Zacarias Moussaoui, the man known as “the 20th 9/11 hijacker,” was indicted on six charges related to the 9/11 conspiracy in December 2001. He was sentenced to life in prison on May 3, 2006. In the 4-1/2 intervening years, Moussaoui refused to enter a plea, fired his court-appointed attorney, was ordered to submit to a mental evaluation, and received permission to represent himself (a decision the judge in the case later reversed, citing inflammatory and unprofessional briefs he submitted). Moussaoui then pled guilty after being psychologically evaluated and determined competent to plead. At his sentencing hearing, against the advice of his attorney, he gave damaging testimony against his own interests.

On November 10, 2009, former astronaut Lisa Nowak pleaded guilty to charges of felony burglary of a car and misdemeanor battery. Military charges are still under consideration. Prior to her guilty plea, Nowak’s attorney had indicated that she would plead not guilty by reason of insanity, but possibly after evaluations performed by forensic psychologists, the strategy changed. Nowak had been charged in 2007 with the attempted kidnapping of another astronaut who was in a relationship with her former lover, a man who was...
also an astronaut. In an incident widely covered and derided in the media, Nowak had driven virtually non-stop some 900 miles over a short period of time, after packing items including a black wig, latex gloves, pepper spray, a drill, and a folding knife.

Albert Crowel was convicted of his third driving-while-intoxicated offense. At the time of the incident, he was driving with a suspended license. He had a 6-year history of substance abuse but had never received treatment for this problem. He also had been convicted of domestic assault, for which he had served a 2-year prison term. In prison, he had participated in a program for violent offenders and had been a model prisoner. At his sentencing hearing, the defense lawyer called to the stand a forensic psychologist who had examined Crowel and concluded that he would be a good candidate for a substance abuse program that was available in the community, on an outpatient basis. The psychologist also reported that he was a very low risk for further violence.

The above three scenarios, reporting on actual court cases, illustrate some of the most common roles performed by psychologists and psychiatrists consulting with criminal courts: competency evaluations, assessment of mental state at the time of the offense (sanity evaluations), and presentencing evaluations. In these roles, the clinicians conduct forensic mental health assessments (FMHAs). By far, the most frequent is the assessment of competency to stand trial, also called adjudicative competence. At the end of the 20th century, it was estimated that some 60,000 criminal defendants were evaluated for this purpose every year (Bonnie & Grisso, 2000); since then, the number has increased steadily given a steady increase in arrest rates (Zapf & Roesch, 2006). Zapf and Roesch also estimate that the cost of both competency evaluations and the treatment to restore individuals to competency probably reaches $1 billion annually. It is important to emphasize, as well, that the term *adjudicative competence* covers not only competency to stand trial, but also competency to waive one's rights, competency to serve as one's own lawyer, and competency to plea bargain, among other “competencies.”

Sanity evaluations—also called criminal responsibility (CR) or mental state at the time of the offense (MSO) evaluations—are believed to be less frequent than competency evaluations. However, many defendants—like Lisa Nowak—indicate they will use the insanity defense and ultimately do not, presumably after evaluations do not support it. CR evaluations also are often combined with evaluations of competency to stand trial. That is, some jurisdictions allow the examiner to evaluate both competency and sanity, although in other jurisdictions this is frowned upon or even forbidden. At sentencing, psychological and psychiatric input is the exception rather than the rule, but it is becoming more common, particularly if the sentencing judge is interested in knowing an offender's amenability to respond well to substance abuse treatment or sex offender treatment. Clinical input is also sought in death penalty cases, particularly when the court wishes to appraise the “dangerousness” of the offender being sentenced.

This chapter will be devoted primarily to these three areas: competency, insanity, and sentencing. Throughout the chapter, we will be referring to the forensic psychologist, but it is important to remind readers that forensic examiners are often psychiatrists or psychiatric social workers. In addition, we will cover the controversy surrounding the civil commitment of sexual predators after they have served their criminal sentences, a topic that reminds us of the interrelationship between criminal and civil courts. It should be noted that an important service provided by forensic psychologists—the assessment of victims of crime—will be covered in Chapters 10 and 11. Before beginning with the main material, though, we will discuss a less traveled area, the bail denial process.

**Preventive Detention**

Because criminal defendants are considered to be innocent until proven guilty in a court of law, there is a presumption that they will be free pending their trial or the final resolution of their case. At their initial appearance or their arraignment, the law allows judges and magistrates to set bail to ensure that the defendant will return...
to court for the next scheduled hearing in the case. Research has consistently shown that the great majority of defendants who are released on bail do return to court (Neubauer, 2002).

The U.S. Constitution does not guarantee a right to bail; it only specifies that the bail must not be excessive (U.S. v. Salerno, 1987). Thus, some defendants are denied bail on the basis of their dangerousness. In most jurisdictions, if an individual is charged with a capital crime (one that carries a possible life sentence or a sentence of death), dangerousness is presumed and bail is usually (but not invariably) denied. However, for a number of violent crimes that are not capital crimes, prosecutors may ask the judge to deny bail. A request like this is not unusual in domestic violence situations, such as when a woman expresses intense fear that the person who allegedly assaulted her will be released prior to trial and may harm her again. In these cases, defendants are entitled to a hearing on the issue of their dangerousness before the presiding judge can deny bail. At the hearing, the prosecutor presents evidence of the defendant’s dangerousness, and the defense lawyer refutes that evidence by cross-examining the prosecution’s witnesses and presenting evidence and witnesses in the defendant’s favor.

Forensic psychologists, then, may be asked to “predict the dangerousness” of the defendant charged with the violent crime. As we discussed in the previous chapter, the preferred term in the psychological literature is risk assessment. In addition to conducting such an assessment and filing a written report, the psychologist may be called to testify during the bail hearing. Risk assessments conducted for bail decision-making purposes are very similar to risk assessments conducted for other release decisions in the criminal justice process. For example, at sentencing, judges often must decide whether to place an offender on probation or send him or her to prison. A risk assessment may also occur when an imprisoned offender has become eligible for parole or early release. Because sentencing will be discussed later in the chapter, we will defer the discussion of risk assessment until that point.

Criminal Competencies

We began this chapter with an illustration of competency to stand trial. In that case, the case of the “20th hijacker,” the defendant was found competent and was ultimately sentenced to life in prison (see Photo 5.1). Approximately 20% of individuals whose competency is questioned are found not competent to stand trial. It should be noted, however, that although courts and statutes continue to use the term competency to stand trial, the psychological research literature is increasingly replacing the term with adjudicative competence (e.g., Mumley, Tillbrook, & Grisso, 2003; Nicholson & Norwood, 2000). This is in response to the theory proposed by Richard Bonnie (1992), who suggests that competency to stand trial must involve both “competency to proceed” and “decisional competency.” As Bonnie has stated, courts thus far have focused almost exclusively on the competence to proceed without thoroughly taking into
account the complex decisional abilities that are required of defendants in a wide variety of contexts—for example, competency to plead guilty, to represent themselves, and to engage in plea bargaining. Bonnie and others (e.g., Mumley et al.) urge psychologists evaluating defendants to consider these abilities very carefully. Thus, the term *adjudicative competence* is increasingly being used in the literature to recognize Bonnie’s important contribution (Mumley et al., 2003).

*Adjudicative competence* also is broad enough to subsume a wide range of abilities defendants are expected to possess. For example, if defendants waive their rights to lawyers, the law says they must be competent to do so. If they plead guilty to a crime—and thereby waive their right to a jury trial with all of the due process protections that a trial entails—they must be competent to do so. It is estimated that 90% of criminal defendants plead guilty rather than going to trial.

Criminal defendants have much to lose in the face of criminal prosecution (e.g., their freedom and sometimes their lives). Therefore, the law guarantees them a number of due process protections, including the right to a lawyer during custodial interrogation, the right to a lawyer at every critical stage of the criminal proceedings, and the right to a jury trial in most felony and some misdemeanor cases. Again, if they waive these rights, they are supposed to be competent to do so. The U.S. Supreme Court has often reiterated that a waiver of constitutional rights must be knowing, intelligent, and valid (e.g., *Fare v. Michael C.*, 1979).

**Legal Standard for Competency**

Due process also requires that defendants not be tried if they do not have a sufficient present ability to help their attorneys and a rational and functional understanding of the proceedings against them. This is the standard for competency to stand trial that was announced by the U.S. Supreme Court in the 1960 case *Dusky v. U.S.* and has been adopted in most states. The Supreme Court ruled in *Dusky* that defendants are competent to stand trial if they have “sufficient present ability to consult with [their] lawyer with reasonable degrees of rational understanding . . . and a rational as well as a factual understanding of the proceedings” (p. 402). Competency requires not only that defendants understand what is happening, but also that they be able to assist their attorneys in the preparation of their defense. This has become known as the *Dusky standard*. The two requirements created a “two-pronged’ standard. However, many clinicians have pointed out that the law does not give enough attention to the level of competency required in a particular case (e.g., Brakel, 2003; Roesch, Zapf, Golding, & Skeem, 1999). For instance, a defendant might meet the standard for competency if charged with retail theft in a straightforward case. The same defendant, charged with manslaughter and facing what is expected to be a protracted trial, might not meet the standard.

The Supreme Court has ruled (*Godinez v. Moran*, 1993) that the *Dusky* standards apply to guilty pleas as well; that is, defendants pleading guilty must have a rational understanding of the court process. Again, some mental health professionals believe that this “one size fits all” approach leaves much to be desired. Guilty pleas, they argue, should be scrutinized very carefully because of their implications. The waiver of a number of constitutional rights that a guilty plea entails requires decisional competence that many defendants simply do not have.

It is not altogether clear whether the unitary standard announced in the *Moran* case applies to proceedings before arraignment or after the verdict (Perlin, 2003). Waivers—and the question of competency—can occur during the police interrogation stage, while police are conducting searches, during lineups, at a sentencing hearing, at a hearing on the revocation of probation or parole, or during the appeals process, for example. The Supreme Court’s opinion did not touch on these, although the concurring opinion of Justice Kennedy suggested that the *Godinez* rule might possibly not apply in these pretrial and after-verdict situations (Perlin, 2003).
In some criminal cases, defendants choose to waive the right to an attorney and to represent themselves, a right guaranteed under the U.S. Constitution (Faretta v. California, 1975) but which is exercised by very few criminal defendants. Alternatively, some defendants choose to ignore the advice of their attorneys and proceed with a defense that the attorney believes is not in their best interest. Two high-profile criminal cases in the 1990s led many scholars to question the wisdom of allowing criminal defendants who are presumably mentally disordered to take such an approach (e.g., Litwack, 2003; Slobogin & Mashburn, 2000). Theodore Kaczynski (the Unabomber) was an apparently delusional defendant who rejected the advice of his attorney to plead not guilty by reason of insanity. He subsequently pleaded guilty and avoided a death sentence, but had he taken his attorney’s advice, he might not have been convicted. Colin Ferguson, who opened fire on a Long Island commuter train, killing six people and injuring many others, was allowed to waive his right to a lawyer and represent himself during his trial.

