Training Manual
Interdisciplinary Fitness Interview

Revised

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RATIONALE AND USAGE OF THE IFI-R

The Interdisciplinary Fitness Interview - Revised is designed to address competency (fitness) for adjudication in a manner that specifically distinguishes mental health issues and impairment of psycholegal abilities. The IFI-R thus produces a systematic psycholegal inquiry into a defendant's competency to proceed that is more useful to the courts. The IFI-R is designed to be utilized by mental health professionals who are already skilled and experienced in clinical evaluation and assessment of mental disorders, especially those involving major impairment in cognitive, affective and social functioning. While the manual that accompanies the IFI-R contains an essential summary of the jurisprudential doctrines, case law, statutory authority, and professional ethical principles and standards that shape the contours of most competency to proceed evaluations and communications to the courts, it is not a substitute for the broader specialty training and supervised experience required to practice competently as a forensic mental health professional.

This training manual is divided into two major sections. Section I ("The construct of competency for adjudication") provides an historical, jurisprudential and psycholegal overview of the construct of competency and its range of applications. Section II ("The Interdisciplinary Fitness Interview - Revised") describes the assessment procedure itself and also contains the associated interview and rating forms. Section II also provides commentary on professional practice issues that are likely to arise in competency determinations.

SECTION I: COMPETENCY FOR ADJUDICATION

The phrase "competency for adjudication" refers not only to the core issue of competency to proceed with trial, but also to a set of issues which arise with increasing frequency: competency to waive Miranda[7] rights, competency to confess, competency to plead guilty, competency to waive certain defenses, competency to proceed pro se, competency to refuse certain treatments when one is committed for competency restoration, and competency to be executed, among others. Competency for adjudication is the most prevalent issue for mental health professionals, lawyers and other professionals working with mentally disordered offenders, and it is one of the most costly aspects of the system.

PREVALENCE AMONGST CRIMINAL DEFENDANTS

Regrettably, most jurisdictions do not maintain an adequate database on forensic evaluations and their outcome. Thus, it is difficult to know how many defendants are evaluated for competency to stand trial, how many are found unfit to proceed, how many are restored to competency in what time frames and with what treatments, and so forth. Older survey statistics, based upon evaluations conducted in local jails or on an outpatient basis, an increasingly large proportion of all evaluations. These older studies estimated that roughly one percent of all criminal defendants were evaluated for competency at some time during their criminal adjudication. Recent data from the National Institutes of Mental Health indicate that there has been an increasing trend in the commitment of defendants whose competency is under question. Given these trends and the dramatic increase in community-based evaluations, it is probably safest to assume that the "one percent" rate represents an underestimate, and that actual referral rates are now approaching two percent of all defendants arraigned on felony criminal charges. Given the large number of felony cases, the legal and financial costs associated with inappropriate referrals and evaluations, and the scarcity of "mental health dollars," the need for a more efficient and reliable referral, evaluation, and treatment system for pre-trial defendants whose competency is questioned becomes apparent.

REASONS FOR APPROPRIATE AND INAPPROPRIATE COMPETENCY EVALUATIONS

Ideally, a defendant would not be evaluated for competency unless a bona fide doubt existed as to his/her competency (the legal standards involved in this threshold issue are discussed subsequently). Furthermore, once referred, one would hope that the most efficient and reliable system for competency determinations would be employed. However, competency referrals and determinations are influenced by a number of other considerations, many of which are unrelated to either the defendant's actual mental capacities or an optimal evaluation system. Several important factors have been identified:

- There is a general confusion among trial attorneys as to the role of mental disorder in the adjudication of criminal defendants. Competency for adjudication, mental disorder negating or diminishing criminal responsibility, and mental disorder as a mitigating factor at sentencing or as a basis for alternative dispositions are frequently confused. Thus, many attorneys (defense as well as prosecution) petition the court for a competency evaluation whenever there is any hint that a particular defendant is mentally disabled or retarded. Since roughly 10% of pre-trial defendants or prisoners have some form of significant mental disorder (i.e., psychotic conditions), many "inappropriate" competency referrals are made when an attorney confuses mental illness, criminal responsibility and competency for adjudication.

Some trial attorneys know such distinctions quite well, but use the possibility of a competency evaluation to accomplish other goals. While the U.S. Supreme Court in Ake v. Oklahoma[8] mandated the availability of pre-trial assistance from mental health professionals under certain circumstances, many attorneys feel that a competency evaluation, while lacking the confidentiality associated with privately obtained pre-trial consultations, is a reasonable means of guaranteeing them the assistance they need in preparing their case with an indigent defendant who has some degree of significant mental disorder.

Some trial attorneys base their decisions on other, somewhat more dubious, rationales. For example, trial attorneys may use competency referrals to seek a delay of trial in order to "cool down" a community or to increase the probability that the memory of witness against the defendant will deteriorate. Prosecutors may also misuse competency referrals as a means of gaining early access to information that might be denied to them, under ordinary rules of discovery, until a defendant puts his mental state into question as when he raises the insanity defense.
Judges rarely make a permissible Pate inquiry into whether or not a bona fide doubt exists as to a defendant’s fitness. Under Pate (discussed below), a judge must order a hearing on a defendant’s competency when such a bona fide doubt exists, but is permitted to inquire as to whether such a bona fide doubt exists. Because most judges strive to avoid having their decisions overturned on appeal and receive little training in this area of the law, they almost routinely grant petitions for evaluation, even when they suspect that no real doubt exists. The “safest” course is often to simply grant the petition.

While community-based evaluations are theoretically “cost-effective,” they are unreliable if not conducted on the basis of adequate information (prior mental health history, forensic and criminal history, collateral sources to detect malingered mental illness or retardation) since most jurisdictions that use community evaluations do not have a centralized coordinating, training and supervisory administrative structure. Many evaluations are based upon inadequate information. Similarly, if community evaluators are not trained and supervised, they, like attorneys, tend to confuse presence of mental disorder/retardation and/or treatment needs with incompetency and often base their evaluations on traditional mental health assessment techniques rather than techniques specifically appropriate to competency determinations.

Various systems factors that increase inappropriate competency referrals and determinations have to do with interactions with other aspects of the mental health - criminal justice interface. There is a relationship between the strictness of civil commitment criteria and the number of competency referrals. As civil commitment criteria have been generally tightened, police and prosecutors are increasingly tempted to charge mentally disordered individuals, and then divert them into mental hospitals for competency evaluations and/or treatment. In a related fashion, the availability of adequate pre-trial mental health treatment to competent, but mentally disordered defendants, is related to competency referrals. In jurisdictions where such treatment resources are not available in pre-trial detention, jail personnel, attorneys, and other legal actors tend to use competency evaluations and hospitalizations as a means of securing needed treatment. Finally, jurisdictions which have limited defenses on the grounds of mental disorder or retardation tend use competency evaluations and determinations as a dispositional alternative.

Another perspective on the problem of inappropriate competency referrals and determinations is in terms of their costs, both legally and financially. Legally, there is a lessening of the "quality" of justice from the perspective of both the defendant and the state. From the perspective of the state, the cost is in terms of the speedy administration of justice. From the perspective of the defendant, the legal cost may be conceptualized in terms of deprivation of liberty interests, due process, and other constitutional rights. Even when the competency referral is for the understandable reason of attempting to obtain treatment, the legal costs may be significant because the defendant might otherwise be able to obtain the needed treatment in a less restrictive environment.

The financial costs associated with the competency referral system are significant in two respects -- the direct cost, and the unavailability of these “mental health” dollars for other treatment and evaluation needs. On a national basis, outpatient evaluations can be estimated to cost between $3000 - $6000; inpatient evaluations are more costly, averaging $20,000 - $50,000. Regardless of the actual cost, it should be clear that considerable financial and legal costs may be associated with the competency adjudication system. It is therefore critical that all legal and mental health professionals involved in the system understand the construct of competency, and use the most accurate and efficient means in its determination.

