FOURTH EDITION

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A Handbook for Mental Health Professionals and Lawyers

Gary B. Melton,
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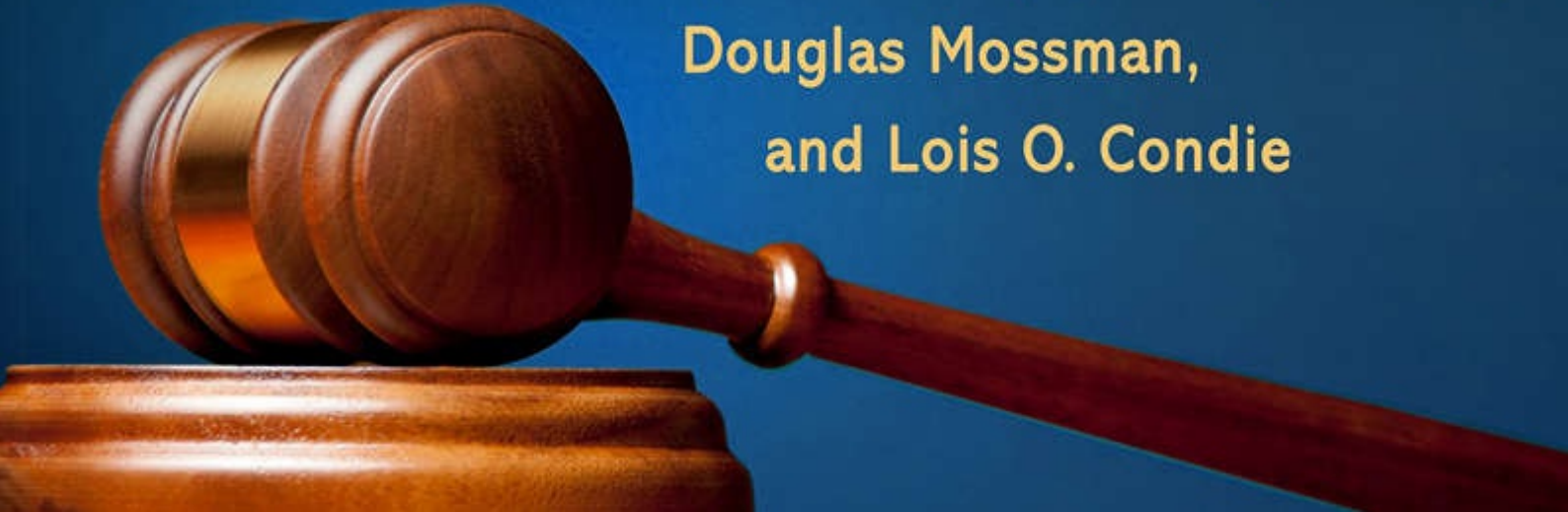

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Preface

GENERAL REMARKS

This is the fourth edition of this book. Since the first edition appeared in 1987, the fields of forensic psychology and psychiatry have expanded enormously, whether one focuses on theory, practice, or empirical findings. Taking account of these explosive developments has required us to revise virtually every aspect of the book—first in a second edition published in 1997, then again in 2007, and now, once again, in 2018. To ensure comprehensive coverage of all these new developments and areas of practice, we've also added three authors since the first edition: psychologist Randy K. Otto, who joined the book in the third edition, and psychiatrist Douglas Mossman and psychologist Lois O. Condie, who join in this edition. (At the same time, we have reluctantly proceeded without the insights of one of the original four authors, Norman G. Poythress, who has retired.) Like the first three editions, this edition is aimed at two groups: mental health professionals who perform psychological evaluations for the courts, and lawyers and judges who request such evaluations. We aim to provide these groups with a comprehensive guide to the issues the legal system has most commonly asked mental health professionals to address.

The contexts examined in this book are thus quite diverse. They include insanity and competence determinations; sentencing and civil commitment proceedings; probate and guardianship hearings; personal injury and workers' compensation claims; juvenile delinquency and status offense adjudications; custody and child abuse/neglect disputes; federal discrimination, Social Security, and immigration claims; and educational "mainstreaming" issues. In each of these areas, we first summarize the relevant legal rules and their jurisprudential underpinnings. We then try to analyze the law's approach critically, both to increase the mental health professional's understanding of the issues and to enhance the lawyer's ability to argue for change. In addition, unlike many works on "forensics," this book incorporates or refers to research on each topic—including pertinent studies concerning the validity of clinical opinions and specific evaluation techniques, actuarial data on persons subject to evaluation, and empirical assessments of the manner in which the legal process actually works. Finally, we offer suggestions about evaluation procedures and ways of communicating information to the courts. These recommendations are not offered solely for the benefit of mental health professionals; they should also help demystify the evaluation process for the lawyer.

The collective experience culminating in this book is wide-ranging. Two of the original authors (C. S. and J. P.) are lawyers with specialized educational backgrounds in mental health law, one of whom (C. S.) is a law school professor who at one time represented individuals with mental disabilities, and the other of whom (J. P.) directed an interdisciplinary program of research and policy on law and mental health after serving for many years as chief counsel to the New York State Office of Mental Health. The other two original authors

(G. B. M. and N. G. P.) are psychologists—one (G. B. M.) a policy scholar who has worked for about 40 years in interdisciplinary graduate programs, centers, and institutes on children, families, and communities, and the other (N. G. P.) a recently retired practicing clinician and university professor who devoted much of his career to studies of the forensic process. One of the three new authors (R. K. O.) is a professor who specializes in forensic psychological assessment and has performed hundreds of evaluations focused on a variety of legal matters. The other new authors are a psychiatry professor (D. M.) whose teaching, clinical practice, and scholarship emphasize a variety of practice-related and academic issues in law and mental health, and a psychologist (L. O. C.) who specializes in children's issues, especially in connection with education, entitlements, and parenting capacities. Each of us has trained both mental health professionals and legal practitioners in mental health law, and we have all observed or performed scores of psychological evaluations for the courts. The idea for this book grew out of a training program in Virginia, which involved two of us (C. S. and G. B. M.) in establishing a statewide community outpatient evaluation system.*

While the diversity in our backgrounds has led to differing areas of specialization, we have reached some common conclusions about psychological evaluations for the courts. These themes permeate the book and are worth stating here at the outset.

First, we obviously believe that mental health professionals play important roles in the legal system. To put this somewhat differently, we believe that in most contexts, the potential contributions of mental health professionals outweigh the prejudice and systemic inefficiency that may result from their use. Contrary to the assertions of some writers, clinicians do have specialized knowledge that can assist judges and juries in arriving at better-informed decisions.

On the other hand, input from mental health professionals is frequently misused, overused, and on occasion underused by the legal system, depending upon the specific issue. At times, the law appears interested only in obtaining a conclusory "expert imprimatur," which hides the moral (and uncomfortable) nature of the decision being made [see § 9.09(c)(7) on dangerousness assessments]. At other times, the legal system demands more detailed inferences from a clinician, but in situations in which lay testimony and common sense are all that are required [see § 16.01(a) on custody determinations]. And at still other times, the courts completely disregard valid scientific findings, apparently out of fear that the factfinder will pay too much attention to them [see § 18.05(a) generally, and Table 18.1 on judicial acceptance of actuarial evidence].

A significant goal of this book is to sort through this seemingly contradictory approach to clinical expertise and to provide some guidance for its use in the legal areas we address. Throughout this volume, we urge lawyers and judges to look carefully at the foundations of clinical opinions, and we urge mental health professionals not to overstep the bounds of their existing knowledge. More specifically, we admit a strong preference for research-based testimony, although we would not bar evidence founded on theoretical constructs or "educated intuition" in most contexts. We also believe that mental health professionals have an obligation to make clear the uncertainty of their offerings, whether research-based or theory-based, and that lawyers should not attempt to deny or gloss over the probabilistic nature of clinical decisionmaking. Perhaps most controversially from the practitioner's point of view, we think that mental health professionals should be neither permitted nor cajoled to give so-called "ultimate" legal opinions lacking in clinical content, even when they make clear that the opinions are nonscientific. All these stipulations stem from our belief that if mental health professionals are to assist the legal system, they and the lawyers who seek their aid must tread a fine

line between co-opting the legal decisionmaker and condoning legal results uninformed by credible information concerning human behavior.

Assuming that mental health professionals can contribute constructively in the legal process, the task becomes one of maximizing their usefulness. First and foremost, this requires making clinicians (and lawyers) aware of the legal framework in which they will participate, and making lawyers (and clinicians) at least cognizant of basic forensic evaluation procedures. Most of the chapters in this book are devoted to this enterprise. It also requires, in our opinion, that forensic evaluations be tailored to the specific legal problems at hand. At several points in this volume, we stress that lawyers should generally not request, and that clinicians generally should not perform, global evaluations aimed at discovering "what's wrong" with litigants. Nor should either type of professional distort legal issues to fit clinical constructs. Competence evaluations, for instance, primarily require an assessment of the defendant's current functioning, not categorization by diagnosis, regurgitation of family and social histories, or intricate psychodynamic formulations.

Adopting these precautions will go far toward achieving full use of clinical expertise. But we believe that if mental health professionals are to be as useful to the courts as they possibly can be, conceptual as well as practical steps need to be taken. First, it is important for members of both professions to develop a better understanding of the paradigmatic differences between them. Second, it is crucial that both groups become sensitive to the ethical and legal dilemmas raised when a court asks a member of the "helping" profession to assess the mental condition of a person whose interests may be harmed by the results of the evaluation. Although these issues are most directly addressed in Chapters 1 and 4, respectively, they too are interwoven throughout the book.

A final pervasive theme of this volume has to do with the forensic clinician's "job description." It has become commonplace to characterize mental health professionals involved in the legal system as "hired guns." Assuming, as we feel confident in assuming, that most professionals honestly believe in their testimony, it is still true that the adversary process tends to define differences sharply. This should not mean, however, that clinicians must be pigeonholed as mere puppets of the attorneys who have retained them. At several points in this book, we recommend that the best way to conceptualize the clinician's role is as an exercise in consultation and dissemination of information. That is, the mental health professional is often utilized most efficiently in advising various members of the legal system—judges, lawyers, jail personnel, or parole officers—about the behavioral idiosyncrasies of the individual in question. Certainly, this may involve testimony in an adversarial setting. But this testimony should above all be informative; moreover, there are other less dramatic ways in which the clinician as evaluator can aid the legal system prior to adjudication. In this book, we try to identify some of these nontraditional uses of clinical expertise.