Many scholars and observers believe that the trial of Colin Ferguson was an embarrassment to our system of justice (Perlin, 1996). Some argue that he was not competent to stand trial; others argue that he was competent to stand trial but not competent to defend himself. Ferguson was evaluated by two psychologists who found him educated and articulate but suffering from paranoid personality disorder (Slobogin & Mashburn, 2000). Nevertheless, they believed he was competent to stand trial under the Dusky standard, and the judge agreed. Ferguson rejected the advice of his attorney that he plead not guilty by reason of insanity, insisted on defending himself, and was allowed to do so. “Ferguson proceeded to represent himself in a fashion that observers unanimously considered bizarre” (Slobogin & Mashburn, 2000, p. 1608). During the trial, he made rambling statements, proposed conspiracy theories, and tried to call President Clinton as a witness. Critics of that trial process (e.g., Perlin, 1996; Slobogin & Mashburn, 2000) believe he was not competent to reject an insanity defense and should not have been allowed to represent himself, although others disagree (e.g., Litwack, 2003). Ferguson is presently incarcerated in the New York prison system, serving life sentences. Over 10 years after the Ferguson case, the Supreme Court ruled that a defendant who was competent to stand trial was not necessarily competent to serve as his own lawyer (See Focus 5.1, Indiana v. Edwards).

**FOCUS 5.1. INDIANA v. EDWARDS**

Ahmad Edwards, an individual with schizophrenia, had a lengthy psychiatric history. In relation to the present case, Edwards had tried to steal a pair of shoes from a department store. In the process, he fired at a security officer and wounded a bystander. He was charged with attempted murder, battery with a deadly weapon, criminal recklessness, and theft.

Edwards’s case illustrates the circuitous route criminal cases can take on the road to the actual trial. The defendant had three different competency hearings; he was found incompetent in the first and was hospitalized for competency restoration. In a second hearing he was found competent, but his lawyer soon asked for another competency evaluation; in a third hearing he was found incompetent, was rehospitalized, and subsequently found competent to stand trial. He then asked to represent himself but was denied the request, was appointed a lawyer, and was ultimately convicted. Edwards appealed to the Indiana Court of Appeals, arguing that his right to represent himself was violated. The court agreed with Edwards and ordered a new trial. The state then appealed to the Indiana Supreme Court, and that court also agreed with Edwards. As a last resort, the state of Indiana asked the U.S. Supreme Court to review the decision, which it agreed to do.
When the case reached the U.S. Supreme Court (Indiana v. Edwards, 2008), the Court ruled that a judge could insist that a seriously mentally ill defendant be represented by a lawyer, even if he was found competent to stand trial; in other words, just because a defendant was competent to stand trial, this did not mean he was competent to represent himself. It is interesting to note, though, that Indiana also asked the Court to allow a unitary standard that would deny criminal defendants the right to represent themselves at trial if they could not communicate coherently with the court or a jury. The Supreme Court rejected that unitary standard, preferring to have judges make the determination on a case-by-case basis, and based on their information and observations of the defendant.

Like most cases that reach the level of the U.S. Supreme Court, the Edwards case is obviously more complex than what we can present here. However, it is now clear that, although defendants still have a constitutional right to self-representation, states can allow judges to deny that right to seriously mentally ill defendants. Had that ruling been in effect at the time of the Ferguson case, described above, one wonders whether the Long Island Railroad trial might have proceeded differently.

The Byron Keith Cooper case provides another sobering illustration of the problems that can occur when the mentally ill are charged with crimes (Cooper v. Oklahoma, 1996). Cooper, charged with the murder of an elderly man, was originally ruled incompetent to stand trial (IST), was treated in a mental institution for 3 months, and then was found competent, although his lawyer had argued that he was not. His behavior during the competency hearing and the trial was bizarre at best. He refused to wear civilian clothes during his trial, claiming that these clothes were burning him, so he wore prison overalls. He crouched in a fetal position and talked to himself during much of the trial. However, the state of Oklahoma required that defendants persuade the court of their incompetence by clear and convincing evidence, and the judge in the case concluded that Cooper had not met that burden (see Focus 5.2 for a review of burdens of proof). The U.S. Supreme Court emphasized that states could require defendants to establish their incompetence by a preponderance of the evidence but no more than that. Cooper's behavior may not have demonstrated his incompetence according to the clear and convincing standard, but it would be difficult to argue that it was not demonstrated by a preponderance of the evidence. In other words, is it more likely than not (the preponderance standard) that Cooper was incompetent to stand trial?

There are several reasons why competency evaluations are so common—recall that approximately 60,000 defendants are evaluated for competency every year. First, questions about a defendant's adjudicative competence can arise at many different stages of the criminal process. In Byron Cooper's case, questions about competence were raised five different times, the last time at his sentencing hearing. The defendant in the Edwards case had had three competency hearings and two hearings on whether he could represent himself at trial. Second, an unknown number of criminal defendants are reevaluated over a period of years because they are charged with additional crimes. In virtually every state, certain defendants charged with misdemeanors or lesser felonies are well-known to both the judicial system and the mental health system. They continually appear before the court, are sent for competency evaluation, are found incompetent (or competent), are hospitalized (or not), have charges dropped (or plead guilty), spend time on probation (or in jail), and go forth into the community until their next criminal charge. The mental health courts mentioned in Chapter 4 are intended to prevent the perpetuation of this revolving door process by diverting nonviolent, mentally disordered individuals from the criminal process and providing community supervision and meaningful treatment. Finally, developments in
forensic psychology itself may explain the frequency of competency evaluations. As we will discuss later in the chapter, the evaluation process has been made considerably simpler with the development of competency assessment instruments and the training of graduate and postgraduate students in making these assessments.

FOCUS 5.2. BURDENS OF PROOF

In adversary proceedings, the final legal decision requires that proof be established at a specified level.

Beyond a Reasonable Doubt

This is the standard of proof required in all criminal proceedings as well as delinquency proceedings when a juvenile is charged with a crime. It is proof that is just short of absolute certainty. “In evidence [it] means fully satisfied, entirely convinced, satisfied to a moral certainty” (H. C. Black, 1990).

Clear and Convincing Proof

This is the standard required in some civil proceedings, such as when the state wishes to commit an individual to a mental hospital against his or her will. It is an intermediate standard, resulting in “reasonable certainty of the truth of the ultimate fact in controversy. Clear and convincing proof will be shown where the truth of the facts asserted is highly probable” (H. C. Black, 1990).

Preponderance of the Evidence

This is proof that one side has more evidence in its favor than the other. It is “evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not” (H. C. Black, 1990). It is the standard required in most civil suits and may be relevant to criminal proceedings as well. For example, when states require criminal defendants to prove they are incompetent to stand trial, they cannot require this by a standard more demanding than the preponderance of the evidence.

Evaluating Adjudicative Competence

Forensic psychologists evaluate defendants for adjudicative competence in a number of different settings. For example, a brief competency screening may be carried out very early in criminal processing while the defendant is being held in jail. Defendants also may be evaluated in the community, on an outpatient basis, while on pretrial release. (See Personal Perspective 5.1, in which forensic psychologist Kirk Heilbrun mentions a clinic in which graduate students are trained for these and other purposes.) Although such outpatient evaluations are on the increase (Roesch et al., 1999), many defendants are evaluated while hospitalized in a public mental facility. In fact, most states either permit or require hospitalization for both the evaluation of competence and the treatment to restore competence (R. D. Miller, 2003). Outpatient evaluation is far more common than outpatient treatment, however. In other words, the estimated 20% of defendants who are found incompetent to stand trial are usually hospitalized for treatment, whether or not they were evaluated in the community.
PERSONAL PERSPECTIVE 5.1

My Life as a Forensic Psychologist

Kirk Heilbrun, PhD

I have always enjoyed the chance to work on diverse tasks. The Boulder model, emphasizing the importance of the clinical psychologist as a scientist-practitioner, offers an ideal framework for this kind of professional diversity. I have been employed in settings that are mostly applied, such as a forensic hospital, a federal prison, and a specialized treatment unit for juveniles. When I worked in those settings, I always tried to be involved in research and writing on the individuals who were assessed and treated, and ideas that occurred to us as we were providing professional services.

For the last 15 years, I have worked in an academic setting—at MCP Hahnemann University, then Drexel University—in Philadelphia. This job has offered me the chance to work in four domains: teaching and training (undergraduates as well as graduate students), research and scholarship, administrative leadership, and forensic practice. These areas often overlap. For example, training graduate students requires teaching courses and seminars, but it also requires research mentorship and clinical supervision.

I constantly look for ways to be as efficient as possible across areas. One of the first goals I set when I arrived at the university in 1995 was to establish a departmentally based forensic assessment clinic that would provide high-quality psychological evaluations to courts and attorneys at reasonable rates, while involving graduate students on a practicum basis in this clinic. This has been accepted well by judges and attorneys in the Philadelphia area, so we have had enough referrals to stay busy without becoming overwhelmed. Doctoral students who take this practicum must also have taken the two-quarter forensic assessment series I teach. This means I have the chance to work with them in the classroom, earlier in their training, and then in the clinic when they have become more advanced. Some students have developed research ideas from their classroom or clinic experience; they may write theses or dissertations using principles of forensic assessment that are taught in the classroom or using archival data collected through the clinic. Graduate students who plan to make forensic assessment a part of their professional lives enjoy the chance to participate in this practicum.

I have also had the opportunity to chair the psychology department for about a decade. This is a challenging and important job that involves the day-to-day tasks needed to run a department, the occasional intensive attention to a crisis, and the predictable yearly tasks such as faculty evaluations and budget planning. It requires

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a broad perspective within psychology, though. Faculty members and students within the department are often quite specialized, and the department chair must know enough about their areas to be able to describe them to a dean or provost. Promoting the department for purposes of university planning or fund-raising means communicating the department’s strengths and needs in language that non-psychologists can understand—and appreciate.

There is some predictability within my professional life, but it is never boring. I have research meetings scheduled weekly on several topics with my graduate student teams and faculty colleagues. I work on clinic cases and supervision two mornings a week. I am in the classroom weekly or twice weekly. I must build in time to run research projects, write papers and chapters, review submissions to journals, and edit drafts of forensic reports. But sometimes the unexpected intrudes. A crisis in the department, a reporter asking for a comment, a colleague requesting a consultation—each can demand thoughtful attention. Being productive means staying busy doing everything you have committed to do, and much of what you are asked to do beyond that, to contribute to your department, university, and profession—and staying interested yourself!

Dr. Heilbrun is Professor and Head, Department of Psychology, Drexel University, and coordinator of the forensic concentration within the doctoral program in clinical psychology. His research and practice interests include forensic mental health assessment, violence risk assessment and management, and diversion of mentally disordered offenders. He enjoys travel, reading, and racket sports.

It should be noted that the persons referred for competency evaluations tend to be those with a past history of mental disorder or those presenting signs of current mental disorders. The typical evaluation is conducted when defendants are deemed mentally disordered, such as suffering from schizophrenia or psychosis (Mumley et al., 2003). Therefore, competency evaluations often are prompted by a defendant’s past history of psychiatric care, institutionalization, bizarre behavior at arrest, or attempt to commit suicide while held in detention. On the other hand, developmental disability, emotional distress, or even advancing age might lead to questions about a defendant’s competence. For example, a defendant charged with vehicular homicide might be so distraught over the incident that she is unable to meet the standard for adjudicative competence. In such situations, the individual is less likely to require hospitalization during the evaluation process.

