Therapeutic Issues Associated With Confidentiality and Informed Consent In Forensic Evaluations

Kathy Faulkner Yates*

I. INTRODUCTION

Any particular rule, procedure, or role may be therapeutic, antitherapeutic, both, or neither. This forms the basic tenet of David Wexler and Bruce Winick's construct, "Therapeutic Jurisprudence."¹ Therapeutic jurisprudence is concerned with the extent to which the law itself causes or contributes to psychological dysfunction or "judicial psychopathology," a concept similar to that of iatrogenic illness in medicine. The law may contribute to psychological dysfunction through substantive rules, legal procedures, or the behavior of legal and judicial professionals. This paper will focus on contributions of the legal system and mental health professionals pertinent to a therapeutic or antitherapeutic outcome for the mentally disabled defendant which occur as a result of the relationship between forensic evaluation, confidentiality, and informed consent. Although special attention will be directed at competency evaluations, many of the issues are relevant for any type of assessment.

Forensic mental health professionals perform a variety of services within the judicial system from administrator and consultant, to examiner and therapist. The responsibilities of these roles are different and the focus of allegiance for the professional varies according to

---

* Kathy Faulkner Yates, Ph.D., Psychologist, is a research scientist with Nathan Kline Institute for Psychiatric Research and is Assistant Director of Research at Kirby Forensic Psychiatric Center. The author would like to thank Michael L. Perlin for his helpful comments, suggestions, and encouragement. The author would also like to thank Debbie Dorfman for her research guidance.

both the role and the "employer." For example, a therapist needs to establish a relationship of trust with his patients. Although a certain amount of trust is necessary for successful completion of a forensic assessment, the clinician (in the role of examiner) needs to maintain skepticism, distance, and objectivity in formulating an accurate opinion based on the test findings regarding the defendant's status. This objectivity might be difficult if the clinician had an established or ongoing therapeutic relationship with the defendant. Conversely, the ability to maintain a trusting, psychotherapeutic relationship might be jeopardized if, in the course of conducting a forensic examination, the clinician believes the patient may be exaggerating his psychopathology or that presentation of symptoms may not be entirely genuine, or both. The Criminal Justice Mental Health Standards formulated by the American Bar Association\(^2\) appear to reflect this distinction in role. This Standard states: "When professionals function as either evaluators or consultants, they establish no therapeutic or habilitative relationships with defendants and thus owe them no loyalty. However, if a treatment or habilitative relationship commences, a professional owes loyalty to the person undergoing treatment or habilitation.\(^3\)

Although some mental health professionals may not recognize the distinction between roles such as therapist and examiner, keeping these roles separate has been strongly recommended.\(^4\) With respect to the issue of the "employer," a psychotherapist employed by a correctional facility is likely to experience a different relationship with a patient than a psychotherapist providing treatment in a private practice setting or a therapist employed by a forensic psychiatric institution.\(^5\)


3. ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, supra note 2, § 7-1.1, at 13; ABA STANDARDS FOR CRIMINAL JUSTICE, supra note 2, § 7-1.1, at 7-13.


II. CONFIDENTIALITY AND FORENSIC ASSESSMENT OF THE MENTALLY DISABLED DEFENDANT

Until recently, confidentiality and informed consent were not seen as relevant to forensic evaluations, especially those requested by court order. By definition, the results of an evaluation were not private or confidential because the purpose of the assessment was to convey information to one or more third parties concerning the individual who was the focus of the evaluation. The striking misuse of forensic evaluations in Estelle v. Smith, however, provided the impetus for much concern regarding informed consent as well as what information is given a defendant regarding limits of confidentiality of the evaluation.

In Estelle, the Texas state trial court appointed a psychiatrist who found Smith competent to stand trial. Later, at the sentencing phase of the trial, this same witness testified (based on results from his competency evaluation) that given his diagnosis, the defendant was certain to commit further acts of violence and posed a threat to society. The Texas Court of Criminal Appeals affirmed the conviction and death sentence. "After unsuccesssfully seeking a writ of habeas corpus in the Texas state courts," the defendant sought a writ of habeas corpus in the federal district court. The United States District Court for the Northern District of Texas found constitutional error in admitting psychiatric testimony during the penalty phase and vacated the death sentence. The American Psychiatric Association filed an amicus curiae brief which clearly implied the need for the defendant to understand how the information gleaned from his examination would be used in court and of the need for informed consent by the