OVERVIEW OF COMPETENCY FOR ADJUDICATION

Historically, our jurisprudential system placed great weight on the role of pleading; if the accused was mentally or physically impaired, to the extent of not understanding the charges or the proceedings, then such a defendant could not plead properly to the charges. The modern standard for competency to stand trial was established, on constitutional grounds, by the United States Supreme Court in Dusky v. United States. Although the exact wording varies, all states use some variant of the Dusky standard to define trial competency. In Dusky, the Supreme Court held that:

It is not enough for (a) ... judge to find that “the defendant is oriented to time and place and has some recollections of events,” but that the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding -- and whether he has a rational as well as factual understanding of the proceedings against him. [at 402]

Regardless of the exact wording in any particular jurisdiction, the main competency principle that emerges in all cases, statutes, and scholarly commentary upon the doctrine may be stated in the following way:

In an adversarial system of jurisprudence, it is a fundamental violation of fairness and due process to proceed against a defendant who, by virtue of mental or physical impairment, is not able to factually as well as rationally understand the nature of the judicial proceedings against him/her, and to rationally participate as vigorously or effectively in his/her defense as would be expected of a normal defendant. The concern is not only that failure to participate vigorously and effectively may lead to an erroneous result (conviction of an innocent defendant), but also that the moral authority of the judicial system will be diminished by proceeding against a defendant who is unable to comprehend rationally the proceedings, the judgment or the sentence.

The Dusky standard as interpreted

The major problem with the Dusky standard has been a great deal of ambiguity as to the meaning of its key terms. “No one quarrels with what the Supreme Court actually held in Dusky: unhappiness with Dusky is produced by the fact that the Supreme Court said so little as to why it held what it did.” What is meant by "sufficient present ability?" How does one determine whether a defendant "has a rational as well as factual understanding?" A comprehensive review of scholarly writings, case law, and empirical evidence, helps to put the meaning of these terms in a reasonable perspective with sufficient guidance to construct assessment instruments such as the IFI.

First, it is important to note that the Dusky standard concerns competency to proceed, not mitigation of criminal responsibility as a consequence of mental disorder. The two issues are frequently confused, in no small measure because many individuals who subsequently raise the “insanity defense” are also evaluated for trial competency, and many are found unfit before they are ultimately adjudicated as “not guilty by reason of insanity.”
A second ambiguity of the Dusky standard concerns what level of mental incapacity or disturbance is needed for the threshold of "sufficient present ability." Almost all empirical research on incompetent defendants finds that the vast majority are diagnostically psychotic or are significantly developmentally disabled. These results form the basis for a continuing misunderstanding of the Dusky standard by mental health and legal professionals alike. Many professionals continue to equate the existence of psychosis or severe mental retardation with incompetency, but this is both a legal and an empirical mistake. It is legally erroneous because court opinions which address the subject hold that the presence of severe mental illness (i.e., psychosis) or mental retardation is not dispositive of the competency issue.

All courts that have addressed this aspect of the Dusky standard have concluded that the standard is a functional and context-dependent one in which merely presence of severe disturbance or retardation (a psychopathological criterion) is only a threshold issue -- it must be further demonstrated that such severe disturbance in this defendant, facing these charges, in light of existing evidence, anticipating the substantial effort of a particular attorney with a relationship of known characteristics, results in the defendant being unable to rationally assist the attorney or to comprehend the nature of the proceedings and their likely outcome.

The "standard" set forth in Dusky for general competency to proceed has thus been characterized as "open-textured." This logic was utilized in the development of the Interdisciplinary Fitness Interview-Revised, which is described in detail in Section II. Rather than attempt to define competency in any operational fashion, the IFI-R allows clinical and legal decision makers to evaluate the global logic of the Dusky standard in flexible ways that make sense given the particulars of a given defendant, charge and legal context. Thus, to utilize the IFI-R properly, an examiner must (a) understand the jurisprudential theory that underlies competency to proceed; (b) understand the specific contextual factors that occur given a particular defendant, the charges, the existing evidence, the capacities and strategies of the attorneys involved, and any other relevant, context-dependent factors; and (c) understand how a particular defendant's psychological strengths and weaknesses relate to the specific psycholegal abilities that will be required in the given context.

Since the Dusky decision, considerable attention has been given to understanding the domain of "psycholegal" abilities encompassed by the "rationally understand and assist" language of the standard. Several states have incorporated this understanding into explicit statutory guidance for both legal and mental health professionals. For example, Florida adopts the Dusky standard with this language:

(1) A person is incompetent to stand trial ... if he does not have sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding or if he has no rational, as well as factual, understanding of the proceedings against him.

(2) A defendant who, because of psychotropic medication, is able to understand the nature of proceedings and assist in his defense shall not automatically be deemed incompetent to stand trial simply because his satisfactory mental functioning is dependent upon such medication; and then goes on to give specific guidance to evaluators and judges as follows:

In considering the issue of competence to proceed, the examining experts shall consider and include in their report:

(A) the defendant's capacity to:

(i) appreciate the charges or allegations against the defendant;

(ii) appreciate the range and nature of possible penalties, if applicable, that may be imposed in the proceedings against the defendant;

(iii) understand the adversary nature of the legal process;

(iv) disclose to counsel facts pertinent to the proceedings at issue;

(v) manifest appropriate courtroom behavior;

(vi) testify relevantly; and

(B) any other factors deemed relevant by the experts.
OVERVIEW OF PROCEDURAL ASPECTS OF COMPETENCY TO STAND TRIAL

State laws regarding procedural aspects of competency vary a good deal, although all jurisdictions follow the constitutionally mandated procedural principles.

Raising the issue

The issue of competency may be raised by any officer of the court at any point in the criminal process. It must be raised and formally considered if the court determines that a bona fide doubt exists as to a defendant's competency (Drope v. Missouri, [35]). The question, of course, is what constitutes "bona fide" doubt?

The meaning of bona fide doubt is problematic because, if interpreted too liberally (as seems to be the case), it results in an overuse of competency hearings, while if interpreted too conservatively, it results in the deprivation of critical due process rights. A review of case law makes clear that the mere presence of a mental disorder or a history of mental disorder is not sufficient to raise a bona fide doubt. As expressed by the Supreme Court:

The import of our decision in Pate v. Robinson is that evidence of a defendant's irrational behavior, his demeanor at trial, and any prior medical opinion on competence to stand trial are all relevant in determining whether further inquiry is required, but that even one of these factors standing alone may, in some circumstances be sufficient. There are, of course, no fixed or immutable signs which invariably indicate the need for further inquiry to determine fitness to proceed; the question is often a difficult one in which a wide range of manifestations and subtle nuances are implicated. (Drope at 180)

A series of California decisions put the matter more directly:

More is required to raise a doubt than mere bizarre actions ... or bizarre statements ...(or) a statement of defense counsel that defendant is incapable of cooperating in his defense ... or psychiatric testimony that the defendant is immature, dangerous, psychopathic, or homicidal or such with little reference to defendant's ability to assist in his own defense, (People v. Laudermilk, [37]) citations omitted and emphasis added, at 289

Pate v. Robinson stands for the proposition that an accused has a constitutional right to a hearing on present sanity if he comes forward with substantial evidence that he is incapable, because of mental illness, of understanding the nature of the proceedings against him or of assisting in his defense. (People v. Pennington, [38] emphasis added, at 949)

In light of the potential ambiguities of the "bona fide or substantial doubt" test for granting a defendant's motion for a hearing on competency to proceed, several states have adopted what seems a rather rational procedure, that of requiring more than a pro forma motion. For example, Florida requires, of the party raising the issue, that the

motion ... shall contain a certificate of counsel that the motion is made in good faith and on reasonable grounds to believe that the defendant is incompetent to proceed. [To the extent that it does not invade the lawyer-client privilege, the motion shall contain a recital of the specific observations of and conversations with the defendant that have formed the basis for the motion (for defense counsel).] ... [and shall include a recital of the specific facts that have formed the basis for the motion, including a recitation of the observations of and statements of the defendant that have cause the state to file the motion (for prosecution counsel)]. (29)

When competency is raised by the prosecution, however, a potential problem arises concerning information obtained in a competency evaluation that could be used against a defendant during a trial or other legal proceeding. In Estelle v. Smith, [39] the Supreme Court of the United States held that

a criminal defendant, who neither initiates a psychiatric examination nor attempts to introduce any psychiatric evidence, may not be compelled to respond to a psychiatrist if his statements can be used against him at a capital sentencing proceeding. [at 465]

With respect to the issue of counsel, the American Psychiatric Association, the American Bar Association and the Committee on Ethical Guidelines for Forensic Psychologists have taken the further position that, even in the context of the Estelle rule, it is unethical for a mental health professional to evaluate a defendant for competency unless counsel has been appointed, and is aware of the intended examination (presumably to allow for various motions to be filed). Furthermore, as discussed in Section II of this manual, an examiner must be cautious in their judgment as to what “facts and data” to place in their competency report. While such facts and data cannot be used against a defendant unless he/she "introduces" mental state evidence on the issue of guilt or disposition, many subtle indications can provide the prosecution with pre-trial strategy information to which they are not entitled. The full ramifications of this problem are discussed subsequently.