The request for an evaluation may come directly from the defense attorney or from the court. It is important for psychologists to note the difference. When the defense requests and pays for the evaluation, the client is the person being examined and the report goes to his or her representative, the defense attorney. Depending on the evaluation’s results, the attorney may or may not share the report with the prosecutor. When the evaluation is court ordered, even if ordered at the request of the defense attorney, the client is the court. Motions for court-ordered examinations may be made by the defense attorney (whose client is unable to pay for a private evaluation), the prosecutor, or the judge. The examiner should expect that the report of a court-ordered evaluation will be shared among all parties.

Research indicates that most competency evaluations are court ordered and that no more than one evaluation is performed (Melton et al., 1997, 2007), although some jurisdictions do require at least two evaluations. And, in high-profile cases, such as the kidnapping of Elizabeth Smart mentioned in Chapter 4, or in cases that
might involve a life sentence or the death penalty, competing evaluations are more likely. When there are no opposing experts, though, judges almost always accept the recommendation of clinicians conducting the evaluation (Cruise & Rogers, 1998; Melton et al., 1997). Some researchers report agreement rates well over 90% (Cruise & Rogers, 1998; Zapf, Hubbard, Galloway, Cox, & Ronan, 2002). In at least this pretrial context, therefore, clinicians seem to have considerable influence on the courts. However, competency evaluations, like many other forensic mental health assessments, raise the “ultimate issue” question discussed in Chapter 4. Competency is a legal issue, not a clinical issue, and there continues to be debate over whether a psychologist should express an opinion as to whether the defendant is competent to stand trial.

As in all forensic mental health evaluations, the assessment of adjudicative competence should begin with a notice to the person being evaluated of the limits of confidentiality and the purpose of the evaluation (see Focus 5.3 for a list of factors common to all evaluations; see also Heilbrun, Grisso, & Goldstein, 2009). As noted above, unless the psychologist is hired directly by the defense attorney for an appraisal of his or her client’s competency and general mental status, the competency report will be shared among the attorneys and the presiding judge. For this reason, examiners are often reminded to carefully limit the report to the defendant’s present status and not to include information that might provide details about the crime itself (Grisso, 1988; Roesch et al., 1999).

Examiners are also warned about avoiding the dual relationship of evaluator and treatment provider. If a psychologist has been seeing the defendant in a therapist–patient relationship or has any other prior relationship with the defendant, the psychologist should not examine the defendant for adjudicative competence. Recall from Chapter 1 that dual relationship still remains a contentious issue among some forensic psychologists, however.

The examination process itself varies widely according to the examiner’s training and theoretical orientation. As Cruise and Rogers (1998) stated, “There is no clear consensus on a standard of practice for competency evaluations” (p. 44). Some examiners conduct only a clinical interview, whereas others conduct an interview and administer a variety of projective or objective tests. Other examiners file a generic report that includes behavioral observations of the defendant and extensive background information. Traditionally, competency evaluations tended to include a good deal of information that was irrelevant to the issue of whether the defendant was competent to stand trial (Grisso, 1988). In recent years, with more guidance provided to clinicians, misconceptions about competency evaluations have lessened, and reports have improved in quality (Roesch et al., 1999).

**FOCUS 5.3. FACTORS COMMON TO FMHAs**

Although forensic mental health assessments (FMHAs) are conducted for a wide variety of reasons, they have at least the following features in common:

Before meeting with the person being assessed, the examiner should

- Understand the purpose of the referral;
- Decline to conduct the evaluation if there is a conflict of interest or if the examiner has ethical or moral objections to participating;
- Gather background information and records when available;
- Be knowledgeable about the law relative to the assessment;
- Clarify and agree on the time and method of payment;
- Clarify when a report is needed and to whom it should be submitted.

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Before conducting the evaluation, the examiner should

- Explain its purpose to the person being evaluated;
- Stress that this is not a treatment relationship;
- Explain the limits to confidentiality;
- Warn the examinee of the possible uses of the examination;
- Tell the examinee who will be getting copies of the report;
- Obtain the examinee’s written consent, if consent is needed.

The examiner’s written report should

- Be clearly written and free of slang or excessive “jargon”;
- Be submitted within a reasonable time after the evaluation has been completed;
- State the purpose of the report, identify the legal issues, and note who requested the report;
- Specify documents reviewed and any tests/inventories that were administered;
- State clearly the basis for any conclusions reached;
- Be submitted with an awareness that a variety of individuals will see the report.

**Competency Assessment Instruments**

Over the past 20 years, researchers have developed and attempted to validate a variety of instruments for the assessment of competency to stand trial. Some are screening instruments generally taking under 30 minutes to administer, whereas others are more elaborate instruments based on both interviewing and test administration. Screening instruments serve as quick appraisals to determine if someone is potentially incompetent; if so, they are then referred for a more extensive examination. Also available is a computer-assisted tool—the CAD-COMP (Computer-Assisted Competence Determination of Competency to Proceed)—which is heavily based on the defendant’s self-reports of his or her background, legal knowledge, and behaviors (Barnard et al., 1991). Zapf and Viljoen (2003) and Zapf and Roesch (2006) have provided recent reviews of these assessment instruments. Although we do not provide a comprehensive review here, we will discuss a few of the instruments for illustrative purposes.

The **Competency Screening Test** is a sentence-completion test that is intended to provide a quick assessment of a defendant’s competency to stand trial. The test taps the defendant’s knowledge about the role of the lawyer and the rudiments of the court process. For example, defendants are asked to complete the following: “When a jury hears my case, they will . . .” If defendants score below a certain level, they are evaluated more completely. The test’s main advantage is the ability to screen out quickly the obviously competent defendants. According to Roesch et al. (1999), the test has a high false-positive rate (53.3%), identifying many competent defendants as incompetent. Because persons so identified in a screening test are likely to be hospitalized for further evaluation, this presents a significant deprivation of liberty for the defendant who would otherwise be free on bail. On the other hand, some defendants unable to post bail might prefer the security of a hospital to the chaos and crowded conditions of some jails. Nevertheless, hospitalization is no bargain.

The **Georgia Court Competency Test (GCCT)** and its Minnesota State Hospital revisions (GCCT-MSH) have received mixed reviews. These are short tests—17 and 21 items, respectively—that some examiners
prefer to use primarily as a screening mechanism. The GCCT apparently has good internal consistency and interrater reliability, and it has a promising screen for malingering or feigning incompetence (Gothard, Rogers, & Sewell, 1995). Internal consistency refers to the degree to which all items on a particular test measure the same thing. Interrater reliability refers to the extent to which different examiner or test administers agree with the ratings in judging a person's abilities or characteristics. However, the test has been criticized for its lack of addressing decisional competency (Zapf & Viljoen, 2003)—in other words, how well a person can make important decisions.

The MacArthur Foundation Research Network on Mental Health and the Law initially developed the MacArthur Structured Assessment of the Competencies of Criminal Defendants (MacSAC-CD) (Hoge et al., 1997). This was a rather cumbersome research tool that led to a shorter instrument, the MacArthur Competence Assessment Tool—Criminal Adjudication (MacCAT-CA), containing 22 items. Defendants are provided with a vignette describing a situation in which a person is charged with a crime and are asked questions about it. They are also asked questions about their own situation. Shortly after its introduction, the MacCAT-CA began to receive good reviews as being superior to other assessment instruments (Cruise & Rogers, 1998; Nicholson, 1999; Zapf & Viljoen, 2003).

Despite the continuing development of forensic assessment instruments, they do not appear to be widely used in forensic practice, particularly by practitioners who serve as occasional experts (Skeem, Golding, Berge, & Cohn, 1998). A study by Borum and Grisso (1995) indicated that 36% of psychologists in their sample never use such forensic assessment instruments, whereas 40% use them almost always or frequently, a finding that—according to Zapf and Roesch (2006)—indicated a slow increase. The research literature tends to support the use of these instruments, both for their efficiency and for the fact that trained examiners, using the instruments, achieve a high level of interexaminer reliability (Zapf & Roesch, 2006).

**Assessment of Malingering**

Virtually every type of forensic mental health assessment requires some appraisal of possible malingering (or faking) on the part of the person being evaluated. For a variety of reasons, criminal defendants may pretend they have symptoms of a serious disorder when they actually do not. Rogers (1997) has described malingering as a response style in which the individual consciously fabricates or grossly exaggerates his or her symptoms. He observes that this is understandable in the light of the individual's situation. The obvious example is the offender who pretends to be mentally ill, believing that the judge is less likely to sentence him to prison. In the competency context, a defendant may pretend to have symptoms of a mental disorder to postpone the trial or avoid going to trial altogether. Although we discuss malingering in this chapter, it should not be assumed that this problem is limited to the criminal context. As we will note in Chapter 6, individuals being assessed in civil cases may be equally motivated to feign symptoms.

Forensic psychologists have at their disposal a variety of validated tests for detecting malingering. The Structured Interview of Reported Symptoms (Rogers, 1992) is a well-regarded instrument for detecting the malingering of psychotic symptoms. Another example is the Test of Memory Malingering (Tombaugh, 1997). In addition, some commonly used psychological tests, such as the Minnesota Multiphasic Personality Inventory (MMPI-2) and the Millon Clinical Multiaxial Inventory—III (Millon, 1994), as well as some forensic assessment instruments (e.g., the Rogers Criminal Responsibility Assessment Scales [R-CRAS]), also have power to detect malingering. There is, though, no foolproof way to detect malingering (Butcher & Miller, 1999). As Heilbrun et al. (2002) assert, it is important for the clinician to use multiple measures rather than one or two tests to assess this.
Restoration to Competency

Research indicates that approximately 15 to 20% of defendants referred for competency evaluations are ultimately found incompetent. Persons found incompetent tend to be those with a history of institutional treatment or diagnosis of a serious mental disorder. Research also suggests that a clinical diagnosis, when included in a competency evaluation report, is a strong predictor of a finding of incompetence (Cochrane, Grisso, & Frederick, 2001). Interestingly, forensic examiners are often advised not to include diagnoses in their reports (Golding & Roesch, 1987; Grisso, 1986). The diagnosis may not be accurate, and even if it is, it is subject to misinterpretation on the part of persons not trained as mental health practitioners.

The majority of persons found incompetent to stand trial are those suffering from schizophrenia and psychotic symptoms (Morse, 2003). Although mental disorder seems to be a requirement for most incompetency determinations, mental disorder itself—even serious mental disorder—is not sufficient. Andrea Yates, a woman who drowned five of her children in a bathtub in 2001 and whose case was publicized widely, had a long history of mental disorder. Yet she was found competent to stand trial and was convicted in a first trial. (The conviction was later overturned, and she then was found not guilty by reason of insanity. She remains institutionalized in a psychiatric facility.) Once an individual has been found incompetent to stand trial (IST), efforts are made to restore the person to competence to bring him or her to trial. Clinicians typically are asked to make some assessment of the likelihood that an individual will be restored to competency. If restoration is highly unlikely, the state must decide whether to drop the criminal charges and, if necessary, initiate involuntary civil commitment proceedings.

Every state has its examples of defendants who were found incompetent to stand trial and who are held in institutions for seemingly very lengthy periods. In the federal system, we have the example of Russell Weston, charged in the deaths of two Capitol police officers in July of 1998. As of this writing, 13 years after the fact, Weston remains hospitalized and has not been brought to trial. The U.S. Supreme Court did place a limit on this practice, ruling in Jackson v. Indiana (1972) that incompetent defendants could not be held indefinitely if there was no likelihood that they would be restored. However, they can be subjected to civil commitment, as mentioned above. In most states, periodic hearings are held to assess an incompetent defendant’s status; defendants are kept institutionalized as long as some progress is being made. Some states do not allow incompetent defendants to be held for longer than the maximum sentence they would have served had they been convicted. Research suggests that the average period for inpatient treatment is 6 months, but many defendants are held for much longer periods (R. D. Miller, 2003).

