The Interface of Clinical, Legal, and Rehabilitative Aspects of Patients With a Neuropsychiatric Disorder in Forensic Psychiatry Setting in India: A Systematic Approach

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Substance use1 and seizure disorder2 have been independently associated with violence, and sometimes violent crimes. An expert perspective from a forensic psychiatrist would play a pivotal role in such cases because these conditions have been used as a defense in the court of law.3 The scenario would further be complicated when both chronic alcohol use and seizure disorder are present simultaneously. Here the authors discuss one such case with potential interaction of alcohol use and epilepsy with forensic psychiatric implications, and the multidisciplinary approach toward the case. The case identification and demographic details have been changed to maintain the anonymity of the patient. This case has been discussed only for an academic purpose, with an intent to help health professionals to provide an opinion in the court of law.

Case Vignette

Mrs. C, a 32-year-old married and separated woman, from a lower socioeconomic status, a day laborer from an urban background of northern India, was brought to a tertiary care center by the police, with an alleged history of assaulting six individuals, eventually leading to the death of two among them.

Reason for Referral

Referral was made by the additional magistrate and the investigating officer for treatment and to ascertain whether the patient had mental illness, respectively.

Circumstances Around the Alleged Crime

Mrs. C’s Report

During the inpatient care, Mrs. C denied the knowledge of committing any crime and was amnestic for the events on the day of the alleged crime and had fragmentary memory of the events after the crime till the point of hospitalization, which was around eight days after the alleged crime. She gave the history of consuming alcohol and tobacco in a dependence pattern, with the last intake being approximately one hour before the alleged crime.
Investigating Officer’s Report

Mrs. C had approached a butcher shop around 8 a.m. on the day of the crime and had enquired about the cost of the meat. While the butcher was engaged with another customer, she picked the butcher knife that was kept on the table and ran around 1.5 km. Mrs. C allegedly stabbed those individuals who tried to come in her way and asked for the knife. When the police reached the crime scene and asked her to give the knife, she tried to place the knife under her clothing, during which she sustained an abdominal laceration. She did not try to escape from the crime scene and denied having injured anyone.

Motive for the Crime

As per the police, none of the victims were known to Mrs. C, and the investigation elicited no clear ascertainable motive for the alleged crime.

Past History

The patient had developed a left occipital lobe abscess and had three episodes of generalized tonic–clonic seizures (GTCS) three years ago. For that, she had undergone left occipital craniotomy with drainage of the abscess and was discharged on antiepileptic medications. She took those medications for one year and subsequently discontinued them. The patient reported having two episodes of seizures after the discontinuation of medication but did not consult any doctor. She was not on any antiepileptics at the time of presentation to the hospital.

Personal History

The patient was married and separated from the husband due to interpersonal issues secondary to alcohol use and was living with her elderly mother. As per the patient’s report, there was a history of multiple arguments and fights under intoxication, for which she was warned by the police, but no formal complaint was lodged.

Inpatient Observation and Assessment

A comprehensive history was taken using the National Institute of Mental Health and Neurosciences (NIMHANS) Detailed Workup Proforma for Forensic Psychiatry Patients (NDFPP; Table S1). Collateral information was obtained from the first investigation report, the interview of the investigating officer, and medical records of the hospital where the patient was taken immediately after the alleged crime. Attempts were made to contact her family members through the police and psychiatric social work team, but to no avail.

As per the information obtained through the aforementioned sources, the patient was intoxicated on the day of the crime. On examination, she was oriented. She had multiple scaly, hyperpigmented lesions on the extensor aspects of her leg, with central clearing, which raised the suspicion of pellagra. Witnesses did not describe any behavior or episodes suggestive of a generalized seizure or confused behavior before the alleged crime. Ward behavior of the patient was documented every day using the NIMHANS behavioral observation report (NBOR; Table S2).

Differential Diagnosis

The diagnoses of mental and behavioral disorders due to the use of alcohol and tobacco, i.e., dependence syndrome, and seizure disorder were kept. Various diagnostic possibilities were considered as the possible causes for the behavior during the crime, including the ictal or postictal state, epileptic automatism, delirium associated with pellagra, Wernicke's encephalopathy, pathological intoxication, dissociative fugue, and malingering.

Management

1. Magnetic resonance imaging of the brain showed postoperative gliotic changes with an overlying irregular pachymeningeal enhancement and a craniotomy defect in the left occipital region. Neurosurgery consultation was done, and no active intervention was advised.
2. An electroencephalogram was done ten days after the alleged crime. It showed bilateral temporal slow waves with occasional left temporal spikes and wave discharges.
3. The neurology team initiated her on Tab. Phenytoin 300 mg/day.

