded accordingly

Try to mimic

- Mood Disorder
- Psychosis

Feign

- Hallucinations
- Delusions
- Depression or “mood swings”

The peculiar allure of the CTC and PIP
A partial list

Less restrictive housing –considered

Inpatient-diet: hot food breakfast and dinner

Change in level of care

Change of medication regimen

Easier access to phone

Victimize lower functioning

Company

Staff attention

Medical care

Nurses

Porters

Not (necessarily) markers of SMHD

- Dramatic self injury
- Suicidal ideation
- Suicide attempts
  - Razors
  - Nooses
  - Batteries
- Command auditory hallucinations
- Auditory hallucinations
- CTC and PIP Admissions;
- DSH transfers and commitments
- Racing thoughts
- Proclamations of suicidality
- Entrenched mental illness as excuse or ticket to better life habit (C3!)
- “Paranoid” of ‘grandiose” statments

Feigning, manufacturing, exaggerating A brief refresher

- Rare symptoms
- Improbable and absurd responses
- Indiscriminate symptom endorsement
- Unlikely symptom combinations
- Contradictory symptoms
- Symptom severity
- Non-malingerers seldom have a crime partner
- Malingerers are likely to have non-psychotic alternative motives

Rogers & Shuman (2000)

Resnick and Scott Handouts

Paraphilic Disorder AKA Starr 2002

None are precluded

None are equated

- “The clinical diagnosis of a mental disorder , such as….or pedophilic disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or the lagal standard.”DSM-5 Cautionary Statement

Criteria often misapplied

- Prepubescent
- Duration

Diagnosis is not enough

- Additional information is usually required.
- Impairments vary widely within a diagnostic category

Bayes, A. and Parker, G. (2019). Cognitive and behavioral differentiation of those with borderline personality disorder and bipolar disorder. The Journal of Nervous nad Mental Disease. V 207, (8).

Coulter, C. Baker, K. Margolis, R. (2019) Specialized consultation for suspected recent-onset schizophrenia: diagnostic clarity and the distorting impact of anxiety and reported auditory hallucinations. *Journal of Psychiatric Practice* March 2019 - Volume 25 - Issue 2 - p 76–81

Freeman, D. & Garety, P. (2014). Advances in understanding and treating persecutory delusions: a review. *Social Psychiatry-Psychiatry Epidemiology.* 49:1179-1189.

Garrison. J. , Fernyhough, C., , McCarthy-Jones, S., Simons, J. & Sommer, E. Paracingulate Sulcus Morphology and Hallucinations in Clinical and Nonclinical Groups. Schizophrenia Bulletin vol. 45 no. 4 pp. 733–741, 2019 doi:10.1093. Advance Access publication 30 October 2018

Kleiger, J and Khadivi, A (2015) Assessing psychosis; a clinicians guide. Routledge.

Paris, J (2011) Differential bipolar and borderline personality disorders. *Neuropsychiatry*. 1 (3) 251-257.

Paris, J, & Black, D. (2015) Borderline personality disorder and bipolar disorder—What Is the difference and why does It matter? *Journal of Nervous and Mental Diseases.* 203:3–7.

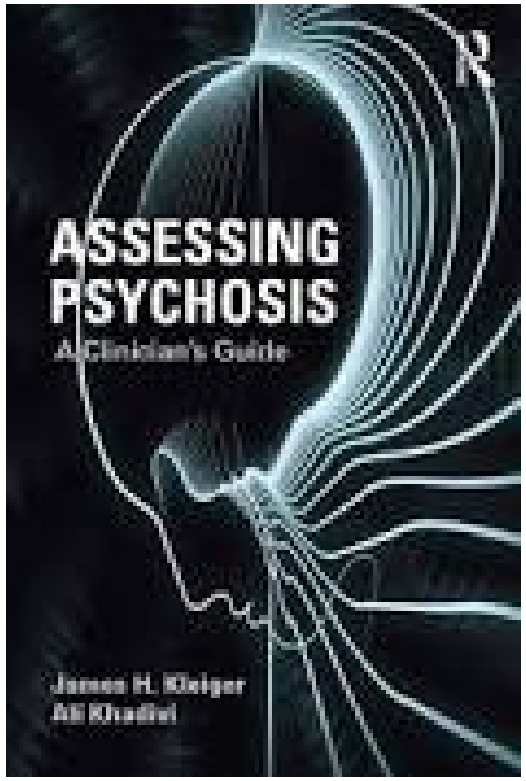
Paris, J. (2015) Why patients with severe personality disorders are over-medicated. *Journal of Clinical Psychiatry* 76:4, April 2015.