Restoration of competence need not be done in an institution. Like competency evaluations, treatment for incompetent defendants can be provided in community settings. In fact, many legal commentators as well as clinical practitioners believe that outpatient treatment rather than institutionalization should be made available to more defendants found IST (R. D. Miller, 2003; Roesch et al., 1999). R. D. Miller surveyed mental health program directors across the United States and found that, though outpatient evaluation was on the increase, outpatient treatment to restore competence was rare: “Despite the availability of outpatient treatment, few states utilize it very often” (p. 384). Miller found that 18 states required the hospitalization of incompetent defendants and 21 permitted it, but without specific criteria for doing so. In five states, incompetent defendants had to meet civil commitment criteria before they could be hospitalized. In 21 states, there were no effective time limits on hospitalization, whereas in 11 states, the limit was between 1 and 5 years.

R. D. Miller (2003) notes that the length of stay for forensic patients—such as those found incompetent to stand trial or not guilty by reason of insanity—is measured in months or years, but the length of stay for non-forensic civil patients is measured in days or weeks. Thus, although most states have made significant
progress in “deinstitutionalizing” those with mental disorders, the liberty interests of forensic populations remain unacknowledged. Although conceding that some defendants clearly need hospitalization for both evaluation and—if found incompetent—for treatment, Miller notes that hospitalization is overused: “For defendants who have demonstrated their ability to remain safely in the community before determination of their competence, there is little justification for hospitalization” (p. 386).

According to Roesch et al. (1999), “The disposition of incompetent defendants is perhaps the most problematic area of the competency procedures” (p. 333). Many researchers have observed that, although restoration to competency is the intent, IST defendants are rarely treated differently from other hospitalized populations (Siegel & Elwork, 1990). For the IST defendant, however, restoration should focus not only on his or her decisional capacities, but also on his or her understanding of the criminal process. In other words, depending on the defendant’s individual situation, restoration may require education about the legal system. To illustrate, we will use the example of a defendant who is intellectually disabled and has been found incompetent to stand trial.

In recent years, much attention has been given to the plight of individuals with developmental or intellectual disabilities, still termed “mental retardation” (MR) in much of the literature, who are arrested and processed by the criminal justice system. Intellectual disability does not guarantee that an individual will not be held responsible for a crime; indeed, prisons and jails in the United States are believed to hold a substantial number of convicted offenders who are intellectually disabled. Furthermore, as Zapf and Roesch (2006) have noted, persons with mild disability may try to “hide” it, even from their lawyers. Thus, the issue is not raised either in pretrial evaluations or in mitigation for the offense, if they are convicted.

However, when individuals with developmental disabilities are found incompetent to stand trial, restoration is unlikely to occur because of the chronicity of their condition. S. D. Anderson and Hewitt (2002) reported on an education program in Missouri that specifically addressed the restoration needs of these defendants. The program consisted of a series of classes in which defendants learned about the legal system and participated in role-playing activities. The competency training had very little success, with only one-third of all defendants restored to competency. The defendant’s IQ contributed to the outcome, but the IQ score was just short of reaching statistical significance. According to the researchers, “Persons with certain levels of MR may inherently lack the skills needed to actively participate in trial proceedings. Abilities such as abstract reasoning, decision-making, and so forth are not only difficult to teach but are extremely difficult to learn” (p. 349). Once again, this speaks to the importance of mental health courts and their ability to divert some individuals from the criminal process.

Although states vary in their approaches to restoring competency, the most common means of doing this appears to be through medication (Roesch et al., 1999). Psychoactive drugs are widely administered in the efforts to restore competency. In fact, in the study mentioned above, S. D. Anderson and Hewitt (2002) noted that—before a special program was initiated—defendants with intellectual disability had been treated with psychoactive medication just like other IST defendants. In recent years, the involuntary administration of these drugs has received considerable national attention. Both a high-profile case involving the alleged shooter of Capitol police officers (the Weston case) and the U.S. Supreme Court case Sell v. United States (2003) revolved around this issue.

**Drugs and the Incompetent Defendant**

Antipsychotic or psychoactive drugs have improved significantly in effectiveness, but they still may produce unwanted side effects, including nausea, headaches, loss of creativity, inability to express emotions, and lethargy in some individuals. In one key case that reached the U.S. Supreme Court (Sell v. United States), a defendant
found incompetent to stand trial refused to take antipsychotic medication that was intended to restore him to competency. Charles Thomas Sell was a former dentist charged with fraud, and he had a history of mental disorder and bizarre behavior, including once calling police to report that a leopard was boarding a bus. During an earlier period of hospitalization he had taken antipsychotic medication. Sell’s case proceeded through a number of administrative and court hearings. Staff at the federal medical facility, as well as a federal magistrate, determined that he was dangerous to others and therefore required involuntary medication. He had apparently become infatuated with a nurse and had inappropriately accosted her, though he had not physically harmed her. A district court judge and the 8th Circuit Court of Appeals both ordered the medication on different grounds. These courts did not consider him dangerous, but they did approve the forced medication to render him competent to stand trial.

In 2003, the U.S. Supreme Court sent the case back for further inquiry (Sell v. United States, 2003). According to the Justices, Sell’s dangerousness had not been established, a fact that had been noted by the federal district court and the court of appeals. However, those lower courts had not sufficiently reviewed the possible trial-related risks and side effects of the medication. “Whether a particular drug will tend to sedate a defendant, interfere with communication with counsel, prevent rapid reaction to trial developments, or diminish the ability to express emotions are matters important in determining the permissibility of medication to restore competence,” the Court said.

Sell’s alleged crimes (Medicaid fraud, mail fraud, and money laundering) were not violent. However, the crimes allegedly committed by Eugene Russell Weston, the shooting death of two Capitol police officers and the wounding of two others in the summer of 1998, were. Like Sell, Weston had a history of mental disorder that included serious delusional symptoms. Like Sell, he was found incompetent to stand trial and, like Sell, he resisted taking the medication that was intended to restore him to competence. He languished in federal detention for 3 years, unmedicated, while his lawyers argued before various courts that he should not be forced to take medication against his will. In July 2001, a federal court of appeals ruled that the government’s strong interest in bringing this defendant to trial overrode his right to remain free of psychoactive drugs and therefore allowed the medication. The Supreme Court refused to hear the case, leaving the decision of the lower court standing.

Although some might wonder if the Court would rule differently today, in light of its decision in the Sell case, there are distinguishing features. Weston’s alleged crime, the nature of his illness, and his past violent behavior all suggest that he is a probable threat to others. Furthermore, the crime of which he is charged—murder—is a capital offense, one that the government has a strong interest in prosecuting. More important, though, the court in Weston’s case carefully considered the side effects of the medication and was careful to note that heightened scrutiny was required before forcing medication on incompetent defendants. Significantly, 13 years after the offense, Weston remains hospitalized and medicated and has yet to be tried. In another high-profile case, the kidnapping of Elizabeth Smart discussed in Chapter 4, codefendant Wanda Barzee was initially found incompetent to stand trial. A judge ordered her to be forcefully medicated, and she subsequently chose to plead guilty rather than go to trial. She is now serving 15 years in prison.

The medication controversy extends to the trial process itself. Although defendants often respond well enough to medication to render them competent to stand trial, continual medication during the trial itself is often, if not invariably, warranted. In other words, to remain competent, the defendant must continue to be medicated. Yet the medication itself may affect the defendant’s ability to participate in the proceedings, as the Supreme Court observed in the Sell case. Medication also creates an interesting conundrum for defendants who have raised an insanity defense. We will return to this issue later, after introducing the concept of insanity and its assessment.
Insanity

A person cannot be held responsible for a crime if he or she did not possess the “guilty mind” that is required at the time the criminal act was committed. The law recognizes a number of situations under which the guilty mind is absent. For example, if a person acts in self-defense, believing he or she is in imminent danger of grave bodily harm, that person will not be held responsible provided a judge or a jury agrees with his or her perceptions. Likewise, if a defendant charged with sexual assault can convince a judge or jury that the alleged victim consented to the sexual activity, he or she will not be held responsible. When it is mental disorder that robs the individual of a guilty mind, the law refers to this as insanity.

The distinction between insanity and competency to stand trial is crucial. Competency refers to one’s mental state at the time of the criminal justice proceedings (e.g., when waiving the right to a lawyer, pleading guilty, standing trial). Sanity (or criminal responsibility) refers to mental state at the time of the crime. It is possible for a person to be insane yet competent to stand trial or sane but incompetent. Obviously, it is also possible for people to be both insane and incompetent or sane and competent. Furthermore, in contrast to competency to stand trial, where the Dusky standard is universal, there is no uniform standard for determining insanity. Federal courts and state courts use a variety of “tests” for this purpose, a common one being knowledge of the difference between right and wrong. In some states, even if a person knows the difference between right and wrong, the evidence of an inability to conform his or her conduct to the requirements of the law will suffice. For example, in these states a person who—as the result of a mental disorder—is compelled by “voices” to kill his victim could be excused. The U.S. Supreme Court has given wide latitude to states to decide their own insanity standards (see Focus 5.4).

Over the past 20 years, changes in the federal law as well as the law in numerous states have made it more difficult for defendants pleading not guilty by reason of insanity to win acquittal. The following are examples of why this defense has become more difficult:

- The federal government and some states now no longer allow defendants to claim they could not control their behavior; if they knew the difference between right and wrong, they can still be held responsible.
- The federal government and most states now require defendants to prove their insanity by a preponderance of the evidence.
- A minority of states abolished the insanity defense.
- In federal courts and in some states, forensic examiners are not allowed to express an ultimate opinion on whether the defendant was insane.

Interestingly, research indicates that juries sitting on cases involving the insanity defense very rarely apply the tests for insanity, so changes in the tests may not be that significant. Rather, insanity cases appear to be decided more on moral grounds or on what jurors believe is the “right” decision rather than on correct legal grounds. In her first trial, Andrea Yates was found guilty of killing her children despite evidence of a long history of psychiatric disorder. There are clearly exceptions, though. John Hinckley was tried in the attempted assassination of President Ronald Reagan and the shooting of his press secretary, James Brady, in 1980. The federal jury carefully applied the federal standard that was in effect at that point in time, and it found Hinckley not guilty by reason of insanity.

It should be noted that cases in which defendants actually plead not guilty by reason of insanity are rare, comprising a mere 1 to 3% of all criminal cases (Golding, Skeem, Roesch, & Zapf, 1999). Furthermore, despite media publicity surrounding the insanity defense—one commentator (Perlin, 2003) has referred to it as the “media darling”—the defense is usually not successful. Most defendants who argue that they were not
criminally responsible are found guilty, which may be one reason why individuals who initially indicate they will use the defense change their mind.

The rates of acquittal vary widely by jurisdiction, though. Some multistate surveys have found acquittal rates of 20 to 25% (Cirincione, Steadman, & McGreevy, 1995). Although a “success” rate of 1 in 4 may surprise some observers, acquittal does not bring freedom to NGRI defendants. The defense may be used in both misdemeanor and felony cases, and it is sometimes used to obtain treatment for an individual who might not otherwise qualify for civil commitment. Consider the following example.