8. 451 U.S. at 456-57.
9. Id. at 457.
10. Id. at 460.
11. Id. The defendant first unsuccessfully sought a writ of habeas corpus in Texas State Court. Id.
12. Id.
The United States Supreme Court affirmed the decision of the Fifth Circuit, which had affirmed the district court's decision to vacate. The Supreme Court held that the defendant had not been warned that he had a right to remain silent for the court-ordered, in-custody psychiatric examination, in that statements he made could be used against him during capital sentencing (i.e., his Fifth Amendment privilege against compelled self-incrimination), and that defense counsel was not notified in advance that additional issues such as future dangerousness would be assessed (i.e., his Sixth Amendment right to the assistance of counsel was violated). The Court's decisions effectively conveyed the following: 1) a defendant must be apprised of the limits of confidentiality concerning the findings of the evaluation; 2) the purpose of the examination and associated forensic expert testimony regarding the findings must be clarified prior to the examination (i.e., his statements can be used against him at the sentencing stage of a trial); and 3) defense counsel must be notified in advance of a court-ordered forensic examination and must be apprised of the issues to be assessed so as to be able to effectively counsel his client. As a result of Estelle, several courts have required forensic examiners to give patients a full Miranda warning prior to the commencement of a forensic examination, clarifying that results obtained from the evaluation "can and will be used against the individual in court." "Mirandizing" is not consistently practiced from one jurisdiction to another and admissibility of testimony varies on a case by case basis. For example, in Powell v. Texas, the United States Supreme Court reversed the Texas State Court of Appeals' judgment that the defendant waived his Fifth Amendment right of self-incrimination by introducing psychiatric testimony in support of an insanity defense. In this case, the state court had incorrectly held that the defendant did not require a Miranda warning.

13. Id. at 456.
14. Id. at 474.
15. Id. at 461.
16. Id. at 460.
17. Id. at 468.
18. Id. at 471.
19. Id.
20. Id. at 467 (quoting Miranda v. Arizona, 384 U.S. 436, 467-69 (1966)).
22. Id. at 683.
A second source of confusion that contributes to the complexity of this issue is the attorney-client privilege. Evaluators hired by the defense may fall under this privilege, and thus, all information gleaned from the assessment may be confidential. *United States v. Alvarez* is the most well-known federal case to deny the government the right to call the defendant’s expert to testify. Although a forensic psychiatrist had conducted an evaluation and found the defendant legally sane, neither insanity nor competency to stand trial were raised as an issue by the defense. Furthermore, defense counsel had not called this expert to the stand. Although use of the Alvarez logic varies according to state and federal jurisdiction, it is a widely recognized standard as long as the defendant’s mental state does not become an issue in the case (i.e., an insanity defense or competency issue is not raised). Raising an insanity or competency defense is regarded as placing the defendant’s mental state into litigation and thus waives the attorney-client privilege. Such was the case in *People v. Edney*. In this New York case, insanity was offered as a defense. Thus, the court ruled that the defendant waived his attorney-client privilege and the State was allowed to call the defendant’s forensic expert to the stand.

III. Judicial System Contributions to Problems Associated with Forensic Evaluations

Forensic clinicians are routinely requested to conduct competency evaluations to determine whether a defendant is competent to stand trial. Research on incompetence to stand trial has consistently indicated that the forensic expert’s conclusions tend to be accepted by judges when making the ultimate competency decision. Although a national legal standard of competency exists and is widely recognized, there has been little uniformity in local determination of competency. The constitutional standard for competence was set by the United States Supreme Court in the landmark case of *Dusky v. United States*.
Unfortunately, this standard provides at best, only a general guideline to steer the examiner and the courts. This guideline states: "[t]he test must be whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding . . . and whether he has a rational as well as factual understanding of the proceedings against him."

There are considerable differences among jurisdictions for the existence of specific competence criteria and for the qualifications of forensic expert. These differences can dramatically impact the reliability and quality of forensic testimony respectively. Some states have taken a progressive attitude and have added procedural protections for mentally disabled defendants by identifying a specific set of criteria which the forensic examiner must address in his determination of fitness report (such as Florida) and/or have regulations requirements to serve as a forensic expert (such as Massachusetts). The development of such procedural safeguards serves in

---

30. 362 U.S. at 402.
31. The Florida Rule of Criminal Procedure provides:
   (a) Examination by Experts. Upon appointment by the court, the experts shall examine the defendant with respect to the issue of competence to proceed, as specified by the court in its order appointing the experts to evaluate the defendant, and shall evaluate the defendant as ordered.
   (1) The experts shall first consider factors related to the issue of whether the defendant meets the criteria for competence to proceed; that is, whether the defendant has sufficient present ability to consult with counsel with a reasonable degree of rational understanding and whether the defendant has a rational, as well as factual, understanding of the pending proceedings.
   (2) In considering the issue of competence to proceed, the examining experts shall consider and include in their report:
      (A) the defendant's capacity to:
         (i) appreciate the charges or allegations against the defendant;
         (ii) appreciate the range and nature of possible penalties, if applicable, that may be imposed in the proceedings against the defendant;
         (iii) understand the adversary nature of the legal process;
         (iv) disclose to counsel facts pertinent to the proceedings at issue;
         (v) manifest appropriate courtroom behavior;
         (vi) testify relevantly; and
      (B) any other factors deemed relevant by the experts.
   FLA. R. CRIM. PROC. § 3.211(a)(1), (2) (1994).
sharp contrast to states such as North Dakota which do not only rely on the constitutional minima offered in *Dusky*, but also do not identify qualifications for the forensic expert outside of being a "physician".34

