I25 Clinical Psychiatry and Neuropsychiatry in the Forensic Context

Vernon M. Neppe, MD, PhD, Pacific Neuropsychiatric Institute, 6300 Ninth Avenue, NE, Ste 353, Seattle, WA 98115*

The goals of this presentation are to: (1) educate mental health professionals in three important medicolegal areas; (2) provide greater understanding of Tardive Dyskinesia (TD) and of Traumatic Brain Injury (TBI); and, (3) demonstrate methods to practice better psychiatry and more properly evaluate patients clinically and forensically. This presentation will provide a greater understanding of clinical psychiatry and neuropsychiatry in the forensic context and consists of lectures on the forensic aspects of TD, TBI, and proper evaluations.

This presentation is applicable to all psychiatrists and mental health professionals. This presentation will impact the forensic science community by raising awareness of the need for careful clinical care, prophylaxis, and proper evaluations and will highlight principles generalized to other areas of civil and criminal forensic practice.

Psychiatric evaluations include appropriate examination, ongoing assessments, diagnosis, management, prognosis, attributions of proximate causality, and damages. Prior medical histories are critical. Forensic data has an even higher standard emphasizing causality attributions and prognoses.

Two key common illustrative medical conditions are: (1) Tardive Dyskinesia (TD) — a complex neuroleptic-prescription-induced, sometimes irreversible, movement disorder. Here, physicians commonly err in management, and the pharmaceutical industry may not properly put "warnings" on drug labels; and, (2) traumatic brain injuries — these could be repeated and catastrophic. Proper acute and chronic care is complex and sometimes additive to previous events.

TD is possibly the most well-known but often missed drug-induced neuropsychiatric forensic condition. TD is sometimes incurable and induced by long-term prescription neuroleptic treatment (antipsychotic medications as well as gastro-intestinal medications, such as metoclopramide). Civil litigation against prescribers (physicians, particularly psychiatrists) and the pharmaceutical industry is a common, major consideration. Several steps for ensuring ongoing proper clinical evaluation and management are often neglected, including early detection, appropriate follow-up, including testing, outside specialized expert referral, differential diagnosis, and recognition of patients at risk. Evaluations include an effective specific TD scale (Neppe's STRAW scale) with other formal examinations (AIMS, Simpson-Angus and possibly SCT Hans). Videotaping monitors progress. Management requires prophylaxis, early recognition, and ongoing interventions. It has been found that off-label, high-dose buspirone treatment (1989-2017 experience) is extraordinarily successful, efficacious, cost-effective, and safe. This study regards it as far preferable to expensive, tetrabenazine derivatives (e.g., valbenazine), with theoretically significant side-effects and ostensibly incomplete control long-term.

Traumatic brain injury (TBI) is very common with variable symptomatology: (1) non-recognition of the blow, but still having subtle changes; (2) concussion is common with several presentations, but sometimes incorrectly labeled; (3) unrecognized, seldom diagnosed yet treatable focal cerebral abnormalities; this includes particularly temporal or frontal lobes dysfunctions and uncommonly, subtle changes; (4) ranges through to prolonged deep coma, where acute lengthy hospitalization and rehabilitation is specialized. Management clearly varies acutely compared with the subacute and chronic residual phases; (5) recently, Chronic Traumatic Encephalopathy (CTE) with repetitive TBI has become increasingly recognized in contact sports and has major potential medicolegal implications; and (6) subtle differences must be recognized. To facilitate, the presentation has classified head injury forensically and clinically.

Some management nuggets include: (1) missing the subtle focal injuries can be disastrous in clinical and forensic consequences, and yet can be commonly helped with appropriate, but often unprescribed, medications (including anticonvulsants and azapirones); (2) cognitive rehabilitation (previously expensive and lengthy) has largely been replaced by appropriate computer programs facilitating easier, often effective, management and rehabilitation (important medicolegally); (3) certain less well-known tests, such as the Inventory of Neppe of Symptoms of Epilepsy and the Temporal Lobe (INSET) and Soft Organic Brain Inventory of Neppe (SOBIN) are very important, structured ways of monitoring symptoms clinically and in follow-up; (4) costly, sometimes beneficial, specialized evaluations (e.g., home ambulatory electroencephalography, head Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) with contrast, **Positron Emission Tomography** (PET) scanning, Single-Photon Emission Computed Tomography (SPECT) scan, and polysomnography amplify diagnoses. Civil litigation may involve contradictory clinician and forensic roles.

Testing in Clinical and Forensic Psychiatry and Neuropsychiatry: Every clinical patient *could* be a potential forensic case, because a major basis of litigation is substandard care. Applying standardized techniques while recognizing individual differences facilitates the appropriate clinical and forensic evaluations. Treatments are sometimes necessarily off-label while repeatedly assessing progress and ongoing management revisions. Clinical and forensic evaluations must include appropriate diagnostic, symptom, and risk assessments. Particularly, medicolegally appropriate data correlations, all pertinent records (medical and psychosocial), and outsider validations by family members, friends, and sometimes law-givers are important. Standardized neuropsychological testing has significant strengths by applying comparative norms. Accounting for baseline data — education, background, and previous test exposures — is essential. Yet, unrecognized testing weaknesses can imply over-inclusiveness and ignore significant individual differences. The clinical neuropsychiatric evaluation with repetitive individualized longitudinal monitoring is essential. Repeated follow-ups, including reviewing critical neglected areas (e.g., subtle malingering, motivation and fatigue), are ideal. These evaluations also require individual clinical tailoring of broad structured psychiatric and neurological questionnaires. The Pacific Neuropsychiatric Institute (PNI) has developed and meaningfully applied many such medicolegal neuropsychiatric screens. These include the detailed "Diagnostic-Screen questionnaires" ("DS-10"), the INSET and SOBIN, plus the BROCAS Screening Cerebral Assessment of Neppe (SCAN) cognitive examination.

Tardive Dyskinesia, Traumatic Brain Injury, Evaluations

*Presenting Author