However, during the hospital stay, while being on regular medication, she had two episodes of GTCS, followed by brief disorientation lasting for 5 to 8 min, with no agitation or aggressive behavior. Tab. Sodium Valproate 1000 mg/day was added to prevent the recurrence of seizures.

4. The patient was started on parenteral multivitamin supplementation, nicotine replacement, and Tab. Naltrexone 50 mg/day as an anticraving agent.
5. During the hospital stay, serial mental status examinations and cognitive assessments were done. There was a gradual improvement in the Hindi mental status examination score, from 13 on the day of admission to a score of 26 after seven days of admission and treatment. Intelligence quotient (IQ) assessment with the Vineland Social Maturity Scale showed an IQ of 92 (social age of 13.8 years), suggestive of average intelligence.
6. Fitness to stand trial was assessed using a guidance proforma (Table S3), and she was noted to be fit to stand trial.
7. A structured assessment of risk was done using version 3 of the Historical, Clinical, and Risk management-20 scale.

Discussion

The present case highlights the complex interaction between substance use and seizure and its potential diagnostic and legal challenges. This section discusses the approach to the case, possible diagnosis, opinion on insanity defense, and rehabilitation of the patient.

Importance of Collateral Information and Structured Documentation

In legal cases, the information regarding the illness is difficult to obtain as the patient is under judicial custody and family members are often unavailable. Hence, it is important to obtain information through all the sources possible. The possibility of withdrawal-related delirium became less likely once the medical records were obtained, which mentioned that the patient was intoxicated at the time of the crime and did not have any signs of withdrawal. The
description of events before, during, and after the alleged crime by the witnesses and the investigating officer suggested that there was no episode of GTCS and no hallucinatory behavior. NDFPP and NBOR were used to obtain and document the information systematically.

Diagnostic Possibilities

Considering the lack of a clear history of the circumstances around the alleged crime, providing a definitive diagnosis is challenging. Various diagnostic possibilities are discussed below.

Alcohol-Related Pathological Intoxication, Seizures, and Law

Pathological intoxication is a recurrent, transient psychotic reaction, triggered by even a small amount of alcohol consumption, which presents as violence. It is seen in individuals with predisposition such as temporal lobe epilepsy, brain pathology, physical exertion, or prior psychiatric illness. Considering the underlying left occipital brain abscess and seizures in the past, with alcohol intoxication on the day of the alleged crime, there is a possibility of pathological intoxication. In the criminal justice system of the United Kingdom, pathological intoxication is considered as a defense even in cases of voluntary intoxication. However, in India, it is not considered a defense as per section 86 of the Indian Penal Code (IPC). Although seizures are uncommon with alcohol intoxication as it is a central nervous system depressant, there is a possibility of seizures in an acutely intoxicated patient with binge type of alcohol use or in the relative withdrawal phase, neither of which has been noted in our patient.

Epilepsy, Homicide, and Law

Epilepsy has been reported in cases of homicide. Crime can be committed during the ictal, postictal, or interictal phase. Sudden, unprovoked violence without an apparent motive should raise the suspicion of a seizure episode. The points favoring the possibility of a seizure include sudden aggression with no obvious motive, no attempts to conceal or escape, amnesia for the event, nontargeted reactive and resistive aggression with a history of seizures, and an abnormal electroencephalogram. Points against the possibility of a seizure at the time of the alleged crime include a difference from the usual seizure semiology. Historically and in the ward observation, the patient had seizures with a semiology suggestive of GTCS. Hence, it is difficult to conclude that the behavior noted during the alleged crime is a manifestation of seizure. Also, there was no impairment in awareness or irrelevant replies as per the witnesses just before/during/after the alleged crime. International panel criteria on violent crime have laid down five points to be necessary for the diagnosis of a seizure at the time of the crime, among which, apart from the diagnosis of a seizure disorder by neurologists, other criteria have not been fulfilled in this case. From a legal perspective, it is necessary to prove that the patient had an episode of seizure at the time of the crime and that she was unconscious and had no recollection of the event, which is difficult to ascertain in this case.

Amnesia for the Crime and Law

Crime-related amnesias are common. It is necessary from a forensic perspective to identify whether the amnesia is secondary to organic disease, substance use, dissociation, or malingering. It is not uncommon to find amnesia due to alcohol use. It might be en bloc or fragmented and is often anterograde memory loss. This is possible in the current scenario, considering the long-standing history of alcohol dependence. It may also be secondary to Wernicke's encephalopathy or pellagra. Organic amnesias are often associated with temporal lobe pathology.