Lack of specific legal criteria for competency and for qualifying forensic expert accounts for only a part of the problem with reliability and quality of the forensic examiner's opinions and decisions. There has been variability across jurisdictions in the interpretation of the legal definition of terms such as incompetence, "reasonable degree" and "certainty" which lends considerable ambiguity. Additionally, confusion exists regarding the implementation of the standard, "reasonable degree of medical or psychological certainty."37

These difficulties become even more problematic in light of the Supreme Court's landmark decisions in *Jackson v. Indiana* and *Ford v. Wainwright* which place substantial responsibility on forensic mental health professionals for assessment and treatment. The Court's decision in *Jackson* requires determination of whether or not an incompetent defendant will probably attain competency in the foreseeable future. This determination is essential for appropriate, alternative judicial proceedings. When the defendant is as intellectually and physically compromised as was Jackson (a deaf mute, unable to read or write and who had the mental level of a pre-school child), determination of competency may be relatively clear-cut. Such clarity, however, tends to be the exception rather than the rule.

In *Ford v. Wainwright*, the United States Supreme Court affirmed the common law practice of every state prohibiting capital punishment of defendants deemed incompetent.41 The Court also concluded that procedural due process should be available to death row inmates

35. THOMAS GRUSO, EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS (1986); Michael L. Radelet & George W. Bernard, Ethics and the Psychiatric Determination of Competency to be Executed, 13 BULL. AM. ACAD. PSYCHIATRY & L. 37 (1986).
37. Rogers, supra note 5.
41. Ford, 477 U.S. at 401.
being evaluated for sanity.\textsuperscript{42} This per se rule establishing that execution of a mentally-ill prisoner violates the Eighth Amendment, can be contrasted with \textit{Penry v. Lynaugh},\textsuperscript{43} where the courts rejected a singular rule in cases of execution of mentally retarded persons. Penry was found competent to stand trial in a capital murder trial despite expert testimony that he carried a diagnosis of Organic Brain Dysfunction, had an IQ of fifty-four, and had a mental age of six and one half years with a social maturity of nine to ten years.\textsuperscript{44} The jury subsequently rejected a defense of insanity and found Penry guilty of capital murder.\textsuperscript{45} He received the death sentence.\textsuperscript{46} Although it was the judgment of the Supreme Court that the Eighth Amendment did not preclude execution of a mentally retarded person, it is important to note that the Court was split in this decision.

Despite the fact that competency decisions are ultimately the responsibility of the courts, research on incompetence to stand trial has consistently indicated that judges tend to accept the conclusions of the forensic expert.\textsuperscript{47} Essentially, considerable reliance is placed upon the opinion and testimony of the forensic expert, despite the lack of specific, guiding legal criteria utilized to determine competence \textit{and} in spite of the confusion regarding implementation of the standard "reasonable degree of medical certainty." The potential for an antitherapeutic outcome is obvious.

\textbf{IV. MENTAL HEALTH PROFESSIONALS' CONTRIBUTIONS TO PROBLEMS ASSOCIATED WITH FORENSIC EVALUATIONS}

\textbf{A. Inconsistent Assessment Format}

Forensic mental health professionals also contribute to a plethora of ills associated with the competence issue. Although the \textit{Dusky} formula identifies the general qualities to be found in the defendant, there is no formal or consistent approach in how clinicians operationalize such qualities and subsequently infer fitness. Despite

\textsuperscript{42} Id. at 416-17.
\textsuperscript{43} 492 U.S. 302 (1989).
\textsuperscript{44} Id. at 308.
\textsuperscript{45} Id. at 310.
\textsuperscript{46} Id.

the availability of formal and reliable competency to stand trial measures, many evaluation centers and private practitioners create and utilize their own assessment tools. Furthermore, disciplinary differences exist between psychiatry and psychology as a function of training, both in method of diagnosis and in treatment approach. In the context of assessments, differential importance is placed upon data sources considered helpful in examinations. Although both professions use a diagnostic, clinical interview and a mental status examination for resolution of competency issues, psychologists tend to rely more on data gleaned from psychological testing than do physicians.

B. Insufficient Ethical Guidelines

Forensic mental health professionals do not have clear professional or ethical guidelines to steer them, especially when confronted with conflicting clinical and legal issues such as confidentiality, informed consent, reliability and validity of available clinical tools to address referral questions. Existing ethical standards are similar to the constitutional guidelines for competence. They are loosely constructed constellations of principles which outline a small number of general and difficult-to-interpret guidelines for professional ethics.

