BEST PRACTICES IN FORENSIC MENTAL HEALTH ASSESSMENT

EVALUATION OF CRIMINAL RESPONSIBILITY

IRA K. PACKER

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About Best Practices in Forensic Mental Health Assessment

The recent growth of the fields of forensic psychology and forensic psychiatry has created a need for this book series describing best practices in forensic mental health assessment (FMHA). Currently, forensic evaluations are conducted by mental health professionals for a variety of criminal, civil, and juvenile legal questions. The research foundation supporting these assessments has become broader and deeper in recent decades. Consensus has become clearer on the recognition of essential requirements for ethical and professional conduct. In the larger context of the current emphasis on "empirically supported" assessment and intervention in psychiatry and psychology, the specialization of FMHA has advanced sufficiently to justify a series devoted to best practices. Although this series focuses mainly on evaluations conducted by psychologists and psychiatrists, the fundamentals and principles offered also apply to evaluations conducted by clinical social workers, psychiatric nurses, and other mental health professionals.

This series describes "best practice" as empirically supported (when the relevant research is available), legally relevant, and consistent with applicable ethical and professional standards. Authors of the books in this series identify the approaches that seem best, while incorporating what is practical and acknowledging that best practice represents a goal to which the forensic clinician should aspire, rather than a standard that can always be met. The American Academy of Forensic Psychology assisted the editors in enlisting the consultation of board-certified forensic psychologists specialized in each topic area. Board-certified forensic psychiatrists were also consultants on many of the volumes. Their comments on the manuscripts helped to ensure that the methods described in these volumes represent a generally accepted view of best practice.

The series' authors were selected for their specific expertise in a particular area. At the broadest level, however, certain general principles apply to all types of forensic evaluations. Rather than repeat those fundamental principles in every volume, the series offers them in the first volume, *Foundations of Forensic Mental Health Assessment*. Reading the first book, followed by a specific topical book will provide the reader both the general principles that the specific topic shares with all forensic evaluations and those that are particular to the specific assessment question.

The specific topics of the 19 books were selected by the series editors as the most important and oft-considered areas of forensic assessment conducted by mental health professionals and behavioral scientists. Each of the 19 topical books is organized according to a common template. The authors address the applicable legal context,

forensic mental health concepts, and empirical foundations and limits in the "Foundation" part of the book. They then describe preparation for the evaluation, data collection, data interpretation, and report writing and testimony in the "Application" part of the book. This creates a fairly uniform approach to considering these areas across different topics. All authors in this series have attempted to be as concise as possible in addressing best practice in their area. In addition, topical volumes feature elements to make them user-friendly in actual practice. These elements include boxes that highlight especially important information, relevant case law, best-practice guidelines, and cautions against common pitfalls. A glossary of key terms is also provided in each volume.

We hope the series will be useful for different groups of individuals. Practicing forensic clinicians will find succinct, current information relevant to their practice. Those who are in training to specialize in forensic mental health assessment (whether in formal training or in the process of respecialization) should find helpful the combination of broadly applicable considerations presented in the first volume together with the more specific aspects of other volumes in the series. Those who teach and supervise trainees can offer these volumes as a guide for practices to which the trainee can aspire. Researchers and scholars interested in FMHA best practice may find researchable ideas, particularly on topics that have received insufficient research attention to date. Judges and attorneys with questions about FMHA best practice will find these books relevant and concise. Clinical and forensic administrators who run agencies, court clinics, and hospitals in which litigants are assessed may also use some of the books in this series to establish expectancies for evaluations performed by professionals in their agencies.

We also anticipate that the 19 specific books in this series will serve as reference works that help courts and attorneys evaluate the quality of forensic mental health professionals' evaluations. A word of caution is in order, however. These volumes focus on best practice, not what is minimally acceptable legally or ethically. Courts involved in malpractice litigation, or ethics committees or licensure boards considering complaints, should not expect that materials describing best practice easily or necessarily translate into the minimally acceptable professional conduct that is typically at issue in such proceedings.

The present volume describes one of the most important, complex, and controversial forensic evaluations in forensic psychiatry and psychology. The notion of "insanity"—that it is unfair to hold "mentally impaired" people fully and criminally responsible for transgressions—is very old. It arises in the earliest recorded legal records of many civilizations. European and American law have long relied on information from medical experts to identify those who might qualify for this exemption from responsibility. The early identity of forensic psychiatry was substantially shaped by its ability

to address criminal responsibility, through the scholarly contributions of its founders (such as Isaac Ray's 1838 *Treatise on the Medical Jurisprudence of Insanity*), as well as their testimony in those famous 19th-century cases that established some of our current legal definitions of insanity. Forensic psychologists joined forensic psychiatrists as insanity examiners later in the 20th century.

