



Quality of criminal responsibility reports submitted to the Hawaii judiciary[☆]



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ABSTRACT

This paper is the third in a series of research reports on quality of forensic mental health evaluations submitted to the Hawaii judiciary. Previous studies examined quality of reports assessing competency to stand trial (CST) and post-acquittal conditional release, in felony defendants undergoing court-ordered examinations. Utilizing a 44-item quality coding instrument, this study examined quality of criminal responsibility reports in a sample of 150 forensic mental health evaluations conducted between 2006 and 2010 by court-appointed panels. Raters attained high levels of agreement in training and quality coding. Similar to the previous studies, overall quality of reports was mediocre, falling below the .80 quality criterion score for report elements, regardless of evaluator professional identification or employment status. Level of agreement between evaluators and judicial sanity determinations was “fair” using Cicchetti’s (1994) standards for interpretation of intra-class correlations. Level of agreement was lower than previously published findings for CST reports and better than conditional release reports. Reasons for mediocre report quality and “fair” inter-rater agreement are discussed, including the fact that criminal responsibility evaluations are complex, retrospective in nature, and involve significant degrees of inference. In contrast to CST evaluations, assessment of criminal responsibility involves a mental state at the time of the offense evaluation. Threats to reliability in forensic reports are discussed. Suggestions for improvement of report quality are proffered, including standardization of procedures and report format and use of forensic assessment instruments.

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1. Introduction

The insanity defense has been the focus of intense public attention and misperception. Inaccurate knowledge of the insanity defense prevails (Golding, Skeem, Roesch, & Zapf, 1999; Hans & Slater, 1983). Common public conceptions view the insanity defense as a loophole allowing the guilty to avoid responsibility for their actions. The public overestimates legal application of the insanity defense; some studies have shown that laypersons believe the insanity defense to be raised in about one-third of all felony cases (Pasewark, McGinley, & Blau, 1989). In reality, criminal responsibility pleas are a relatively rare occurrence within the criminal justice system, with roughly one percent of criminal cases raising an insanity defense (Melton, Petrila, Poythress, & Slobogin, 2007). An insanity acquittal occurs in about one in four of these cases (Blau, McGinley, & Pasewark, 1993; Murrie & Warren, 2005; Quinsey, 2009; Zapf, Golding, & Roesch, 2006). Warren, Fitch, Dietz, and Rosenfeld (1991) reviewed 894 pre-trial reports for criminal responsibility in Virginia and found that 8% of the defendants were adjudicated not criminally responsible. In Hawaii, the rate of insanity

pleas is slightly higher than the national average, with estimates of 1–3% of criminal cases raising an insanity plea, with the courts determining acquittal in about 25% of felony cases raising this defense (Gowensmith, 2008). There are approximately 300 felony criminal responsibility evaluations conducted in Hawaii annually, most of which occur in the First Judicial Circuit (Island of Oahu, Gowensmith, 2008).

1.1. Mental state at the time of the offense evaluations

In contrast to a competency to stand trial (CST) evaluation, criminal responsibility assessments require the clinician to conduct a retrospective evaluation of the defendant’s mental state at the time of the offense (Acklin, 2007a; Melton et al., 2007; Roesch, Viljoen & Hui, 2004; Simon & Shuman, 2002). “The overriding goal of the insanity evaluation is a comprehensive reconstruction of the defendant’s functioning at the time of the offense” (Rogers, 2008, p. 113). Given the retrospective and inferential nature of the examination, assessment of mental state at the time of offense is one of the most challenging forensic assessments (Acklin, 2007a; Melton et al., 2007).

Retrospectively, the forensic examiner must dissect the offense and examine and integrate the clinical and collateral data (Acklin, 2007a; Melton et al., 2007; Murrie & Warren, 2005; Simon & Shuman, 2002; Warren et al., 2004). This requires reconstruction and evaluation of events leading up to, during, and following the offense, thereby creating

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“a reconstruction of the defendant's thought processes and behavior” (Melton et al., 2007, p. 201; Rogers, 2008; Weiner, 2006).

