Alison Cullen

Forensic and Clinical Psychologist

Objectives

To address each of the following misconceptions:

1. Psychologists are substandard to psychiatrists
2. Any referral can be provided to any psychologist
3. Assessing psychologists can provide treatment and vice versa
4. Every treating psychologist is willing to oversee treatment plans
5. Psychologists rely solely on self-report
6. PTSD can develop from any ‘trauma’
7. Selection of tests used are the same across all individuals
8. Psychological tools administered can be understood in isolation, including extractions from within one test
9. Psychologists can omit any requested component of their report
10. The impact of incarceration is the same for all inmates

Myth 1: Psychologists are substandard to psychiatrists

- ***Psychologists***

Triangulation approach (overcomes limitation of self-report)

Biopsychosocial model of understanding human behaviour (helps with 5P formulation and tx plans/rehab prospects)

Psychometrics (cognitive functioning and severity of dx)

- ***Psychiatrists***

Medical model – prescribes and can quantify total levels of impairment for medicolegal cases

Primarily rely on clinical interview

But only psychiatrists can diagnose, no? NO!!!

Cases supporting the capacity of psychologists to diagnose mental illnesses or conditions *Jones v Booth* [2019] NSWSC 1066

Although there exist cases which criticise reliance upon psychologists' reports, there is also case law which criticises the undue rejection of psychologists' reports: [64]-[66], citing *R v Whitbread* (1995) 78 A Crim R 452 at 460-461; R v Arnold [2004] NSWCCA 294 at [63]-[64].

Nepi v The Northern Territory of Australia NTSC [1997] Unreported Martin CJ allowed the appeal on the ground that the Trial Judge had erred in law in making a finding that the psychologist had crossed his barrier of expertise. Martin CJ referred to Whitbread "…where the view was expressed that **once the question of medical treatment of mental illness is put to one side, there is no reason why a psychologist may not be just as qualified, or better qualified, than a psychiatrist to express opinions about mental states and processes**".

MENTAL HEALTH AND COGNITIVE IMPAIRMENT FORENSIC PROVISIONS ACT 2020 – SECT 5

5 Cognitive impairment

(1) For the purposes of this Act, a **"person has a cognitive impairment"** if--

(a) the person has an ongoing impairment in adaptive functioning, and

(b) the person has an ongoing impairment in comprehension, reason, judgment, learning or memory, and

(c) the impairments result from damage to or dysfunction, developmental delay or deterioration of the person's brain or mind that may arise from a condition set out in subsection (2) or for other reasons.

(2) A cognitive impairment may arise from any of the following conditions but may also arise for other reasons--

(a) intellectual disability (REQUIREMENTS TO SATISFY – WAIS and ABAS)

(b) borderline intellectual functioning,

(c) dementia,

(d) an acquired brain injury,

(e) drug or alcohol related brain damage, including foetal alcohol spectrum disorder,

(f) autism spectrum disorder.

Myth 1: Psychologists are substandard to psychiatrists

Fact 1: Psychologists aren’t the B-team to psychiatrists' A-team—they bring their own superpowers to the mental health world. Different, but just as crucial!

Myth 2: Any referral can be provided to any psychologist

Difference between Psychologists

Forensic - uses scientifically based principles to assess a client, collect evidence that relates to the psychology of the person, and table a report to be used in evidence. Use a biopsychosocial model and 5p case formulation to understand human behaviour. Specialised training in MH that intersect with the law (i.e. Legislation/Acts) and specific use of some tests (i.e., SO, psychopathy, malingering)

Clinical - are trained in the assessment and diagnosis of mental illnesses and psychological problems and are qualified to provide advice in clinical/treatment and compensation areas.