THE CONTENT OF THE BOOK

With these themes in mind, the specific subjects covered in the book can be described. The book is divided into five parts: "General Considerations," "The Criminal Process," "Noncriminal Adjudication," "Children and Families," and "Communicating with the Courts." With a few exceptions, noted below, this edition maintains the organization of previous editions. But legal, clinical, and empirical materials in each chapter have been updated to reflect 21st-century developments. The reader will also find more references to the

medical and neuroscientific literature than in previous editions. At the same time, the book continues to cite and discuss leading cases (regardless of their age), classic scholarship, and 20th-century practices and research that have stood the test of time.

Part I, "General Considerations," contains five chapters examining topics of overarching consequence to the book. Chapter 1, "Law and the Mental Health Professions: An Uneasy Alliance," sets the conceptual stage for the rest of the book by addressing two central questions, both briefly alluded to above. The first of these focuses on the implications of the philosophical differences between the legal and mental health professions: What, if any, are the implications of these differences for clinical participation in the legal system? Perhaps legal and mental health professionals are so far apart in their basic worldviews that understanding one another on any more than a superficial level is a hopeless task. Perhaps their assumptions about the motivations behind human behavior, the concept of "knowledge," or the process of discovering "truth" (to name a few points of contention) are so divergent that the law, if it is to maintain its integrity, must either change its basic tenets or refrain from relying on mental health professionals at all.

The second question addressed in Chapter 1 assumes that paradigmatic differences can be resolved short of taking either of these two drastic steps, but is nonetheless also fundamental: Is the type of information a mental health professional can provide of any use to the legal system, or are clinical offerings so flimsy that the courts are better off seeking evidence from more traditional sources? That is, are mental health professionals really "experts" who can assist factfinders on the issues raised by the law? As noted above, under the most modern definition of the term (informed by the Supreme Court's decision in *Daubert v. Dow Chemical*), we think the answer to this question is a qualified yes, despite the courts' increasing insistence on a "scientific" basis for opinion testimony. This edition contains a number of new reflections on these issues.

Chapter 2, "An Overview of the Legal System: Sources of Law, the Court System, and the Adjudicative Process," is on a decidedly different level from Chapter 1, but, like that chapter, it is intended to provide a backdrop for subsequent parts to this book. It is essentially a primer on the "infrastructure" of the law—where the law comes from, the procedures governing its application, and the points at which it seeks clinical testimony. Concepts that are part of a lawyer's daily armamentarium sometimes befuddle mental health professionals, thereby reducing their effectiveness as forensic clinicians. Chapter 2 provides answers to a number of basic questions: For example, what does it mean to say that a law is "constitutional"? What is the difference between a state court and a federal court? What are the stages of the criminal process, and how do they differ from the stages of "civil" proceedings? And (new with this edition) to what extent does international law affect the forensic evaluation process in the United States? These questions should illuminate the legal arena for the clinician and thus should facilitate interdisciplinary cooperation. The chapter should also help the mental health professional put in context the legal discussions in the following chapters.

Chapter 3, "The Nature and Method of Forensic Assessment," describes in more concrete terms than Chapter 1 the "attitude adjustment" that is necessary when mental health professionals whose training and experience typically focus on treating people become forensic evaluators. The chapter begins with a general exploration of the multiple practical differences between therapeutic and forensic pursuits, emphasizing the investigative nature of the latter. It then discusses the limited usefulness, for forensic purposes, of traditional clinical tools such as psychological tests and diagnostic procedures; describes various ways of gathering all-important third-party information; and analyzes a number of forensic evaluation methods, including selected

specialized evaluation protocols and procedures for detecting malingering. This edition includes new extended commentary on instruments and other procedures designed to detect feigning of mental disorder. The chapter ends by describing the evidentiary rules that govern the admissibility of testimony based on use of these techniques.

Chapter 4, "Constitutional, Common-Law, and Ethical Contours of the Evaluation Process: The Mental Health Professional as Double Agent," examines the complex, interwoven legal and ethical principles that control the process of evaluation, ranging from the Fifth Amendment's privilege against self-incrimination to the "*Tarasoff* duty," the Health Insurance Portability and Accountability Act (HIPAA) requirements, and professional practice rules. From the clinician's point of view, each of these principles aims at answering a single question: "Who is the client?" Unfortunately, the answers they suggest often conflict. Although this chapter attempts to reconcile the various legal and ethical pressures on the clinician, it is probably impossible to do so entirely satisfactorily, at least in the abstract. The primary goal of the chapter, therefore, is to identify these pressures concisely so that judges, lawyers, and mental health professionals will be sensitive to them in individual cases. In pursuing this goal, the chapter explicitly analyzes the professional guidelines that have been developed since the third edition appeared.

Like the other chapters in Part I, Chapter 5, "Managing Public and Private Forensic Services," deals with issues that affect all of the substantive evaluation contexts discussed in Chapters 6–17. It looks at three separate topics, organized somewhat differently than in previous editions. The first part of the chapter examines different types of systems for delivering forensic evaluations and offers suggestions for how to implement them. The second part discusses ways of diffusing behavioral science research to legal policymakers. The third part is aimed at the individual practitioner, providing hints on how to establish and maintain a forensic "business." The overarching theme of the chapter is that to protect the integrity of traditional mental health practice, ensure a viable forensic system, and systematize the transfer of behavioral knowledge to the legal system, specialization in forensic work is necessary.

With the general backdrop provided by Part I, the reader is better equipped to tackle specific areas of forensic assessment. The next three parts of the book deal with over 20 "substantive" evaluation areas. Any such treatment of forensic issues that attempts to be comprehensive must describe basic legal rules and procedures and must recognize fundamental clinical realities. But we have also tried to add fresh material from the legal, empirical, and clinical archives, and to mix in our own insights when we think we have something to offer. In the brief descriptions of Parts II, III, and IV that follow, these latter aspects of the book are emphasized. The table of contents should be consulted to obtain a more complete overview of each chapter's scope.

Part II, "The Criminal Process," is devoted to psychological evaluations performed for the criminal justice system. The classic example of the mental health profession's involvement in this system has been expert testimony about "insanity." But responsibility assessments are only one small aspect of current clinical participation in the criminal process.

Chapter 6, "Competence to Proceed," discusses an issue that demands the services of more mental health professionals each year than all other types of criminal evaluations combined. As a way of combating the abuses associated with the huge and easily manipulated system that fitness determinations have spawned, the chapter emphasizes the narrow focus of the competence evaluation and points out the opportunities clinicians

have for consulting with the legal profession about alternative pretrial dispositions. It also examines critically the various psychometric instruments designed to aid in assessing competence. Several sections of this chapter have been rewritten to reflect developments in the past decade.

Chapter 7, "Other Competencies in the Criminal Process," deals with less frequently acknowledged areas of clinical input in the criminal justice system. Specifically, it covers competence to consent to a search, competence to exercise the right to silence during interrogation, competence to plead guilty, competence to waive one's right to an attorney, competence to refuse an insanity defense, and competence to be sentenced and executed—subjects not normally addressed in forensic volumes. The chapter also discusses competence to testify and the related issue of expert testimony on the credibility of a witness, both of which arise in the civil as well as the criminal context. Of particular note is the chapter's attempt to provide some framework for assessing "voluntariness"—a problematic concept for both lawyers and clinicians, but one that is nevertheless extremely relevant in any situation involving the waiver of rights like the right to remain silent or the right to counsel. Among other additions to this edition is an analysis of research about the impact of interrogation techniques on criminal suspects.

Chapter 8, "Mental State at the Time of the Offense," confronts perhaps the core issue of the criminal law: the scope of one's responsibility for one's actions. Because the insanity defense still triggers the mental health profession's most visible forensic endeavor, the legal portion of this chapter is largely a discussion of that doctrine's historical development, its component parts, and the popular myths that surround it. But this part of the chapter also investigates other doctrines relevant to the responsibility inquiry, such as the defenses of automatism, diminished capacity, and intoxication, and the verdict of "guilty but mentally ill." Chapter 8 also addresses the use of mental health testimony in connection with more traditional defenses such as self-defense and duress, and tackles the difficult issue of when "character evidence" should be admissible, independent of other defenses. As in the legal section, the research and clinical sections of this chapter are particularly careful to address whether mental health professionals have anything to offer in these areas. To that end, we discuss the newest studies concerning novel "syndromes" that might be accorded exculpatory significance (including dissociative states and posttraumatic stress disorder); examine research on recently developed techniques for evaluating past mental impairment; look at the usefulness of clinical formulations; and offer our own recommendations for conducting a "reconstructive" evaluation of a defendant's mental state at the time of the offense.

The final chapter in Part II, "Sentencing," considers the area of the criminal law that has long been thought to be a special preserve of the mental health professions. Chapter 9 describes the rise of the "rehabilitative ideal," which led to this notion; the advent of "determinate" sentencing; and the research suggesting that clinical opinion generally has minimal impact under either se®ntencing system. This edition looks particularly closely at "sexual predator" statutes and developments in capital sentencing law. The chapter then examines the extent to which clinicians can offer useful sentencing information, focusing on the three "clinical" issues that most often arise in this context: amenability to treatment, culpability, and dangerousness. We pay special attention to the last of these areas, since much has been said about the "inability" of clinicians to evaluate violence-proneness. We closely examine the research on the topic (updated through 2016) and address its evidentiary and ethical implications, concluding that a combination of clinical, actuarial, and anamnestic assessment is necessary in this area.

The four chapters in Part III, "Noncriminal Adjudication," leave the criminal arena and deal with contexts that have traditionally been described as "civil" in character. As Chapter 10, "Civil Commitment," makes clear, however, the term is a misnomer when applied to commitment. The deprivation of liberty associated with involuntary hospitalization—combined with the extensive empirical findings indicating the failure of efforts to "legalize" the commitment process, and other data suggesting the relative ineffectiveness of hospital care—lead us to conclude that clinicians should participate cautiously in this area. Recognizing that professionals must work within the commitment system despite its defects, we criticize the Supreme Court's decisions relaxing strictures on the process, recommend an adversarial role for attorneys, and supply clinicians with current data on the predictability of short-term dangerousness to self and others. The chapter also contains significant material on outpatient commitment and a completely new section on suicide prediction. The chapter ends with a discussion of commitment and "special" populations: minors, people with intellectual disabilities, prisoners, insanity acquittees, and people who abuse substances.

Chapters 11 and 12 look at areas that are more accurately deemed "civil" in nature. Chapter 11, "Civil Competencies," discusses a number of contexts involving assessments of current functioning: competence to handle one's financial and personal affairs (i.e., need for guardianship), competence to consent to treatment (experimental or otherwise), and competence to execute a will. As in Chapters 6 and 7 on criminal competencies, this chapter stresses the focused nature of the capacity assessment and the consultative role available to mental health professionals. New descriptions of the available assessment instruments appear in this edition.