In assessing criminal responsibility, it is insufficient to opine that a defendant possesses a mental disease or disorder with impaired understanding, appreciation and/or control of their behavior. The mental disorder must also cause functional and legally definable impairments (Grisso, 2003). While most successful criminal responsibility cases involve psychotic disorders, psychosis is not synonymous with insanity (Acklin, 2007a; Melton et al., 2007). Psychiatric diagnoses do not drive the findings of insanity; rather, diagnoses provide the forensic evaluator with a framework for assessing pertinent clinical symptomatology and linking these factors with conduct at the time of the offense (Grisso, 2003; Rogers, 2008). Linking psychiatric factors to conduct at the time of the offense relevant to legal capacities carries weight in addressing the pending legal issue (Grisso, 2003; Melton et al., 2007).

1.2. Quality issues in criminal responsibility reports

Quality of forensic work products is a central component in the evolution of standards in the field of forensic mental health assessment (Heilbrun, DeMatteo, Marczyk, & Goldstein, 2008). Nicholson and Norwood (2000) observed, “The practice of forensic assessment falls far short of its promise” (p. 40). Warren et al. (2004) suggest that ordinary forensic practice typically falls short of professional aspirations. Wettstein (2005) reviewed the empirical research regarding perceived quality of forensic evaluations, highlighting problems in several areas: definitional criteria, process of quality assessment, quality indicators and measures, in the ongoing quality improvement enterprise. The developing literature emphasizes the need for improvement in the practice of forensic assessment, noting the wide variability and inconsistency in forensic evaluations across different jurisdictions (Gowensmith, Murrie, & Boccaccini, 2012; Heilbrun et al., 2008; Nguyen, Acklin, Fuger, Gowensmith, & Ignacio, 2011; Nicholson & Norwood, 2000; Otto & Heilbrun, 2002; Robinson & Acklin, 2010; Wettstein, 2005). Identified areas of quality variability include inconsistent use of psychological testing, failure to assess factors related to the legal issue at hand, lack of use of third party data, and lack of a linkage between clinical findings, capacities, and legal questions (Nicholson & Norwood, 2000).

Grisso (1986) outlined a variety of common criticisms that are often leveled against forensic evaluators, including lack of relevance of the opinions relative to the legal question, lack of confidence in expressed opinions, and opinions based on inadequate sources of information. Frequent faults include opinions that lack rationales, where the forensic purpose or referral question is unclear, organizational problems in report format, inadequate database (i.e., lacking data sources or use of irrelevant data), and overuse of clinical jargon (Grisso, 2010). Grisso characterizes competent forensic practice as: *accurate and accountable* (i.e., clear and logical explanations for what one does, what the data holds, and the conclusions), *specific* (i.e., efficiently answering the question that was asked by the referral source with necessary and logical clinical and forensic information), and *conceptually integrated* (i.e., the conclusions of the forensic evaluation should be consistent and based on logical and sound techniques, theories and information).

Heilbrun and Collins (1995) noted that forensic evaluators infrequently addressed important psycholegal components in criminal responsibility evaluations. Only 41% of the sample reported a conclusion regarding whether the defendant knew what they were doing, 27% addressed the awareness of consequences, and 29% addressed the awareness of wrongfulness in the defendant. In a study of 46 criminal responsibility reports, Borum (1994) found that 20% failed to mention criminal responsibility. In Hawaii, Acklin et al. (2005) found that 49% of criminal responsibility evaluations and 63% of CST evaluations failed to include a rationale for the psycholegal opinion. Robinson and Acklin (2010) found that 74% of CST evaluations included a rationale for their findings. In a study of conditional release report quality in Hawaii, Nguyen et al. (2011) found that only 35% of conditional release reports

gave a complete rationale for the opinion of dangerousness. Only 60% gave a complete rationale for the conditional release recommendation. A necessary and sufficient forensic opinion links clinical and legal factors to the legal standard and standard of proof (“To a reasonable degree of psychological certainty, Mr. Doe's cognitive and volitional capacities were substantially impaired by schizophrenia”; Babitsky & Mangraviti, 2002).