Neuropsychologists – possess advanced skills in assessment, diagnosis and treatment planning of disorders that affect memory, learning, attention, language, reading, problem-solving and decision-making as well as the cognitive, emotional and behavioural effects of a wide range of brain conditions that range from developmental and nutritional to endocrine-related, degenerative, traumatic and epileptic. *Use when TBI, Dementia/Alzheimers has not been formally diagnosed to date*

Optimising Fit

- Area of expertise
- Preferences regarding the nature of cases (i.e. SO)
- Access to particular testing (SO/cognitive/YP)
- Different jurisdictions (FLC; Children's court; medico-legal; NCAT; Immigration; Criminal – LC/DC/SC)

Myth 2: Any referral can be provided to any psychologist

Fact 2: General psychologists are similar to GPs whereby they know a little about a lot. Endorsed psychologists are similar to the specialists GP refer you onto who know a lot about a little (area of practice)

Myth 3: Assessing psychologists can provide treatment and vice versa

Myth 4: Every psychologist is willing to oversee treatment plans

Distinctions between Forensic and Therapeutic Psychological Assessments

- Identification of the client/referrer (purpose & nature of service)
- Informed consent (LOI – anticipated use of findings)
- Control of the examination (consequences of non-participation)
- Confidentiality (who will have access to the info; limitations on privacy; who is authorised to release/access info)
- Payment (who is responsible for payment; medicolegal/DCJ) including anticipated additional costs (neurodiversity/cog testing)
- Dual vs single roles (rural places exception)
- Sources of information
- Psychologist-client relationship (obligations of psych to Court/tribunal)
- Assessment and interview techniques (i.e., challenging/critical evaluation; MSE)
- Reports (Tx vs Ax)
- Court expectations

Ethical Guidelines for psychological practice in forensic contexts, Australian Psychological Society, 2014.

S14/s20BQ Reports

- **Limb 1: Has a MH diagnosis**

- **Limb 2: Direct Nexus**

AOD as secondary. To include ax of tx undertaken (identify what has and hasn't worked and *why.* This also speaks to client's insight into MH and motivation to address). Can a longstanding treating psychologist thereby be impartial and independent in assessing why their own treatment may have been inefficacious to prevent the index offence?

- **Limb 3: Responsible Person to oversight Tx plan**

Discretionary limb

Myth 3 & 4: Assessing psychologists can provide treatment and vice versa; Every treating psychologist is willing to oversee a s14 treatment plan

Facts 3 & 4: It’s like a psychological rollercoaster—thrilling for some, but for others. The world needs both kinds of psychologists: the calm conversationalists and the courtroom warriors! 👩‍⚖️🧠✨

Myth 5: Psychologists rely solely on self-report

If the client is not forthcoming/inconsistent they (and therefore the assessment) cannot be relied upon as the psychologist relies on self-report

If collateral information doesn't exist to corroborate findings than weight cannot be given to claim/s OR If collateral information exists, it must be relied upon (i.e, dx of ADHD/cPTSD)

Factors to bare in mind:

Cognitive heuristics:

Assumption of *mutual exclusivity/overgeneralisation* (i.e., one lie = a dishonest person as a whole)

Understand the motivation - sometimes being reticent aids in case formulation

- Lack of insight (cultural stigma/unawareness) – reason for not accessing psychological help
- Shame (of CSA/drug misuse severity)
- Protection of self/family (perpetuating AOD/MH)
- Anxiety – absentminded

Confirmation bias

Case studies of clients diagnosed with: a) ASPD when it was ASD

and b) with ADHD when it was cPTSD and BPD (both share hyperarousal symptoms, interpersonal social rejection sensitivity and impulsivity).

Absence of collateral considerations:

- Deprived upbringing whereby access to needed services not carried out?
- How many people keep school records?
- Limitations on record-keeping (7 years)
- How many people actually report DV to police?? Recent statistics show 60 per cent of victim-survivors of domestic and family violence don't go to police, however that figure is likely much higher for various reasons

Sometimes the absence of evidence is evidence itself (i.e., invalid tests due to mania rather than attempts for IM; or item 81 on the PAI for institutionalised ppl) Thus, we need to consider motivation/reason for why the client is not seemingly being forthcoming.

……..

Highlights the importance of our PR process and/or seeking professional supervision

R v JK [2018] NSWSC 250 Sentence proceedings for murder. Per Hamill J:

While the opinions of the psychologist were based on the self-reported and untested assertions of the offender, the psychologist was not cross-examined. As Allsop P explained in Devaney v R [2012] NSWCCA 285 **part of the professional skill and expertise offered by witnesses is the ability to provide opinions based on the history provided set against what is known and hypothesised by the expert.** As Allsop P noted, it is one thing to discount self-serving statements made to an expert witness when the source of those statements is not called to give evidence, but it is another thing to criticise the professional opinions of an expert in the absence of cross-examination. **This psychologist formed his opinions based on the history, supported by the independent evidence** of the high levels of alcohol consumption, **and psychometric testing administered in the course of the examination**.