Shanker, S., Koller, D., Foroud, T., Edenburg, H., Xioaling, X., Niculescu, A., the Bipolar Genome Study Consortium, and Numberger, J. (2015) Characteristics of BiPolar I patients grouped by externalizing disorders. *Journal of Affective Disorders*. Jun 1, 178, 206-214.

McCarthy-Jones , S. Resnick P. (2013) Listening to voices: The use of phenomenology to differentiate malingered from genuine auditory verbal hallucinations International Journal of Forensic Psychiatry and Psychology. Nov (21)

Swann, A. (2011) *Antisocial personality and bipolar disorder: interaction in impulsivity and course of illness*. Neuropsychiatry. 1 (6) 599-610.Swann, A., Liffijit, M., Lane, S., Kjome, K., Steinberg, J., & Moeller, F. (2011). Criminal conviction, impulsivity, and course of illness in bipolar disorder *Bipolar Disorder* Mar, 13 (2) 173-181

References


ASSESSING
PSYCHOSIS
A Clinician's Guide
James H. Kleiger
Ali Khadivi

Reference

	Perception of Reality	Thought (Judgment)	Emotional Process	Behavior
Psychosis	**Impaired reality** **Internally preoccupied** Guarded Impaired source monitoring AH-negative and berating Less control	**Impaired reality** Disorganized speech Derailments Clang Assn/Neologisms Degrades over time **Impaired Insight**	Independent of co-morbid Bipolar, Schizoaffective or psychotic mood disorders" **Inappropriate affect** Dysphoric mood<mood disorder	Grooming below standards Malodorous **Consistent w/ delusion**
Bipolar	Hallucinations and delusions in mania	**Flight of ideas** Continuous speech with abrupt shifts in topic, sometimes to **incoherence**	**Distinct, Persistent observable change in energy and activity** **Sustained 4/7 days** Accompanied by thinking and bx change Responsive to meds **Euphoria**	Hypergraphia Accelerated Purposelessness Wakefulness (v insomnia) **Impulse/criminal behavior limited to manic states** Does not remit with age Episodic
Personality	AH common with BPD **Related to stressors** **Transient (< I day)**	Cognitive distortions External blaming Lying & Bragging Can have pressured speech; **no**t incoherent T**emporary** paranoia due to stress	React to triggers Trait irritability **Brief, high intensity dysphoria** Volatile-bullying **Euphoria is rare**	Longstanding, chronic **Volitional** Pervasive Repetitive self harm **Stable across time and context** Remits with age
Normal Prisoner	AH rising/sleeping Bereavement; congruent w/ external stimuli or own voice Ambiguous background Increased sensory activation Cultural pseudo-hallucination	Safety property food EPRD concerns; conspiracies "delusions and grandiose" assertions that check out Overvalued ideas Paranormal beliefs Cultural beliefs	Mood changes in response to external circumstances Anger and sadness	Isolating near EPRD C/O anxiety in response to genuine threats
Feign for Gain	AH unremitting and intolerable Stilted Thrust forward No control strategy	"delusion" Absurd, Rapid onset, delusional Unelaborated Linear thinking and speech **Clears during interaction**	**Normal vegetative signs; intact sleep appetite pleasure seeking; normal**	**Reported not equal to observed** Self advocating Meticulous feces smearing

Perception of Reality

Psychosis	**Impaired reality** **Internally preoccupied** Guarded Impaired source monitoring AH-negative and berating Less control
Bipolar	Hallucinations and delusions in mania
Personality	AH common with BPD **Related to stressors** **Transient (< I day)**
Normal Prisoner	**Intact reality testing** AH awakening/sleeping Bereavement; **Congruent w/external stimuli or own voice** Ambiguous background Increased sensory activation Cultural pseudo-hallucination
Feign for Gain	AH unremitting and intolerable Stilted Thrust forward No control strategy