Rogers and Shuman (2000) suggest that the state of insanity evaluations has “largely been an idiosyncratic process, reflecting the propensities and proclivities of the clinician” (p. 520). Grisso (2010) described failure to document the use of third party information as a common error occurring in forensic evaluations. In a study conducted by Otto et al. (1996), as cited in Nicholson and Norwood (2000), which reviewed 71 criminal responsibility reports, only 10% of the reports used any other data than the defendants' narratives from which they developed their opinions. Warren et al. (2004) found that clinicians tended to offer their opinions based on incomplete data. This study found that over half the examiners offered an opinion without review of the defendant's statement, criminal history or witness statements.

The professional literature defines parameters that represent best practices in forensic report quality. Heilbrun (2001) outlined 29 broad principles, grouped into four broad categories: preparation, data collection, data interpretation, and communication. These include ethical elements, absence of jargon and clarity of exposition (Allnutt & Chaplow, 2000; Giorgi-Guarnieri et al., 2002; Harvey, 1997; Melton et al., 2007), data elements in the forensic database; methodological elements, including procedures utilized in the assessment (Acklin, 2007a,b; Archer, Buffington-Vollum, Stredny, & Handel, 2006; Borum & Grisso, 1995; Lally, 2003; Melton et al., 2007; Nguyen et al., 2011; Robinson & Acklin, 2010), and opinion and rationale demonstrating linkages between clinical and legal impairments in relation legal standards (Gagliardi & Miller, 2008; Grisso, 2003; Melton et al., 2007; Zapf et al., 2006). The evaluator's justifications for an opinion should be clearly communicated (Gagliardi & Miller, 2008; Golding et al., 1999; Grisso, 2003; Hecker & Scoular, 2004; Melton et al., 2007; Wettstein, 2004). “Reports that only provide cursory psycholegal opinions or those that leap from a diagnosis to a psycholegal opinion no longer meet the standard in the field” (Conroy, 2006, p. 240). The forensic clinician is held by ethical standards to substantiate conclusions and provide the basis for the conclusions presented in a forensic report (Skeem & Golding, 1998; Specialty Guidelines, 1991, 2011). Determinations, opinions and diagnoses must be independent of other examiners and based on substantiated data and reasoning (Connell, 2008, HRS-704-404). Skeem and Golding (1998) state: “The most critical function involves advising the court about the defendant's specific abilities and deficits and explaining one's reasoned inference about the bases for these deficits” (p. 358).

1.3. Levels of agreement between forensic evaluators and the court

There is a high rate of agreement between a forensic opinions and ultimate judicial determination. Studies of CST evaluations report greater than 90% agreement rates (Greenberg & Wursten, 1988; Hecker & Steinberg, 2002; Warren et al., 2006; Zapf, Hubbard, Cooper, Wheelles, & Ronan, 2004). Research on forensic reports in Hawaii found agreement rates between forensic evaluators and judicial determination at approximately 90% (Acklin et al., 2005). Robinson and Acklin (2010) found that in 66% of these cases, evaluators and judges agreed on defendants' CST. Gowensmith et al. (2012) found “good” agreement rates among evaluators, with 70.9% agreement between all three evaluators in initial CST evaluations in Hawaii; the court and a consensus of evaluators (2 of 3) agreed on initial CST determinations 92.5% of the time. In contrast to CST reports, Nguyen et al. (2011) found that in conditional release evaluations (evaluations for post-acquittal release), all three of the evaluators and the judge reached unanimous agreement in only 39% of cases.

Limited data is available about the inter-rater agreement rates of insanity evaluations. Most recently, Gowensmith, Murrie, and Boccaccini

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