Burden of proof

Jurisdictions differ widely on the issue of who bears the burden of establishing a defendant's incompetency. California, for example, places the burden, by a preponderance of the evidence, on the party raising the issue. New Mexico allows the burden to be placed on the defendant. Delaware places the burden on the prosecution. Quite recently, the United States Supreme Court, in Medina v. California, ruled that, "While reasonable minds may differ as to the wisdom of placing the burden of proof on the defendant in these circumstances, ... we see no basis for concluding that placing the burden on the defendant violates the principle approved in Pate." [LEXIS pagination at 10]
Regardless of the legal rule governing burden of proof, mental health professionals play a key role in the judicial determination of competency to proceed. Most empirical research on the relationship between professional opinion and judicial determinations finds that courts tend to accept professional opinions as to a defendant's competency (the typical finding being concordance rates of 90% or higher). Unfortunately, this rate of concordance seems less attributable to the acumen of the examiners than to the deference of judicial authorities to professional judgment. As is the case with other forms of mental health testimony, judicial authorities need to pay more attention to the "critical links" between the data presented by examiners, the inferences to be drawn from such data, the theories which guide those inferences, and the thoroughness and reliability of the assessment procedures used to generate the data in the first place. The guidance of *Feguer v. United States* is worthy of repeated consideration:

Presence of mental illness [*Feguer was diagnosed as a paranoid schizophrenic*] does not equate with incompetency to stand trial. ... even expert testimony raises no higher than the reasons on which it is based; it is not binding upon the trier of the facts. [at 236, citations omitted]

### COMPETENCY TO WAIVE CONSTITUTIONAL RIGHTS

As a general matter, it is well settled that a defendant who wishes to waive a fundamental constitutional right must do so in an intelligent, knowing, competent and voluntary manner. The language of some of the United States Supreme Court's seminal cases on this subject are instructive in helping us unpack the semantic implications of these terms. In *Johnson v. Zerbst*, the Court, in the context of waiving right to assistance of counsel, expressed the doctrine as:

> A waiver is ordinarily an intentional relinquishment or abandonment of a known right or privilege. The determination of whether there has been an intelligent waiver ... must depend in each case, upon the particular facts and circumstances surrounding that case, including the background, experience, and conduct of the accused. [at 464, emphasis added]

In the context of waiving the rights to avoid self-incrimination, trial by jury, and to confront one's accusers by pleading guilty, the Court, in *Boykin v. Alabama*, concluded that:

> It was error, plain on the face of the record, for the trial judge to accept petitioner's guilty plea without an affirmative showing that it was intelligent and voluntary ... A plea of guilty is more than a confession which admits that the accused did various acts; it is itself a conviction; nothing remains but to give judgment and determine punishment. Admissibility of a confession must be based upon a reliable determination on the voluntariness issue which satisfies the constitutional rights of the defendant. *Jackson v. Denno*, 378 U.S. 368, 387...We think that the same standard must apply to determining whether a guilty plea is voluntarily made...What is at stake for an accused facing death or imprisonment demands the utmost solicitude of which courts are capable in canvassing the matter with the accused to make sure he has a full understanding of what the plea connotes and of its consequence. [at 242-244; emphasis added]

In the famous *Miranda* decision, the same language re-appears:

> ...the prosecution may not use statements, whether exculpatory or inculpatory, stemming from custodial interrogation of the defendant, unless it demonstrates the use of procedural safeguards to secure the privilege against self-incrimination.... Prior to any questioning, the person must be warned that he has a right to remain silent, that any statement he does make may be used as evidence against him, and that he has a right to the presence of an attorney...The defendant may waive effectuation of these rights, provided the waiver is made voluntarily, knowingly and intelligently.

Interpretation of these phrases has proven to be the key to understanding legal and professional disputes in this area. These phrases are interpreted constructively and not literally. That is, just as the courts have stressed that a defendant must have a "rational as well as a factual understanding of the proceedings against him" (*Dusky*) in interpreting competency to stand trial, the meanings of these phrases have not been taken literally, and must be interpreted in the full light of a complex set of psychological capacities and processes.

#### Voluntary waiver

Obviously, one aspect of the interpretation of this phrase involves the non-existence of such factors such as police coercion, intimidation, torture, threats or attempts to otherwise induce a confession "against the will" of the defendant. More problematic, however, are situations in which the defendant's mental state and/or capacities render him more susceptible to implicit coercion or intimidation than a "normal" defendant, or where the defendant's mental disorder may deprive him of the degree of free agency experienced by "normal" defendants. Thus, the influence of mental disorder on an individual's ability to freely choose to waive a fundamental right (to silence, to counsel, to jury trial, etc.) is an important issue. Even the majority in the *Connelly* case (discussed below) acknowledged that "as interrogators have turned to more subtle forms of psychological persuasion, courts have found the mental condition of the defendant a more significant factor in the 'voluntariness' calculus." Plainly, the mental state of the defendant (as a function of physical or psychological trauma, medication, sleep deprivation, surgical procedure, or ongoing severe mental disorder or retardation) may influence either his susceptibility to persuasion or his ability to freely choose. In *Blackburn v. Alabama*, the defendant, a paranoid schizophrenic who had a long history of hospitalizations, was interrogated by the police for a period of at least five hours during which there was no indication of police misconduct or threatening behavior. His confession during that interrogation was ruled involuntary:

> The evidence indisputably establishes the probability that Blackburn was insane and incompetent at the time he allegedly confessed. Surely in the present stage of our civilization a most basic sense of justice is afforded by the spectacle of incarcerating a human being upon the basis of a statement he made while insane; and this judgment can without difficulty be articulated in terms of the unreliability of the confession, the lack of rational choice of the accused, or simply a strong conviction that our system of law enforcement should not operate so as to take advantage of a person in this fashion. [at 207]
The judicial evaluation of the voluntariness of a defendant's waiver of constitutional rights is made from the totality of the circumstances with the defendant's mental capacity, intelligence and possible incompetency receiving special attention. In sum, the act of waiver must be the product of a "rational mind and a free will."

**Intelligent waiver**

The phrase "intelligent" is not used to connote a certain level of intellectual functioning in the psychological sense, although this may be involved. Rather, "intelligent" is used as a synonym for "rational." While some defense counsel may feel that any decision to represent oneself or confess is per se "irrational," the courts have always held that a defendant may rationally choose when he understands the legal implications of his decision and its likely consequences. "Intelligent" thus refers to both a rational understanding of the consequences, comnotations and implications of the act of waiver and to the form of reasoning ("rational") which lies behind it. Thus, a decision to confess based upon a firm understanding that it will likely result in conviction and such-and-such sentence will be seen as intelligent if it is also based upon a set of reasons that could be viewed as "rational." A defendant with normal intellectual capacities and without serious mental disorder who chooses to confess to spare her family the embarrassment of publicly revealing her sexual promiscuity could be seen as doing so for rational reasons even though many might choose otherwise in order to avoid imprisonment on a manslaughter charge arising from the slaying of her lover. Arguably, however, a paranoid schizophrenic defendant, whose rationale for confession was based in delusional system that God would destroy her or her family if she did not confess, would be found to have waived her Fifth Amendment rights in a non-rational, i.e. non-intelligent manner, even if she "understood" the likelihood of conviction and sentencing.

