FORENSIC PSYCHOLOGICAL ASSESSMENT

AN INTEGRATIVE APPROACH

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Forensic Psychological Assessment

Preface

Since the publication in 1983, of *Psychological Evaluation and Expert Testimony: A Practical Guide to Forensic Work*, there has been a virtual ferment of change in litigation affecting mental health professionals. Such litigation has been extensive and affects virtually every area of psychological practice. I was faced with the possibility of tracing the developments in case law across all of the areas covered in the first volume. However, since the publication of the first volume, my practice has become far more specialized, concentrating on the areas of competency to stand trial, criminal responsibility, related issues within the criminal justice setting (diminished capacity, competency to confess, competency to waive *Miranda* rights), the role of the expert witness and professional liability, and malpractice.

I, therefore, decided to restrict this volume to an update of the areas in which I have specialized.

One of the other issues that has come to my attention over the course of the past seven years since the first book appeared was the fact that with the profusion of case law and statutory regulations, mental health professionals were consistently seeking some guidance regarding ways in which seemingly abstract legal concepts could be integrated into the realities of everyday clinical practice. This, then, became the secondary focus of this volume, to provide a way of translating case law and statutory regulations into a series of practical steps that could be easily integrated into clinical practice.

One way of doing this, of course, would be to emphasize a large number of detailed case studies that were not presented in the initial volume, with these case studies illustrating not only the basic forensic concepts earlier enumerated, but pointing out ways in which the law could be integrated into practice.

Readers familiar with the earlier work will recognize the basic skeletal outline covering the chapters on competency to stand trial, criminal responsibility, expert testimony and professional liability, and malpractice. What has been added, of course, is extensive case material, as well as an update of and integration of recent legal developments into the forensic methodology initially described.

Once again, this volume is not intended as an exhaustive survey of all areas of forensic practice but based on twenty years of practical experience in forensic practice and in the courtroom, the volume illustrates the issues that come up most frequently in such practice and how mental health professionals need to respond to them.

Acknowledgments

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BASIC CONCEPTS

Competency to stand trial refers to a defendant's mental state at the time that the practitioner is examining him or her. It does not refer to past behavior or to anything that occurred at the time of the offense. Behavior at the time of the offense is a separate issue, namely, the issue of

criminal responsibility. (Issues of criminal responsibility are discussed in Chapters 2 and 3.) Despite this relatively clear-cut differentiation, the number of people in the fields of both law and mental health who use these terms interchangeably is remarkable. One will hear people refer to a defendant's "competency at the time of the offense" or to the fact that a person is incompetent because "he doesn't know the difference between right and wrong." The inappropriate interchanging of competency and criminal responsibility, tends to confuse the issues dealt with by the courts. Chapters 1 through 3, therefore, attempt to delineate the differences between these two concepts, as well as the legal issues impacting on each of them.

Although statutes regarding competency to stand trial vary slightly from state to state and across various jurisdictions, there are two dimensions that are common to most of them: the defendant must have an understanding of the charges and an ability to assist in his or her own defense. A good example of a frequently used and comprehensive standard is the Duskey standard, presently used in the District of Columbia (*Duskey vs. United States,* 1960). Under the Duskey standard, a person is considered competent to stand trial if he or she possesses a factual understanding of the proceedings, has a rational understanding of the proceedings, and is able to consult with counsel with a reasonable degree of rational understanding.

Factual understanding refers to a person's ability to state the charges against him or her. The patient should be able to provide a relatively intact statement about the actual facts of what allegedly occurred. Whether the patient did or did not commit the crime is irrelevant; as long as the patient is able to recognize that he or she is charged or that the formal indictment states that the patient committed a particular crime, the patient possesses a factual understanding of the offense.

Of the three criteria—factual understanding, rational understanding, and ability to consult with counsel—the least stringent requirement is factual understanding. Most defendants, except the most seriously psychotic and disorganized, are able to meet the criterion of having a factual understanding of the proceedings. However, as is noted in the following example, even factual understanding at times may be impaired by a patient's psychotic process.

Case Example

The patient was a 27-year-old male who was charged with rectal sodomy with a young boy. Clinical evaluation and testing showed the patient to be seriously psychotic, with a marked breakdown in reality

testing and a very concrete manner of reasoning. The concrete reasoning was evident when the patient was asked what it was he was charged with and he replied, "Breaking and entering."

Determining whether a patient possesses a rational understanding of the proceedings is somewhat more complex. It involves several dimensions, the first of which is whether the person can appreciate the severity of the charge against him or her: Does the person know whether the charge is a misdemeanor or a felony, and in general, can he or she appreciate the appropriateness or inappropriateness of various forms of penalties as the outcome of various crimes?