A person who is mentally disordered breaks into a home to obtain shelter for the night (breaking and entering). Because he is not a danger to himself or others, nor is he gravely disabled, he would not be eligible for involuntary hospitalization. Charged with a crime, though, he may be referred for a competency evaluation. The evaluation allows his hospitalization for at least a temporary period, which may be sufficient to stabilize his mental disorder. Returned to court, he is found competent, but his attorney wonders whether a defense of not guilty by reason of insanity could be supported. The defendant is returned to the hospital for another evaluation, which concludes that such a defense could indeed be supported. The prosecutor and defense attorney stipulate to the report (accept its findings), and the judge enters a not-guilty verdict. The acquitted individual then may be returned to the hospital for more treatment. Such “backdoor” commitments are believed to be common in many communities where community mental health services and resources for the mentally disordered are not available.

In approximately 13 states, an alternative verdict of guilty but mentally ill can be returned. This interesting but troubling verdict form allows judges and jurors a middle ground, supposedly reconciling their belief that the defendant “did it” with their belief that he or she “needs help.” It makes little difference in the life of the person who obtains this verdict, however. Defendants found guilty but mentally ill are still sent to prison and are no more likely to receive specialized treatment for their disorder than other imprisoned offenders (Borum & Fulero, 1999; Bumby, 1993; Zapf, Golding, & Roesch, 2006).

Assessment of Criminal Responsibility

The evaluation of a defendant’s criminal responsibility at the time of the crime is widely recognized by clinicians as an extremely complex one. Note that it is, by definition, retrospective. The clinician must look back and attempt to gain some understanding of the defendant’s state of mind at the crucial point in the past when the crime was committed. This may be weeks or even months after the event itself. According to Golding et al. (1999), the clinician must determine whether and what sort of disturbances existed at the behavioral, volitional, and cognitive levels and clarify how those disturbances relate to the criminal act. Melton et al. (1997) have likened the clinician’s role to that of an investigative reporter, who gathers information and documents from a wide variety of sources. Likewise, D. L. Shapiro (1999) notes that in addition to a clinical interview, the evaluator should obtain copies of police reports, hospital records, statements of witnesses, any past psychological tests, and employment records, if possible.

All of the cautions mentioned in our discussion of competency evaluations (and the principles in Focus 5.3) apply here as well. One point on which clinicians seem to lack consensus, though, is the appropriateness of conducting dual-purpose evaluations. It is not unusual for clinicians to conduct evaluations of a defendant’s competency to stand trial and criminal responsibility at the same time. In fact, statutes in many states encourage this practice. Judges will frequently order both a competency evaluation and a criminal responsibility evaluation “to see whether an insanity defense could be supported.” In one study (Warren, Fitch, Dietz, & Rosenfeld, 1991), 47% of competency evaluations also addressed questions of sanity. Although this seems like an efficient and cost-saving practice, it poses problems, and some scholars have been extremely critical of the
process (e.g., Roesch et al., 1999). They emphasize that competency and criminal responsibility are very separate issues requiring separate determinations. According to Roesch et al., it is “cognitively almost impossible” for a judge to keep them distinct when the reports are combined. In addition, an evaluation of criminal responsibility is likely to include a good amount of background information that should be irrelevant to the limited question of whether the defendant is competent to stand trial.

Clinicians have access to forensic assessment instruments similar to those discussed in the competency evaluation process to help in their CR evaluations. By far, the most dominant are the Rogers Criminal Responsibility Assessment Scales (R-CRAS), developed by Richard Rogers (1984). (Dr. Rogers is featured in Personal Perspective 6.2.) Defendants are rated on a number of characteristics, including psychopathology, reliability of their report of the crime, organicity, cognitive control, and behavioral control. Rogers has used a quantitative approach and notes that the R-CRAS has been validated through a series of empirical studies (Rogers & Sewell, 1999; Rogers & Shuman, 1999).

A second instrument, the Mental State at the Time of the Offense Screening Evaluation (MSE; Slobogin, Melton, & Showalter, 1984), is, as its name implies, a way of both screening out the clearly not insane as well as screening in the “obviously insane” (Zapf et al., 2006). Compared with the R-CRAS, the MSE has received less research attention. Zapf et al. report that there have not been any published studies of its reliability, although its validity was established by Slobogin et al.

The use of instruments for assessment of criminal responsibility may be on less solid ground than the use of instruments to assess competency (Grisso, 1996; Nicholson, 1999). Far more research has been conducted on competency assessment, and the Dusky standard has remained relatively stable through the years. As we noted earlier, the MacCAT-CA in particular shows promise as an instrument that will take competency assessment to a higher level. In light of their complexity and the wide range of information that must be obtained in sanity assessments, however, the greatest use of assessment instruments may be as screening measures (e.g., the MSE) or as supplementary information to a more comprehensive examination procedure.

**Insanity Trials**

Once a defense attorney has received a clinician’s report suggesting that an insanity defense could be supported, the attorney hopes for a verdict that his or her client is not guilty by reason of insanity. As in the competency context, this is a legal decision, not a clinical decision, and it is one that must be rendered by a judge or a jury. Research indicates that judges are far more sympathetic to the insanity defense than are juries, so a bench trial is more likely to result in a not-guilty verdict than a jury trial (Callahan, Steadman, McGreevy, & Robbins, 1991). Juries also have been found to have many negative attitudes toward, as well as misconceptions about, the insanity defense (Bailis, Darley, Waxman, & Robinson, 1995; Golding et al., 1999; Perlin, 1994). They often do not realize, for example, that defendants found NGRI do not often “go free,” but are subject to civil commitment and hospitalization.

The most difficult insanity cases are those in which defendants are charged with serious crimes and go to trial. A critical issue that has emerged in recent years pertains to the case of the medicated defendant. As we noted earlier, defendants found incompetent to stand trial are typically given psychoactive medications to restore them to competency. However, to maintain trial competency, defendants may need continued medication. Thus, during their trials, juries see them in a calm, often emotionless state that is far different from the mental state they claim they were in at the time of the crime. Recall that the Supreme Court expressed some concern about this in the Sell case. In an earlier case, the Court had ruled that defendants claiming an insanity defense have a right to be seen by a judge or jury in their natural, unmedicated state (Riggins v. Nevada, 1992).
FOCUS 5.4. **CLARK v. ARIZONA (2006): RECENT DECISION ON INSANITY DEFENSE**

On June 21, 2000, Officer Jeffrey Moritz of the Flagstaff, Arizona, Police Department responded to citizen complaints that a pickup truck with loud music blaring was circling a residential block. When he located the truck, Moritz pulled over Eric Clark (age 17). Within a minute of the traffic stop, Clark shot the officer, who died soon after calling for police backup. Clark ran off on foot but was arrested later that day and was charged with first-degree murder for intentionally and knowingly killing a police officer in the line of duty. Clark was first found incompetent to stand trial and committed to a mental hospital. Two years later, the trial court found his competence restored and ordered him to be tried.

Clark, who had been diagnosed with paranoid schizophrenia, argued that he was mentally ill at the time of the crime and believed that Flagstaff had been taken over by hostile aliens. Arizona had adopted a variant of the *M’Naghten standard* for determining insanity. Although the state had originally used the two-pronged *M’Naghten* standard, it had recently dropped the first component, which stipulates that a person must be able to understand what he is doing—or appreciate the nature and quality of his actions. This “cognitive capacity” element is no longer part of Arizona law. Under current law, an individual was insane only if he was unable to understand that his actions were wrong, a so-called “moral incapacity” standard. A jury apparently believed that Clark understood that his actions were wrong and convicted him of first-degree murder. He was sentenced to 25 years to life in prison.

In appealing his conviction, Clark argued that Arizona’s elimination of the first part of the traditional *M’Naghten* test violated his due process rights. On June 29, 2006, the U.S. Supreme Court ruled in favor of Arizona by a 5-to-4 vote. The Court held that the abbreviated version of the *M’Naghten* standard was within the state’s right, as no universal standard of what constitutes insanity has been established. In other words, there is considerable disagreement on the insanity defense. In essence, the Court affirmed that insanity standards are substantially open to state choice (DeMatteo, 2007b). The American Psychological Association, however, felt that the Court missed the opportunity to establish a Constitutional rule that precludes punishing an offender who, because of mental illness, lacked rational appreciation of his criminal conduct (DeMatteo, 2007b).

The case highlights the need for forensic psychologists and psychiatrists to be highly familiar with the standards for insanity in the states in which they practice. Fine distinctions such as the one illustrated in *Clark v. Arizona* may be relevant in choosing assessment measures as well as questions to be addressed to the defendant who is being examined.

**Treatment of Defendants Found Not Guilty by Reason of Insanity**

When a defendant is found not guilty by reason of insanity, he or she will rarely be free to go. All states and the federal government allow a period of civil commitment in a mental institution or, less frequently, on an outpatient basis. In practice, hospitalization is the most common outcome of a finding of not guilty by reason of insanity, and also in practice, numerous individuals found NGRI are hospitalized for longer than the time they would have served had they been convicted (Golding et al., 1999). John Hinckley, found NGRI
after shooting President Ronald Reagan and seriously wounding Press Secretary James Brady, has remained hospitalized for about 30 years, although he has been allowed visits to his parents’ home in nearby Virginia (see Photo 5.2).

Civil commitment cannot be automatic, however. A hearing must be held to document that the individual continues to be mentally disordered, in need of treatment, and a danger to the self or others. Commitment also cannot be indeterminate, without periodic reviews of the need for commitment. Most states require NGRI patients to prove they are no longer mentally ill and dangerous in order to be released. However, an individual cannot be held solely based on dangerousness if there is no longer evidence of mental illness (Foucha v. Louisiana, 1992). The exception may be the case of sexually violent predators, who we will discuss later in the chapter.

Recall that persons found incompetent to stand trial are hospitalized with the goal of being restored to competency, so that the legal process may continue. Especially in serious cases, the state has a strong interest in bringing them to trial. In the case of persons found NGRI, the state cannot retry them—this would be an example of double jeopardy, which is in violation of the Constitution. Thus, if they are institutionalized, they receive treatment that is usually indistinguishable from the treatment received by other hospitalized patients. In recent years, some states have crafted programs that are particularly directed at persons found NGRI, both in forensic hospitals and in community settings. Furthermore, aware that many insanity acquittees have “significant lifelong psychopathological difficulties” (Golding et al., 1999, p. 397), some states discharge individuals on a conditional basis and provide follow-up and monitoring services in the community. We will discuss outpatient commitment for a variety of individuals in more detail in the following chapter.

**Sentencing Evaluations**

Criminal sentencing in the United States went through a period of “reform” during the last quarter of the 20th century. Until that time, sentencing was primarily indeterminate, with offenders being sent to prison for a range of years (e.g., 5 to 10). Indeterminate sentencing was based on a rehabilitative model of corrections; it was assumed that prisoners would be provided with rehabilitative services while in prison and that they would be released when they had made sufficient progress. Alternatively, offenders could be placed on probation to serve their sentences in the community, but again with the assumption that rehabilitation would be offered.
The psychologist or psychiatrist might be asked to evaluate the offender and offer a recommendation for treatment, which would then be forwarded to correctional officials.