**Knowing waiver**

To the extent that this term has semantic implications beyond those already covered by "voluntary" and "intelligent," it refers to cognitive and intellectual capacities to understand the legal terms utilized in various waiver situations. Thus, in a "Miranda" warning situation, the primary focus has been upon the theoretical and functional intelligence of the defendant in relationship to the meaning of the words and phrases of the warning. This aspect of competency to waive constitutional rights, in the context of Miranda, has received the most empirical attention, primarily in Grisso's work which focuses on juveniles. Grisso developed a series of assessment instruments (Comprehension of Miranda Rights; Comprehension of Miranda Vocabulary; Function of Rights in Interrogation) designed to assess the capacities of defendants (both adult and juvenile) to waive their "Miranda" rights in a meaningful fashion. Grisso's work in this area represents a substantial contribution because these instruments, when taken together, provide a specific means to assess the cognitive aspects of comprehension of Miranda rights. While intelligence as measured by standardized tests (Stanford-Binet, Wechsler) is surely relevant to this concern, it is too global a construct to be useful in judicial decision-making. While these instruments are relatively new, they, or instruments like them, seem to be a better index of functional comprehension of Miranda rights than can be indexed by global IQ scores.

Having laid the general groundwork for an analysis of competency in the context of waiver of certain constitutional rights, we now turn to a more specific examination of five of the most problematic areas: competency to plead guilty, competency to waive right to counsel, competency to waive certain defenses, competency to confess, and competency to refuse treatment.

**COMPETENCY TO PLEAD GUILTY**

When a defendant wishes to plead guilty, he obviously is waiving a number of fundamental constitutional rights, and so must do so in an intelligent, voluntary and competent fashion. Are the mental capacities necessary to do so of a fundamentally "higher" nature requiring a different and higher standard of competency? Two Federal Appellate circuits (the 9th and the 4th) have ruled that this is the case, while the remaining circuits have found that the language of Dusky suffices to address the constitutional requirements.

In Sieling v. Eyman,(49) the Ninth circuit adopted a higher standard which had previously been expressed by Justice Hufstedler in her dissent in Schoeller v. Dunbar.(48)

The standards measuring a defendant's competency to stand trial are not necessarily identical to those defining his competency to enter a plea of guilty. To the extent that they differ, the standards of competency to plead guilty are higher than those of competency to stand trial. A defendant is not competent to plead guilty if mental illness has substantially impaired his ability to make a reasoned choice among the alternatives presented to him and to understand the nature of the consequences of his plea.

Regardless of whether or not a jurisdiction follows the "general" Dusky standard or the "higher" Sieling standard, the competency hearing on the issue of waiving the set of rights implied by pleading guilty must focus on the competency of that waiver. As discussed below (under waiver of counsel), the Supreme Court, in Westbrook v. Arizona,(50) determined that a general hearing as to trial competency will not suffice in determining competency to waive fundamental constitutional rights. While the courts may debate whether the "lens" of Sieling ["substantially impaired ... ability to make a reasoned choice among the alternatives presented ... and to understand the nature of the consequences of ... (the) plea"] seems to bring the issue into sharper focus than Dusky ["the defendant's understanding as well as factual understanding of the proceedings"], a forensic mental health evaluator must understand the need to bring forth data on the critical nexus of mental disorder and voluntariness, rationality and understanding. In most cases, if testimony and evidence on these issues is properly framed and presented, the outcome probably does not depend upon the lens.
utilized. In those waiver cases where the "standard" may make a difference (see, for example, Goode below), the mental health and legal professionals involved have an ethical and scientific obligation to continue a constructive debate on the issue of "standards."

COMPETENCY TO WAIVE THE INSANITY DEFENSE

Imposing an insanity defense upon an unwilling defendant is a situation which arises, in direct form, infrequently in the United States. Indirectly, in the form of waiving right to representation by counsel (who intends to pursue an insanity defense), it occurs with greater frequency. Direct imposition of an insanity defense is permissible in Canada and, in restricted form, in England. A leading case in Canada is Regina v. Simpson (53) where a defendant was found not guilty by reason of insanity on an indictment of two counts of attempted murder even though he did not place his state of mind at issue during the trial. The Simpson court allowed the prosecution to introduce evidence of a defendant's insanity, given that substantial evidence created a grave question whether the accused had the capacity to commit the offense. Fundamental fairness required the trial judge to submit the defense and the appropriate instructions to the jury as a verdict option, even when post-acquittal commitment of an insanity acquittee was automatic and indeterminate in Canada at the time. In England, the prosecution may enter evidence of insanity only if the defendant introduces his state of mind as an issue at trial. Thus, if a defendant attempts to prove that he suffered a non-insane automatism (which would result in absolute discharge), the prosecution may attempt to show that the automatism was "insane," i.e. the product of a disease of the mind, which would result in a mandatory hospitalization (Bratty v. A.-G. Northern Ireland). (54)

In the United States, a small group of cases have addressed this issue directly or indirectly. In Whalem v. United States (55) and United States v. Robertson (56), the District of Columbia Court of Appeals set forth authority for a trial judge to raise the defense of insanity over the objection of a defendant found competent to stand trial. Some of the factors that should be considered in interposing such a defense include the defendant's behavior at trial, the trial counsel's desire to raise the defense (thwarted by defendant), the bizarreness of the actus reus, and the opinions of experts about the defendant's mental state.

In light of a series of Supreme Court cases stressing a defendant's right to make fundamental decisions about their own case (see discussion of Faretta below), the D.C. Court of Appeals was persuaded in Frendak v. United States (57) that there may be "persuasive reasons why defendants convicted of an offense may choose to accept the jury's verdict rather than raise a potentially successful insanity defense." [at 378] Among such reasons are a) a potentially longer period of confinement than if convicted; b) a desire to receive treatment as a prisoner rather than as a mental patient; c) a desire to avoid subsequent legal and social stigmatization as "twice cursed" (criminally insane); and d) a desire not to admit the actus reus, or not to have an act of political or religious protest construed as "insane." In light of this, the Frendak Court held that a trial judge may not force an insanity defense on a defendant found competent to stand trial if the individual intelligently and voluntarily decides to forgo that defense.

In reaching this result, however, we further hold that the court's finding of competency to stand trial is not, in itself, sufficient to show that the defendant is capable of rejecting an insanity defense; the trial judge must make further inquiry into whether the defendant has made an intelligent and voluntary decision. [at 367]

In modifying and reinterpreting its rule, the District of Columbia Court of Appeals is appears to be adopting a version of the Sieving standard for competency to plead guilty:

The Dusky standard is designed to indicate whether the accused knows enough about the facts of the case to relate them coherently to his or her attorney and to understand the nature of the proceedings. It is not intended to measure whether the defendant is also capable of making intelligent decisions on important matters relating to the defense...because the court is dealing with an individual whose sanity has been questioned, a cursory explanation or a rote interrogation cannot satisfy the court's duty... (furthermore, the trial court has) discretion to raise an insanity defense sua sponte only if the defendant is not capable of making, and has not made, an intelligent and voluntary decision. [Frendak, at 379-380, citations and other text omitted]

This same court continues to allow the procedure, but not over the objection of a "competent defendant," hence overruling Whalem to the extent it was so construed.

We hold that a district court must allow a competent defendant to accept responsibility for a crime committed when he may have been suffering from a mental disease... When a defendant can make no clear choice for or against raising the defense, and the evidence suggests that the defense is viable, it might then be appropriate for the court to exercise its discretion to instruct the jury sua sponte (United States v. Marble) (58). While the use of "imposed" insanity defenses can raise important and troubling jurisprudential and ethical concerns, the alternative, especially in capital murder cases, is troubling as well (see Goode below). It is the rare defendant whose "reasons" for refusing an insanity defense fall into the "Frendak" caution zones, i.e., arguing that they will be institutionalized longer, or wanting a political statement not to be seen as "insane." Rather, the more typical scenario involves a delusional or schizophrenic patient who does not believe she is mentally ill or who views his "commands from God" to be defined by "secular courts." Such reasoning can, and should be, examined carefully under the Supreme Court's Boykin - Westbrook - Zerbst rulings.