Abovementioned highlights the importance of a triangulation methodology (including testing, collateral and observations) undertaken by an appropriately trained psychologist

Myth 5: Psychologists rely soley on self-report

Fact 5: Imagine a detective who can only gather clues from what a suspect or victim *says*. Non-verbal cues/body language, established chronologies, collateral and other tests are all elements of our toolkit to aid in uncovering the truth!

Myth 6: PTSD can develop from any ‘trauma’

DSM-5 Criteria A: *Exposure to actual or threatened death, serious injury, or sexual violence*

Use of PCL-5 alongside PAI elevations on trauma – need to explicitly identify stressor that the client has responded in relation to. High elevations on these scales screen for PTSD symptoms rather than diagnose per se. Why administering additional forms such as DES can also be helpful as dissociation occurs when the person has limited insight into criterion A – they don't want to believe it happened (thereby may fail to identify) and so trauma remains unintegrated.

What about the child who is not receiving adequate care (i.e., protection and/or food); relentless workplace bullying; coercive controlling relationship/emotionally battered wife – may be potentially life threatening yet not currently captured by the DSM-TR-5.

Complex PTSD is not currently used in the DSM (American classification system) however is in the European ICD-10 (International Statistical Classification of Diseases and Related Health Problems of the World Health Organisation). Most people doing trauma research refer to the ICD criteria as it encapsulates 'psychological injury'

Issue arises with the DSM with the potential overdiagnosis in BPD (and even ADHD) when in fact it is cPTSD. While not inherent in the definition of BPD, 81% of BPD have reported interpersonal trauma ('attachment wounding') histories. cPTSD is typically used when abuse or neglect is chronic, begins in early childhood and occurs within the child's primary caregiving system and/or social environment. Both cPTSD share overlapping behaviour and affective patterns, including negative self-concept, difficulties in emotional regulation, and significant interpersonal relationship issues. Key differences include self-harming and avoidance of relationships. 7 of the 9 PTSD criteria currently overlap with BPD in the DSM-5.

Finally, consideration of premorbid functioning AND supports readily available to buffer person post trauma equally important determinants in predicting development of PTSD – 911 feeling stuck and CSA example – where response is nurturing and client is believed by people as opposed to invalidated. In this sense, trauma is often not necessarily what you experienced and rather how it was responded to by those around you

Myth 6: PTSD can develop from any ‘trauma’

Fact 6:

Not every bump in the road leads to a one-way ticket to PTSD-ville. Premordid functioning, the nature/context of the trauma, the consequences of the trauma and the supports available post trauma are all important determinants which guide both diagnosis and delineate between other conditions

Myth 7: Selection of tests used are the same across all individuals

Myth 8: Psychological tools administered can be understood in isolation, including extractions from within one test

Psychometrics

- Chosen based on specificity and sensitivity
- Reliant on self-reports however some comprise validity indicators (i.e., inconsistency index on Conners/PAI) and some rely on collateral info (actuarial measures)
- LSI-R as *general* indicator of recidivism
- Standard battery + additional psychometrics chosen based on *nature* of offending (i.e,. Sexual/Violent recidivism) Sexual recidivism tests also depend on Cat A vs B offences and are normed across that population group (why communicating risk percentages is not the same across offender types)
- Additional psychometrics (and collateral) is necessary for neurodiverse conditions (When asking for a cognitive assessment – need to be specific). Furthermore ADHD assessments generally ought to include malingering ax to rule out any extrinsic motivation (i.e.,. Access to stimulants)
- Tests differ in length and time to administer/score/interpret as well as cost
- Comparing in/consistency across and between (i.e., PAI and PCL-5) – additional testing for malingering
- No specific tool to measure DV per se given nature of this but rather subcategories of DV can be assessment (i.e., Spousal Assault Risk Assessment – SARA)