Recently, the Committee on Ethical Guidelines for Forensic Psychologists has offered Specialty Guidelines for Forensic Psychologists (Guidelines). This document represents a thoughtful and relatively comprehensive effort to provide more precise guidelines for psychologists specializing in the forensic arena. Several problems exist. First, although the Guidelines were constructed to be national in scope and was intended to conform with state and federal law, it may not be fully compatible. For example, situations may occur where the requirements of the law might conflict with the Guidelines. This may

48. For a review, see GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATION FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 81-86 (1987); Grasso, supra note 35, at 78-104.
result from jurisdictional variations or from a clash between this aspirational model of desirable professional practice by forensic psychologists and legal requirements. Second, individuals may choose to ignore such available ethical guidelines, such as in the case of Texas psychiatrist Dr. Grigson. Dr. Grigson was hired by the State on numerous occasions to conduct forensic assessments and offer testimony even though his views disagree with those of the American Psychiatric Association (APA). The Board of Trustees of the APA has reprimanded Dr. Grigson for offering testimony on future dangerousness of a criminal defendant without having actually met with the defendant. Third, without similar constitutional modifications, enforcement of such guidelines would be difficult, if not impossible.

Additionally, although there may be some overlap in the ethical principles which guide professional behavior for different professional organizations, there are also differences. Such differences can influence the recommendations these organizations make to the court. For example, both the American Psychological Association and the American Psychiatric Association submitted amicus curiae briefs to the court in United States v. Byers regarding informed consent, confidentiality, and possibilities for self-incrimination. The briefs were quite different for these two organizations. In the Byers case, results from psychological and psychiatric examinations offered by defense experts conflicted with the second opinion found by the expert hired by the United States Attorney’s Office with regard to whether or not Byers had been psychotic at the time of the offense. Furthermore, at the time of trial, the prosecution’s expert offered the opinion that Byers was malingering in a deliberate attempt to feign mental illness. This opinion was a surprise to the defense as it had not been noted in the letter sent to the court. The case was appealed based on reasoning analogous to Estelle v. Smith because Byers had not been informed that statements made during the government compelled examination could be used against him in a capital sentencing phase.

54. 740 F.2d 1104 (D.C. Cir. 1984).
55. Id. at 1139-40.
56. Id. at 1140.
57. Id.
of the trial.

As has been stated, the briefs offered by these two professional associations were quite different. Essentially, the American Psychological Association argued that evidence obtained in the clinical interview could be used to establish appreciation of wrongfulness of the act or control of conduct. Thus, an opinion on criminal responsibility did incriminate the accused. In their brief, provision of additional safeguards were recommended regarding the role of the “government expert,” both with respect to access to the patient and to nature of testimony. Conversely, the American Psychiatric Association held that there was no Constitutional need for the presence of counsel or for the provision of other safeguards because the principles of medical ethics dictated that the psychiatrist would carefully explain the limits of confidentiality to the defendant. If the limits of confidentiality were explained, procedural safeguards advocated by the American Psychological Association were unnecessary. Differences in position between these two organizations may exist as a function of training differences in how they conceptualize the fine line between an evaluative and therapeutic relationship, politics, or "turf war." However, it is critical to point out that a defendant who is psychotic may be too compromised in terms of decision-making capacity to understand or appreciate the subtleties of confidentiality distinctions exemplified in Byers. The potential for an antitherapeutic outcome for the mentally disabled defendant in this type of situation is clear.

Such dissimilarities have raised the question of whether the type of training has different influences on the resolution of competency for execution and competency in general. Some research suggests that differences in thoroughness of forensic assessment and relevancy of reports exists, with a bias against medically trained experts.

58. Id. at 1153.
59. Id. at 1156 n.104.
60. Id. at 1159 n.124.
C. **Examiner Characteristics**

Studies assessing the impact of mental health professionals’ attitudes, orientations, and opinions on their clinical decisionmaking and subsequent court testimony have consistently indicated a positive relationship between these subjective characteristics and decision outcome. The potential influence of professional bias constitutes the third problem. For example, Robert Homant and Daniel Kennedy found that forensic experts’ attitudes toward the insanity defense affected their decisionmaking in a particular case and consistently predicted their decisionmaking. Mary Ann Deitchman, Wallace Kennedy and Jean Beckham explored the extent to which competency evaluators’ attitudes toward the death penalty and their attribution of criminal responsibility predicted their willingness to participate in competency for execution evaluations. Their findings suggested that self-selection factors might be operating in mental health examiners, which in turn, might suggest bias in outcome of such evaluations. They found that forensic examiners who oppose capital punishment were unlikely to participate in those evaluations.

D. **Summary of Mental Health Professionals’ Contributions**

Although additional investigation of examiner bias needs to be conducted, results support concerns regarding the fear that examiner characteristics may directly influence, or specifically bias, the outcome of competency for execution evaluations. Moreover, the potential for subjective, examiner characteristics (e.g., attitude toward the insanity defense and opinion of the death penalty) to influence judgment, and thereby produce bias, is enhanced when the clinical factors in competency assessments are not clear-cut and critical legal defini-

---


65. Deitchman et al., *supra* note 61.
tions are not precise. Given the consequences of competency for execution assessments and the importance of mental health professionals in this decisionmaking, every effort must be made to develop precision in the definition of competency and to eliminate bias in the evaluative process. However, the concern of potential bias resulting from both subjective characteristics and differences in professional training should be extended to all forms of forensic assessments, such as dangerousness, malingering, criminal responsibility, and presentencing and pretrial diversion evaluations.