COMPETENCY TO CONFESSION

Confession by a suspect in a criminal investigation is one of the primary means by which the police solve cases. Since the admission of an unimpeached confession at trial almost invariably leads to a conviction, the assessment of the reliability (validity) of a confession is central in the adjudication of a criminal case. When the defendant is suspected of being mentally disordered or retarded, a number of legal, psy Logtical, and social policy concerns arise in addition to the traditional issue of "coercion." As a matter of fundamental fairness, the common law assumption has always been that "the law will not suffer a prisoner to be made the deluded instrument of his own conviction" (Columbe v. Connecticut) (59). As discussed previously, a constitutional waiver of this dimension (right to remain silent) must be a "knowing, intelligent and voluntary" waiver of fundamental rights. Since the Supreme Court's jurisprudentially confusing decision in Connely v. United States (60), the analysis of the voluntariness of confessions has become complex.
**Factual background of Connelly**

Francis Connelly approached a Denver police officer on August 18, 1983 and stated, without prompting, that he had murdered someone and wanted to talk about it. He was promptly "Mirandized" and claimed he understood his rights but wanted to talk anyway. He denied taking drugs or being drunk when asked, but did state that he had been a patient in several mental hospitals. He repeated that he understood his rights to this officer and to another officer. He told the police officers and a detective that he had come from Boston to confess to the murder of a young girl in 1982. He subsequently took them to the scene where the body had been previously discovered. The officers testified that he did not appear to them to show any signs of mental disorder, other than his admission that he had been previously hospitalized. The next day, he was interviewed by the public defender, who found him disoriented, incoherent, and claiming that he was hearing voices which had commanded him to withdraw all his money, buy a plane ticket to Denver (from Boston), and send the rest of the money to his mother or else he would be forced to commit suicide. Connelly was evaluated for competency to stand trial, found incompetent, and hospitalized until March, 1984, at which time he was judged restored to competency. At his trial, the defense moved to suppress all of his prior statements to the police on the grounds that his waiver was incompetent.

At the suppression hearing, the primary witness was a psychiatrist from the state mental hospital who had examined Connelly during his competency evaluation and treatment. Dr. Metzner testified that a) Connelly was suffering from a chronic mental illness, schizophrenia; b) Connelly had a long history of disorder including five hospitalizations since 1979; c) that at the time of his waiver and confession he was actively psychotic, and was experiencing "command hallucinations" which interfered with his ability to make free and rational choices, although he did understand his rights in an abstract and purely cognitive fashion. On the basis of this evidence, the trial court ruled that Connelly's statements, both before and after the Miranda warning were involuntary, being the product of mental disorder not the operation of a rational intellect and free will. In State v. Connelly, the Colorado Supreme Court upheld this finding with respect to both Connelly's pre- and post-custodial statements, and specifically relied upon the Culombe, Blackburn, and Townsend cases discussed earlier in this section.

The testimony ... established that the defendant on this occasion was suffering from a serious mental disorder which placed him in the dilemma of confessing his crime to the police or committing suicide. Given this state of the evidence, it was within the court's prerogative to rule that the defendant's initial statement to Officer Anderson was not the product of a rational intellect and a free will notwithstanding the fact that this statement was neither solicited by the officer nor was the result of any form of police action... The testimony ... (also) clearly established that the defendant's mental condition of August 18, 1983 was such that he was incapable of making an intelligent and free decision with respect to his constitutional right of silence while in custody and his constitutional right to confer with a lawyer before talking to the police. [at 731]

The United States Supreme Court reversed Connelly in a decision that generated considerable controversy. The majority in Connelly held that:

Coercive police activity is a necessary predicate to finding that a confession is not 'voluntary' within the meaning of the Due Process Clause of the Fourteenth Amendment. [at 167]  

Thus, because no police coercion or wrongdoing was evident in the behavior of the Denver police, Connelly was not due any further consideration of the voluntariness issue. The Court went on to observe that accepting Connelly's claim that his mental disorder alone could render his decision to confess involuntary would "import into this area of constitutional law notions of 'free will' that have no place here." [at 169]

This decision is a troublesome one from both jurisprudential and psychological perspectives. It is important to note that nowhere in the majority opinion is the fact that Connelly was found incompetent to stand trial even mentioned. Three Justices (Brennan, Marshall, and Stevens) strongly dissented from the Court's analysis of Connelly's waiver of his Miranda rights:

The Court seems to believe that a waiver can be voluntary even if it is not the produce of an exercise of the defendant's 'free will'...The Court's position is not only incomprehensible to me; it is also foreclosed by the Courts recent pronouncement in Moran v. Burbine...[106 S. Ct. 1135, 1141, (1986)]...that "the relinquishment of the right must have been voluntary in the sense that it was the product of a free and deliberate choice" [Justice Stevens, dissent, at 173]

Today the Court denies Mr. Connelly his fundamental right to make a vital choice with a sane mind ... (Connelly's) ... seriously impaired mental condition is clear ... At the time of his confession (he) suffered from a 'longstanding mental disorder,' diagnosed as chronic paranoid schizophrenia ... He had been hospitalized for psychiatric reasons five times prior to his confession; his longest hospitalization lasted for seven months, ... (He) heard imaginary voices and saw nonexistent objects, .... He believed that his father was God, and that he was a reincarnation of Jesus. ... At the time of his confession, Mr. Connelly's mental problems included 'grandiose and delusional thinking' ... He had a known history of 'thought withdrawal and insertion' ... He denied taking drugs or being drunk when asked, but did state that he had been a patient in several mental hospitals for at least six months prior to his confession ... [Justice Marshall, dissent, at 174, citations and other text omitted]

Thus, the jurisprudentially troublesome part of this opinion is that it totally ignores the entire precedent of constitutional analysis of "intelligent, voluntary, and competent" waiver of any fundamental right, relying instead on the creation of a separate class of voluntary rights, those which only apply when there has been police misconduct. It also ignores the uncontradicted evidence of Connelly's serious and legally relevant mental disorder. Nevertheless, the decision only impacts defendants whose confessions were obtained prior to "coercive police activity." Since police custody is viewed as "inherently coercive," the issue functionally turns on whether or not the defendant is officially "in custody" at the time of the confession. Thus, the courts continue to apply the "intelligent, voluntary, and knowing" standard and view mental illness or mental retardation as a significant factor in that analysis, but would not apply that analysis, under Connelly, to confessions obtained in a non-custodial situation.

Recent developments in the area of confessions are also troubling. Modern police interrogation methods, based upon the techniques originally outlined by Inbau and Reid, constitute a very intense form of psychological coercion and manipulation. These techniques are based upon and justified by the strongly held assumption that such psychological plays cannot induce an innocent defendant to incriminate him/herself. Unfortunately, as empirical and scholarly attention have focussed on this assumption, it turns out to be quite false. So-called "false confession" cases, where a defendant, subject to such interrogation,
gives a false confession (proven false by hard evidence that someone else committed the alleged crime), were once thought a puzzling rarity. A series of spectacular cases in the United Kingdom and the United States made clear that the assumption was erroneous, and, as attention has focussed on the issue, more and more false confession cases emerge. Sometimes these false confession cases involve individuals who are especially vulnerable because of mental illness, mental retardation, or because of their susceptibility to influence by authority figures. Forensic evaluators need to be especially sensitive to this problem of false confessions, and examine the nature and details of interrogation procedures most carefully when involved in a case where the "voluntariness" of a confession is at issue (see Section II of this manual).