Chapter 12, "Compensating Mental Injury: Workers' Compensation and Torts," describes the two primary systems for reimbursing the individual injured through the "fault" of another: workers' compensation and tort law. Both systems compensate "mental injury," but both have great difficulty designating the circumstances under which such compensation should occur. This chapter exposes the conceptual gap between the legal and clinical professions on the key compensation issue of "causation," and offers some hints as to how mental health professionals should approach it, with new material on assessment methodologies. Developments that have tended to restrict recovery for mental injury are highlighted.

The final chapter in Part III, Chapter 13, has a new title, "Federal Antidiscrimination, Entitlement, and Immigration Laws," because it now includes a discussion of law and evaluation issues relevant to immigration, a developing area of forensic practice. Before discussing that topic, the chapter addresses three other federal laws—the Americans with Disabilities Act, the Fair Housing Amendments Act, and the Social Security Act—that have a significant impact on people with mental disorders. The first two laws prohibit unnecessary discrimination against people with mental and physical disabilities in the employment and housing contexts. The third law, which is of much older vintage, provides those who are more severely impaired with a modicum of financial security (although amendments governing eligibility of children significantly diminish this security for that group). After canvassing the complicated legal rules created by these statutes, the chapter details the relatively rigid, recently updated evaluation procedures the government has imposed in these areas.

Part IV, "Children and Families," is the last substantive section of the book, devoted entirely to the subject of children's involvement in the legal process—a topic that has received considerable legal and empirical attention in recent years. Its first three chapters, entitled "Juvenile Delinquency," "Child Abuse and Neglect," and "Child Custody in Divorce," are each organized around a triad of themes. First, clinicians know very little

about the effectiveness of court dispositions involving children and families because the topics are so difficult to study, given the number of variables involved. For instance, in the typical case there are an infinite variety of dispositions available; the possible interactions between these interventions and the characteristics of children and families are complex; outside variables such as the impact of teachers can have a major impact; and any effects discovered may vary enormously over time, so that a good disposition for an 8-year-old may be a bad disposition for a 15-year-old. Second, because of this empirical ignorance, mental health professionals should view their assessment role primarily as one of providing information about these issues, not of judging what the information means legally, and judges and lawyers should be cautious about imposing interventions. Third, the investigative data sought by evaluators should come not only from the child and the family, but from a wide range of other sources as well; that is, the evaluation should be ecological in nature. All three chapters are updated to take into account the significant legal, empirical, and therapeutic developments over the past decade in connection with children, including efforts to transfer jurisdiction to adult criminal courts; research on juvenile competence to proceed, juvenile psychopathy, and juvenile treatment programs; and data concerning the etiology of abuse and the impact of divorce.

The fourth chapter in Part IV, "Education and Habilitation," sounds the same themes, but focuses on a single federal law, the Individuals with Disabilities Education Act, which requires the evaluator to address additional issues connected with "mainstreaming" children with disabilities into the public school system. Chapter 17 was included because the Act has given rise to a vast disability education "industry," which might benefit from a structured inquiry into the purposes of the law and the best ways to implement them. This edition includes significant new material on relevant research and tips about how to focus the evaluation.

Part V, "Communicating with the Courts," concludes the book by delving into the important task of communicating the results of an evaluation to the legal system. Chapter 18, which provides suggestions to mental health professionals and lawyers about "Consultation, Report Writing, and Expert Testimony" (including new material on social psychology research relevant to being an effective witness), is the principal chapter in this part. But because reports are often the primary way in which many mental health professionals and lawyers communicate, we also include Chapter 19, containing sample evaluation reports devoted to several of the issues covered in this book (for a total of 19 sample reports, with reports describing Social Security and immigration evaluations new to this edition). This chapter serves two different purposes. First, it provides examples of the types of reports we think should be presented to the courts (although no doubt they can be improved upon substantially). Second, the reports, and the commentary that accompanies each of them, provide concrete illustrations of the abstract legal and clinical points made in earlier chapters. The final chapter in the book, Chapter 20, contains two glossaries: one of legal terms, the other of clinical and research terms. These glossaries define much of the jargon used in this book, as well as other words that might pose obstacles to communication between the lawyer and the mental health professional.

SOME COMMENTS ON THE BOOK'S STRUCTURE

As noted at the beginning of this Preface, all the chapters on the substantive evaluation issues follow a simple format designed to benefit both legal and mental health professionals: They begin with analysis of the law; then examine the research, if any, on the subject; and end with a discussion of the proper method for

performing an evaluation in the area. While the legal sections are written with nonlawyers in mind, lawyers should find them useful because they try to canvass the relevant legal positions; often include state-by-state reviews of the law; and provide citations to leading cases, statutory material, and secondary resources. At the same time, our hope is that this depth of legal coverage will help mental health professionals better appreciate the policies that find expression in "the law."

The research and clinical sections stress precepts unique to forensic practice. While it is obvious that without basic knowledge about human behavior and psychopathology, one cannot hope to be a skilled forensic clinician, we felt that the most efficient approach to take in this volume would be to assume such knowledge rather than rehearse it. This approach should not frighten legal professionals away, however. As already noted, the research and clinical sections can provide lawyers with insights into the clinical process and with knowledge that can help them measure the quality of any evaluations or reports they request. Thus we recommend that lawyers as well as clinicians read both the legal and clinical sections.

As we did in the third edition, we have included in this edition one or more case studies or problems in most of the chapters (for obvious reasons, we have not constructed problems for the report-writing and glossary chapters). Each of the case studies describes a fact situation, occasionally with variations, and then asks questions that raise legal and/or clinical issues covered in the relevant chapter. The problems, in contrast, are not fact-based, but rather are policy-oriented. The primary reason we have included these exercises in the book is to assist those who use it as a pedagogical text in understanding and explicating the subject matter. However, relative veterans in the forensic field might also find them helpful as "self-test" mechanisms. Not all the exercises have definitive answers, but we have tried to provide, in close proximity to each, enough material to provoke incisive thought on the issues raised.

Each chapter is divided into numbered sections and lettered and numbered subsections—an organizational device that is perhaps somewhat "bureaucratic," but that we think makes the contents of the chapters more accessible and provides ease of cross-referencing. If the practitioner is interested in discovering the relevant law or research on a particular topic, a quick look at the table of contents should generally suffice, although referring to the extensive index may be helpful as well.

The reader interested in exploring further the topics covered in the book should find it useful to consult the bibliography at the end of each chapter. These bibliographies are not meant to be comprehensive. Rather, they represent a compilation of some of the books and articles in each subject area that are noteworthy for their conceptual contributions and their thoroughness. We have also included leading cases. The reader who seeks still further information can find many other sources in the Notes section at the end of the book.

A word about the terminology used in this book is in order. As should already be clear, we use the word "clinician" interchangeably with "mental health professional" to designate any professional in the mental health system, including social workers and psychiatric nurses as well as psychiatrists and psychologists. As we indicate in Chapter 1, many of the distinctions among these groups that are imposed by the law and guild concerns are less meaningful in forensic practice. We also try to use "consumer-oriented" language when referring to people who have a mental disability. Any lapses in this regard are matters of oversight.

We hope that this book will improve the contributions mental health professionals make to the legal system. We also encourage criticisms and comments about its content, so that this improvement can continue. Finally, we acknowledge the research assistance of Rebecca Alley, Robin Kimbrough-Melton, and Sam

Swindell on previous editions, and of Neil Greenwell on this edition.

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* *See* Gary B. Melton, Lois Weithorn, & Christopher Slobogin, COMMUNITY MENTAL HEALTH CENTERS AND THE COURTS: AN EVALUATION OF COMMUNITY-BASED FORENSIC SERVICES (1985).

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7. Other Competencies in the Criminal Process

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PART I

GENERAL CONSIDERATIONS

CHAPTER 1

Law and the Mental Health Professions

An Uneasy Alliance

1.01. THE CONTEXT FOR LAW AND BEHAVIORAL SCIENCE

In the late 19th century, a well-known lawyer and judge once grouped witnesses into three classes: "simple liars, damned liars, and experts."[1] As this declaration and several similar ones from that era make clear,[2] expert witnesses of all types have long been the objects of scorn in some quarters. But mental health professionals have been particularly popular targets of critics. Although the criticism has diminished somewhat in recent years, society in general, the legal profession, and mental health professionals themselves have long voiced a dim view of what mental health professionals say in court.[3]

The public's antipathy toward clinical opinion appears to stem from the belief that much "expert" testimony is based on "junk science" from professionals who, for a fee, will find evidence of almost anything.[4] Although seldom successful,[5] highly publicized psychological defenses—often associated with flamboyant names like "abuse excuse" or "urban survival syndrome"[6]—have led many in the public to question the objectivity and expertise of the mental health professions.[7] For decades, popular commentators have worried that liberal psychologists and other experts use the legal process to undermine the political judgments of popularly elected legislators.[8] Thus, for instance, dismay about mental health testimony led both houses of the New Mexico legislature to pass legislation in 1995 (ultimately vetoed by the governor) that would have required mental health professionals who testified in criminal cases to "wear a cone-shaped hat that is not less than two feet tall."[9]

Legal professionals have echoed these concerns. The late Judge David Bazelon, who at one time advocated for liberal use of behavioral science in legal decisionmaking, ultimately described himself as a "disappointed lover" chagrined by clinicians' overreaching into moral and political domains.[10] A deputy associate attorney general with the federal government stated that "quite frankly, you'd be better off calling Central Casting to get 'expert psychiatric testimony' in a criminal trial."[11] Legal scholars have called most forms of clinical opinion testimony "story-telling" and "suppositional," because it is untested by any scientific method.[12] Published appellate cases document numerous in-court statements impugning the morals and objectivity of mental health experts.[13] Partly because of the controversy associated with courtroom behavioral expertise, law schools now offer entire courses on use of expert social science evidence.[14]

Concerns expressed by the public and the legal world about psychological expertise have been more than matched by criticisms leveled by the mental health profession itself.[15] A crucial turning point in this conflict was the publication, in the late 1980s and early 1990s, of articles by Jay Ziskin and David Faust in *Science* and other prestigious journals arguing that clinical opinions were neither reliable nor valid enough to be used as

evidence in court.[16] Although others had previously made similar arguments,[17] the prestige of the forum in which Ziskin and Faust's views appeared led to a remarkable professional brouhaha. Their articles not only stimulated special symposia at professional meetings, but also provoked replies from both the chief executive officer and the president of the American Psychological Association.[18]

The criticisms of Ziskin, Faust, and others have led innumerable investigators to pursue research over the past two decades that has vastly enhanced the scientific bases of mental health opinions. This book is devoted in large part to describing those advances, which have justifiably muted the harshest critics.[19] But even in our original 1987 edition, which came out when the criticisms of forensic clinicians were the most vehement, we took the position that the various controversies about the use of mental health professionals' opinions in the legal process had been blown out of proportion and reflected a misunderstanding of the purpose of expert evidence and the standard for its admission. As we describe in more detail later in this chapter, in scientific terms the law expects *incremental*—not absolute—validity. The question is whether mental health professionals' opinions will *assist* legal decisionmakers, not whether the opinions meet a particular standard of scientific rigor. At the same time, we believe that professional credentials by themselves are not enough to guarantee that opinions will be sufficiently helpful to warrant their admission into evidence.