Despite this long history, the concepts associated with criminal responsibility are still complex and difficult to define. Nevertheless, in recent years, the field has developed a greater consensus regarding essential data collection methods, as well as how to manage the type of reasoning that is required to fit data to the legal definitions. This volume offers guidance for the forensic mental health examiner, based on tradition as well as the latest developments for improving practice in criminal responsibility evaluations.

Thomas Grisso
Alan M. Goldstein
Kirk Heilbrun

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Acknowledgments

The questions posed about how to respond to criminal behavior by individuals who may be mentally disordered are intriguing from legal, moral, and psychological perspectives. I have learned a great deal from writing this book, and I want to thank the editors of this series, Tom Grisso, Alan Goldstein, and Kirk Heilbrun for honoring me by inviting me to participate. They also contributed substantively to this book. First, the edits and feedback provided by Tom (primary editor for this book) and Alan (secondary editor) were extremely helpful. Second, as I was writing, I often imagined how Tom, Alan, and Kirk would respond to certain points, and this always forced me to articulate my ideas more clearly.

I especially want to thank Steve Bank, the external reviewer for this book. His detailed comments were extremely helpful in clarifying a number of important nuances, as well as forcing me to rethink some crucial points. I appreciate his sharing his expertise and his willingness to take the time to discuss the issues with me at length. My thanks also go to Julia TerMaat, the developmental editor from Oxford University Press, for her contributions to make this book more readable and user friendly.

I am appreciative of my many forensic psychology and psychiatry colleagues, both in Massachusetts and across the country, from whom I have learned a great deal. I value the opportunity to consult with such outstanding colleagues and discuss complicated practice and ethical issues. I particularly rely on the extremely sophisticated and thoughtful responses that come, almost daily, from my colleagues on the American Academy of Forensic Psychology's listserv. Discussions with my psychiatric colleague, Debra Pinals, of some of the "minutiae" of forensic work, such as what does the term "wrongfulness" mean, have come in very handy in writing this book. But, of course, I have learned even more from my students, the Forensic Psychology and Psychiatry Postdoctoral Fellows at the University of Massachusetts Medical School. Their inquisitiveness, thoughtful and challenging questions, and thirst for knowledge have forced me to ponder many of the issues discussed in this book.

There are also some people whose contributions are more global. Having spent almost 30 years as a forensic psychologist working primarily in the criminal arena, I have often had to deal with the tragic and cruel aspects of life. I have been able to maintain a balanced perspective on life and keep my own "sanity" due to in large part to my wonderful family. I am grateful to my wife Sharon, my sons Ben, Daniel, and Avi, and my daughter-in-law Aviva for serving as a daily reminder of the wonderful and beautiful aspects of human nature.

Last, but not least, this book is dedicated to the two people to whom I owe the most: my mother, Rosalind, and my father of blessed memory, Ben. In particular, I appreciate how hard they worked to ensure that I received a top-quality education. It is thanks to their willingness to sacrifice that I have been able to achieve whatever successes I have in life.

Ira Packer

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FOUNDATION

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The Legal Context 1

The Purpose of the Insanity Defense

The issue of legal and moral blameworthiness for violations of established laws is complex and controversial. It would be much simpler if individuals were considered guilty of crimes simply based on the nature of the act (the term used in the American legal system, borrowed from the Latin, is *actus reus* or "bad act"). However, even a cursory exploration of this area reveals that such a model would violate commonsense criteria.

For example, if Mr. Jones, while driving his car, strikes and kills Mr. Smith, is he guilty of a crime? It depends. Did Mr. Jones deliberately aim his car at Mr. Smith? Had they been involved in an argument right before the incident? Had Mr. Jones ever threatened to harm Mr. Smith? If the two parties were strangers, was Mr. Jones intoxicated at the time and hit Mr. Smith because he was driving erratically and did not see him? Had Mr. Jones been speaking on his cellphone at the time and become distracted? Was Mr. Jones driving carefully and had to swerve to avoid an oncoming truck, thus inadvertently striking Mr. Smith?

In all these scenarios, Mr. Jones committed the same act; the differences between the scenarios revolve around his mental state and his intentions. The decision about whether or not Mr. Jones is guilty of a criminal act, and if so, the severity of the crime, will be contingent upon whether he is deemed to have had *mens rea*, or "guilty mind." If it is determined that Mr. Smith intended to kill Mr. Smith, he is likely to be convicted of murder. The degree

of murder is likely to hinge on an assessment of whether it was premeditated or not. If he were intoxicated or negligent in his driving, he is likely to be convicted of manslaughter. And, if it were determined that this was an accident beyond his control, he will not be found guilty of any crime.