Assessing Psychometrics

PAI

- PAI indicates ASPD as possible diagnosis – traits/behaviours vs full dx however does not capture ASD per se as a possible diagnosis (Misdx of PDs with ASD!!!)
- Conduct Dx as a prerequisite however what if the stealing involved in adolescence was food to survive? Context is important and not captured in psychometric tests
- PAI doesn't differentiate between past and current behaviours. Possible ASPD traits exhibited in past when client using excessing AOD and/or had no purpose/identity
- PIM and NIM – refers to psychopathology per se which explains why may be discrepancy with other IM measures across other tests (why erroneous to extract one part of either test without understanding how this relates across tests – i.e. repressor PDS with negative IM on PAI)

PDS

- Low/low – forthcoming and frank – more weight provided to self-disclosures. Anectodical support of ADHD (absence of forethought)
- High/high – repressor – likely underreporting. Specific to cultures where MH is taboo
- High IM/Low SDE – Aware of shortcomings and want to appear publicly acceptable (would expect a profile such as this with dx of social anxiety)
- Low IM/high SDE – narcissistic tendencies DOES NOT naturally infer narcissistic PD. Rather, would expect therefore to see fragile self-esteem/self-concept and (social) compensation strategies identified in other parts of the assessment

DASS/PCL-5/ASRS/CAARS – timeframe specific and therefore cannot necessarily infer from these at the commission of the index offence however speak to pervasive/current symptomatology

Releasing psychometrics require a subpoena however we can release tests readily available online.

With respect to releasing the additional psychometric tests administered (i.e., PAI and PDS), doing so in the absence of a subpoena, would be a direct violation of our APS Code of Conduct in addition to Copyright Laws. Due to the need to maintain professional integrity utilised in psychological assessments, we are not permitted to provide these. This is stated on Page 25 of our Code of Ethics as follows: *B.13.6. Psychologists do not compromise the effective use of psychological assessment methods or techniques, nor render them open to misuse, by publishing or otherwise disclosing their contents to persons unauthorised or unqualified to receive such information.*

Providing such raw data offers limited assistance to the Court as we have scored (in the form of profiles or percentiles as per respective manuals) and interpreted the findings of same, alongside other information gathered through the course of IA (via a triangulation methodology) within the produced report.

We are not trying to be evasive as we appreciate our obligations to the Court with respect to transparency and providing further assistance. We are therefore happy to address any questions raised by the Crown by either written or verbal communication, and/or by responding to a subpoena if they still believe it is necessary to obtain 'actual testing'.

Facts 7 & 8: Psychological tests are like ingredients in a recipe. Not every cake has the exact same ingredients. Moreover, just pulling out one test or one answer is like trying to figure out a cake's flavour by just tasting a single grain of flour. You need the whole picture to get a real taste.

Myth 9: Psychologists can omit any requested component of their report

Requested Amendments

- Need to adhere to Uniform Civil Procedure Rule 2005 – Schedule 7 (specifically our general duty to the Court) and Expert Witness Code of Conduct of the Supreme Court Rules 1970 (NSW) Schedule K

- Basic spelling/date/grammatical errors

- When account provided may traverse a plea

- Requests to elaborate or make specific info more explicit

- Where continuing AOD use is in breach of bail conditions, however omission conflicts with opinion re chronicity of AOD and underlying trauma (likely compounded by psychosocial stressors/helplessness/hopelessness associated with legal proceedings) – especially relevant in drug-related charge/s

- Appropriate vs inappropriate (when impacts on reader's understanding of trajectory, case formulation [including protective factors] and/or dx [including differential diagnosis] and necessary treatment plan)

Addendum/Supplementary Reports

Following change of opinion (based on new/additional info) – as per Uniform Civil Procedure Rule 2005 – Schedule 7 and Expert Witness Code of Conduct of the Supreme Court Rules 1970 (NSW) Schedule K

Also when:

- significant time has passed between the IA and sentencing date;

- the client has been charged with additional offences;

- initial report has already been served and there is significant changes to circumstances or update provided by way of subpoenaed material that arrived subsequent to report being finalised that corroborates prior reported info (i.e., compliance with rehabilitation program as part of a s14 treatment report);

- submissions identify issue of contention arising (following receipt of our report) addendum could mitigate cross examination as psychologists are NOT mind readers or magicians

Fact 9: Omitting anything that doesn't 'fit' is like ordering a sundae and expecting it to come with *only* the cherry—no ice cream, no fudge, no nuts and no sprinkles.