The "moderate" view that we express in this chapter and throughout the book may take some of the sting out of arguments advanced both by advocates of outright exclusion and by those who defend professional prerogatives. Nonetheless, it is important to understand the underlying conflicts because they involve fundamental differences of epistemology and worldview; they will not disappear with a good-natured exchange of views. Thus the purposes of this chapter are to analyze the sources of the current ambivalence about the interaction between law and mental health, and to address generally the limits of expertise possessed by mental health professionals. In discussing these questions, we also make some initial inquiry into the problems of who is an expert, and for what purpose—questions that recur throughout this volume.

1.02. SOME PRELIMINARY PROBLEMS IN LAW AND MENTAL HEALTH

CASE STUDY 1.1

Below are excerpts of expert testimony from two different proceedings involving Mike Drake, who is charged with embezzlement. The issue addressed in the first proceeding, a criminal trial on the embezzlement charges, is whether Mr. Drake was "insane" at the time of the offense. In this jurisdiction, insanity is defined as a "mental disease or defect that causes a substantial inability to appreciate the wrongfulness of the act or to conform behavior to the requirements of the law."

Q: Now, Doctor, your testimony is that the defendant is suffering from a gambling disorder?

A: Yes.

Q: And this is a mental disease?

A: Yes, it is in the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual,* and I suppose there are 20 or 30 psychologists like myself who specialize in this area and are convinced it's a serious problem.

Q: What led you to give him this diagnosis?

A: This individual admits he is preoccupied with gambling, and can't stop himself from doing it. He feels anxious unless he is gambling or planning a gambling trip. Though he's never been in trouble with the law before, he's now at the point where he's embezzling from his company.

Q: Does this make him incapable of distinguishing right from wrong?

A: Well, here's a man who normally knows the law well, who knows about right and wrong, but a man who is in a desperate strait. He is

under a tremendous amount of stress, does not consider right and wrong. Based on my experience with these people, I don't think that becomes part of his thinking process. His process is to survive. He's losing his job, his family, his children, his reputation, everything is going down. So he functions this way, in an irrational way, which leaves his judgment impaired.

Q: And what about his ability to conform his acts to the requirements of the law?

A: He has virtually none. While he probably intends to return the money, he can't help himself from embezzling because of the urge to gamble. Again, based on my experience, people like this are prone to commit crimes to get money. There's also a study of 70 people with this disorder, which shows that one out of five have committed crimes like forgery, theft, or embezzlement. Whereas, as a conservative estimate, only 1 of 200 people in the general population commit such crimes, meaning pathological gamblers are 40 times more likely to commit these crimes than the average person. This man needs treatment, not punishment.

Q: So would you say he's insane?

A: I would, yes.

Mr. Drake is acquitted by reason of insanity and is committed to an institution for observation. A month later, the court holds a commitment hearing to determine whether he should remain in the hospital. Continued hospitalization is permitted only if Mr. Drake is shown to be "dangerous to self or others," defined as "a likelihood that, as a result of mental disorder, the individual will cause substantial harm to himself or another." The lone expert witness at the 15-minute hearing, a member of the hospital staff, testifies as follows:

Q: What is Mr. Drake's condition at this time?

A: He's unresponsive to treatment.

Q: Does that make him dangerous to others or self?

A: He is still dangerous [here the doctor describes the same study described at trial]. There is no guarantee he won't steal again to feed his habit. Also, studies show that 15–20% of persons who seek treatment for gambling disorder have attempted suicide.

Questions: Applying the test of *Frye v. United States* [see § 1.04(c) for a discussion of this case], at least one court has held that clinical testimony attempting to link gambling disorder to insanity is inadmissible.[20] On the facts of this case, do you agree? Assuming that such testimony is admissible as a general matter, should any of the witnesses' statements be legally or ethically prohibited? Assuming that the witnesses accurately described the studies they cited, should the results be admissible? What else would you like to know about the studies? Does it matter whether testimony about clinical findings or research is presented in a criminal trial by the defendant as opposed to the state at a commitment proceeding? How would your answers to these questions change if a jurisdiction followed *Daubert v. Merrell Dow Pharmaceuticals* [see § 1.04(c) for a description of this case]?

As the introduction to this chapter suggests, some clashes between law and the mental health professions reflect fundamental conceptual differences, which the next section discusses. Here we tackle some of the more practical reasons for tension between lawyers and mental health professionals.

(a) Bridging Gaps in Training

Discussions of what is "wrong" in the relationship between the legal and the mental health professions have tended to focus on relatively superficial problems of communication—typically suggesting that the core problem is that lawyers and mental health professionals do not "speak the same language." Hence (this view suggests), lawyers may be awed when a mental health professional appears to be able to sweep away the complexities of the human mind with profundities about "diffuse ego boundaries," and mental health professionals may complain that the sorts of questions lawyers ask force them to compartmentalize their observations in foreign and untenable ways. If the tension between law and mental health is the result of semantic difficulties, it should be erasable by facilitating communication between the two professional groups —perhaps through some combination of cross-disciplinary training and transformation of legal tests into language and concepts commonly used by mental health professionals.

Such a view strikes us as naive, at least for the near future.[21] We do not mean to minimize the need for training, of course. Indeed, this book is oriented toward facilitation of an understanding of the kinds of questions that the law poses for mental health professionals. We, like others, are troubled by "expert" mental health professionals who testify on a particular legal issue without any understanding of the nature of the issue they are purporting to address. We are also troubled when legal authorities claim ignorance of "medical" problems in the law and effectively avoid hard decisions by demanding conclusory opinions from mental health professionals. Both examples indicate inappropriate avoidance of "confusion by the facts." Whether legally or behaviorally trained, professionals whose practice takes them into interdisciplinary matters have an ethical obligation to learn enough to be able to function competently in such a context.

Such training will not eliminate interdisciplinary problems, however. Simply inculcating a common understanding of key terms will not eradicate the philosophical problems inherent in interdisciplinary endeavors. A well-known example of this fact was the failure of an experiment by the District of Columbia Circuit Court of Appeals in the 1950s with a new formulation of the insanity defense. In *Durham v. United States,*[22] that court, quoting well-known forensic psychiatrists, concluded that the 19th-century *M'Naghten* test[23] was based on an "entirely obsolete and misleading conception" of insanity because it focused on a defendant's ability to know right from wrong. The sole emphasis on knowing, wrote Judge Bazelon for the court, "does not take sufficient account of psychic realities and scientific knowledge." Rather than constrain mental health professionals to "one symptom," Bazelon reasoned, the law should ask psychiatrists to inform the court of the character of the defendant's mental disorder, so that jurors could determine whether the defendant's alleged act was the "product of mental disease or defect." Essentially, under this test the question was simply whether the legally relevant behavior was caused by the defendant's mental illness, a concept assumed to be well within the repertoire of mental health professionals [see § 8.02(b) for further discussion of the *M'Naghten* and *Durham* tests].

The *Durham* test ultimately failed, however,[24] because as we discuss in § 1.03(a), mental health professionals have no conceptual basis for determining which behaviors are produced by "free choice" and which behaviors are the products of mental illness. Simply medicalizing the terms of the insanity test does not eliminate the much more fundamental philosophical differences between how the law and the behavioral sciences explain human action. In Case Study 1.1, for example, the question of whether Mr. Drake's embezzlement was the "product" of a gambling disorder is not a *medical* question at all; knowing that Mr. Drake's behavior fits the gambling disorder diagnoses neither tells us whether or how the disorder "produced" embezzlement nor answers the ultimate legal question of whether he should be held responsible for it. In short, the differences between the questions the law asks jurors to decide and the questions behavioral sciences answer will not be eliminated—although they may be clarified—by acquiring a working knowledge of key concepts in the law (for mental health professionals) or the behavioral sciences (for lawyers).

(b) Bridging Attitudinal Differences

If hoping that training programs will eliminate problems in the interaction between law and mental health seems naïve, viewing these conflicts as merely reflecting attitudinal differences is simplistic. Those who emphasize the significance of these differences tend to see all lawyers (for example) as overly vigorous

advocates for the civil liberties for people with mental illness irrespective of their need for treatment. Conversely, all mental health professionals are deemed to be paternalistic problem-fixers, undeterred by concerns for individual liberty, who advocate hospitalization and treatment whether the context is civil commitment, criminal trial, or sentencing. Such perceptions lead to the conclusion that reaching some middle ground of attitudes toward people with mental disabilities would eliminate conflicts between the law and the mental health professions; what is needed, this position remonstrates, is simply some consciousness raising.

Undoubtedly, there are substantial differences in the socialization of the professions. However, we believe that differences between libertarian and paternalist attitudes are overemphasized as a source of disciplinary conflict. First, as proponents of "therapeutic jurisprudence" note, rules based on a preference for autonomy and rules meant to promote a person's mental health may lead to the same ends.[25] Second, attitudes differ as much within the professions as between them.[26] For example, the American Psychiatric Association has commonly advocated for less deference to patients' wishes and less cumbersome legal procedures in decisionmaking about treatment than have the American Psychological Association and the American Orthopsychiatric Association.[27] And many lawyers tend to be paternalists themselves when they actually encounter and work with people who have serious mental illnesses. This remains as true today as it did decades ago, when Poythress found he could not get lawyers to take a more adversarial stance when representing respondents in civil commitment actions.[28] Although the lawyers Poythress observed could recognize the inadequacies of testimony by mental health professionals (e.g., problems of reliability and validity of diagnosis), they would not cross-examine testifying doctors vigorously, because they thought their clients needed to be hospitalized. In short, particular attitudes are not the province of any one profession. Rather, they are again the product of fundamental philosophical positions that may not be reconcilable.

(c) The State of the Art

A more significant source of trouble between law and the mental health professions, although still one that is practical rather than philosophical, is the paucity of scientific knowledge concerning human behavior in many contexts. Even if it were easy to translate knowledge about the behavioral sciences into legal concepts, mental health professionals often have little legally relevant knowledge to apply. Moreover, when they do have such knowledge, the conclusions that can be drawn from it may not be sufficiently reliable to warrant their use in legal decisionmaking.