In this patient, the lesion was in the occipital lobe, which generally presents with visual symptoms rather than memory-related symptoms. Dissociative amnesia may be complete or partial, sudden in onset, and with blur in the beginning and the end. It is often associated with violent crimes. In such situations, the offenders generally know the victim closely, the crimes are generally unplanned with no motive, and the offenders are more likely to report to the police by themselves and do not deny the offence. In this patient, there is a possibility of dissociative amnesia for the event, considering the lack of motive, severe violence involved, and alcohol use associated with the crime. Amnesia as an insanity defense is often unsuccessful in practice in western countries, with a success rate of below 25%. An insanity defense is only provided if amnesia is a part of preexisting mental illness. The defendant must prove the lack of mens rea at the time of crime, irrespective of the presence or absence of amnesia. However, amnesia is not a ground for an insanity defense in India.

Legal Opinion

Opinion on Fitness To Stand Trial (FTST)

Assessment of the mental abilities of the individuals to defend their case is called FTST. Currently, there is no validated screening instrument available for the Indian population. Table S3 provides five broad domains and guidance questions that a psychiatrist may ask while evaluating the FTST. FTST is a dynamic construct as it might change over a course of time. The fitness may be “restored” by the following interventions: (a) pharmacotherapy, (b) psychosocial interventions such as cognitive retraining, therapy, etc., and (c) legal counseling. While providing an opinion about fitness, it should be clearly communicated whether the person is fit or unfit. If unfitness is opined, the reason should be mentioned.

Opinion on Insanity Defense

The insanity defense plea is often used by the individuals who report a lack of motive and amnesia for the crime. Section 84 of IPC describes the insanity defense as a concept that is not a medical one but a legal one. It should be established that the individual had mental illness and was incapable of understanding the nature of the act or that what he/she is doing is wrong or that it is contrary to the law at the time of crime. The considerations that would favor the insanity plea in the above-described case include the possible organic amnesia or seizure during the crime (which might have precipitated unsoundness of mind, leading to the alleged crime), the lack of motive to commit the crime, and the lack of an attempt to escape from the crime scene or conceal the crime. However, considering that the accused accepts to have consumed alcohol voluntarily before the crime and that it might have contributed
to either the behavioral disturbance or pathological intoxication, as per section 86 of IPC, legal insanity will be void.

Rehabilitation

Risk Assessment

In forensic psychiatry cases, it is necessary to ascertain the risk of recurrence of violence. It is always important for a clinician to aid the legal system in balancing the rights of the individual to live freely in the community and the community’s safety. It becomes important in cases where patients are acquitted of their charges on the grounds of an insanity plea. In the presented case, a risk assessment indicated that she would be dangerous to others because of underlying brain pathology in the form of occipital lobe gliosis, seizure disorder, alcohol dependence syndrome, poor family support and relationships, a prior history of poor compliance to medication, and a history of violent crimes, all of which suggested that there is a possibility of recurrence of seizure/intoxication/violence. It was opined that the patient would require treatment in a supervised setting in a long-term continuous-care home.

Structured Environment for Rehabilitation

Once an accused with mental illness is incarcerated, it is necessary to consider rehabilitation. It should be targeted at alleviating suffering during incarceration, reducing hospitalization due to psychiatric illness, and reducing recidivism when released into the community. Various developed countries have specialist forensic facilities that provide services for criminally nonresponsible mentally ill individuals, either as inpatient care or as long-term outpatient-based care, depending on the illness and the crime. These settings are run by both private and government organizations, primarily taking care of mentally ill offenders who have committed serious offenses, after completing their trial. In India, there are no exclusive forensic psychiatric hospitals or correctional/rehabilitative facilities for mentally ill prisoners, due to which they often continue to stay in prison. Systematic studies from India are required to assess the need for a specialized forensic setting that caters to the prisoners with mental illness, with supervised treatment and vocational rehabilitation.