Howard Owens and colleagues reviewed the literature on judges' views of competency evaluations and reported the following findings: 1) the courts frequently used competency evaluations to address ultimate issues of guilt or punishment; 2) many court-ordered evaluations failed to specify the reason for the exam or the questions it desired answered; 3) judges varied among themselves as to the degree of mental capacity required for one to stand trial; 4) concepts of competency and responsibility were used interchangeably by both judges and psychiatrists; and finally, 5) judges and psychiatrists frequently operated in isolation from each other, and, because the judges were not clear or precise as to the information they wanted, psychiatrists often did not provide the information the judges desired. In their own studies, Owens and his colleagues obtained findings which contrasted with previous investigations. Several significant methodological problems, such as sample bias and data collection issues and non-structured interviews, existed, which makes it necessary to view their results cautiously. What is important to note, however, is that the evidence strongly indicates that the indeterminacy of the competency criteria, coupled with the potential for personal and professional biases on the part of the forensic decisionmakers has contributed to considerable inconsistency in the quality and outcome of the evaluative process.

Finally, a review of cases associated with a variety of topics relevant for the mentally disabled defendant suggests that the various officers of the courts, whether counsel for the defense, prosecution, or the judge, vary in their legal philosophies and knowledge about

67. Id.; Howard Owens et al., The Judge's View of Competency Evaluations II, 15 BULL. AM. ACAD. & L. 381 (1987) [hereinafter Owens, Evaluations II].
68. Owens, Evaluations I, supra note 66.
mental health issues.\textsuperscript{69} Michael Perlin suggested that it is a "fatal assumption" to assume that mentally disabled individuals regularly receive competent counsel, regardless of the specific nature of their legal needs.\textsuperscript{70} Thus, even if the forensic clinician clearly and accurately comprehends his role as one of consultant for the court, by necessity, he must be sensitively responsive to the diverse needs of other participants in the criminal justice system. Consequently, it essential that the mental health professional be knowledgeable of the constitutional minima and statute requirements for his state.

V. THERAPEUTIC RELEVANCE—ISSUES FOR THE DEFENDANT

A. Limits of Confidentiality and Informed Consent

With respect to forensic assessment (especially competency evaluations), two general issues can be identified which have therapeutic relevance for the mentally disabled defendant: 1) the defendant's understanding of how the information gleaned from the evaluation will be used for or against him in a court of law, and 2) the comprehensiveness of the assessment and subsequent accuracy of interpretation.

Although the Court's decision in \textit{Estelle v. Smith}\textsuperscript{71} acknowledged the need to appraise the defendant about the purpose of the examination, of the limits of confidentiality concerning the findings, and of any associated forensic expert testimony regarding the findings, clarification of such matters may not always be effectively accomplished. Furthermore, when giving expert testimony, clinicians are frequently encouraged by the courts to apply information obtained from one type of examination to other issues which were not specifically addressed in the evaluation. For example, findings from the evaluation assessing the need for involuntary hospitalization as a result of a present threat of danger to self or others were used to establish competency to stand trial in \textit{Buchanan v. Kentucky}.


\textsuperscript{70} Perlin, \textit{Fatal Assumption}, supra note 69, at 39-59.

\textsuperscript{71} 451 U.S. 454 (1981).

\textsuperscript{72} 483 U.S. 402 (1987) (holding use of psychiatric report to rebut "mental status"
derstanding how information can be used in judicial proceedings, and choosing either to consent or to refuse participation in such a procedure, clearly has therapeutic relevance for the defendant.

Understanding limits of confidentiality concerning test findings with associated testimony is also important in civil commitment cases. By understanding the limits of confidentiality, and deciding whether to consent to the assessment, the patient has an opportunity to assume some responsibility for his situation and whether to actively cooperate in his judicial proceedings. This participation and involvement can be therapeutic for the defendant and is consistent with the position advocated by John Ensminger and Thomas Liguori. They contend that active involvement in one’s civil commitment procedure can be therapeutic for the defendant because the hearing provides a confrontation with reality, gives the defendant the opportunity to draw a connection between his behavior and social consequences, and can serve as a learning experience. Similar to the ability of the judge to regulate the hearing process, the clinician can limit the confusion of the assessment process by taking an active role with the patient and by explaining his role in the patient’s legal proceedings. Ideally, the defendant’s attorney would be present for the assessment, intervening if and when appropriate for his client.

At the same time, common sense dictates the consideration that one’s awareness of the potential for self-incrimination could easily lessen the frankness with which one responds to the evaluator’s inquiries. A decrease in honesty and forthrightness would likely have a negative affect on the accuracy and validity of the examination and potentially produce an antitherapeutic outcome. There have been a number of investigators who have studied the impact of “psychological Mirandizing.” In Jefferey Klotz’s review of the literature, he found that “empirical research suggests that informing the patient as to the scope and limits of his rights should not reduce the defense did not violate defendant’s Fifth or Sixth Amendment rights).