COMPETENCY TO WAIVE COUNSEL

The fundamental right to effective assistance of counsel during an adversarial confrontation during which an individual may lose an even more fundamental right, i.e. to liberty, is acknowledged in all mature systems of law. When a defendant seeks to waive this right and proceed pro se, a serious issue of competency arises. In the hierarchy of factors which may compromise the fairness of adjudication, right to assistance of counsel is high on the list. Nevertheless, some defendants wish to represent themselves, for a variety of reasons. In Faretta v. California, the Supreme Court of the United States addressed this issue in detail. As is the case with other fundamental rights, the waiver must be made in a "knowing, intelligent and voluntary" manner [In Faretta this is expressed as "literate, competent, and understanding, ... voluntarily exercising his informed free will" [at 836]]. The standard set in this case was that the wisdom or stupidity of the defendant's decision was not the issue. Rather, the defendant must only show that the waiver meets the criteria of "literate, competent, and understanding." While the Supreme Court had previously announced in Westbrook v. Arizona that a hearing on competency to stand trial did not suffice to determine competency to "waive ... constitutional rights to the assistance of counsel and ... to conduct (one's) own defense" (at 150), it did not choose to rule on whether or not the standard was a higher one. Unfortunately, no comprehensive empirical study of actual trial court practice is available. The American Bar Association, in its Criminal Justice Mental Health Standards, declined to advocate a higher standard, but did advocate an explicitly different standard, as follows:

...the present ability to knowingly, voluntarily and intelligently waive the constitutional right to counsel, to appreciate the consequences of the decision to proceed without representation by counsel, to comprehend the nature of the charge and proceedings, the range of applicable punishment, and any additional matters essential to a general understanding of the case (Standard 7-5.3).

In our experience, however, trial courts have had a difficult time dealing with potentially incompetent defendants who seek to waive their right to counsel. While some trial courts have reached similar conclusions based on either higher standards or on the basis of tailoring the Faretta language as advocated by the ABA, most have difficulties when confronted with an articulate but mentally disordered defendant.

The case of Arthur Goode illustrates this point. Goode sexually assaulted and murdered a ten year old boy in Florida. At the time, he was an escapee from an involuntary commitment in Maryland. Following the Florida murder, Goode returned to Maryland, kidnapped two other boys, murdering one and telling the other of his Florida murder victim. Goode was convicted and sentenced to life. He then confessed to the Florida killing, and demanded to be returned there in order that he might be executed. Goode asserted his right to waive counsel. One of the psychiatrists who examined him, and found him competent, characterized Goode's reasons as follows:

He is making a choice based upon non-psycho analytic reasons, and his reasoning basically consists of his feeling that he has already been convicted of a murder, Number One. Number Two, he wishes not to spend the rest of his life in prison. Number Three, despite his insistence that he feels no remorse he does indicate that he still considers himself to be dangerous and in a very vague way, but in a very true way indicates that somewhere within himself there is the thought that he should not be allowed to continue to go on in his present course which includes mental illness, which includes murdering young children. [Goode v. Florida 112 at 383]

Two other psychiatrists for the state shared in this conclusion, while one psychiatrist for the defense (testifying over Goode's objections to his counsel) characterized Goode as showing

signs of schizophrenia of the latent type with disturbance in his thoughts, in his thinking, in his affect and his behavior. In addition, I think that he meets the criteria as I understand them related to the issue of competency to stand trial in that - and I think here is the misleading part - he can give factual information and he does so very readily, and I think that this is deceiving to people in that he appears to make sense about what he is saying, but - and I think this is a matter to be argued by you and the State and for the Judge to decide, but is it rational, and I think that is the key issue. [at 382]

Whether or not Goode was or was not psychotic (or "merely" suffering from substantial personality disorder), his reasons for wishing to offer no defense, for wishing to confess at trial, and for desiring to be executed were "rational" enough to persuade the trial court, the Florida Supreme Court, the Court of Appeals and the United States Supreme Court that he was competent to waive counsel and proceed as he wished based upon his Faretta rights. Whether viewed under either Dusky or some higher standard, this interpretation of Faretta is most troublesome. Goode, while evidently much more dangerous than other mentally disordered individuals, is not atypical in viewing his situation and his disorder as hopeless, and therefore wishing to die. What would the result have been if, absent the murders, Goode had sought approval from the courts for passive suicide because he had grown tired and dispirited after battling severe mental disorder until the age of 27? Clearly, all courts would have refused to cooperate, and would have committed him as mentally ill, dangerous to self, and incompetent to refuse treatment. Is it jurisprudentially consistent to reach a different result here solely on the basis that he committed murder (while arguably insane) and wishes to assert his Faretta right to represent himself and thereby to block any attempt to adjudicate his case sort of sentencing him to death?
When the defendant's paranoid system involves obviously delusional content (e.g. "little green men from Mars"), courts will have no difficulty. However, in our clinical experience, almost all other mentally disordered defendants seeking to represent themselves do so on the basis of either religious or paranoid delusions or suicidal ideation in the face of admittedly difficult circumstances. We believe that the courts need more explicit guidance in this matter, and that, on both pragmatic and theoretical grounds, a higher as well as a different standard are required. There are simply too many possibilities of abuse.

There are indications that the ambiguity of the applicability of Faretta to situations involving mentally disordered and possibly incompetent defendants may be clarified in the near future. In Moran v. Godinez, the Ninth Circuit Court of Appeals overturned Moran's murder conviction and death sentence on grounds that Moran had not been properly found competent to waive his right to counsel and to plead guilty --

A defendant is competent to waive counsel or plead guilty only if he has the capacity for "reasoned choice" among the alternatives available to him. By contrast, a defendant is competent to stand trial if he merely has a rational and factual understanding of the proceedings and is capable of assisting his counsel. ... Our analysis ... reveals that the state court erroneously applied the standard for evaluating competency to stand trial, instead of the correct "reasoned choice" standard. [at 266-267, citations and text omitted]

The issue with respect to competency to waive Faretta is not whether or not the Dusky standard applies, but rather, whether or not a full inquiry is made into a defendant's decisional capacities and his/her ability to make a "reasoned choice" given their mental disorder and/or retardation. It matters less whether one considers this a "higher standard," a "different standard" or a "contextualized standard:" the key element, to be explored in great depth, is the nature and quality of the defendant's cognitive functioning and decisional abilities.

COMPETENCY TO REFUSE TREATMENT

In the context of a criminal indictment, what rights does a defendant preserve when committed under court order for competency restoration? A particularly troublesome set of jurisprudential and psychological issues arises when one tries to determine whether such a defendant has a right to refuse treatment or has any right to the form and context of treatment given. In addition, issues arise as to whether the involuntary medication of a Jackson defendant may compromise future adjudication by producing what may be termed "iatrogenic incompetency," i.e., can involuntary medication disadvantage the defendant who wishes to raise a mental state at the time of offense issue by making him appear less psychopathological at the time of trial? Does it alter his or her psychological state so as to render the defendant less able to effectively consult with trial counsel?

Constitutional considerations

Some aspects of the constitutional parameters of medication or treatment refusal have been addressed by the Supreme Court and by other federal and state courts. These cases, however, require careful reading because their contexts differ significantly, and the Supreme Court itself has yet to articulate a comprehensive standard that is applicable to the range of circumstances which normally apply. Individuals who have been lawfully detained, arrested, tried or convicted with due process retain certain constitutional rights, their imprisonment or detention notwithstanding. Many of those retained interests were addressed in Washington v. Harper (76) a case involving the rights of prison inmate to refuse involuntary psychotropic medication. In Harper the Supreme Court re-affirmed that all persons have a constitutionally protected liberty interest in avoiding involuntary treatment ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty") [at 229]. Nevertheless, the Court in Harper ruled that a prisoner could be involuntarily treated, liberty interests notwithstanding, if "the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." [at 227] In Riggins v. Nevada, the Supreme Court applied a similar logic to Riggins' assertion that his involuntary medication at trial violated a variety of due process rights, observing that

Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings ... due process [would have been satisfied] ... if the prosecution had demonstrated and the ... Court had found that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others. ... Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less obtrusive means [at 1815-1816, citations omitted]

Thus, Riggins established some of the contours of a "test" for the involuntary treatment of defendants at trial or pre-trial: a) the treatment must be judged medically appropriate; b) less intrusive treatment must have been considered and judged less appropriate; and c) the purpose of the treatment must be safety of the defendant, the safety of others, or competency restoration. Thus, the decision allows for such involuntary treatment given a showing that the State's interests "compellingly" outweigh the defendant's liberty interest. The "hidden message" of Riggins, however, is found in Justice Kennedy's concurring opinion where he states