Although rehabilitation remains an important consideration, it is no longer the dominant consideration in the sentencing schemes of the federal government or approximately 15 states today. These jurisdictions have adopted determinate sentencing, which attempts to make the punishment fit the crime and have an offender serve the sentence he or she supposedly deserves, regardless of individual characteristics and the extent to which rehabilitation is accomplished. The sentencing discretion provided to the judge in these states is usually quite limited; judges are usually provided with guidelines that take into consideration the seriousness of the crime and the individual's prior record in determining the appropriate sentence. Additional factors—such as the offender's age or the extent to which he or she might be a good candidate for a particular program—are not taken into account at sentencing. For this reason, the psychologist's role in recommending rehabilitation strategies has been diminished in these states.

In determinate sentencing states, though, courts may consider evidence of diminished mental capacity or extreme emotional distress and may reduce the sentence that would otherwise be imposed. In addition, psychologists may be called on to assess risk or to testify as to whether the individual might benefit from specific types of treatment, such as substance abuse, anger management, or sex offender treatment. In short, sentencing evaluations may focus on treatment needs, the offender's culpability, or future dangerousness (Melton et al., 1997).

Regardless of whether the jurisdiction has determinate or indeterminate sentencing, however, the forensic psychologist might be called in to assess an offender's competency to be sentenced. There is very little literature on this as a separate competency assessment, and we have virtually no information on how often it occurs.

In those states where indeterminate sentencing is still in effect, the psychologist may still play a crucial role. The defense attorney is the legal practitioner who is most likely to contact the clinician. The attorney is attempting, in this context, to craft the best sentencing package for his or her client. Thus, a lawyer trying to keep his or her client in the community rather than imprisoned might offer to the court a report from a forensic psychologist suggesting that the client would likely benefit from substance abuse treatment, which is only intermittently available in the state prison system.

**Risk Assessment**

Clinicians are now being called in frequently to assess the offender's dangerousness to society. As we noted at the beginning of the chapter, such risk assessments may occur very early in the criminal justice process, when a decision is being made whether to deny bail to a defendant who has been charged with a violent crime and would allegedly be dangerous if released. Furthermore, as discussed in Chapter 4, many clinicians today see their task as one of assessing risk rather than predicting dangerousness. This is to emphasize that human behavior, including that which is violent, cannot be comfortably predicted. Rather, the best a clinician can do is assess probabilities based on a variety of factors in the individual's unique situation. Risk assessments are useful to the courts in deciding whether an individual should remain in the community.

Heilbrun et al. (2002) emphasize the importance of clarifying the purpose of the risk assessment, as in all forensic mental health assessments. They note that the clinician must ascertain “whether the purpose . . . is to predict future behavior (e.g., provide a classification of risk or a probability of the likelihood of future violence), to identify risk factors and include recommendations for reducing risk, or both” (p. 461). They add that if the purpose is one but not the other, it may not be appropriate to address the other. We might illustrate this with the following example: A lawyer requesting a risk assessment prior to representing his or her client at a sentencing hearing may be interested only in an identification of risk factors and strategies for reducing risk in the hope
that the judge will agree to place the convicted individual on probation. To include a statement that the individual has an extremely high probability of reoffending would be problematic for the client.

Instruments for assessing risk are more widely available and empirically supported than are instruments for assessing the reduction of risk, or the second question referred to above (Heilbrun et al., 2002). Yet, even though researchers have developed empirically sound instruments for assessing risk, even the most well-known (e.g., the Violence Risk Appraisal Guide [VRAG], the Historical/Clinical/Risk Management Scale [HCR-20], and the Iterative Classification Tree [ICT]) have their limitations. (These and other instruments are listed in Focus 5.5.). “If they were developed on different populations, or predict outcomes that are different from what is being assessed in the immediate case, or use an outcome period that is not applicable, then they might not be particularly useful in that case” (Heilbrun et al., 2002, p. 461).

Readers should also recall the limitations of actuarial risk assessment, as discussed in Chapter 4. On the whole, however, actuarial assessment has fared better than clinical prediction in terms of success at accurately foretelling whether an individual will engage in violent behavior. Nevertheless, the combination of actuarial assessment and structured or guided clinical judgment may be the most worthwhile approach.

For purposes of assessing change in risk level, Heilbrun et al. (2002) recommend a number of strategies, even if instruments are not widely available. They suggest, for example, assessing the dynamic risk factors that were in operation at the time of the individual's violent act and determining whether they still exist. Recall that dynamic risk factors are those that can change. For example, at the time of the alleged assault, the individual had just lost his job; he has since gained new employment. “Protective factors” that may have inhibited violence in the past should also be assessed to see if they are still in place. An example of a protective factor would be a stable marital relationship or a child who looks up to the individual and for whom he is responsible. Heilbrun et al. also recommend close observation of an individual's behavior, modification of the environment that may be conducive to violent behavior, and an assessment of the impact on monitoring, “which has been empirically demonstrated to lower an individual's risk for engaging in violent behavior” (p. 462).

FOCUS 5.5. RISK ASSESSMENT INSTRUMENTS

The risk assessment enterprise includes a variety of instruments that researchers have designed specifically to assess risk of violence among certain populations. As noted in the chapter, there is no perfect test for predicting that a person will or will not engage in violent or other antisocial behavior. Nevertheless, some of the more promising instruments and guidelines are the following:

**HCR-20** (Webster, Harris, Rice, Cormier, & Quinsey, 1994). The Historical/Clinical/Risk Management Scale is a 20-item instrument that includes items based on a person's background (historical), attitudes or mental disorders (clinical), and external risk factors (R) such as housing or family support. It assesses violence risk among persons with serious psychiatric or personality disorders.

**Iterative Classification Tree** (Monahan, Bonnie, et al., 2001). Developed on psychiatric patients, the Iterative Classification Tree (ICT) is a yes/no flowchart that takes into consideration both clinical observations and variables traditionally associated with a prediction of violence. It is particularly effective at identifying those individuals at high risk and low risk of offending.

(Continued)
SARA (Kropp & Hart, 2000). The Spousal Assault Risk Assessment (SARA) guide assesses an individual's risk of committing violence against a spouse or intimate partner. It may be used in situations when a release decision is being considered (such as bail or parole). It assesses risk factors relating to psychosocial adjustment (such as employment or relationship problems) as well as the seriousness of criminal offenses.

VRAG (Harris, Rice, & Quinsey, 1993). The Violence Risk Appraisal Guide (VRAG) is based on 12 variables, including such background variables as alcohol abuse and elementary school maladjustment, as well as present mental status, such as schizophrenia and symptoms of psychopathy. It assesses the risk of violence in the community over a relatively long period (e.g., average is 7 years).

LSI-R (Andrews & Bonta, 1995). The Level of Service Inventory—Revised assesses dynamic and static risk factors to determine offender needs for services as well as risk of reconviction, including for violent offenses. It is used in many correctional facilities and has attracted a long line of research.

SAVRY (Borum, Bartel, & Forth, 2005). The Structured Assessment of Violence Risk for Youth is, as its name implies, designed for use with adolescents aged 12 to 18 years. It takes into consideration both static and dynamic risk factors as well as protective factors, and research suggests it can predict nonviolent as well as violent offending (Vincent, Chapman, & Cook, 2010).

Researchers have also developed instruments designed to assess risk among sex offenders, including juvenile sex offenders. These instruments are less widely accepted, primarily because they have not yet been subjected to extensive empirical research, although this situation is changing rapidly (e.g., Viljoen, Elkovich, Scalora, & Ullman, 2009, pertaining to juvenile measures). Examples are the Minnesota Sex Offender Screening Tool—Revised (Mn-SOST-R) (Epperson, Kaul, & Hesselton, 1998); the Static-99 (Hanson & Thornton, 2000); the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR); and the Registrant Risk Assessment Scale (Ferguson, Eidelson, & Witt, 1998), which was developed in New Jersey to evaluate and place sex offenders into risk tiers for sex offender registration purposes. Juvenile assessment instruments will be discussed again in later chapters.

Capital Sentencing

Risk assessments are useful to courts in the 38 death penalty states, as well as the federal government and the military, where the decision between life and death may revolve around the extent to which the individual is a danger to society. As noted by Melton et al. (2007), “the modern death penalty process has been shaped by a long series of United States Supreme Court decisions” (p. 265). In cases in which offenders face a potential death sentence, forensic psychologists and other forensic professionals sometimes work with the defense team to present arguments for mitigation, a process known as death penalty mitigation. Mitigation in this sense means to reduce the sentence by avoiding the death penalty. In a recent Supreme Court case (Cone v. Bell, 2009), a Vietnam-era veteran went on a crime spree during which he killed an elderly couple; he was ultimately convicted and sentenced to death. The Supreme Court vacated the death sentence, stating that the veteran's
drug addiction and his diagnosed posttraumatic stress disorder (PTSD) should have been considered as mitigating circumstances by the sentencing jury.

Death penalty mitigation investigations are comprehensive psychobiological evaluations of potential neuropsychological deficits, mental disabilities, mental disorders, and conditions that may have affected a defendant’s criminal actions. The psychologist also may be asked to provide a more general evaluation of the offender’s psychological functioning to learn whether there is anything that might lessen the offender’s culpability for the crime. (See Personal Perspective 5.2, which introduces you to Dr. Mark Cunningham, who does extensive research and consulting work relating to the death penalty.)

Some clinicians, however, also work with the prosecutor who seeks evidence against mitigation or evidence of aggravating factors associated with the crime. Thus, if a psychologist or psychiatrist gives the opinion that the individual is not developmentally disabled or is likely to engage in serious violent behavior, this would bolster the prosecutor’s argument against mitigation. This aspect of capital sentencing is particularly controversial, and it may create ethical problems for some psychologists, as Dr. Cunningham notes in Personal Perspective 5.2. Some researchers have suggested that the psychopath designation should not be used at this phase of the criminal process. Psychopaths are widely believed to be cold, unfeeling, nonresponsive to treatment, and—of course—dangerous.

PERSONAL PERSPECTIVE 5.2

Capital Defendants, Capital Sentencing, and Capital Inmates

Mark D. Cunningham, PhD, ABPP

Where some people’s recreational passion is golf or tennis, mine is scholarly writing. I am a clinical psychologist by graduate training, a forensic psychologist by career evolution, and a researcher and scholar by avocation. I am in independent practice. Capital sentencing (i.e., death penalty jeopardy) determinations are my subspecialty. I was in mid-career before I figured out that when you have a good mind, nothing is quite as enjoyable as challenging those faculties with scientific investigations and their real-world applications. Research and writing are not only enormously stimulating in their own right, but also have the collateral returns of camaraderie with coauthors, the realization of an identity as a scientist, and the satisfaction of illuminating an issue that has been incompletely or even erroneously understood. My research efforts have been recognized with the 2006 American Psychological Association Award for Distinguished Contributions to Research in Public Policy and the 2005 Texas Psychological Association Award for Outstanding Contribution to Science. These awards are a demonstration that psychologists in independent practice, as well as academicians, can make meaningful scientific contributions. Please allow me to describe some of this research.

(Continued)
Representation of Mississippi death row inmates: As of 1998, indigent death row inmates in Mississippi had not been provided with state-funded attorneys at an important stage of their appeals known as postconviction proceedings. By comprehensively assessing the intellectual capabilities, literacy level, psychological status, specific knowledge of post-conviction law, and legal aptitude of inmates on Mississippi’s death row, Dr. Mark Vigen and I established that these prisoners were wholly deficient to represent themselves. Soon after being informed of the findings of this study through a highly detailed affidavit I authored, the Mississippi Supreme Court (Jackson v. State 1998) reversed its prior rulings and found that death row inmates did not have the capability to represent themselves in state post-conviction efforts, and thus their meaningful access to the courts did entail a right to appointed and state-funded representation in post-conviction proceedings. This was the first such ruling by a high court in the United States. Our research findings were credited for this extraordinary change in public policy.