Provisions for Accused With Mental Illness on Being Released From Judicial Custody

There are instances in which a mentally ill offender might not have FTST or may get released on the grounds of an insanity plea. Chapter 25 of the Criminal Procedure Code (CrPC) discusses the provisions of accused persons with sound mind. Sections 328 and 329 of CrPC pertain to the procedures to be followed in case of prisoners who are mentally ill and are unable to make their defense. If the court finds out that prima facie case is against the accused with mental illness, he/she shall be referred to a district surgeon who further shall refer the patient to a psychiatrist or a psychologist for evaluation and treatment in a psychiatric hospital as per the mental health legislation until he/she becomes fit to stand trial. Section 330 of CrPC discusses the release of a person with unsound mind pending investigation or trial. If the magistrate or court considers the defense of unsound mind, bail or order to release can be provided to an individual if he/she does not require inpatient care and the family or a friend is willing to take the responsibility. The family or a friend has to ensure that a regular outpatient follow-up occurs and that any subsequent harm from the patient to others in the community is prevented. While deciding to provide the bail, the court shall consider the nature of the act committed and also the extent of unsoundness of mind or mental retardation. In the above-discussed case, even if the court considers an insanity defense, the patient does not have any family or friends at this point to take the responsibility following her release. In India, there are no dedicated residential facilities for those considered dangerous to the community after being released from the judicial custody. Services such as assisted outpatient treatment and forensic assertive community treatment are important measures taken in developed countries for preventing and reversing criminalization.

Conclusion

A multidisciplinary and systematic approach is necessary when multiple comorbidities are present in a perpetrator of homicide. To decipher the circumstances leading to the crime, information should be obtained from all the possible sources. Amnesia for the crime is not a ground for unfitness to stand trial. While providing testimony, the psychiatrist has to weigh the risk of harm to others and the rights of the accused. Even when an insanity defense is considered, if there is a higher risk of recidivism, it may be recommended to keep the patient in a supervised environment, with a periodic risk assessment. There is an urgent need to have more systematic studies from India to assess the need to develop exclusive services for managing and rehabilitating patients with mental illness during and after the release from the judicial custody.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Supplemental Material

Supplemental material for this article is available online.

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References

1. Bennett T and Holloway K. The causal connection between drug misuse and crime. Brit J Criminol 2009; 49: 513–531.
2. Pandya NS, Vrbancic M, Ladino LD, et al. Epilepsy and homicide. Neuropsychiatr Dis Treat 2013; 9: 667–673.
3. Rosner R. Principles and practice of forensic psychiatry. 2nd ed. 2003.
4. Gowda, G. S., Komal, S., Sanjay, T. N., Mishra, S., Kumar, C. N., & Math, S. B.
Sociodemographic, legal, and clinical profiles of female forensic inpatients in Karnataka: A retrospective study. 
*Ind J Psychol Med* 2019; 41(2): 138–143.

5. Douglas KS. Version 3 of the Historical-Clinical-Risk Management-20 (HCR-20V3): Relevance to violence risk assessment and management in forensic conditional release contexts. *Behav Sci Law* 2014; 32: 557–576.

6. Tiffany LI and Tiffany M. Nosologic objections to the criminal defense of pathological intoxication: What do the doubters doubt? *Int J Law Psychiatry* 1990; 13: 49–75.

7. Brooks T. Involuntary intoxication. *J Crim Law* 2015; 79: 138–146.

8. Delgado-Escuenta AV, Mattson RH, King L, et al. The nature of aggression during epileptic seizures. *N Engl J Med* 1981; 305: 711–716.

9. Sharma KM. Defence of insanity in Indian criminal law. *J Indian Law Inst* 1965; 7: 325–383.

10. Bourget D and Whitehurst L. Amnesia and crime. 2007; 35: 469–480.

11. White AM. What happened? Alcohol, memory blackouts, and the brain. *Alcohol Res Health* 2003; 27: 186–196.

12. Go, G. Amnesia and criminal responsibility. *J Law Biosci.*, 2017; 4(1): 194–204. doi:10.1093/jlb/lsx003

13. Bapu @ Gajraj Singh vs State of Rajasthan. Appeal (crl.) 1313 of 2006. Date of judgement on June 4, 2007.

14. Mossmann D, Noffsinger SG, Ash P, et al. AAPL practice resource for the forensic psychiatric evaluation of competence to stand trial. *J Am Acad Psychiatry Law* 2007; 35: S3–S72.

15. Math S, Kumar C, and Moirangthem S. Insanity defense: Past, present, and future. *Ind J Psychol Med* 2015; 37: 381–387.

16. Morgan RD, Flora DB, Kroner DG, Mills JF, Varghese F, and Steffan JS. Treating offenders with mental illness: A research synthesis. *Law Hum Behav* 2012; 36: 37–50.

17. The Code of Criminal Procedure. 1973; li–lxvii.

18. Sarkar J and Dutt AB. Forensic psychiatry in India: Time to wake up. *J Forensic Psychiatry Psychol* 2006; 17: 121–130.

19. Sadock BJ, Sadock VA, and Ruiz P. Kaplan and Sadock Comprehensive textbook of psychiatry. 10th ed. Wolters Kluwer Health 2017.