Thought & Judgment

Psychosis	**Impaired reality Disorganized speech Derailments** **Clang Assn/Neologisms** **Degrades over prolonged interaction** **No Insight**
Bipolar	**Flight of ideas** vs “racing thoughts” Continuous speech with **abrupt shifts** in topic, sometimes to **incoherence**
Personality	Cognitive distortions External blaming; excuses Lying & bragging Can have pressured speech; not incoherent **Temporary paranoia** in response to stress
Normal Prisoner	Safety property food EPRD concerns; conspiracies **“delusions and grandiose” assertions that check out** Overvalued ideas Paranormal beliefs Cultural beliefs
Feign for Gain	“delusion” absurd, rapid onset, resolution Unelaborated Linear thinking and speech Clears during prolonged interaction

Emotional Process (Mood)

Psychosis	Independent of co-morbid Bipolar, Schizoaffective or psychotic mood disorders” **Inappropriate affect** **Dysphoric mood<mood disorder**
Bipolar	**Distinct, Persistent observable change in energy and activity** **Sustained 4/7 days** **Accompanied by thinking and bx change** **R**esponsive to meds
Personality	React to triggers Mood swings Trait irritability Brief, high intensity dysphoria Volatile-bullying **Euphoria is rare**
Normal Prisoner	Mood changes in response to external circumstances Anger and sadness
Feign for Gain	**Normal vegetative signs;** intact sleep appetite pleasure seeking; normal activity level when mental health staff are out

Behavior

Psychosis	Disheveled Malodorous Consistent w/ delusions
Bipolar	**Hypergraphia** Accelerated Purposelessness Wakefulness (v insomnia) Impulse/criminal behavior limited to manic states Does not remit with age Episodic
Personality	Longstanding, chronic Volitional **Pervasive** Repetitive self harm **Stable across time and contexts** **Remits with age**
Normal Prisoner	Isolating near EPRD C/O anxiety in response to genuine threats
Feign for Gain	**Reported not equal to observed** Self advocating **Meticulous feces smearing**

Step 3 Impairments

So now you know there is a mental disorder, not attributable to excluded conditions. So how do you know it's an SMHD?

Look for

- **Substantia**l Impairments In
  - Perception of reality
  - Thought / Judgment
  - Emotional process
- **Gross** Impairments in
  - Behavior

Recall the Definitions

Substantially

Black's Law dictionary defines "substantially" as:

"Essentially; without material qualification; in the main; in substance, materially; in a substantial manner. About, actually, competently, and essentially."

Oxford Dictionary defines "substantially" as:

"1. to a great or significant extent,

2. for the most part; essentially:"

Grossly

Great; culpable; general; absolute. A thing in gross exists in its own right, and not as an appendage to another thing. Before or without diminution or deduction. Whole; entire; total; as in the gross sum, amount, weight—as opposed to net. Not adjusted or reduced by deductions or subtractions.

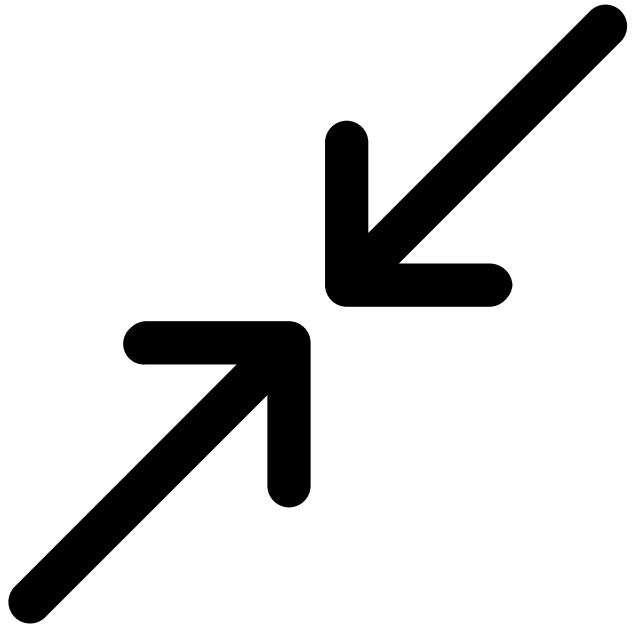
Link

Illness disease or condition

to

Substantial or gross Impairments

(not functional impairment necessarily)