The situation becomes more complex when a claim is made that the individual's lack of *mens rea* was due to a mental impairment. Many additional questions arise in such cases. What is the threshold for severity of the mental disorder? How do we determine the functional impairments that will be considered relevant to absolving the individual from culpability? How do we know the disorder is genuine?

Historical Basis for the Insanity Defense

Most jurisdictions in the United States have provisions for acquittal of defendants who are deemed legally insane. All jurisdictions have provisions for consideration of the impact of mental status on elements of the alleged crime or on the degree of culpability. This is not a modern concept. The Hebrew *Mishna* (almost 2,000 years ago), for example, recognized that certain individuals, due to their mental impairments, would be excused from *criminal responsibility* (CR). Included in this category were young children and individuals who today would be called "mentally ill" or "mentally retarded." Various terms were subsequently used in Anglo-Saxon law, including references to "lunatics" and "idiots," terms that apparently were assumed to have a commonsense meaning (that is, not requiring specialized expertise to diagnose). Similarly, in 18th-century England, what has become known as the "wild beast" standard was proposed: "a man must be totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, brute, or a wild beast" (*Rex v. Arnold*, 1724). This standard required absolute impairment ("totally deprived").

The next section of this chapter describes the evolution of standards for insanity across the past 200 years. Despite those efforts, the insanity defense remains a very controversial topic. This is due, in part, to misunderstandings about the concept, the

INFO

Despite public perception, the insanity defense is seldom employed. Furthermore, it is frequently unsuccessful when used.

prevalence of its use, and the consequences for those who are found insane. There is public confusion about how someone who actually committed an act can be found *Not Guilty by Reason of Insanity* (NGRI). Furthermore, the public overestimates how often the insanity defense is used and thinks that insanity acquittees avoid negative consequences (e.g., Pasewark & Pantle, 1979; Steadman et al., 1993). As Appelbaum (1982) noted: "the public's perception that mentally ill offenders are being processed through a revolving-door system that rapidly returns to the streets those acquitted on grounds of insanity has provoked calls for reform" (p. 14). This public outcry has affected public policy, despite the inaccuracy of the perception.

In contrast to these public fears, it is estimated (Melton et al., 2007, summarizing data from studies across a number of jurisdictions) that only one-tenth of 1% of all felony cases (i.e., 1 out of every 1,000 cases) involves an insanity plea and, of those, only about a quarter are successful. Thus, the insanity defense is rarely raised and, when raised, is not often successful. Nevertheless, public opinion, and legislative action, are influenced to a great degree by the infrequent, but highly publicized case (what is known as the "representativeness heuristic," Kahneman, Slovic, & Tversky, 1982). This contributes to the misperception that the insanity defense is overused and abused.

Realities of the Outcome of the Insanity Defense

Similarly, the public has a tendency to see the insanity defense as a way for the defendant to "get away with it." Yet, a defendant found NGRI may end up spending more time in the hospital than he would have spent incarcerated if convicted. Consider the case of Mr. Jones (*Jones v. U.S.*, 1983), who was found NGRI of larceny. In 1975, Mr. Jones was arrested for attempting to steal a jacket from a department store and was arraigned in the District of Columbia Superior Court on a charge of attempted petit larceny,

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Jones v. U.S. (1983)

- After being found NGRI, Jones was committed to a psychiatric hospital and remained committed for a period longer than the maximum sentence he would have received had he been convicted.
- Jones appealed, claiming that his due process rights were violated by his commitment extending beyond the maximum sentence.
- The U.S. Supreme Court rejected Jones's claim, declaring that no correlation exists between the length of criminal sentence one would have received if convicted and the length of confinement required for treatment and protection.
- The Court also ruled that insanity acquittees could be subjected to more stringent standards for release than individuals civilly committed.

a misdemeanor punishable by a maximum prison sentence of 1 year. Jones subsequently pled not guilty by reason of insanity. The prosecution did not contest the plea, and the judge found him NGRI and sent him to St. Elizabeth's Hospital for an evaluation. At a hearing 50 days later, the District of Columbia Superior Court found that the Mr. Jones was mentally ill and dangerous, and ordered his commitment to the hospital. Per the D.C. statute, the burden then shifted to Jones to prove by preponderance of the evidence (that is, more likely than not) that he was no longer mentally ill or dangerous. The maximum sentence he had faced for conviction was 1 year, but he was committed for significantly longer than that (his case was heard by the Supreme Court in 1983). He therefore appealed, arguing that it was unconstitutional for him to be deprived of liberty as an insanity acquittee for longer than the sentence he would have received if convicted.