The state-of-the-art problems may be divided into three types. First, legal determinations usually concern individuals, and what mental health professionals can say about individuals may not be precise or objective enough to warrant admitting their opinions—or, if such opinions are admitted, to warrant placing much weight on them. For example, mental health professionals who study violent behavior can make insightful, scientifically grounded comments about social, psychological, and biological processes that precipitate aggression in general. Yet when they discuss why a *particular* individual acted aggressively at a particular time, they often invoke the same types of "folk psychology" explanations[29] that laypeople do.[30] In part, this is because even when mental health professionals can adduce statistically demonstrated factors that help explain individual behavior, the explanatory power of those factors is often only partial[31] and may have limited generalizability to specific situations outside the experimental setting.[32] The ambiguity often found in legal

constructs can exacerbate this difficulty. While the accuracy of clinical opinions on some issues such as risk or competency can sometimes be evaluated through studies of their reliability[33] and validity[34] (many of which are described in this book), in other contexts, such as determinations of insanity, the legal norms are so variable that a meaningful measurement of accuracy is virtually impossible.[35]

Irrespective of general uncertainties in the behavioral sciences, a second problem stems from lack of knowledge that directly addresses questions asked by the law. For example, mental health professionals know a good deal about how parents' divorces affect their children. But as Chapter 16 explains, little of that research is directly applicable to questions pertaining to custody disputes, either in individual cases or as a matter of policy. Similarly, although many studies describe the types of cognitive impairments associated with schizophrenia and other diagnoses, no instrument measures awareness of wrongfulness during antisocial acts committed by mentally ill individuals, the key issue in insanity cases.[36] Thus, although the state of knowledge about general effects of divorce and the cognitive impact of schizophrenia may be rather advanced, the literature may tell mental health professionals and courts very little about how to resolve legally relevant questions. To return to Case Study 1.1, the considerable research on the effects of stress might seem relevant to explaining Mr. Drake's behavior, but virtually none of that research addresses how stress affects people's decisions about gambling or committing crimes.

A third state-of-the-art problem arises when questions asked by the law are inherently unanswerable. Sometimes the differences between possible dispositions are so subtle that it is extremely unlikely that behavioral science would ever advance to a point where their effects would be distinguishable. To give an extreme example, one of us was once asked to evaluate a child in a divorce dispute to assess the relative impact of spending one week a year versus two weeks a year with his mother. We know of no scientific findings that even begin to address that question.

1.03. PARADIGM CONFLICTS

While it may be difficult to reconcile variations in attitude, flaws in training, or tensions created by state-of-the-art problems, the most likely cause of rifts between the law and the behavioral sciences are differences in paradigm. This section addresses the following questions: How might interactions between lawyers and mental health professionals be affected by differing ways of conceptualizing problems? Do the differences in the philosophies of law and science imply inherent conflict?

(a) Individual Choice versus Biology and Social Influences

Perhaps the most obvious philosophical difference between the law and the behavioral sciences is that the former is predicated on the assumption that people act for reasons, can control themselves, and make choices for which they may deserve praise or punishment. By contrast, the behavioral sciences generally seek to find causes or influences on people's behavior that people themselves are unaware of, do not choose, or do not control. Indeed, the point of much behavioral science often is to show that the factors that really determine or predict persons' behavior are something other than those persons' conscious, expressed reasons.

As an illustration of the difference between the law's traditional explanatory motifs and those sought by

mental health professionals and behavioral scientists, consider the hypothetical case of John Doe, an individual who has schizophrenia and who smokes a pack of cigarettes a day. Video footage shows Mr. Doe entering a convenience store, where he waited near the checkout counter until the clerk looked away; then he quickly grabbed a pack of cigarettes from behind the counter, stuffed it under his coat, and hastened out the door. Security personnel gave chase and caught Mr. Doe as he was opening the pack of cigarettes in the store's parking lot. Police arrested Mr. Doe and charged him with misdemeanor theft.

The law assumes that most of us are responsible for our conduct because, as Stephen Morse puts it, we "are the sort of creatures that can act for and respond to reasons."[37] In Mr. Doe's case, the law might acknowledge that Mr. Doe had a serious mental illness (schizophrenia). Yet his actions—waiting until the clerk's attention was directed elsewhere before taking the cigarettes, hiding the cigarettes under his coat, and hurrying out the door—showed that he knew he was doing something illegal. No one forced Mr. Doe to steal the cigarettes by threatening him. Mr. Doe just wanted some smokes but had no money, so he stole the cigarettes rather than pay for them. He chose to break the law but got caught. Now, the law states, he deserves punishment for his wrongdoing. As Morse states, "[t]he law properly treats persons generally as intentional creatures and not as mechanical forces of nature" unless "an excusing condition, an affirmative defense, such as legal insanity (essentially a rationality defect) or duress (a compelling 'hard choice' situation, such as a 'do-it-or-else' threat at gunpoint) was present when the agent committed the offense."[38]

This straightforward account of Mr. Doe's criminal responsibility is insufficiently nuanced for many mental health professionals. While they understand the meanings of guilt and innocence and the role of punishment in a criminal justice system, to physicians, psychologists, and other professionals who use or create the findings of behavioral scientists, the previous paragraph's discussion of Mr. Doe's conduct lacks real explanatory value. Most people don't steal cigarettes, behavioral scientists would note. The important questions are these: *Why* did Mr. Doe steal them, and why did he do it *when* he did it?

In answering these questions, a behavioral scientist, especially one with a neurobiological background, might point out, first, that sufferers of schizophrenia have a brain disease; specifically, they have abnormalities in brain structure that lead (among many things) to reduced control over the release of dopamine and glutamate, two of the chemicals that brain cells use to communicate with each other.[39] Second, for persons with schizophrenia who have no prior drug exposure, these abnormalities result in neural and motivational changes similar to those seen in persons who have long-term substance use problems.[40] Third, most individuals with chronic schizophrenia smoke, and perhaps for good reasons: Nicotine interacts with many of the disturbed neuronal pathways affected by schizophrenia and mitigates many of the brain-based impairments that characterize schizophrenia.[41] Smokers with schizophrenia, in other words, are medicating themselves to get their brains to work better.

Fourth, recent discoveries show that repeated exposure to addictive substances (including nicotine) causes a host of epigenetic changes that perturb levels of key intracellular protein, modify neuronal signaling, and alter information processing in those brain circuits that control responses to stresses, rewards, and punishments.[42] Thus we can posit a clear set of biological links from the inborn brain pathology of schizophrenia to nicotine addiction to Mr. Doe's failure to obey the law. Mr. Doe's nicotine craving and intense pursuit of cigarettes reflects disease- and addiction-altered dopamine functioning in those parts of his brain circuitry that are required for self-restraint. His previous, chronic nicotine exposure has left him with abnormally enhanced

motivation to procure cigarettes; he, like other drug-addicted individuals, can be *expected* to engage in illegal behavior to get drugs, even in the face of known adverse consequences.[43]

We also know (a behavioral scientist might continue) that the use of addictive substances is clearly affected by factors such as low socioeconomic status and poor parental support, which are sources of stress that increase vulnerability to drug use. Finally, the widespread availability of addictive substances and the criminal penalties associated with their procurement is determined by social factors far larger than Mr. Doe's decisionmaking. The legislators who enact laws and set punishments (the behavioral scientist might suggest) are not always well informed about or cognizant of the biological and social forces that *really* explain use of substances like nicotine, alcohol, and psychoactive drugs and the behavior associated with such use, including crime.

This neurobehavioral explanation for Mr. Doe's conduct focuses on questions quite different from those that customarily concern the criminal justice system. Notice, moreover, how the neurologically based explanation of Mr. Doe's actions contrasts with what the law seeks to establish. When neuroscientists (and scientifically knowledgeable mental health professionals) adduce biological *explanations* for mental problems, they are not simply trying to say why mental disorders, including addictions, are often modifiable by psychotropic medications. They are also recharacterizing *what* is happening when someone is mentally ill and behaves in ways linked to the illness. More specifically, when neuroscientists talk about addictions, schizophrenia, and many other severe psychiatric disorders, they often focus largely on problems with brain processes and information processing, not on the beliefs and desires that occupy legal decisionmakers. In doing so, they take human action outside the explanatory psychological framework that the law uses to assign responsibility and blame.

One response to this approach to assessing responsibility, common among legal thinkers, is to point out that most of the time we can find no direct link between an organic condition and someone's behavior. We know, for example, that many severe mental disorders have a genetic basis. Yet the relationship between genes and disorder is generally one in which genetic factors account for only a portion of the variance. Genetic factors merely *predispose* an individual to psychopathology; the psychopathology is activated only after the individual has experienced something in addition—for example, events found in a pathogenic, stressful environment.[44] Moreover, although our knowledge of gene–environment interactions has grown enormously in the last 40 years,[45] we still cannot identify the inherited anatomical or biochemical abnormalities associated with most instances of individual criminal acts.

This counterargument has some merit today.[46] But as organic and other scientific explanations for behavior have become more detailed and encompassing, this response has become weaker.[47] A more important counterargument against replacing individual choice with explanations that invoke biosocial causes is that *all* behavior occurs in social contexts and is governed by people's nervous systems. A biosocial explanation for behavior provides no philosophical basis for distinguishing the lawfulness of behavior attributable to a defective central nervous system and behavior emanating from someone with a "normal" nervous system. Both types of behavior are shaped by genetic makeup in interaction with life experiences. To salvage this situation, some thinkers have argued that humans are "caused causers" who can be held accountable for actions that are the result of their reasons and beliefs (at least rational ones).[48] From the perspective of neurobehavioral scientists, however, the assumption that reasons and beliefs cause behavior, and the assumption that reasons and beliefs are in any meaningful sense independent of prior, uncontrollable causes, are both dubious.[49] Most

of the many clinicians who are more likely to focus on an individual's social and interpersonal interactions rather than organic explanations agree with this position.[50]

In short, if clinicians are theoretically consistent, the paradigm within which psychiatrists and many other mental health professionals now work would appear to be in inherent conflict with legal worldviews. Notwithstanding attempts at reconciliation by some commentators,[51] the legal and mental health disciplines use very different philosophical perspectives and approaches when they explain behavior. These differences are of substantial significance as matters of policy in attempting to apply the behavioral sciences or clinical opinions to legal problems.