Violence risk assessment in capital prosecutions: Expert testimony by mental health professionals regarding the likelihood of future acts of violence by capital defendants has been notoriously unreliable and ethically controversial. This was largely due to the absence of either a reliable methodology or relevant group statistical data (i.e., base rate data) to anchor these predictions. These same deficiencies also drive public policy decisions regarding capital prosecutions, legislative and clemency considerations, and conditions of death row confinement. In providing expert testimony in capital cases as well as in my scholarship and research, I have articulated a scientifically sound capital risk assessment methodology based on rates and correlates of violence in prison and on capital parole. Subsequent scholarship has refined the applications and implications of this methodology and data. My colleagues and I have further explored these considerations through a series of studies, some quite large in scale (i.e., N = 2,000–50,000), on rates and correlates of prison violence, and the institutional conduct of capital offenders and other inmate groups.

We have also tested the capability of capital jurors to predict the future violence of a capital offender and to utilize this as a consideration in death penalty sentencing, finding that the predictions of these jurors were no better than random guesses. This has enormous public policy implications. Jury appraisal of the “dangerousness” of capital offenders has been a factor in many of the death sentences handed down in the past 35 years.

Relationship of offense of conviction and life-without-parole sentencing to prison misconduct: In a number of studies, my colleagues and I established that convicted murderers and capital murderers are not a disproportionate source of prison violence. Contrary to popular “nothing to lose” expectations, we also found that life-without-parole inmates were often better adjusted than short-term inmates. I testified regarding these research data before the Criminal Justice Committee of the Texas Senate in 2005 as this legislative body considered legislation to provide a life-without-parole sentencing option at capital sentencing. The bill was signed into law, and our research findings were identified as critical to its passage.
Conditions of confinement for death-sentenced inmates: My colleagues and I examined the 11-year policy of the Missouri Department of Corrections of “mainstreaming” death-sentenced inmates in the general prison population of a maximum security prison rather than segregating them on a death row. The mainstreamed death-sentenced inmates we studied had frequency rates and prevalence of institutional violence that were quite similar to life-without-parole inmates, and well below fellow inmates that were sentenced to parole-eligible terms. The findings of this study also have significant public policy implications, as they cast serious doubt on the security-driven assumptions that have resulted in the segregation of death-sentenced inmates elsewhere in the nation. This finding has important constitutional implications as well. If death-sentenced prisoners are not a disproportionate risk of serious violence in prison, then their confinement under draconian super-maximum conditions does not serve a legitimate penological interest and arguably represents a violation of the Eighth Amendment bar against cruel and unusual punishment.

From clinician to forensics to research: Though trained in a “scientist-practitioner” model in my doctorate program at Oklahoma State University, I had anticipated a career as a practitioner more than a researcher. True to this expectation, I established an independent practice that gradually evolved from clinical to forensic in focus. In early 1995, I became board-certified (American Board of Professional Psychology, ABPP) in forensic psychology. The several-year process of intensive study of research and case law in preparing for this board-certification examination reawakened the scientist in me and stimulated 15 years of research and scholarship. Forty-six publications and a remarkable career niche have followed.

Dr. Cunningham received his PhD in clinical psychology from Oklahoma State University and completed a 2-year postdoctoral training program at the Yale University School of Medicine. He was an assistant professor of psychology at Hardin-Simmons University in Texas for 2 years and has since been in independent practice. He is board-certified (ABPP) in clinical and forensic psychology. His practice is national in scope.

After the reinstitution of the death penalty in the United States in 1976, the first case to consider mitigating evidence in capital cases was Lockett v. Ohio (1978) (R. King & Norgard, 1999). Sandra Lockett was convicted of felony murder as an accomplice in the robbery of a pawnshop during which the owner was killed (She encouraged the robbery and drove the getaway car.). In 1978, Ohio passed a statute that required individuals convicted of aggravated murder to be given a death sentence. The defense argued that the Ohio statute was unconstitutional because it does not allow the sentencing judge to consider mitigating factors in capital cases, which is required by the Eighth and Fourteenth Amendments. At sentencing, Lockett offered evidence from a psychologist who reported that she had a favorable prognosis for rehabilitation. Among other things, she was only 21 years old at the time of the offense and had committed no other major offenses. The U.S. Supreme Court agreed and stated,

We conclude that the Eight and Fourteenth Amendments require that the sentencer, in all but the rarest kind of capital case, not be precluded from considering, as a mitigating factor, any aspect of a defendant’s character or record and any of the circumstances of the offense that the defendant proffers as a basis for sentence less than death. (pp. 604–605)
The Court overturned the Lockett sentence and asserted that a law which prohibits one from considering mitigating circumstances is unreasonable and unconstitutional. Although mitigating factors vary among jurisdictions, most mitigators are phrased in legislation in terms that invite the participation of forensic practitioners (Melton et al., 1997). For example, many jurisdictions allow mitigation circumstances to include intellectual disability, mental or emotional distress, or the inability to appreciate the criminality of one’s actions. Age, a childhood marred by extensive abuse, neuropsychological deficits, and—as noted above—PTSD are other examples.

The U.S. Supreme Court abolished capital punishment for offenders under the age of 16 in Thompson v. Oklahoma (1988) and in 2005, in Roper v. Simmons, it struck down the death penalty for all juveniles up to age 18. Thus, if a 16- or 17-year-old commits a capital murder, he is not eligible for the death penalty, regardless of his age at the time of the trial. In recent years, the Court has also ruled that neither intellectually disabled offenders (Atkins v. Virginia, 2002) nor offenders who are so mentally ill that they cannot understand what is happening to them (Ford v. Wainwright, 1986) are eligible for the death penalty. Furthermore, someone who is mentally ill at the time of execution cannot be executed. Finally, persons who commit rape (Coker v. Georgia, 1977), including rape of a child (Kennedy v. Louisiana, 2008), cannot be executed if their victims did not die. Regardless of the heinous nature of these offenses, the death penalty is to be limited to situations resulting in murder. Despite these limitations, over 3,000 individuals were on death row in the United States at the end of 2010 (www.deathpenaltyinfo.org). (See Photo 5.3, depicting a death chamber in Texas.)

According to Heilbrun et al. (2002), “Capital sentencing evaluations are among the most detailed and demanding forensic assessments that are performed” (p. 116). The clinician is called in to provide a broad-based report that will presumably assist in determining whether a person convicted of a capital crime should be sentenced to death. Some psychologists have strong moral objections to participating in any phase of a death penalty case, with particular antipathy toward assessing risk at the sentencing stage. Many also do not choose to participate in assessments of competency for execution, which occur later in the criminal process, as the execution date is approaching. Evaluations of competency to be executed will be discussed in Chapter 12.

In light of a long line of research documenting the deficiencies of clinical predictions of dangerousness, many forensic examiners are reluctant to rely on clinical impressions alone (Heilbrun et al., 2002). Nevertheless, as we noted in this and earlier chapters, actuarial or statistical data are not foolproof, either. In the death penalty context, actuarial data may be especially suspect. Cunningham and Reidy (1998, 1999) have brought attention to a problem dealing with the base rate, which is the fundamental group statistic in risk assessment. The base rate of murderers, they say, does not justify a prediction of dangerousness in death penalty cases. As a group, convicted murderers are neither violent in prison nor violent if released on parole (Bohm, 1999; Cunningham, Sorensen, Vigen, & Woods, in press).
In sum, the role of the forensic psychologist at capital sentencing is both crucial for obtaining possible evidence in mitigation and controversial for its contribution to the jury’s prediction of dangerousness. Cases in which the death penalty is a possible outcome are unique. As the U.S. Supreme Court has so frequently observed in its death penalty opinions, death is different, and there is a bright line separating capital from noncapital cases. In *Furman v. Georgia* (1972), where the death-is-different principle was first expressed, the Court noted that death is “an unusually severe punishment, unusual in its pain, in its finality, and in its enormity.” The bright line that separates death penalty cases from those in which death is not a possible outcome is one that many psychologists prefer not to cross. Yet, others believe that they are in a unique position to document the existence of mitigating factors that may spare a convicted offender the death sentence.

**Sex Offender Sentencing**

Psychologists have conducted extensive research on the nature, causes, and treatment of sexual offending. Because of their expertise, psychologists are often asked to provide assessments of convicted sex offenders to help courts decide on a just punishment. In many jurisdictions, these evaluations are known as “psychosexual assessments.” They are typically very broad based, with the psychologist providing a wealth of background information, test results, observations, and—in some cases—risk assessments. Psychosexual assessments also typically include recommendations for treatment and for managing any risk believed to be posed by the offender. For example, if an offender will almost assuredly be sent to prison, the evaluator may indicate that he is a good candidate for a sex offender treatment program known to be available in the prison system. For an offender who may be placed on probation, the evaluator might suggest that the supervising probation officer pay close attention to his employment status because he was particularly vulnerable to committing offenses during periods in which he was laid off from work.

Heilbrun et al. (2002) warn clinicians to be very careful in using some of the typologies to classify sex offenders in their reports to the courts. Although the typologies may be useful in clinical practice and may be intuitively appealing, few have received empirical support. Typologies also offer convenient and catchy “labels” that may follow an offender throughout his prison career, again with little validity. An offender tagged by professionals as a “sadistic rapist” or a “fixated child molester” may encounter adjustment problems in prison over and above the problems faced by inmates with more innocuous or “normal” labels—burglar, killer, or even rapist. In addition, the typologies may unjustly confine an offender to a higher security level than is warranted or limit his opportunity for participation in work programs or for early release.

According to Heilbrun et al. (2002), more promising than typologies are the risk assessment scales that have been developed specifically for sex offenders (see Focus 5.5). As with other risk assessment instruments, though, care must be taken to choose the appropriate instrument and to be sure it is used in combination with other methods of assessment.

It should be emphasized that both the ethical code of the American Psychological Association (1992, 2002b) and the “Specialty Guidelines for Forensic Psychologists” (Committee on Ethical Guidelines for Forensic Psychologists, 1991) make it clear that psychologists should use validated instruments. Furthermore, they should acknowledge the limitations of the instruments they do use and should communicate their findings in a manner that will promote understanding and avoid deception.

**Civil Commitment of Sexually Violent Predators**

In the 1980s and 1990s, Congress as well as many state legislatures passed laws and funded programs that were designed to address the many problems associated with sex offending. Most of us are familiar with variants of
these laws or programs that are named after the victims of heinous offenses (e.g., Sex Offender Registration and Notification Act [SORNA], Megan's Law, the Adam Walsh Child Protection and Safety Act, the Amber Alert). As a group, these legislative enactments provide resources for police in the prevention of sex offending as well as services for victims and their relatives. Many of the laws also provide for registration of sex offenders after they have been released from prison and, in some instances, community notification. Today, names of registered sex offenders are widely dispersed on the Internet.