The Supreme Court rejected his claim, ruling that no relationship existed between the maximum sentence an insanity acquitee would have faced and the length of his psychiatric hospitalization. Their rationale was that

> The length of a sentence for a particular criminal offense is based on a variety of considerations, including retribution, deterrence,

> and rehabilitation. However, because an insanity acquittee was not convicted, he may not be punished. The purpose of his commitment is to treat his mental illness and protect him and society from his potential dangerousness. There simply is no necessary correlation between the length of the acquittee's hypothetical criminal sentence and the length of time necessary for his recovery. (p. 369)

Thus, the length of confinement of insanity acquittees may exceed the period of incarceration they would have been subject to if they had been found guilty. Furthermore, a number of states have instituted *conditional release* programs for insanity acquittees. This means that, even after release from a psychiatric hospital, these acquittees are subject to restrictions and conditions placed upon them in the community, including continuing mental health treatment, abstaining from substance abuse, and other terms similar to probationary conditions for convicted defendants.

Several jurisdictions with conditional release programs have followed up acquittees in the community (e.g., Wiederanders, Bromley, and Choate, 1997). Results from these studies indicate that insanity acquittees are less likely than those convicted to recidivate, particularly for violent crimes. An encouraging finding is that those conditionally released are more likely to be rehospitalized rather than reincarcerated. This suggests that the conditional release programs are effective in intervening early with mental health treatment, rather than allowing an individual to decompensate to the point that he picks up new criminal charges. The realities related to the insanity defense, therefore, are quite different from the often-mistaken public perception that it is overused and that it results in increased risk to the public.

Consequences of Abolishing the Insanity Defense: Data From Montana

It is instructive, in this context, to consider the consequences in Montana, which abolished the insanity defense in 1979. The sociologist, Henry Steadman, and his colleagues (Steadman et al., 1993) compared data from the periods pre (1976–1979) and post

(1980–1985) abolition. Although, by definition, there were no insanity acquittees after 1979, the number of defendants adjudicated as *Incompetent to Stand Trial* (IST) increased significantly after abolition. Their conclusion was that the system responded in this way to the phenomenon of severely mentally ill individuals who violated the law and who were not considered criminally blameworthy. Once the option of insanity acquittal was removed, the alternative of adjudication as incompetent was more widely used. The long-term disposition was the same; mentally ill individuals were psychiatrically committed rather than incarcerated in penal institutions. This reinforces the principle underlying the insanity defense: a class of individuals exists who are mentally impaired and thus cannot be held to the same level of accountability as the majority of citizens. One way or another, societies must accommodate to this reality and develop laws that provide for alternative dispositions.

These data are relevant because they highlight the important idea that the forensic evaluation is embedded within a legal and social context. This is useful for the forensic evaluator to keep in mind regarding the attitudes that jurors typically bring to the courtroom. The issue of CR is ultimately not a psychological concept; it is a legal and moral one.

The Evolution of Legal Standards for Insanity

Unlike the legal concept of *competence to stand trial* (referring to a defendant's current capacities to participate in a trial), definitions of insanity are concerned with the defendant's past mental state (i.e., at the time of the alleged offense). The legal system's efforts to develop and apply legal standards defining insanity have resulted in several different definitions, so that different jurisdictions employ somewhat different standards. Appendix A identifies the legal standards for insanity in each of the states, as well as in the federal system. We will return to this table at the end of this section, which describes the origins and legal precedents for the major standards currently employed in the United States.

The M'Naghten Standard

The modern underpinning for the insanity defense standards prevalent in most U.S. jurisdictions stems from the case of Daniel M'Naghten in England in 1843. (For a detailed discussion of the M'Naghten case, see Moran, 1981.) M'Naghten was acquitted by reason of insanity of killing the secretary of the leader of the Tory party, Sir Robert Peel (who was the target of the assassination). Public outrage at the verdict resulted in new criteria for the insanity defense being established in England (known as the *M'Naghten standard*). This standard includes the following criteria:

> To establish a defense on the ground of insanity, it must be proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing or if he did know it, that he did not know he was doing what was wrong. (M'Naghten case, 1843)

This has come to be known as the "right–wrong test" and was adopted in many jurisdictions in the United States. One of the criticisms of this standard (e.g., American Law Institute [ALI], 1985) has been its one-sided focus on the "cognitive" aspect (i.e., focused on "knowing" and ignoring the impact of various emotional states on actions). As a result of this focus, the standard fails to take account of possible impairments in volitional control. Some states responded to this latter criticism by incorporating what is known as the "irresistible impulse" test—that is, a defendant can also be found insane if she acted in response to an irresistible impulse. However, this was not a workable solution because of the difficulty in developing criteria for assessing this standard. Specifically, how could mental health professionals and

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M'Naghten case (1843)

- Established a standard that has been adopted in many U.S. jurisdictions
- Included as criteria for insanity whether the defendant
  a. did not know the nature and quality of the act, or
  b. did not know that what he was doing was wrong