	Perception of Reality	Thought (Judgment)	Emotional Process	Behavior
Substantial Impairment	**Impaired reality** **Cannot distinguish AH** **Internally preoccupied** **Responding to internal stimuli**	**Impaired reality** **Impaired Insight** **Cannot communicate** **Acting on delusional content**	**Inappropriate affect** Uncontrolled impulsivity Cannot sleep or eat Severe weight loss	Uncontrolled deviant urges Spending/sex sprees leading to prison time Feces/food strewn cell IEX-sometimes Unrelenting pacing Uncontrolled hypersexuality Impulsive/criminal behavior **(increased in limited to)**mood or psychotic disturbance Severe self injury (**psychotic-based**; remove eye/testes)
Gross Impairment				

Some Potential Impairments

Inmate Schmedlap
Does he have an SMHD?

Inmate Schmedlap

- Crime: L & L with a child under 14 (13 year old)
- TABE: 12.9
- Level of Care: CCCMS 6 months
- Diagnosis Schizoaffective Disorder
- Medication: Effexor
- Substance Use History: Methamphetamine Use Disorder; Severe; Institutional remission
- Hospitalization: 1 MHCB (noose in cell) X 10 days; 1 5150 DTS X 2 days
- Progress notes: 4 each
  - “I am stressed out; the porters are spitting in my food”
  - ‘Delusional”
  - Denies AH/VH/HI/SI
  - Judgment: Impaired
- MSE
  - “People are trying to keep me from paroling.” My cellie started a fight”
  - Linear and logical thoughts
  - Smiling; gait and speech normal
  - Clean clothing; closely cropped hair

Apply the statute: PC 2962

Does he have a "severe mental health disorder": an illness or disease or condition

1. What are the facts supporting a mental disorder ?

2. Is the disorder distinguished from/attributable to …
   - personality or adjustment disorder,
   - epilepsy,
   - Intellectual disability
   - other developmental disabilities,
   - or addiction to or abuse of intoxicating substances

3. Is it linked to

Substantial impairments in?
   - thought,
   - perception of reality,
   - emotional process, or
   - judgment?

Gross impairments in behavior?

WIC 6600-SVP-
Diagnosed Mental Disorder

Susan Napolitano, Ph.D.

WIC 6600-Sexually Violent Predator Law

WIC 6600 provides for the involuntary civil commitment of person's who have committed a sexually violent crime, have a diagnosed mental disorder and are likely to commit a sexually violent predatory offense without custody and supervision.

- These three prongs are statutorily defined.
- The SVP Regulation provides guidelines and structure.
- The second prong of the evaluation relates to the issue of diagnosis.

There is no debate as to whether to use a specific diagnosis. It is required. However diagnosis alone does not make the WIC 6600 "Diagnosed Mental Disorder."

Psychiatric Diagnosis in WIC 6600 Evaluations

WIC 6600 Definition

A “diagnosed mental disorder” is a congenital or acquired condition

affecting the emotional or volitional capacity that

predisposes the person to the commission of criminal sexual acts

to a degree constituting the person a menace to the health and safety of others.