74. Id. at 12.
individual’s willingness to disclose and that rather, omitting such a warning could be therapeutically damaging.” The focus of such research, however, has been on the therapeutic relationship, not forensic assessment. This is clearly an area in great need of empirical investigation.

B. Evaluation Thoroughness and Accuracy

With respect to the second issue, comprehensiveness of an evaluation is a function of understanding the issue to be assessed and selection of reliable and valid tools. As has been previously stated, the Constitutional criteria which define competence are not specific or clear-cut. In addition, there has been no consistent approach for measurement of this construct, or of any other, by mental health practitioners. Furthermore, many jurisdictions do not identify qualifications for forensic experts. It is clear that such deficiencies (individually and collectively) are potentially antitherapeutic for the defendant.

Currently, competency evaluations are generally conducted according to the style of the private practitioner or to the needs/demands of the agency or institution. Disciplinary differences and personal preferences tend to guide the professional in selecting data sources considered useful for obtaining information, despite the availability of published research which identifies measures which are reliable predictors of competency from those which are not. These are sources of potential negative bias against the defendant. The quality of the opinion rendered from an assessment is directly related to how the issue being measured is conceptualized, and is a function of the validity and reliability of the utilized measures, the candor of the patient, and the expertise of the examiner in administering, scoring, and interpreting the data. Given the importance of the expert’s opinions and decisions in the legal process, the more thorough and accurate the assessment, the more therapeutic the outcome, especially for defendants with severe or complex mental disabilities. Even if the ultimate judicial verdict is not one which favors the defendant, participating in an evaluation with a competent professional who administers a thorough assessment can be in-and-of-itself therapeutic. This is consistent with findings that it is more important for a litigant to feel that he has been “taken seriously” within the judicial proceedings and

76. Koltz, supra note 75, at 427 n.52.
has received a fair trial than necessarily to “win or lose.” Conversely, a patient who consents to a forensic evaluation which is subsequently not conducted adequately or properly, is placed at a great disadvantage and may not receive the fair and equitable representation that he deserves. The process may have such a negative impact on the defendant that it could have severe consequences for future willingness to participate in, and potentially benefit from, any form of assistance, producing an antitherapeutic outcome.

A related issue pertains to the location where the evaluation is conducted. In his field experiment, Jan Schreiber found that a comprehensive, single interview produced a reliable competency decision in a majority of the cases. He concluded that it was rarely necessary for a defendant to be hospitalized solely for determination of fitness for trial. He further stated that, if the evaluation was conducted at an early stage in the proceedings, the need for hospitalization could be obviated in many cases. Schreiber adopted the approach recommended by the American Bar Association for a first level of competency. It was determined that any defendant who met that first set of criteria did not need to be examined further, whereas demonstrated deficiency in one or more of those areas indicated the need for further assessment. Although the participants in their study were not “gray area cases,” but rather fell into relatively clear-cut categories, they concluded that the majority of competency evaluations could be conducted on an outpatient basis, thus minimizing the potential for violation of the defendant’s civil rights by inappropriately confining him without his consent.


79. Id.

80. Id.

81. ABA committee set out the following criteria as constituting a first level of competency: (a) understanding of the nature of the trial process, without undue perceptual distortion; (b) capacity to maintain the attorney-client relationship; (c) ability to recall and relate factual information; (d) capacity to testify relevantly; and (e) the above abilities in light of the particular charge, extent of the defendant’s participation, and complexity of the case. ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, supra note 2, § 7-4.1, at 173-75; ABA STANDARDS FOR CRIMINAL JUSTICE, supra note 2, § 7-4.1, at 7-173 to 7-174.

82. Schreiber et al., supra note 78.
once a defendant has been found incompetent to stand trial, and hospital staff fail to notice improvement or ignore it, the period of confinement for incompetent defendants often exceeds the maximum sentence for the crime.\textsuperscript{83} The antitherapeutic implications here are clear.

VI. RECOMMENDATIONS

A. Limits of Confidentiality and Informed Consent

Principles of confidentiality do apply in the forensic setting, but are limited by the purposes of the examination. A consistent approach in apprising a defendant about the limits of confidentiality is recommended, and thus, informed consent should be obtained. This should be mandatory, regardless of the background training of the forensic mental health professional conducting the assessment. The consent discussion should be simple and include all possible, relevant disclosure issues, such as potential for future violence and past unreported criminal activity. This becomes especially important when an examination is being performed for which information about previous crimes would be relevant and, therefore, disclosable. The subject should be so informed regarding the issue of limited confidentiality at the beginning of the evaluation by simply being included in the pre-examination consent discussion. Paul Appelbaum offers such a warning for a court-ordered evaluation:

\begin{quote}
I am performing this evaluation at the request of the court to determine whether you are legally able to stand trial . . . [or insert appropriate referral question] . . . Although nothing you tell me can be used to establish your guilt, you should not assume that anything relating to your ability to stand trial will be kept confidential, as most things would be if you had come to me for treatment. In addition, I may be obliged to reveal any information you tell me about future acts of violence you plan to commit or about any past unreported criminal activity, relevant to the purpose of this evaluation.\textsuperscript{84}
\end{quote}