Case Example

A mentally retarded late-adolescent, who was functioning in the moderately mentally retarded range, was charged with stealing a carton of cigarettes from one store and some canned goods from another. When asked what would happen if he were convicted of these offenses, the individual exhibited relatively little understanding of the relationship of the possible sentence to the severity of the offense. The patient stated that if convicted of stealing the carton of cigarettes, he could be placed on probation; he could be given a month in jail, a year in jail, five years in jail, or life imprisonment; or he could be executed.

Another dimension of the concept of rational understanding is the extent to which the mental disease, defect, or illness intrudes into the patient's understanding of the criminality of the conduct itself.

Case Example

A patient was charged with stealing several bottles of red wine from a liquor store. The patient insisted that he should not have been charged with anything, as certain cosmic forces were draining his body of blood. He felt that since he was Jesus Christ and wine was blood, he was merely replenishing his blood supply. Therefore, he felt that what he did was not a crime at all, but a matter of self-preservation.

Case Example

A patient was charged with robbing a fast-food counter in a restaurant. He indicated that he really should not be charged with a criminal offense because "the lady behind the counter and me had an understanding." When asked to explain this, the patient stated, "I told her that

it was a hold-up, but she saw I had no weapon; therefore, when she gave me the money, and I had not threatened her, it must have meant that we had an understanding." According to the patient, no crime was committed; he could not understand that whether or not he possessed a weapon, his statement of a robbery constituted a criminal offense.

The final dimension involved with competency to stand trial is the ability to consult with counsel with a reasonable degree of rational understanding. Obviously, this dimension overlaps with the first two aspects of competency to stand trial, but it involves another very important consideration: the interpersonal aspect. How well can the defendant or patient actively cooperate in preparing a defense? There are any number of delusional systems that could encompass a lawyer and his or her legal representation. If the patient has developed a paranoid delusional system about an attorney that would render the patient incapable of working with the attorney, or if the patient feels that the attorney is in conspiracy with the government and is simply going through the motions of defense, some serious questions can be raised about the patient's ability to rationally assist the counsel in defense. One practical matter should be considered: the examiner has to take into account the fact that court-appointed lawyers frequently do not represent their clients very adequately. At times it becomes somewhat difficult to determine to what extent the patient's statements about his or her attorney are accurate reflections of what the attorney is or is not doing, and at what point the statements cross over into delusion. One interview technique that is often helpful in distinguishing adequacy of representation from actual delusion is to inquire whether the patient feels simply that the attorney is inadequate, lazy, and unmotivated or rather that the attorney is actively conspiring against the patient.

COMPETENCY CRITERIA IN MORE DETAIL

One very helpful monograph, which delineates the dimensions of competency to stand trial in far more detail than the broad criteria just discussed, is a work by McGarry et al. entitled *Competency to Stand Trial and Mental Illness* (1973). In McGarry's work, a general interview format and a sentence completion test are provided; these are scored according to the patient's level of abstraction in understanding the different dimensions. McGarry et al.'s work specifies a number of areas of competency to stand trial.

One point that is important to note here is that the competency screening test developed by this group is exactly what it states, namely, a

screening test. The intent of the authors was to provide a test that differentiated those who are clearly competent from those who are clearly incompetent, leaving those in the middle range to have more extensive evaluations. Unfortunately, all too often, one sees individuals using the competency screening test as the final determination of whether an individual is competent or incompetent for trial, without any further evaluation being performed.

The first issue presented in McGarry et al.'s material is the patient's or defendant's ability to appraise the available legal defenses. This refers to whether or not the defendant is aware of the various options when he or she goes to court; that is, does the defendant recognize and understand the pleas of guilty, not guilty, not guilty by reason of insanity, no contest, and so forth? The patient needs to be cognizant not only of these options, but of the outcome associated with each one. Does the patient know, for instance, what happens if he or she pleads guilty, giving up the right to trial and the right to appeal, or what might happen if he or she successfully pursues a defense of not guilty by reason of insanity (acquittal resulting in commitment to a mental institution)? One of the difficulties most frequently noted in a patient's ability to understand the options is the fact that often individuals are so impaired, and their reasoning so concrete, that they cannot separate their own situations from the broader situation posed by the legal system. That is, defendants who feel that they are not guilty cannot even conceive of alternative pleas such as guilty, not guilty by reason of insanity, or no contest. In short, they do not possess the level of abstraction necessary to rise above their own limited perception of the events.