KEEP
CALM
AND
BREAK
IT DOWN

Diagnosed Mental Disorder

$$DMD \equiv$$

$$DX + EI \text{ or } VI + P + M$$

Steps

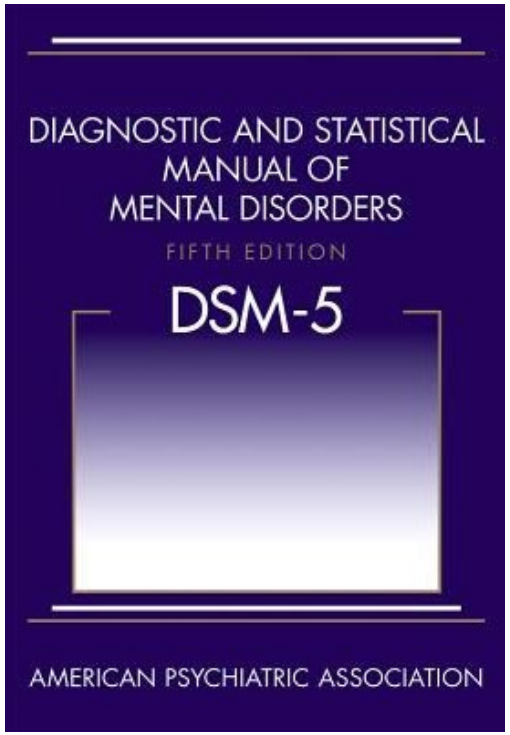
1. Offer and support diagnoses (required)
2. Address whether one or some combination of diagnoses results in emotional or volitional impairment
3. Address whether one or some combination of diagnoses predisposes to criminal sexual acts
4. Address whether one or some combination of diagnoses results person being a menace
5. Tie it all together

Diagnosed Mental Disorder

$$DMD =$$

$$DX + EI \text{ or } VI + P + M$$

California SVP Regulation



The Evaluator shall reference consensus-based diagnostic tools from the professions of psychiatry or psychology, including but not limited to the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases.

The Evaluator may also consider additional evidence in the clinical or empirical literature that is relevant to the Evaluator's assessment of psychiatric diagnoses.

DSM 5 Mental Disorder

Syndrome of **clinically significant disturbance** of cognition, emotional regulation, or behavior reflecting dysfunction in the psychological, biological, or developmental processes underlying mental functioning

Basis of Diagnoses

Use interview and/or record review to gather necessary information:

- Psychosocial History
- Sexual History
- Criminal History/Institutional Adjustment
- Mental Status
- Treatment History
- Symptom Review

Any Diagnosis Could Qualify for WIC 6600

There are no excluded conditions in California, but some diagnoses are a more obvious fit than others:

- Paraphilic Disorders
- General Psychiatric Disorders (Mood/Psychotic)
- Substance Use Disorders
- Personality Disorders (Federal and New York excludes ASPD)
- Cognitive/Developmental Disorders

The Usual Suspects – Paraphilic Disorders

- Pedophilic Disorder
- OSPD: Non-consent/coercive
- Sexual Sadism
- Exhibitionistic Disorder

Paraphilia or Paraphilic Disorder

- Per DSM-5, a paraphilia is any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with physically mature, consenting human partners.
- A paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others.

Paraphilia or Paraphilic Disorder

- A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not justify or require clinical intervention.
- Many dozens of distinct paraphilias have been identified and named, and almost any of them could, by virtue of their negative consequences for the individual or for others, rise to the level of a paraphilic disorder.
- The diagnoses of the other specified and unspecified paraphilic disorders are therefore indispensable and will be required in many cases.

Specific Paraphilic Disorders in DSM5

1. Voyeuristic Disorder
2. Exhibitionistic Disorder
3. Frotteuristic Disorder
4. Sexual Masochism Disorder
5. Sexual Sadism Disorder
6. Pedophilic Disorder
7. Fetishistic Disorder
8. Transvestic Disorder

Other Specified or Unspecified Paraphilic Disorder in DSM

1. Other specified applies when symptoms characteristic of paraphilic disorder cause distress, or impair, but "do not meet the full criteria for any of the disorders in the paraphilic disorders diagnostic class."
   - Specify reason, (e.g., other specified paraphilic disorder, telephone scatologia, necrophilia, zoophilia, coprophilia, klismaphilia, urophilia….)

2. Unspecified is used when a clinician chooses not to specify the reason and there is insufficient information to make a more specific diagnosis

Example: DSM5 Pedophilic Disorder

- Six months
- Recurrent, intense, sexually arousing fantasies, urges or behaviors involving sexual activity with prepubescent child or children
- Acted on it or causes distress
- 16 and 5 years older than child
- Exclusive, non-exclusive
- Male or female

Controversial or Less Common Disorders:

- Hebephilic Disorder
- Other Specified Paraphilic Disorders
- Other Specified Personality Disorders
- ASPD
- Psychotic Disorders

Hebephilic Disorder:

- Not specifically in DSM
- Research conflicts
- What is normal?