This recommended position of limited confidentiality is consistent

with the traditional, clinical principles which guide the mental health practitioner. Appelbaum further suggests that the clinician owes the patient the duty of protecting information which falls outside the scope of the examination in exchange for the development of sufficient trust to enable the examination to proceed. He argues that the effect of the defendant's consent to the examination is to limit expectations of confidentiality only as they relate to findings within the scope of the evaluation. Finally, Appelbaum specifically recommends that the forensic clinician refrain from all disclosure of information obtained in the course of the evaluation unless the revelation is required to fulfill the purpose of the examination. This would also apply to written reports, oral testimony, or discussions with any legal professional. Concurrently, the patient's consent should be obtained for any disclosure of potentially identifying information regardless of the situation (e.g., teaching and publications).

Due to the potential conflict between the professional's oath to maintain limited confidentiality for his patient and safety of society, development of a concrete standard for determining when the clinician is obligated to report the potential for future dangerousness is also recommended. This is particularly relevant when such information is obtained in the context of conducting evaluations where dangerousness is not within the scope of the assessment. For example, if in the context of conducting a competency evaluation, the defendant makes specific or directed threats of violence, the defendant should be reminded about the limits of confidentiality and should be discouraged about making further comments.

Despite being a civil case, Tarasoff v. Regents of the University of California remains the benchmark against which all other litigation and statutory reform in this area is measured. Tarasoff requires mental health professionals to take all necessary and reasonable steps to protect identifiable victims of their patients when they know or should know that their patients will commit violent acts.

85. Id. at 290.
86. Id. at 291.
87. Id.
90. Tarasoff, 551 P.2d at 340.
Karen Rothenberg has offered an argument for applying Tarasoff to the forensic setting. Her basic rationale is that for the purposes of Tarasoff, there are no substantial or relevant differences between the therapeutic and forensic settings, that prediction of dangerousness is no more difficult in one setting than in the other. Within this same context, Appelbaum suggested that if an examiner believes that future violence is likely, he should feel compelled to take measures to prevent it. Although Appelbaum makes it clear that he does not endorse the court’s position on this issue, he states that the moral basis requiring clinicians to act in Tarasoff-like situations is powerful, while the vaguely defined “special relationship” which serves as the basis of the legal reasoning is not. He recommends limiting the Tarasoff obligation to situations where an individual has taken actual steps or has made an overt threat to commit a future act of violence. Such a limit is similar to the requirements for civil commitment. The rationale for limitation of overt threats includes the following: 1) provides a message to society that consistent, reproducible and reliable decisions will be made by clinicians, 2) assures patients that their interests in confidentiality and liberty will not be lightly infringed, 3) provides clarity of guidelines for clinicians, and 4) provides an objective standard for the courts in reviewing clinician’s actions or failures to act.

B. Uniformity of Assessments

In light of the substantial responsibility placed on forensic mental health professionals for assessment and treatment stemming from Supreme Court decisions such as Jackson v. Indiana and Ford v. Wainwright, a uniform and rational approach to forensic evalua-

92. Appelbaum, supra note 84, at 295.
93. Id.
94. Id.
95. 406 U.S. 715 (1972). Petitioner, a mentally defective deaf mute, who cannot read, write, or communicate, was charged with two criminal offenses and committed under IND. CODE § 35-5-3-2 (1971). Id. at 717. A competency hearing resulted in the conclusion that the petitioner lacked the comprehensibility to make a defense. Id. at 718. He was ordered to Indiana Department of Mental Health until the Department could certify that the defendant was sane. Id. at 719. The Supreme Court reversed, holding that a life sentence, without ever having been convicted of a crime, was a violation of the petitioner’s due process and equal protection rights. Id. at 723-39.
96. 477 U.S. 399 (1986). In 1979, Alvin Bernard Ford was convicted of murder and sen-
tions is recommended. This requires the cooperation of both the judicial system and the mental health profession. A joint effort by these two disciplines would contribute even more to the improvement of the evaluative process, and in turn, increase the likelihood of a therapeutic outcome for the defendant. For a cooperative effort to be therapeutic, the judicial system would extend the constitutional minima for competency, identifying a specific, cogent criteria which the examiner must address, point by point, in the submitted report. This could be similar to Florida’s Rule of Criminal Procedure. In addition to serving as an unambiguous guideline for the mental health professional, this clarity could decrease confusion and serve to facilitate consistency in knowledge and understanding among the various officers of the court. The meaning of terms such as “reasonable doubt” and “certainty” would also need to be clarified.