However, the individual expert need not be paralyzed by this dilemma. Indeed, there is at least a partial solution: Mental health professionals should be neither permitted nor cajoled to give opinions on the ultimate legal issue (i.e., the conclusion that the factfinder—the judge or the jury—must ultimately draw). Although practical problems result from this position [see § 18.07], we feel that clinicians should ideally resist requests or the temptation to offer conclusions about legal notions such as "voluntariness" or "responsibility," because these are legal concepts. They are not matters of clinical or scientific expertise, even when mental health professionals can testify about factors that might influence the factfinder's conclusions about voluntariness and responsibility. Rather, mental health experts should present factual findings and their scientific context, so that the factfinder can fit them into the legal framework and make whatever moral–legal judgments follow.

To return to the problem of assessing the "voluntariness" of Mr. Drake's embezzlement [see Case Study 1.1], a mental health expert might assist the factfinder by describing the types of choices Mr. Drake confronted, given his particular characteristics and his specific situation. The mental health expert might also explain that DSM-5 has classified gambling disorder among the "substance-related and addictive disorders" because the "compulsive" behavior involved in problem gambling is very similar to addictive use of drugs; moreover, gambling and drug addiction involve the same brain dysfunction and genetic liabilities.[52] However, whether his behavior was "involuntary"—whether the choice was so hard as to represent an "overbearing" context—should be left to the factfinder. This "ultimate-issue issue" is discussed at greater length below [§ 1.04] and in Chapter 18.

(b) The Process of Factfinding

Still another potential source of tension between the law and the mental health professions stems from how each discipline seeks the truth. Mental health professionals often express discomfort with the adversary process employed in Anglo-American law. Part of this discomfort probably stems from the different socialization that students of the law and the behavioral sciences receive. Behavioral scientists and mental health professionals often disagree amongst themselves, but they generally perceive their role as collaborative and accept advancing knowledge and helping people as common goals. In their direct interactions with each other, mental health professionals are best served by approaches that acknowledge others' points of view, that seek positive interpersonal relations, and that reduce or at least deemphasize conflict. By contrast, the law often approaches disputes by *sharpening* conflict, with the aim of ensuring that issues in the disputes are carefully posed and that they are resolved fairly in accordance with societal values. In view of these differing functions, it's no surprise that mental health and legal professionals differ in the comfort they experience when

dealing with conflict generally and adversariness in particular.

Indeed, to mental health professionals, legal rules governing the admission and consideration of evidence seem at odds with the collegial approach of clinical practice and the collaborative outlook that characterizes scientific inquiry. The resulting culture clash creates ambiguity and conflict about the standards to be applied, leading naturally to the following question: Does forensic work inevitably result in some compromise of mental health professionals' principles, or at least in their mode of operation?[53]

Mental health professionals who want to contribute to legal proceedings need to accept and get comfortable with how lawyers and courts handle disputes. This requires understanding that the purposes and uses of forensic evaluations differ qualitatively from the purposes and uses of evaluations developed for treatment purposes. Although mental health professionals may feel that the adversary system distorts their conclusions by stimulating the presentation of only the evidence that is favorable to one side, they should understand that the legal process is designed not just to uncover *truth,* but also to render *justice.* Due process demands that each side have the opportunity to put forward whatever evidence best makes its case. This is not to say that the law should or does ignore reality. But in legal proceedings, finding the truth is subordinate to the pursuit of justice.[54] Hence, as long as they maintain intellectual integrity, avoid changing their opinion simply to suit the party that retains them, and acknowledge the limits of their observations and expertise, mental health professionals should be undisturbed if they are "used" by one side in the dispute.[55]

A similar source of tension comes when experts find that their observations are "pigeonholed" into categories that strip the clinical data of their richness. For example, for reasons explored earlier, courts are often focused on the desires and beliefs that seem to motivate conduct, not the kinds of detailed personal knowledge and social and cultural contexts that clinicians use to understand people.[56] Similarly, clinicians may feel constrained by certain legal rulings, such as the inability to talk about prior criminal offenses or what the law regards as inadmissible "hearsay" that seems crucial to a well-based opinion.

Concern about these practices again arises from a misunderstanding of purpose. The law is fundamentally conservative. What Justice Oliver Wendell Holmes stated in the late 19th century is still true: "historic continuity with the past is not a duty, it is only a necessity."[57] Following precedent and rules of law is how judges and lawyers convey their respect for the social institutions that courts protect, particularly the even-handed and predictable administration of justice. For instance, the implementation of criminal laws governing homicide often takes a single-minded focus on planning, because, for reasons developed over scores of years, the law has pinpointed premeditation as the primary criterion for establishing murder. Similarly, the evidentiary rule barring evidence of past crimes rests on the belief, reinforced through centuries of trial practice, that otherwise the factfinder may convict a person for what he or she did in the past rather than focus on whether facts support conviction on the current charge. Thus, although at times examination of the evidence within a narrow historical framework may seem to pull attention away from the best interests of the parties, such narrowness of concern ensures that specific points of dispute will be resolved justly.

Occasionally, however, jurists become so focused on normative analysis and historic legal values that they carry precedent beyond its logical bounds. Sometimes, in their zeal to protect legal values, judges seem to derive an "is" from an "ought"—that is, to assume that people in fact operate in the way that they think people do or should. Such blinders to the real world promote unfair decisionmaking. For example, the United States Supreme Court has justified placing limits on minors' autonomy and privacy through empirically

unsupportable assumptions about adolescents' competence and family life (e.g., that youth under age 18 years are not competent to make treatment decisions).[58] Basing the deprivation of liberty on invalid assumptions is unjust and intellectually dishonest. If judges are in fact basing their decisions on particular values, they should state those values clearly. Thus, to return to the example, if the Supreme Court wishes to support a particular view of family autonomy—that parents should control the lives of their children until the age of 18 years—it should say that this is a matter of policy preference. On the other hand, if empirical findings underlie a particular legal analysis, whether of case facts or of legislative facts, the parties should be able to expect that a persuasive display of evidence on point will turn the case.[59]

(c) The Nature of a Fact

Even if we could remove the clashes over explanatory relationships and disagreements about how to discover such relationships, fundamental and probably more problematic epistemological differences between law and the behavioral sciences would remain. Specifically, the two disciplines do not conceptualize a "fact" in the same way. This definitional issue is linked closely to the process issue just discussed, in that whether the law and the behavioral sciences recognize particular information as a relevant "fact" depends on whether the respective truthfinding process has been followed. For clarity of analysis, we separate the process of finding facts from the question of whether a fact exists, and we turn now to the latter issue.

(1) From Probability to Certainty

Perhaps the most basic problem rests in differing conceptions about the role of probability assessments. Although the sciences are inherently probabilistic in their understanding of truth, the law demands at least the appearance of certainty, perhaps because of the magnitude and irrevocability of decisions that must be reached in law. As Haney has noted, "there is a peculiar transformation that probabilistic statements undergo in the law. The legal concept of 'burden of proof,' for example, is explicitly probabilistic in nature. But once the burden has been met, the decision becomes absolute—a defendant is either completely guilty or not."[60]

To give an example of this difference in conceptualization of facts, suppose that a construction company is charged with negligence after a bridge that it built collapses. Specifically, the company is alleged to have used steel rods that were too small for the construction needs. A civil engineer is asked, as an expert, to measure the rods and to determine the width that the rods should have been in order to provide a safe structure. The engineer might take several measurements of the rods and conclude that the probability is greater than .95 that the true width of the rods was between 1.35 meters and 1.37 meters, when measured at 24°C. The engineer then might consider the probability of contraction to a given length at the lowest temperature observed in the bridge's locality, and consider the further probability of an even lower temperatures occurring in the future. Yet from a legal perspective, the "fact" that the judge or jury must determine is either that the rods were too small, or that they were not. Although the legal standard of proof applied to this judgment—preponderance of the evidence—acknowledges the possibility of error, the judge or jury makes a conclusion of fact in an all-or-none fashion.

This difference in conceptualizing facts may seem rather trivial at first glance, but its import is actually

quite substantial. Because of the law's preference for certainty, experts may feel tempted to reach beyond legitimate interpretations of their data both to appear "expert" and to provide usable opinions. Similarly, legal decisionmakers may disregard testimony properly given in terms of probabilities as "speculative," and may attend instead to experts who express categorical opinions about what did or will happen. The result is a less properly informed court. The risk of distorting the factfinding process is particularly great in the behavioral sciences, given that single variables rarely account for more than 25% of the variance in a particular phenomenon, and that the reliability and validity of observations by mental health professionals are far from perfect.

Part of the problem is simply intellectual dishonesty, however well intended it may be. In the desire to be helpful, experts may permit themselves to be seduced into giving opinions that are more certain than the state of knowledge warrants. Yet doing so is contrary to the ethical guidelines of forensic psychologists and psychiatrists, which rightly direct practitioners to describe the uncertainty in their conclusions.[61] These admonitions should be followed even though such honesty may result in the courts' reducing the weight accorded the testimony.[62]

The problem is not simply one of professional ethics, however, or even of overzealousness by attorneys in their attempt to elicit strongly favorable opinions from experts. The style of clinical decisionmaking itself (as opposed to that of scientific research) often may not be conducive to a nuanced truthfinding process. Although researchers customarily report their findings in terms of probability statements, practitioners often must make yes-or-no judgments. To develop and implement treatment plans, for example, clinicians must decide what they think the problem is and how best to treat it, despite the scientific limitations of their diagnostic and therapeutic powers. If this style of thinking and decisionmaking is carried into the reporting of forensic evaluations, the legal factfinder may be misled as to the certainty of the conclusions.

Unfortunately, this style of presentation—especially when it is "idiographic" in nature (i.e., case-centered rather than based on group data)—is often statutorily required[63] and is preferred by the courts as well as lawyers. For instance, testimony like the statements in Case Study 1.1 that Mr. Drake was irrational and anxious will virtually always be accepted by the courts. But testimony in the form of probabilities, such as the statements in that case about the percentage of gamblers who commit forgery and other crimes, may be given less credence because they are expressed in relative terms. This reluctance toward accepting probabilistic information is especially serious if the topic is one on which academic psychologists are more likely to be expert, such as the reliability of eyewitness testimony.[64] In any case, the general point is that even if it heightens the discomfort of both clinicians and courts, clinicians involved in the legal process should aim to think like scientists and give an accurate picture of probabilistic findings.

This general admonition is appropriate even in jurisdictions that attempt to transform probabilistic judgments into certain facts by applying the standard of "reasonable medical (or psychological or scientific) certainty" when deciding the admissibility of expert testimony. Both courts and professionals are likely to have idiosyncratic subjective judgments of "reasonable certainty";[65] moreover, even "uncertain" opinions may still be relevant and of assistance to the trier of fact, provided that the conclusions have some probative value and are not prejudicial. Most important, the standard of reasonable certainty may itself result in prejudicial opinions, because the "certainty" standard masks the fact that the underlying judgments are merely probabilistic. Experts should leave to the judge the question of whether the opinions are so uncertain as to be unhelpful.