Other Specified Paraphilic Disorder (OSPD); Non-consent

Not specifically in DSM

It is a crime, not a disorder

How can you know if arousal to non-consent or a means to an end?

Controversial Disorders: ASPD

Antisocial Personality Disorder and California SVP Commitment James Rokop, Ph.D.: Melinda DiCiro, Psy.D., Jeremy Colley, MD California Department of State Hospitals and New York University

- SVP is the only commitment/involuntary hospitalization scheme allowing an ASPD as initial qualifying diagnosis
- ASPD + Sexual Offending Not (Necessarily) = to Predisposition
- Opportunistic criminal sexual violence or disorder and sexual deviance?

Controversial Disorders: ASPD

Antisocial Personality Disorder and California SVP Commitment James Rokop, Ph.D.: Melinda DiCiro, Psy.D., Jeremy Colley, MD California Department of State Hospitals and New York University

- ASPD alone does not distinguish the SVP from the typical recidivist
- "ASPD is not a disease or disorder that differentially predisposes someone to [sex offenses], just offenses in general, some of which may be sex offenses." Per Vognesen & Phenix (2002)

So you have the diagnoses…Now what?

- May have paraphilic disorder that meets definition of diagnosed mental disorder or not
- May have general psychiatric disorder that meets definition of diagnosed mental disorder or not
- May have substance use, cognitive or personality disorder that meets definition of diagnosed mental disorder or not
- Support your diagnosis(es) and move on to step 2.

Diagnosed Mental Disorder- Step 2

DMD =

DX + EI or VI + P+ M

Something is going on emotionally which causes the person to distort the consequences of his or her actions

What is Emotional Impairment?

Emotional capacity is defined as an understanding or appreciation of consequences.

Impaired emotional capacity is a defective understanding or appreciation of consequences which may occur as the result of an intellectual or emotional impairment.

*SVP Regulation

What is Volitional Impairment?

- Volitional capacity is defined the ability to control behavior.
- Impaired volitional capacity is serious difficulty controlling behavior as demonstrated by an Individual's propensity to act impulsively or an Individual's failure to conform his or her behavior to the law despite the risk of criminal punishment.
- An absolute lack of control is not necessary to find impaired volitional capacity

Case Law

- Kansas v. Hendricks (1997): Persons eligible for confinement are not able to control their dangerousness.
- Kansas v. Crane (2002) : State need not prove total lack of control. There must be proof of serious difficulty controlling behavior.
- In People v. Burris, 2002, the California Court of Appeal, Fourth District, stated, “It follows that a recidivist violent sexual offender who, due to a mental disorder, is **unlikely to be deterred by the risk of criminal punishment lacks control in the requisite sense.”**

Impairment in Person with Pedophilic Disorder

Emotional Impairment	Volitional Impairment
Distorted thinking: I wanted to teach her about sex before she got bad information from her peers	Pathological drive: I know it is wrong but there was something driving me
Distorted thinking: I was in love with her, we really understood each other	Pathological drive: Once I became excited, I could not stop
Distorted thinking: Children are less judgmental, easier to be around	Pathological drive: Offends with children despite prior sanction
Distorted thinking: Sex with children is healthy	Emotional congruence and pathological drive: I can't help interacting with children when I see them
Distorted thinking: I find myself attracted to petite body types because I appear younger than my age	Pathological drive: Sex with children despite available legal sex partners

Impairment in Person with Psychotic Illness

Emotional Impairment	Volitional Impairment
Psychotic disorganized behavior is expressed sexually	Continues to refuse treatment despite risk for offending
Delusions have sexual component	Off medications, reoffends sexually
Auditory/visual hallucinations have sexual component	Poor impulse control is a component of the diagnosis
Highly distorted thinking about courtship behavior	

Diagnosed Mental Disorder- Step 3

$$DMD =$$

$$DX + EI \text{ OR } VI + P + M$$

Step Three- “Predispose” Definitions

- **To render subject, susceptible, or liable: (Dictionary.com)**
- **Predispose usually means putting someone in a frame of mind to be willing to do something. (Merrium-Webster)**
- **To be more likely than other people to behave in a particular way (Cambridge Dictionary)**
- **An inclination to engage in illegal activity …, i.e., that he is ready and willing to commit the crime. (Black’s Law Dictionary)**