The medical and pharmacological data in the amicus briefs and other sources indicate that involuntary medication with antipsychotic drugs poses a serious threat to a defendant's right to a fair trial. ... I file this separate opinion ... to express my view that the Due Process Clause prohibits prosecuting officials from administering involuntary doses of antipsychotic medicines for purposes of rendering the accused competent for trial absent an extraordinary showing, to express doubt that the showing can be made, given our present understanding of the properties of these drugs. ... When the State commands medication during the pretrial and trial phases of the case for the avowed purpose of changing the defendant's behavior, the concerns are much the same as if it were alleged that the prosecution had manipulated material evidence. ... The question is whether the State's interest in conducting the trial allows it to insure the defendant's competence by involuntary medication, assuming of course there is a sound medical basis for the treatment. ... Here the purpose of the medication is not merely to treat a person with grave psychiatric disorders and enable that person to function and behave in a way not dangerous to himself or others, but rather to render the person competent to stand trial. It is the last part of the State's objective, medicating the person for the purpose of bringing him
to trial, that causes most serious concern. ... In my view elementary protections against state intrusion require the State in every case to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react to the testimony at trial or to assist his counsel. Based on my understanding of the medical literature, I have substantial reservations that the State can make that showing. [at 1817-1818, text and citations omitted; emphasis added]

While Justice Kennedy's "substantial reservations" do not have the force of law or constitutional interpretation, it is clear that the Court is on the verge of considering a threshold of "compellingness" that may be impossible for the State to surmount. A recent Utah case, Woodland v. Angus et al. demonstrates just how insurmountable that threshold may be.

Nature of disadvantage at trial

As is evident from Justice Kennedy's opinion, when a defendant is restored to competency by medication, he or she may be disadvantaged at trial because of the medication. Among the potential disadvantages discussed by scholarly commentary are:

a. that the defendant may need to take the witness stand, but may appear very constrained, emotionally withdrawn, and without affect or remorse leading the trier of fact to an adverse inference about the credibility of other testimony that he was insane or otherwise psychologically disturbed at the time of the alleged offense [this was precisely the underlying issue in Riggins that was not directly addressed by the majority];

b. that the psychotropic medications may produce side-effects that alter consciousness, degree of awareness, and emotionality such that the defendant is cognitively confused and less involved in the trial proceedings, thereby reducing the effectiveness of his assistance of trial counsel [so called "iatrogenic incompetency"];

c. the psychotropic medications may alter the defendant's mental state such that he or she will appear distinctly different to court-appointed insanity defense examiners who may not have assessed the defendant prior to competency restoration [altering material evidence].

In light of these concerns, forensic evaluators should consider adopting the following guidelines in their work with pre-trial defendants whose competency is in question and who may be treated with psychotropic medications.

Assess prior response to treatment

An individual's past history of response to treatment (whether psychotropic or psychosocial or both) is an important predictor of his/her future "response to treatment" in two senses: a) the nature of clinical change that is likely; and b) the likelihood that treatment refusal, on either rational or irrational grounds, will occur. With respect to the first issue, it is important to obtain data on the nature of prior treatments and the defendant's response to them. The person may have received competent psychotropic or psychosocial treatment and responded well; conversely, he or she may be "treatment resistant" even in the face of adequate treatment with acceptable therapies. This is important information to share with both the Court and those responsible for the individual's competency restoration treatment. Of course, it is also possible that the person has not responded on account of receiving inadequate treatment, and this too should be addressed. Related to the "treatment response" issue is the question of whether or not the prior treatments received have been directed at the underlying mental disorder generally, or whether specific interventions, targeted at the specific psychosocial ability deficits, have been attempted in the past.

With respect to treatment refusal, it is critical that the defendant's psychological history be explored if this issue is apparent or likely. "Treatment refusal" is a longitudinal process that reflects not only a defendant's psychopathology, but also his/her subjective reactions to prior treatments, the nature of prior interpersonal relationships with treating personnel, the individual's experience with both physical and psychological side-effects, information or mis-information that they may have about medication, and so forth. Even the process of determining this information in a collaborative atmosphere may have positive effects on a developing "treatment refusal" situation. In any event, this information should be gathered and conveyed to both the Court and treatment personnel.

Assess treatment needs

There is considerable variability in the nature of individual response to any treatment modality, whether psychosocial or psychotropic. When a court commits a defendant for competency restoration, the court should request from the treating facility a specific determination of an individualized treatment plan designed to restore the defendant to competency. Such a plan should contain a detailed description of the nature of specific psychosocial deficits, along with proposed treatment interventions and a time-frame for determining whether or not the defendant has responded to the proposed treatment. In the event the defendant refuses one or another treatment modality, the treating personnel should attempt to use whatever other intervention strategies to which the defendant may consent.

At the end of some reasonable period of time (within a 90 to 180 day time-frame), the treating personnel should report back to the court as to restoration progress. If the defendant has not made sufficient progress, and the treating staff believes that non-consented interventions may prove effective, the treating staff should petition the court to hold a hearing to determine if the rationale for involuntary treatment "compellingly" outweighs the individual's liberty interest in refusing treatment. In addition to the various "factors" which ought to be considered at such a hearing, any evidence that pertains to the defendant's "rational" motivation not to consent to treatment should be weighed.
A defendant's need for continued treatment when he or she is returned for a competency restoration hearing should also be considered. The court should investigate, as part of its competency restoration hearing, whether or not the defendant is in need of such continuing medication, and whether or not the defendant objects to being tried in such a state. The determination should be based, in part, upon actual data concerning the defendant's mental state, on and off medication. There is no reason why treating facilities cannot aid in that determination based upon their observations during the last phase of the defendant's treatment, which hopefully would include clinical trials of reduced medication and/or medication cessation. If the court should find that the defendant is competent only when medicated, it should then determine (for all defendants), whether or not the side-effects manifested in this defendant (94) are likely to compromise fundamental fairness.

Provide trier of fact with better data

Assuming that a defendant proceeds to trial while medicated (95), then, at a minimum, both the trial judge or jury should be provided directly with testimony as to the effects of such medication upon this defendant (96). The American Bar Association's Criminal Justice Mental Health Standards explicitly includes this provision:

The defendant should not be considered incompetent to stand trial because the defendant's present mental competence is dependent upon a continuation of treatment or habilitation which includes medication, nor should a defendant be prohibited from standing trial or entering a plea solely because that defendant is being provided such services under professional supervision.

If the defendant proceeds to trial with the aid of treatment or habilitation which may affect demeanor, either party should have the right to introduce evidence regarding the treatment or habilitation and its effects and the jury be instructed accordingly (Standard 7-4.14).

In addition, every attempt should be made to provide the jury with data concerning the defendant's pre-medication mental state. Many insanity-pleaders are found unfit for trial and are treated, primarily with psychotropic medication, until their (predominantly) psychotic symptomatology remits. Goldberg, Eaves & Kowaz (97) have shown that considerable change occurs during this time period. It is therefore extremely likely that a defendant who pleads not guilty by reason of insanity comes to trial disadvantaged if his pre-medication mental state is not preserved. First, if unfit for trial, an extensive "sanity" evaluation is unlikely to have taken place, and no relatively neutral record of his/her pre-medication behavioral, perceptual, cognitive, affective and judgmental capacities at the time of the offense, will exist. Second, the defendant may have changed dramatically by the time of the "insanity" evaluation, especially if medicated. Third, medicated or not, if the defendant was in a disturbed state at the time and in a different state later, she/he will have difficulty recalling/describing the relevant mental state during a subsequent interview. Fourth, the defendant, many months later, has a difficult time convincing a judge or jury of their mental state, especially given the strong societal suspicion of malingering and the defendant's current adequate interpersonal presentation (if fit, she/he is likely to appear in court looking like anyone else; there will be no overt symptoms of agitation, psychotic anxiety, behaving as if hallucinating, and the like). Finally, in the interests of justice (for both the defense and prosecution), no record would normally exist of the objective data upon which the forensic examiner based his/her inferences. Recording interviews removes the disadvantage of cross-examining an expert who is not only "in control" of the expertise but also of the data to which that expertise is applied. Thus, every attempt should be made to videotape a "criminal responsibility" or general "mental status at the time of offense" interview with the defendant, prior to use of medication, when there is any possibility that some mental state defense will be raised at trial (98). The examiner's primary concern in such cases should be to preserve a sufficiently detailed record of the defendant's pre-treatment mental state so as to not disadvantage the defendant at trial subsequent to competency restoration.