(2) From Group to Individual

As already noted, the scientific database for the behavioral sciences on which all researchers and many clinicians rely develops principles of behavior by comparing *groups* that differ on a particular dimension. Given that in psychology a particular variable will almost never perfectly account for the variance in another variable, experts must decide how well group-based psychological findings apply to specific individuals—a scenario that has been called the "G2i" (general-to-individual) issue.[66] Although this usually does not cause problems for the experts themselves, it is a major conceptual obstacle for legal factfinders and may result in rejection of the experts' opinions.

Some examples based on actual cases illustrate the significance of the philosophical dilemmas that are presented when nomothetic principles[67] are applied to the resolution of individual cases.

Case 1.[68] The defendant's 14-year-old daughter accused him of raping her. Two months later (and on two subsequent occasions), she wrote statements recanting her accusation; she said that she had lied so she could get "out on her own." However, at trial, she returned to her original story. Experts testified that such inconsistency is common among victims of incest.

Case 2.[69] The defendant was charged with third-degree murder of his three-month-old son. An expert on child abuse testified that the pattern of injuries was consistent with "battered-child syndrome." He testified further that abusing parents tend to have been abused as children themselves, and that they are prone to a number of negative personality characteristics (e.g., short temper and social isolation). The state then called two witnesses from the defendant's past (his caseworker as a youth; an employee of a therapeutic school he had attended). The caseworker testified that the defendant had been abused; both testified that the defendant had many of the personality traits identified by the first expert. Other witnesses provided additional testimony suggesting that the defendant possessed characteristics that the expert had said were common to battering parents.

Case 3.[70] The defendant was stopped by Drug Enforcement Administration (DEA) agents after she disembarked from an airplane at the Detroit Metropolitan Airport. The DEA agent's suspicions were aroused because the defendant's behavior fit a "drug courier profile": (1) The plane on which she arrived had originated in a "source city" (Los Angeles, thought to be the origin of much of the heroin brought to Detroit); (2) she was the last person to leave the plane; (3) she appeared to be nervous and watchful; (4) she did not claim any luggage; and (5) she changed airlines for her flight from Detroit. On questioning, the defendant appeared nervous, and the agents discovered that she had purchased her ticket under an assumed name. A search revealed heroin hidden in her undergarments. The defendant contested the search on the ground that the agents had no reasonable basis for suspecting that she was involved in criminal activity and for stopping her for an investigation. Testimony at trial indicated that during the first 18 months of the surveillance based on behavioral profiles, agents had searched 141 persons in 96 encounters and had found illicit substances in 77 instances.

Case 4.[71] After serving his sentence for rape, an offender is committed at a civil hearing under the state's sexual predator statute because he is judged likely to engage in future acts of sexual violence, based in part on a risk assessment instrument that assigns him a 58% risk to commit a violent act within seven years of release to the community. He argues that his risk classification is inappropriate, because the psychological test predictions are based in part on his parents' misbehavior (e.g., parental alcoholism) and in part on his failure to meet diagnostic criteria for schizophrenia. Moreover, he asserts that he has "reformed" since participating in a prison-based treatment program for sex offenders, and that he should be considered to be among the 42% of "very-high-risk" offenders who will not be recidivists.

These four cases starkly pose the question of whether attention to probability data in the legal system is legitimate.[72] They represent four different problems (respectively, whether a crime occurred, the identity of a past legal actor, the identity of a present legal actor, and the identity of a future legal actor).[73] Is the issue of whether to consider this type of probability evidence merely a function of its reliability and explanatory power, or is there something inherently unfair about making determinations of past, present, or future guilt based on data about groups of similar people?

A thorough consideration of these issues was presented in an early but still influential article by Tribe,[74] who concluded that for the most part,[75] the law should bar evidence expressed in mathematical probabilities. Tribe raised a number of objections to "precision" in the consideration of evidence:

1. Probability estimates are themselves inherently probabilistic; that is, the precision of the probability estimate itself must be considered. Take, for example, a case in which eyewitnesses saw a blue-eyed, blond-haired male rob a bank in a small New Mexico town. To assess the probability that a defendant who meets the physical description and was found in the town is indeed the robber, jurors must take into account the accuracy of the initial eyewitness's account and the imprecision in statistical estimates of how often people with these characteristics are found in small New Mexico towns. Consequently, the presentation of a single statistic or even a string of statistics may be deceptive. Moreover, jurors' consideration of the data may be complicated by statistical interdependence. For example, blue eyes and blond hair are correlated, so one cannot do a simple computation to learn the probability of their joint occurrence.

2. The presumption of innocence may be effectively negated by permitting consideration of the probability that a person with *X* characteristic is guilty.[76] For instance, direct consideration at trial of such probabilities will necessarily force the factfinder to include in the calculus the probability of guilt that is associated merely with having been brought to trial. Presumably this initial probability is greater than zero, despite legal assumptions to the contrary.

3. "Soft" variables will be dwarfed by more easily quantifiable ones.[77] To return to our example of the bank robber, attention to the defendant's physical characteristics might divert attention from the probability that he has been framed.

4. The "quantification of sacrifice" (i.e., the recognition of the risk of a wrongful conviction) is intrinsically immoral.[78] It seems unjust to tell a defendant that the jury is willing to tolerate *X* risk of error in convicting him.

5. Reliance on statistical evidence dehumanizes the trial process by diminishing jurors' ritualized intuitive expression of community values.[79] Rather than clarify the jury's role in expressing the will of the community, statistical evidence will obscure this role and make the legal process seem alien to the public.

Although Tribe articulated important issues, we are more persuaded by Saks and Kidd's critique of his article.[80] First, Tribe's analysis relied in part on unverified psychological assumptions (e.g., jurors will be overly influenced by quantified evidence, and jurors in the present system feel subjectively certain in their judgments when they reach a verdict based on a standard of "beyond a reasonable doubt"). Second, research on the intuitive information processing preferred by Tribe suggests that jurors will make errors of analysis in their consideration of implicit probabilities unless the actual probabilities are brought to their attention. Third, as Tribe himself acknowledged, all evidence is ultimately probabilistic, regardless of whether it is quantified. Simply pretending that it is not probabilistic and ignoring the clearest, most specific evidence do not lead to morally superior decisionmaking.

At the same time, accuracy of evidence is not the only concern. Other legal considerations may counsel limiting or excluding even relatively reliable probability evidence in some types of cases. Two such concerns are particularly important. The first is that certain types of information used in probabilistic testimony,

although scientifically relevant, may not be legally cognizable. For instance, reliance on race as a statistical predictor may be impermissible for constitutional reasons, even if it is correlated to a legally relevant variable; the Supreme Court has stated that basing a criminal sentence on race, even "in part," "is a disturbing departure from a basic premise of our criminal justice system: Our law punishes people for what they do, not who they are."[81] Indeed, some have argued that, at least in the criminal sentencing context, *every* factor over which one has no control (e.g., parental alcoholism, and perhaps an offender's schizophrenia) should be banned as a basis for an actuarial determination.[82]

A second concern is the effect probabilistic information may have on the factfinder. Tribe exaggerated the layperson's inability to understand such information. But there is a danger that if and when it is understood, statistical information will assume too much prominence in the factfinder's decisionmaking process, at least when it is used by the state to bolster the preconceived and often incorrect notions of the factfinder. This danger of "prejudice," to use the legal term,[83] is probably greatest in the criminal context in cases such as the four described above, where the stakes are high in terms of threats both to individual freedom and to public welfare.

Probably the least prejudicial use of probabilistic information is in connection with police investigation. Using behavioral science techniques to construct a "profile" of offender characteristics that might be associated with a particular kind of crime, law enforcement agents have tried to narrow the range of suspects in a given case (as in Case 3). Although this approach is not without problems,[84] at least it is relegated to the investigative phase of trial, where probability assessments are inherent and thus more easily countenanced.[85]

Use of such evidence in criminal adjudication (Cases 1 and 2), where the legal objective is to determine definitively whether *this* defendant committed a crime, is much more problematic. For instance, when applied to a criminal defendant on trial (as in Case 2), such evidence is character evidence, which is not ordinarily admissible unless the defendant puts character at issue by claiming that he or she is not the type of person who would commit the crime.[86] Even though well-designed research may show a substantial correlation between particular traits and involvement in particular kinds of offenses, the law deems such information too prejudicial to permit except in response to defense assertions. As the Supreme Court stated, defendants must be convicted based on what they did, not who they are.

The character evidence rule is not applicable when profile evidence is used to suggest that a crime occurred (Case 1). Thus initial prosecution use of such evidence has often been permitted, most often as expert testimony to suggest that the purported victim shows behavioral characteristics exhibited by victims of a particular kind of offense [see §§ 8.03(c), 15.04(c)(4)]. Here too, however, syndrome evidence can create problems. Even if it is strong scientifically, it may be inherently misleading because of the difficulty most people have in processing base rates.[87] For example, Table 1.1 presents a hypothetical case in which an extraordinarily valid profile of a sexually abused child—far more valid than anything currently available—still would result in only a 32% probability that a randomly selected child showing the profile would have recently been abused. Yet a judge or jury, once hearing that the victim met the profile, would probably not believe the probability to be so low. Nor would telling them how low it is be likely to diminish the profile's impact, as the mere fact that a prosecution has been brought already has created the strong impression that a crime must have been committed. Thus a "defendant-first" rule barring such probabilistic data unless the defendant opens the door, analogous to the character evidence rule, might be appropriate here as well unless the profile

evidence is very strong.

TABLE 1.1. Probability That a Child Fitting a Hypothetical Profile of a Sexually Abused Child Actually Has Been Recently Abused

1. There are about 74 million children and youth in the United States.
2. Assume that 5% have been sexually abused recently.[a]
3. Therefore, 3.7 million children and youth have been recently sexually abused; 70.3 million have not.
4. Assume that 90% of the children found to fit the profile of a sexually abused child on the Melton Magnificent Measure (MMM) have recently been sexually abused, while 10% of those who fit the profile have not been abused.
5. Sally Doe fits the MMM profile.

What is the probability that Sally has been recently sexually abused?

3.7 million × 0.90 = 3.3 million true positives (TPs)

70.3 million × 0.10 = 7.0 million false positives (FPs)

3.3 million TPs + 7.0 million FPs = 10.3 million positives (Ps)

3.3 million TPs divided by 10.3 million Ps = 0.32

Therefore, the hypothetical probability (under a scenario of far more pronounced base-rate differences than is true in reality) is only about 1 in 3!