Concurrently, mental health professionals would utilize only reliable and valid assessments in addressing competency. The approach recommended by the American Bar Association in 1984 for a first level of competency could serve as a minimum screening. Any defendant meeting that first set of criteria would not need to be examined further. However, demonstrated deficiency in one or more of those areas would indicate the need for further assessment. In a comprehensive review of the literature on the use of psychological tests in forensic assessments, David Schretlen reported that researchers have consistently demonstrated the following: 1) specific psychological tests have proven to be reliable and valid instruments for assessing malingering and competency; 2) no research has demonstrated that the diagnostic, clinical interview is a valid and reliable measure for these same purposes; and 3) test batteries yield more accurate predictions than single tests. These findings suggest that it is important to use psychological test data to render an expert opinion and that multiple measures should be employed in forensic assessments.

tenced to death. Id. at 402. There was no suggestion that he was incompetent at the time of his offense, at trial, nor at the sentencing, but while in prison he began to manifest changes in behavior, indicating a mental disorder. Id. Three psychiatrists interviewed Ford and three different diagnoses were rendered on the question of sanity. Id. at 404. Despite the conflicting reports, the Supreme Court held that the Eighth Amendment prohibits the state from inflicting the penalty of death upon a prisoner who is insane. Id. at 410.

97. FLA. R. CRIM. PROC. § 3.211(a) (1994); see supra note 31.

98. See supra notes 2, 81.

Ideally, the interview measure should be normed and validated as a reliable tool to be routinely used with a forensic population. The format of the clinical interview should be written and semi-structured to assist the documentation of its usefulness by methodologically sound experimental studies.

The consistent use of reliable and valid measures would assure the courts of a standard basis for expert opinion/decisions, and would also serve as a checklist for examiners ensuring that they address the criteria set by the court. Training sessions for forensic mental health professionals are recommended to maintain a high degree of consistency in test administration and interpretation as well as to serve to minimize potential examiner bias which could result from ambiguous clinical and legal guidelines. Interdisciplinary cooperation could contribute significantly to an improvement in modern mental health law and improve the quality and outcome of the evaluative process.

C. Expert Testimony

With respect to the content of forensic evaluations and the use of this information in court, it is recommended that evaluations be topic specific and that testimony taken from the evaluation be used only for the relevant hearing (e.g., evaluation to assess competence to stand trial used only at a competency hearing). This recommendation is made not only to protect the rights of the defendant, but could serve as an additional guide for the examiner. For example, if a patient begins to address information which is not relevant to the issue at hand, but which might have bearing on other important legal concepts such as dangerousness or criminal responsibility, the examiner should interrupt the patient and warn him of the limits of confidentiality for such information and discourage continued self-revelation.

D. Psychological Profiling

Over the years, the courts have attempted to restrict the influence mental health professionals were having on the trier of fact by limiting the issues of expert opinion. In Washington v. United States, Judge Bazelon, writing for the D.C. Circuit, prohibited mental health professionals from rendering opinions on causal relationships between mental disorder and crime. In 1984, the Insanity Defense Reform Act

100. 390 F.2d 44 (D.C. Cir. 1967).
restrained mental health professionals from giving testimony about ultimate issues such as legal insanity in federal insanity trials. Despite these efforts, however, clinicians are frequently asked to respond to such questions and, furthermore, continue to be asked to testify on matters which exceed their limits of expertise. Psychological profiling may proffer an avenue for providing assistance and information which may be useful to the courts in coming to a decision without breaching or compromising the expert's professional limits.\textsuperscript{101} This technique combines psychological testing and general clinical issues. Profiling is an acceptable and helpful tool, but only when used in general terms and in the context of probabilities, never when used to describe a specific case. An example of profiling might be to say that an individual with a particular personality structure is more or less likely to behave in a certain manner.

As with any other data obtained by the clinician, profiling has the capacity to be misused. Great care must be exercised to avoid the potential application of a description to a specific case or to make an unwarranted generalization. For example, it would be a misuse of the data to construct a psychological profile of the defendant and then testify that the individual was not guilty because he did not fit the "profile" of one who would commit the offense. It would be similarly inappropriate to diagnose a defendant and then state the diagnosis would render the individual unable to commit the crime. Another frequent misuse of psychological test data is the potential to utilize test scores to infer more information than can be answered or addressed by the scores, or essentially making an unwarranted generalization from the clinical finding. The role of the forensic expert is simply to describe his clinical impressions based on test data, consistent patterns, and certain potentials for acting in a particular way. The expert's role does not include stating what kind of individual fits a specific offense or what kind of individual would commit a crime in a particular way.\textsuperscript{102}

VII. CONCLUSION

Although a specific focus has been directed at competency examinations, many of the identified problems and recommendations are

\textsuperscript{101} Shapiro, \textit{supra} note 4.
\textsuperscript{102} Id. at 75.
relevant to other forms of assessments including dangerousness and criminal responsibility. Given the consequences of forensic assessments and the importance of mental health professionals in decisionmaking, every effort must be made to develop precision and to eliminate bias in the evaluative process. This can be best achieved by an interdisciplinary cooperation and interchange of insights and knowledge between mental health disciplines and the legal profession. Such cooperation could also contribute significantly to an improvement in modern mental health law by analyzing and understanding the impact of substantive rules, legal procedures, and the roles of the various professionals on therapeutic values.