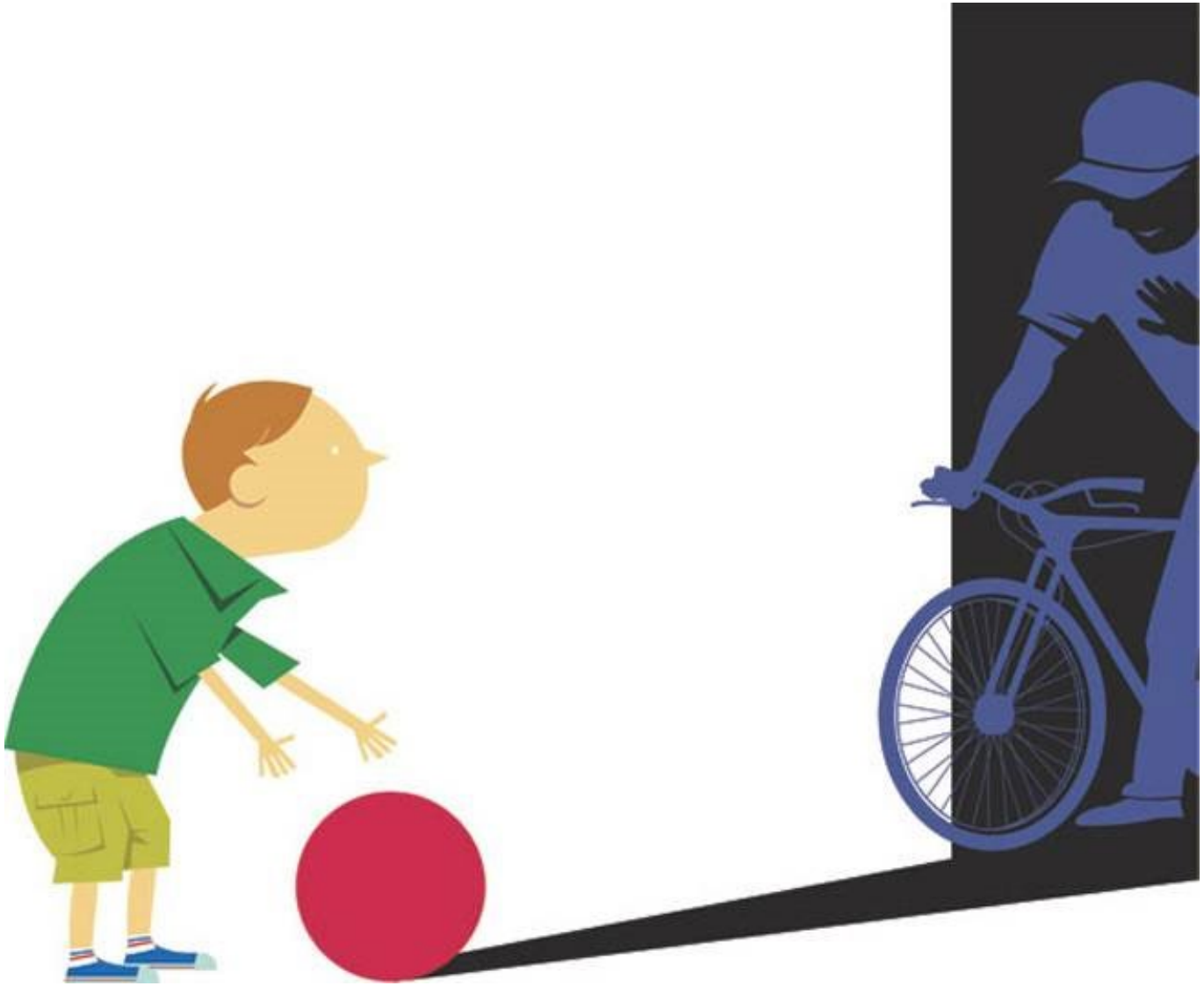
How is “Predisposes” Different from Volitional Impairment?