In the early part of the 21st century, the U.S. government increasingly placed mandates on states to revise their systems pertaining to the classification of sex offenders, thereby presumably making registration and notification laws more consistent across the country (A. J. Harris, Lobanov-Rostovsky, & Levenson, 2010). Researchers are just beginning to assess the effects of these mandates (e.g., Freeman & Sandler, 2009; A. J. Harris, Lobanov-Rostovsky, et al., 2010), and some question the efficiency of these procedures as well as the effect on those sex offenders who, based on sex offender research (e.g., Hanson & Morton-Bourgon, 2005), are unlikely to recidivate. (See A. J. Harris & Lurigio, 2010, for a comprehensive review.) In addition, the monitoring of sex offenders living in the community—such as community notification and residency restrictions—are believed to conflict with or interfere with treatment goals, particularly for those who are mentally ill (A. J. Harris, Fisher, Veysey, Ragusa, & Lurigio, 2010).

The policy issues relating to sex offenders and former sex offenders living in the community are important. Less widely publicized is the commitment of violent sex offenders to mental institutions for indeterminate periods, against their will, after they have completed their prison sentences. In some states, the law also allows persons charged with violent sex offenses to be detained in mental institutions rather than in jails. Approximately 16 states and the federal government have such provisions, cumulatively known as sexually violent predator (SVP) statutes. Estimates of the number of individuals detained or committed under these laws range from 1,300 to 2,209 (La Fond, 2003). Janus and Walbek (2000) report that these commitment schemes are exceedingly expensive, with the annual cost per patient ranging from $60,000 to $180,000. This does not include the cost of commitment proceedings or capital costs for constructing needed facilities.

Numerous legal, ethical, and practical issues have been raised about this practice. However, the U.S. Supreme Court has allowed it, provided the offender has a history of sexually violent conduct, a current mental disorder or abnormality, a risk of future sexually violent conduct, and a mental disorder or abnormality that is connected to the conduct (Kansas v. Hendricks, 1997). In Kansas v. Hendricks, the Court held that dangerous sexual predators may be civilly committed against their will upon expiration of their prison sentences. In Kansas v. Crane (2002), the Court added that the state also has to prove that the individual has some inability to control his behavior. (The Kansas Supreme Court had ruled that the individual had to be found unable to control his dangerous behavior; the federal Court ruled that this was too heavy a burden for the state to bear.) In its most recent ruling on this issue (U.S. v. Comstock, 2010), the Court allowed the federal government also to hold violent sexual offenders beyond their prison sentence if they were mentally ill. The government could either keep them in federal facilities or transfer them to state mental institutions, with a state's permission. They are, however, entitled to periodic reviews of their mental status. The forensic psychologist or psychiatrist may be called in to assess this status. As a result of these and other developments, training sessions, workshops, and publications are now available to offer guidance to psychologists conducting evaluations of individuals designated as sexually violent predators (e.g., Heilbrun, Grisso, & Goldstein, 2008; Melton et al., 2007).

Although the involuntary civil commitment of SVPs technically comes under the purview of civil law, it is so closely related to the criminal justice process and to the risk assessment instruments discussed above that we cover the topic here. In the following chapter, civil commitment of other individuals will be discussed.
Forensic psychologists may face a number of dilemmas relative to the assessment of sexually violent predators. The usual concerns about the assessment of risk, including the use of specialized instruments for use with sexual offenders, must be considered. Although progress has been made on risk assessment in a number of contexts, the enterprise is by no means on solid empirical ground. This is an important point to make in all legal contexts, but when it comes to sexually violent predators, there are additional ethical considerations. Because of the nature of this type of crime, courts are highly likely to err on the side of caution and to accept any documentation provided by the clinician; the high numbers of offenders who have been committed under these statutes suggest that commitment is not difficult to achieve.

It is also important to note that commitment does not require evidence of a recognized mental disorder; mental “abnormality” is sufficient. Researchers have found that many sex offenders do not suffer from mental disorder or mental illness. Nevertheless, the statutes often allow them to be civilly committed. In an analysis of sex offender commitment in Minnesota, Janus and Walbek (2000) learned that more than half of the 99 men in the study for whom diagnostic information was available had not been diagnosed with a sexual deviation disorder. Although other diagnoses were present (e.g., dementia, 2%; antisocial personality disorder, 26%; substance abuse or dependency, 52%), 10% had no diagnosis other than substance abuse or dependency. It should be noted that the civil commitment of persons other than SVPs requires a diagnosis of mental disorder or illness; a substance abuse or dependency diagnosis would not qualify. Under U.S. v. Comstock (2010), civil commitment in the federal system also requires the finding of a mental disorder.

An additional concern expressed in the literature is the possible lack of treatment that accompanies SVP commitment (Janus, 2000; Wood, Grossman, & Fichtner, 2000). Although the statutes typically include a provision that treatment will be offered if available, most statutes do not guarantee that this will occur. “Nevertheless, many states claim that sex offender commitments are aimed at treatment, and that they are providing effective—or at least state of the art—treatment” (Janus & Walbek, 2000, p. 347).

Critics of these commitment statutes maintain that they are really being used to extend punishment rather than provide treatment (La Fond, 2000). In other words, treatment is a secondary purpose. It should be noted also that not all sex offenders are mentally disordered to begin with, as Janus and Walbek’s (2000) Minnesota study confirms. In fact, some researchers maintain that most are not: “The absence of a major mental disorder unique to offenders who commit sex crimes suggests that mental health treatment for most sex offenders needs to be questioned” (L. M. J. Simon, 2000, p. 295).

Still another concern is that sex offender commitment seems to result in very lengthy confinement. Recall from earlier in the chapter that the confinement of persons to civil mental institutions for non-forensic purposes is more likely to be measured in terms of days or weeks, whereas forensic populations are measured in terms of months or even years. Janus and Walbek (2000) observed that committed sex offenders almost never get released. They note that, “[a] practical matter, the burden of proof to support discharge is a heavy one” (p. 346). This is illustrative of an observation that has frequently been made about sex offenders: “Historically, sex offenders have been singled out for differential treatment by the legal and mental health systems” (L. M. J. Simon, 2000, p. 275).

In light of some of the above concerns, La Fond (2003) has advanced an interesting but undoubtedly controversial argument for outpatient commitment for violent sexual predators. Some SVPs, he believes, could benefit from initial outpatient treatment, whereas others could benefit from outpatient commitment as a transitional measure after institutionalization. La Fond refers to the consensus among treatment providers that persons who are enrolled in sex offender treatment programs within a secure facility should be followed up in the community to achieve maximum treatment outcomes. Thus, for those SVPs who get treated within the prison or the mental institution, outpatient commitment would provide continuing supervision and treatment
upon release. Yet, **sexually violent predator statutes** in most of the states that have them do not provide for such outpatient commitment. When they do, there is very little evidence that it is used (La Fond, 2003).

The above are only some of the many issues that have been raised about the wisdom and ethics of involuntary civil commitment for sexually violent predators. Psychologists are likely to be involved in both the assessment and the treatment (if provided) of sexual offenders. Some evaluators may assume, when conducting risk assessments, that treatment will be provided once the individual is civilly committed. As we have seen, this is not necessarily the case. In addition, as we will discuss again in Chapter 12, the **effectiveness** of sex offender treatment programs is still very much in question, even though there is positive movement in this area. Although the forensic psychologist does not set social policy, he or she should be aware of the research and the growing controversy in this matter.

### SUMMARY AND CONCLUSIONS

This chapter has reviewed a wide variety of tasks performed by forensic psychologists in their interaction with criminal courts. The available research suggests that the dominant tasks revolve around the various competencies that criminal defendants must possess to participate in criminal proceedings. Competency to stand trial, competency to waive the right to a lawyer, competency to plead guilty, and competency to be sentenced are examples. The psychological literature uses the term **adjudicative competence** to embrace all of these separate competencies. Adjudicative competence—as conceived by Richard Bonnie—also includes the important aspects of being able to communicate effectively with one’s attorney and making decisions across a wide range of contexts.

There appears to be no consensus about how competency evaluations should be conducted, although most guidelines and publications indicate that the traditional clinical interview by itself does not suffice. Although some psychologists administer traditional psychological tests, instruments specifically designed to measure competency are now widely available. Among the most promising is the MacCAT-CA, developed by researchers from the MacArthur Foundation. The results of the competency evaluation appear to have a significant effect on a judge’s decision, with judges almost always agreeing with recommendations offered by the examiner.

Psychologists also conduct sanity evaluations, more formally known as assessments of criminal responsibility or mental state at the time of the offense. These evaluations are far more complex than most evaluations of adjudicative competence—but there are exceptions. The assessment of criminal responsibility requires the collection of a large amount of background data, interviews with the defendant, and contacts with other individuals who may be able to provide insight into the defendant’s state of mind when the crime was committed. The Rogers Criminal Responsibility Assessment Scales (R-CRAS) and the Mental State at the Time of the Offense (MSO) screening evaluation are the dominant instruments available for this purpose, though research suggests they are less likely to be used than are competency assessment instruments.

A controversial topic relating to both competency and insanity is the administration of psychoactive medication against an individual’s will. Medication is the dominant way of treating incompetent defendants to render them competent to stand trial. However, medicated defendants may suffer a variety of side effects, some of which may interfere with their capacity to participate in the trial process. The U.S. Supreme Court has indicated that extreme care must be taken before medicating defendants against their will to restore them to competency. In the case of a non-dangerous defendant charged with a nonviolent offense, the Court disallowed the forced medication...
because the lower courts had not sufficiently considered its side effects. However, the Court refused to hear another case—and thus allowed the involuntary medication of an incompetent defendant who was charged with a serious violent crime and was deemed to be dangerous. The Court has ruled, though, that defendants have a right not to be medicated during their trials if they are pleading not guilty by reason of insanity and want jurors to see them in their natural, non-medicated state.

Psychologists also consult with criminal courts as judges are preparing to sentence an offender. These sentencing evaluations are conducted primarily to determine whether the offender would be a good candidate for a particular rehabilitative approach, such as substance abuse treatment or a violent offender program. Sentencing evaluations also may involve assessments of risk, however, because courts are often interested in an appraisal of the convicted offender's dangerousness. Risk assessment remains an imperfect enterprise, but a variety of valid instruments are available for this purpose. In this chapter, we reviewed some of the major concerns surrounding risk assessment of special populations, such as sex offenders and defendants convicted of a capital crime and facing a possible death sentence.

The chapter ended with a discussion of sexually violent predators and their indeterminate commitment to civil mental institutions. Approximately 15 states now allow such a commitment, provided that the offender is dangerous and has a mental disorder or some mental abnormality—a very broad term that has been criticized by many scholars. Although statutes often indicate that treatment will be provided, it is widely suspected that the primary intention of these statutes is to keep sexual predators incapacitated.

**KEY CONCEPTS**

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1. List at least five competencies in criminal suspects and defendants that might have to be assessed by forensic psychologists.

2. State and explain the differences between the three burdens of proof discussed in this chapter.

3. List at least five aspects that are common to all FMHAs.

4. Why are dual and multiple relationships problematic?

5. Why are the following cases significant to forensic psychology: Riggins v. Nevada, Jackson v. Indiana, and Foucha v. Louisiana?

6. Compare and contrast the cases of Charles Sell and Russell Weston.

7. Provide illustrations of how changes in federal and state statutes have made it more difficult for defendants pleading not guilty by reason of insanity.

8. Compare the assessment of competence to stand trial and that of sanity/criminal responsibility.

9. List the instruments commonly used in the assessment of risk.

10. What is the role of the forensic psychologist in (a) capital sentencing and (b) sexually violent predator proceedings?