Myth 10: The impact of incarceration is the same for all inmates

Considerations that make gaol more onerous even when arrest itself has been salutary:

- Nature of offence
- Public profile/publicity surrounding charges
- Submissive interpersonal style/personality that may lead to exploitation
- Type of diagnosis (i.e., untreated ADHD resulting in custodial infringements)
- History of trauma in custody (sexual/violent) – may therefore make certain aspects of gaol triggering & more onerous (i.e., strip searches/avoiding visits)
- Lack of visitors due to geographical location (i.e., international inmates despite AVLs supported)
- English proficiency
- Dependent children where attachment has been disrupted
- COVID/medical segregation
- NAs/classification and protective custody
- Constant transfers
- Time spent on remand with no end date

Isolation and hopelessness inherent to being in gaol however isolation in prison deepens this. Even **short periods of isolation can have irreversible detrimental health effects with little, if any rehabilitative potential**. Segregation can cause or worsen mental health conditions such a depression, anxiety, PSTD, psychosis and cognitive deficits. More severely, research identifies a strong correlation between segregation and elevated mortality rates through suicide, overdose and accidental death, even years post-release. Even short periods of isolation can be harmful. Perkins (2023) found that after **15 days** of segregation **changes in brain function** can occur, causing significant psychological and cognitive deterioration. Mandela Rules define the confinement of inmates for >22 hours for >15 days as “cruel, inhuman or degrading treatment. For inmates who have endured segregation, there’s advocacy and instances of sentence reduction (**equating 1 day to 1.5-4 days of a standard term**) Victoria and NSW have applied same in instances of significant ‘medical segregation’ arising from COVID-19

Final points

Letter of Instruction (LOI)

To include:

- Clients contact details
- Offences for which they are attending court (including date) and anticipated outcome (i.e., ICO/CRO/s14 etc)
- Pleas entered (difficulty as S14 don't require however early G plea denotes accountability/remorse)
- Background and subjective circumstances including family/AoD/vocation/other subjective factors identified by client or client's family
- Prior MH dx/hx, if any (including collateral sources)
- Previous MH/tx/rehab attempts (including collateral sources)
- Necessary documents (i.e., Facts/Record of antecedents)
- Details of proposed treating practitioner (TO CHECK with them first!!)

- To SPECIFY if wanting each question outlined in the LOI to be responded to explicitly rather than in narrative form (similar to civil matters)

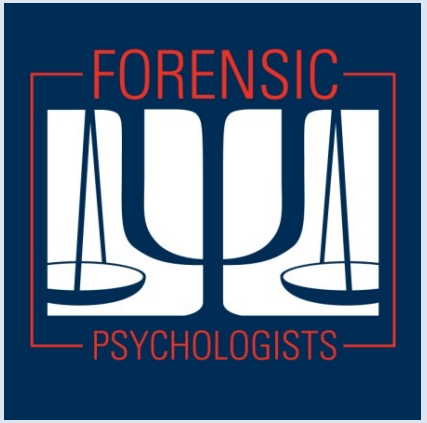
- TIMEFRAMES (when to refer): Currency of reports = validity/reliability while ensuring sufficient opportunity to gather additional collateral as identified. General rule of thumb = 6 weeks prior to court date

Assessment Reports

Purpose of reports is to establish chronology (factors that predispose, precipitate, perpetuate); identify in/consistency (collateral info used); cross reference data (i.e., when doing well, how and why as well as factors that likely perpetuate presentation); and provides summary (dx – tx – prognosis/recidivism) – 5P model of case formulation

Background
Significant Relationships
Education/Vocation
AOD
MH/Physical Hx
Criminality (if prior similar offences, why/what's happened?)
Psychometrics
Collateral – p/calls; correspondence; subpoenaed material including Justice Health (requests for therapy/medical issues) and Corrective services records (importance of work/training)
Account
Differential Diagnosis/es and relevant research
Summary/Conclusion (case formulation deduced to arrive at diagnoses and functional consequences of the MH condition which explains nexus; overall risk assessment including protective factors and/or what may be different this time when compared to prior offending)
Treatment Plan (for s14 or as per s66 for ICO)

QUESTIONS??



Contact:

Alison Cullen

cullenalison17@gmail.com

www.forensicpsychologists.com.au

alison@forensicpsychologists.com.au

0404 029 970

PO Box 6400 Rouse Hill NSW 2155