[a]This hypothetical percentage probably substantially exceeds the actual base rate of recent sexual abuse. Community surveys (most of them retrospective) to determine prevalence *at any point* during childhood have yielded median prevalence rates of 15% for females and 6.5% for males. Stefanie Doyle Peters et al., *Prevalence,* in A SOURCEBOOK ON CHILD SEXUAL ABUSE 15, 20–21 (David Finkelhor ed., 1986).

In forward-looking decisions (e.g., commitment predicated on future risk, as in Case 4, or the commitment decision in Case Study 1.1), the inquiry is, as with investigation and unlike at trial, inherently probabilistic; actuarial data are thus directly relevant [see § 9.09(c)]. Here too, however, the possibility exists that such data will overly impress the factfinder, at least when used by the state to confirm the likely assumption of the factfinder that a person who has just committed a crime will offend again.[88] Although research suggests that actuarial risk assessment is less likely than nonactuarial, clinical testimony about risk to overinfluence the factfinder,[89] courts considering the use of actuarial information should ensure at the least that the data come from a relevant population and that the factfinder understands its nomothetic nature. More is said about all these issues at relevant points of this book.

1.04. SHOULD MENTAL HEALTH PROFESSIONALS BE CONSIDERED EXPERTS?

As the preceding discussion illustrates, and as we reiterate below, some controls on mental health testimony are necessary in circumstances in which it is inherently misleading or prejudicial. Nonetheless, we retain our general preference for liberal use of behavioral science expertise. To explain this view, we come now to what may be the core problem in contemporary forensic mental health: Should mental health professionals be recognized as experts by the law, and if so, for what purposes? Before discussing the courts' answer to this question, we give our own. In doing so, we refer liberally to the Federal Rules of Evidence, the relevant parts of which are listed in Table 1.2. Because most states have adopted all or part of these rules, they will form the baseline for our analysis.

TABLE 1.2. Federal Rules of Evidence, Article 7: Opinions and Expert Testimony

Rule 701.
OPINION TESTIMONY BY LAY WITNESSES

If the witness is not testifying as an expert, the witness' testimony in the form of opinions or inferences is limited to those opinions or inferences which are (a) rationally based on the perception of the witness, (b) helpful to a clear understanding of the witness' testimony or the determination of a fact in issue, and (c) not based on scientific, technical, or other specialized knowledge within the scope of Rule 702.

Rule 702.
TESTIMONY BY EXPERTS

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise if (a) the testimony is based upon sufficient facts or data, (b) the testimony is the product of reliable principles and methods, and (c) the witness has applied the principles and methods reliably to the facts of the case.

Rule 703.
BASES OF OPINION TESTIMONY BY EXPERTS

The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted. Facts or data that are otherwise inadmissible shall not be disclosed to the jury by the proponent of the opinion or inference unless the court determines that their probative value in assisting the jury to evaluate the expert's opinion substantially outweighs their prejudicial effect.

Rule 704.
OPINION ON ULTIMATE ISSUE

(a) Except as provided in subdivision (b), testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact. (b) No expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or of a defense thereto. Such ultimate issues are matters for the trier of fact alone.

(a) The Definition of Specialized Knowledge

The first point to note is that whereas laypersons may generally testify only about what they have directly observed (see Rule 701), experts may testify as to opinions if the "specialized knowledge" of the witness will "assist" the trier of fact in determining a relevant issue (Rule 702). Rule 702's insistence that the expert assist the factfinder is derived in part from the democratic principle that everyone is equal before the bar of justice, and that professional education in itself does not confer special status in the legal system. It follows that occupational status should not infringe the societally designated authority of the judge or jury to decide the case at hand.[90] Experts should be able to go further than lay witnesses only if doing so would provide *specialized* information that will help the trier of fact to understand the evidence presented.

In analyzing the import of Rule 702's requirement that opinion evidence be based on specialized knowledge that can assist the factfinder, it helps to consider the several levels of opinion that an expert might render. For example, in considering whether a defendant meets the *M'Naghten* test of insanity [see § 8.02(b)], the following levels of inference might occur, all of which represent increments in opinion formation:

1. Application of meaning (perception) to a behavioral image (e.g., "He was muttering").
2. Imputation of a general mental state (e.g., "He appeared to be talking to someone who was not present").
3. Formulation of a general mental state that is consistent with theoretical construct or the research literature, or synthesizes observations (e.g., "His behavior during the interview was indicative of having

auditory hallucinations").

4. Diagnosis (e.g., "His behavior during the interview and his reported history are consistent with having schizophrenia").
5. Relationship of formulation or diagnosis to legally relevant behavior (e.g., "At the time of the alleged offense, his psychosis impaired his ability to carefully consider the consequences of his behavior").
6. Elements of the ultimate legal issue (e.g., "Although his mental illness limited his ability to *reflect* upon or care about the illegality of his behavior, he *knew* that he was stealing a pack of cigarettes and *knew* that stealing the cigarettes was illegal").
7. Ultimate legal issue (e.g., "He was sane at the time of the offense").

In considering the question of which, if any, levels of inference mental health professionals should be permitted to state in their testimony, most scholarly commentators agree:[91] Despite the fact that such opinions are commonly requested and even expected by courts, *mental health professionals ideally should refrain from giving opinions as to ultimate legal issues.* As we have already seen, the constructs about which an opinion might be sought (e.g., voluntariness) are often inconsistent with the model of behavior on which an expert's observations are based. Even when the constructs appear familiar, however, experts should avoid giving ultimate-issue opinions; questions as to criminal responsibility, suitability for commitment, parental fitness, and so forth are not based on "specialized" knowledge, but are legal and moral judgments outside the expertise of mental health professionals *qua* mental health professionals. For example, the types of behavior that constitute "mental disorders" as a matter of law may be substantially different from the range of conditions that mental health professionals categorize as "mental disorders." Similarly, a court's decision about dangerousness involves a legal judgment about whether the probability of particular kinds of behavior is high enough to warrant state intervention. While mental health professionals can certainly offer probative evidence about parenting skills or risk, the ultimate determination of whether a person is "fit" to parent or dangerous is the court's. When experts give ultimate-issue opinions, they usurp the role of the factfinder and may mislead the factfinder by suggesting that the opinions are based on their specialized professional knowledge rather than their personal judgment.

Although Rule 704(a) allows experts to give opinions on ultimate issues, Rule 702 prohibits admission of *any* opinion not based on specialized knowledge—a prohibition that presumably can include ultimate-issue opinions. Indeed, Rule 704(b) (an amendment to the original Rule 704 that was inspired by John Hinckley's acquittal on insanity grounds) makes this point concretely with respect to mental state testimony in criminal cases. The position we take is that ideally, the same evidentiary prohibition should apply to *all* types of cases.

Thus, even if a court *permits* ultimate-issue opinions to be admitted as a matter of law, we recommend that mental health professionals not volunteer such opinions because of the explicit or implicit misrepresentation of the limits of expertise involved if a clinician, *acting as an expert on mental health matters,* gives an opinion on a legal issue.[92] Even in cases where courts or statutes request or expect ultimate-issue statements, the thoughtful mental health professional should always ask him- or herself, "To what extent is my response the product of my expertise as a clinician? Does my opinion actually stem from my moral sensibility or my common sense as a citizen?" If the latter, the expert should try to avoid offering the opinion (perhaps by testifying, "That's the issue the court must decide"); if such an opinion is demanded, it should be described as

a legal, moral, or common-sense judgment, not a psychological or medical one ("Given my findings, it would make sense for the court to conclude . . . ").

Under this reasoning, clinicians would not volunteer opinions at level 7 in the hierarchy set out earlier. Testifying that a person is "sane," "dangerous," "competent," "parentally fit," or "disabled" (for workers' compensation or Social Security purposes) tramples on both legal and ethical domains. Testimony at level 6 is concerning as well, because the clinician will be using legally defined language. Admittedly, a rigid prohibition on testimony at this level may sometimes be an artificial constraint. Talk about whether criminal defendants "knew" their act was "wrong" (both aspects of the *M'Naghten* test), even if banned, can easily be replaced with testimony about whether defendants were "aware" or "remained able to recognize" that they were breaking the law (consider, in this regard, the testimony in Case Study 1.1). Similarly, it is often difficult to discuss competence to proceed without directly discussing a defendant's ability to assist counsel—one of the elements of the competence standard [see Chapter 6]. However, the question of *how much* "knowledge" or "awareness" a defendant must have to be sane, or the *extent to which* defendants must be able to "assist" their attorney to be competent, is a decision for the court to make. Consequently, clinicians should at the least avoid parroting the language of the legal test without explanation, unless statutes or the questions posed during testimony demand that they do otherwise.[93]

The question is harder with respect to opinions based on intermediate levels of inference (2 through 5 in the list above, as well as statements at level 6 that avoid legal language). The most articulate proponent of exclusion is Morse, who has argued that only two types of testimony by mental health professionals (when testifying in that capacity) should be permitted.[94] First, Morse would permit presentation of "hard actuarial data," when relevant and available. Second, because mental health professionals usually have much more experience with "crazy" persons than do laypersons, and thus are likely to be better observers of the kinds of behavior that may be legally relevant, he would allow them to present their observations of behavior. For example, Morse believes that mental health professionals are likely to be more skilled than laypersons in asking the right questions to elicit information about hallucinations, suicidal plans, and so forth, and should thus be able to describe the answers to those questions.

On the other hand, Morse would not allow opinions as to the meaning of the behavior; he would bar mental health professionals from stating conclusions on ultimate issues, and from giving testimony about their formulations and diagnoses as well. Therefore, the role of mental health professionals would be that of specially trained fact witnesses. Morse has summarized his objections to most expert testimony by mental health professionals on the following grounds:

> [F]irst, professionals have considerably less to contribute than is commonly supposed; second, for legal purposes, lay persons are quite competent to make judgments concerning mental disorder; third, all mental health law cases involve *primarily* moral and social issues and decisions, not scientific ones; fourth, overreliance on experts promotes the mistaken and responsibility-abdicating view that these hard moral questions (i.e., whether and in what way to treat mentally ill persons differently) are scientific ones; and fifth, professionals should recognize this difference and refrain from drawing social and moral conclusions about which they are not expert.[95]

We have already indicated our agreement with Morse as to his third, fourth, and fifth points. We also agree for the most part with his second point: Whether a person appears sufficiently disabled to warrant special legal treatment is an intuitive social and moral judgment. Diagnosis, for example, is often irrelevant to mental health law questions.[96]