A second dimension has to do with the degree of unmanageable behavior manifested by the patient, that is, whether or not the patient will maintain appropriate courtroom decorum. Although some critics question whether or not this is actually relevant to competency (i.e., whether the patient will appear to be hostile or angry, or will exhibit inappropriate responses in the court), there is another school of thought concerned with which kinds of behavior are indeed appropriate in a courtroom situation. In practical terms, it is relatively rare that a judge will tolerate disruptive behavior on the part of the defendant and still regard him or her as competent to stand trial. One notable exception is the case in which the examining psychologist or psychiatrist finds that the patient is without mental disorder but may deliberately and willfully attempt to disrupt the proceedings. Under these circumstances, such information should be provided to the court in advance, and the court may take this into consideration in its examination of the competency issue.

A third dimension concerns the quality of the patient's relation-

ship with the attorney. This refers to the ability to trust and communicate with the attorney in a relevant and coherent manner.

The planning of legal strategy is another important dimension. It includes the person's understanding of the ability to plead to a lesser offense when a plea bargain option is offered by the prosecution, as well as the rights one surrenders by taking the plea.

A fifth dimension involves the roles of various people within the court system. Does the patient know what functions the defense attorney and the prosecutor serve, what the roles of a judge and jury are, and what the patient's own role is in reference to the proceedings? Furthermore, can the patient understand the function of witnesses, and can he or she intelligently and rationally deal with these roles? This does not call for a terribly high level of abstraction, but instead involves a fairly minimal understanding. For instance, an adequate response to a question regarding what role the prosecutor plays is, "He is there to try to convict me." A question as to the role of the defense attorney could be appropriately answered by a statement as simple as, "She is there to try to help me."

The sixth dimension is concerned with the patient's ability to retain and understand what is learned. A patient who has not been involved in the judicial system before may not understand many matters with which he or she is confronted; this does not result in incompetency. Instead, this involves the patient's ability or lack of ability to understand and appreciate these matters once they have been explained.

This particular dimension, the ability to retain and understand what is learned, is very critical, since a judgment of incompetency to stand trial must be by reason of mental disorder. For instance, if a person is merely unsophisticated about the legal system or has never been arrested before, this does not constitute grounds for incompetency. Therefore, one must establish a "baseline" of the patient's knowledge of the system, identify those areas that the patient knows or does not know, and, following the establishment of this baseline, provide the missing information to the patient. Following this, the examiner proceeds to a different part of the evaluation, such as the history gathering, the psychological testing, or the mental status examination. After a period of time, the examiner asks the patient questions about those areas that the patient originally did not understand to see if that material has been retained.

When one is working within an institutional setting in which patients are under treatment after having been adjudicated incompetent to stand trial, this criterion also becomes very helpful in establishing the specific parameters of a treatment plan. This treatment plan is particularly critical since, in the Insanity Defense Reform Act of 1984, passed

by the United States Congress, the provisions of the treatment plan for restoring the patient to competency must be specified in the hospital record.

Case Example

The patient, a 62-year-old male suffering from a chronic brain syndrome secondary to many years of alcohol abuse, was charged with first-degree murder. On interview, he continually confused the roles of his defense attorney and prosecutor. He was told on several occasions that his defense attorney was there to assist him and that the prosecutor was trying to convict him. If the examiner returned to this topic several moments later, after a discussion of other matters, and asked the patient what the job of his defense attorney was, he would once again confuse the roles. This indicated that he was unable to comprehend the roles even when he was instructed about them. Questions therefore arose about his ability to concentrate on and follow the criminal proceedings at a trial.

The seventh dimension is the patient's understanding or lack of understanding of court procedures. Does the patient understand the sequence of events in a trial? Does he or she understand what direct examination is? Does the patient realize that every witness who testifies can be cross-examined and that the patient, through his or her attorney, has a chance to subject a witness's statements to question?

The next three dimensions refer to what has been described as the rational understanding of the proceedings, namely, the patient's appreciation of the nature of the charges, the range of possible penalties, and the appraisal of likely outcomes.

The eleventh dimension is an exceedingly important one: the capacity to disclose to one's attorney the available pertinent data that will assist the attorney in the preparation of a defense. More directly stated, this dimension refers to the patient's ability to disclose material to the attorney, and whether or not that ability is impaired by the patient's delusional system or, in more general terms, by his or her mental disorder.

Case Example

A patient was charged with first-degree murder and refused his attorney access to the one person who could establish the fact that he was indeed quite disturbed at the time of the offense, namely, his wife. His wife was present at the time of the shooting, yet the patient was so paranoid that he projected his own fears onto his wife, telling his attor-