- This step ties the disorder that is accompanied by “serious difficulty controlling behavior” or “failure to appreciate consequences” to the likelihood of committing…….

Criminal Sexual Acts

“Predisposes”

- What if they have been confined for decades?
- What if they have been sex offense free in the community for years?
- What if they have had offender treatment?



Ask yourself…

Is this man predisposed to commit criminal sexual acts by reason of (whatever diagnoses you offered)?

If so, how?

Traits or States that may Influence Predisposition

Hypersexuality/Sexual Preoccupation

Substance Abuse

ASPD

Intelligence

ASD

Health

Age

Diagnosed Mental Disorder- Step 2

$$DMD =$$

$$DX + EI \text{ or } VI + P + M$$

Menace Definitions

- a person or thing that is likely to cause harm; a threat or danger
- something that threatens to cause evil, harm, injury, etc.; a threat.
- a person whose actions, attitudes, or ideas are considered dangerous or harmful
- Menace means any threat, statement, or act which shows intent to inflict injury upon another person (SVP regulation)

The Final Piece-Menace

Is this disorder that impairs his emotional capacity and/or that he cannot control, and which predisposes him to commit sex crimes, likely to cause harm to another?

Menace

If all other parts of DMD are present, it is rare that the person is not a menace

Step 5- Tie it all together

Per the SVP Regulation….

Section 4014 (2)(C) This subsection shall include evidence of the nexus between the Individual's DMD, his or her emotional or volitional capacity, and criminal sexual acts.

Example: Child Molester

Mr. Chester, age 37 offended against his niece, age six repeatedly over the course of two years. The offending began shortly after his release from a two-year prison sentence related to sexually offending against his own daughter when she was between four and eight. In both cases he told police the children welcomed the sexual activity. He has been in custody for eight years and he denies sexual interest in children. He now states he never sexually offended against a child and the police lied.

What is (are) his likely diagnosis (es)?

Emotional impairment?

Volitional Impairment?

Predisposed to criminal sexual acts?

Menace?

Example: Serial Rapist

Mr. Madman, age 57 raped a stranger in his encampment because voices told him she loved him and wanted it. This is the third time he has raped a stranger due to his voices and odd beliefs in the past 15 years. He has been sentenced to both jail and prison due to his sex offenses. He believes the Bible sanctions and encourages his sexual behavior with the infidels. He was high on methamphetamine and stated the substance increases his hallucinations, his anger and his sex drive. He was high during each prior rape. He was sober for a 10-year period in the 90's and did not offend sexually. He refuses medication in CDCR.

- What is (are) his likely diagnosis (es)?
- Emotional impairment?
- Volitional Impairment?
- Predisposed to criminal sexual acts?
- Menace?

Case Example

This 59-year-old, homeless schizophrenic man suffers from delusions that elderly women are sexually attracted to him. In his last sex offense (rape-2000) he harassed an elderly woman despite multiple restraining orders. Over a ten-year period, he made obscene and threatening phone calls, lurked outside her home and exposed his penis and masturbated in front of her. After he broke into her home and violently raped her, he offered to make her breakfast. When questioned by police, he said the sex was consensual and she was his fleeting lover from the stratosphere.

Case Example

- After his release in 2013, he stalked the victim and made 55 threating and sexual calls in two days. He did not hide from police and justified his behavior by stating she was his property. He was convicted of criminal threats.
- He has been arrested and convicted of rape 6 times since the age of 22. He has numerous prior convictions for indecent exposure and loitering.
- He has been refusing medication and he denies he has a mental illness. He isolates himself, exhibits paranoia and has complained of auditory hallucinations. He has been observed talking to himself. His thinking is illogical.

Summary

Use care in using psychiatric diagnosis in forensic evaluations

Each statute defines the qualifying disorder

Sometimes diagnosis is required

Sometimes diagnoses are excluded

Some diagnoses are controversial

Application of the statute to the individual examinee is critical

Summary

Use care in using psychiatric diagnosis in forensic evaluations

Each statute defines the qualifying disorder

Sometimes diagnosis is required

Sometimes diagnoses are excluded

Some diagnoses are controversial

Application of the statute to the individual examinee is critical