If these steps and safeguards are followed, then it is less likely that a defendant will be disadvantaged at trial. The extreme case of a defendant who will never regain competency without medication, is seriously disadvantaged while medicated with no possible compensatory safeguards, and who runs into the "outer-limit" established by the state's interpretation of Jackson (see below) is an unlikely one.

DISPOSITION AND TREATMENT OF UNFIT DEFENDANTS

The disposition of incompetent defendants is another extremely problematic aspect of competency adjudication, particularly in terms of the length of time governing involuntary treatment and the disposition of charges if competency restoration seems improbable. Until the case of Jackson v. Indiana (99), virtually all states allowed the automatic and indefinite commitment of incompetent defendants. In Jackson, the Supreme Court held that defendants committed solely on the basis of incompetency "cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future." [at 738] The Supreme Court did not specify how long a period of time would be reasonable nor did it indicate how progress toward the goal of regaining competency should be assessed.

The Jackson decision had a substantial effect on commitment laws. Many states revised their statutes to provide for alternatives to commitment as well as limits on the length of commitment. As of 1992, the 50 states and the District of Columbia have interpreted Jackson in a variety of ways. A majority of states either explicitly place no limits on commitment or rely upon the courts to rule in individual cases that the Jackson limit ("reasonable") has been reached. The majority of jurisdictions construct either simple limits (e.g. 18 months or less) or complex limits, as a function of crime charged. There is considerable variability, with limits ranging from 60 days to life (theoretically).

Few data are available with respect to how these various policy options actually operate, how long defendants tend to be held, what treatments they tend to receive, or what kinds of individuals raise objections to psychotropic medication. It is clear, however, that a) it is extremely difficult to predict who will regain competency based upon traditional mental health measures; b) it is extremely difficult to predict treatment response to psychotropic medications; and c) most restoration treatment programs confuse treating incompetency and treating underlying mental disorder (100). Defendants rarely receive treatment specific to the problems associated with their legal status. Psychotropic medication, aimed primarily at the underlying mental disorder, is the most common form of treatment, although there is reason to believe "treatment resistant" patients may form a higher proportion of the incompetent population. A few jurisdictions have established treatment programs designed to increase understanding of the legal process or that confront problems that hinder a defendant's ability to participate in the defense. The establishment and evaluation of treatment programs must be a priority. If the Jackson doctrine is taken seriously, it is incumbent upon mental health professionals to develop programs which can assess the likelihood of successful treatment programs for unfit defendants. This implies, of course, that we have considerably more knowledge than we presently do about how to restore competency.
SECTION II: THE INTERDISCIPLINARY FITNESS INTERVIEW - REVISED

The Interdisciplinary Fitness Interview - Revised (IFI-R) is a method for assisting forensic mental health professionals and the courts in making decisions about pretrial defendants whose competency for adjudication (fitness to proceed) has been questioned. The method involves a semi-structured interview and rating format which addresses both legal and clinical issues associated with the fitness question. While the legal criteria for fitness, in various contexts, contain certain inescapable ambiguities and abstractions, a further problem has to do with the linkage between a defendant's current mental status and his/her fitness: are defendants who are psychotic also unfit to stand trial? Evaluators have sometimes seemed to answer this question in the affirmative, often going so far as to equate psychosis with unfitness. As described in detail in Section I, however, this is a fundamental error in that it is not mental illness per se which determines a defendant's fitness, but rather the manner in which mental illness might affect a defendant's psycholegal abilities. This linkage must be quite specifically made, although unfortunately it is not typically or sufficiently addressed.

The most reasonable approach to the assessment of fitness is a functional one, in which the ultimate criterion is based on how the defendant will behave in the judicial process. The issue should not focus primarily upon symptom description or diagnosis; rather, the more relevant issues are the behaviors and mental processes observed (or predicted based upon observation) and an evaluation of how these behaviors and mental processes relate to fitness to proceed in the particular case at hand. Reference to such unqualified psychopathology descriptors as "inappropriate affect," "thought disordered," "manic," or "delusional," with no behavioral support given as the basis for these opinions, and, more significantly, no justification for the relationship of these terms to fitness, should be avoided. The same holds for diagnostic conclusions, e.g. "defendant is a paranoid schizophrenic," especially when unrelated to specific psycholegal abilities.

As described in Section I, the assessment task in fitness evaluations "is a functional and context-dependent one in which mere presence of severe disturbance or retardation (a psychopathological criterion) is only a threshold issue -- it must be further demonstrated that such severe disturbance in this defendant, facing these charges, in light of existing evidence, anticipating the substantial effort of a particular attorney with a relationship of known characteristics, results in the defendant being unable to rationally assist the attorney or to comprehend the nature of the proceedings and their likely outcome. The Dusky standard (as nearly uniformly interpreted) requires that the evaluator take into account the relationship between the defendant's level of disturbance and the specific demands of the case. Rather than attempt to define competency in any operational fashion, the IFI-R allows clinical and legal decision makers to evaluate the global logic of the Dusky standard in flexible ways that make sense given the particulars of a given defendant, charge and legal context. Thus, to utilize the IFI-R properly, an examiner must a) understand the jurisprudential theory that underlies general competency to proceed; b) understand the specific contextual factors that occur given a particular defendant, the charges, the existing evidence, the capacities and strategies of the attorneys involved, and any other relevant, context-dependent factors; and c) understand how a particular defendant's psychological strengths and weaknesses relate to the specific psycholegal abilities that will be required in the given context."

PREPARATION FOR THE FITNESS INTERVIEW

In any context, but especially in outpatient or jail based evaluations, it is incumbent upon the examiner to prepare for the fitness interview in ways that are different, at times substantially so, from ordinary clinical practice. There are several issues to which an examiner must pay special attention when conducting an evaluation of competency.

Attorney interviews

Even before seeing a defendant face-to-face, it is good clinical practice to speak with the legal party who has raised the Pate-level doubt about the defendant's fitness. Usually, this is defense counsel. In certain cases, when the nature of judicial proceedings is likely to be particularly complicated, both the defense and prosecuting attorneys should be interviewed. The interviews with counsel need not be face-to-face, but the examiner should keep accurate records of the substance of the conversations. The purpose of these interviews is to determine, as accurately as possible, why the fitness issue was raised, what evidence was offered, and what sort of trial and dispositional alternatives are being considered by both sides. Until jurisdictions adopt and enforce some mechanism, like that employed in Florida (see Section I), court orders for fitness evaluations will only very rarely contain sufficient documentation of the nature of attorney-client interactions that have given rise to Pate-level doubts. In addition, this "pre-interview" often helps to determine the existence of other agendas in the referral process to which the examiner must become sensitized. From the nature of the attorney's responses and the information that he/she possesses, it is also frequently possible to obtain data on prior mental health and forensic histories, prior psychological evaluations, and so forth. Much time, effort and confusion can be saved at this point by asking the attorney to obtain, or subpoena, prior records, and to obtain the assistance of counsel in arranging suitable interview conditions, if this is likely to be an issue. The examiner should take the opportunity to question the attorney most carefully with respect to:

a) aspects of the attorney-client interaction that have posed difficulties for the attorney and the nature of the attorney's skill and experience in dealing with mentally disordered defendants;

b) the attorney's assessment of the evidence that will be available for and against the defendant and his/her appraisal of the role the defendant will be expected to play in evaluating or producing this evidence;

c) the attorney's assessment of the nature of trial strategies likely to be needed in the particular case, including whether or not the defendant need testify, likely pleas, and so forth. [N.B. Special care needs to be taken when recording this information to violating a defendant's attorney-client privilege. Thus, the exact strategy that counsel may employ is less important than an appraisal of the psycholegal abilities required of the defendant to pursue that strategy.]

d) any other factors that the attorney believes relevant to the defendant's fitness, particularly those having to do with problems associated with the defendant's reasoning abilities, ability to disclose relevant information, and ability to follow complex trial proceedings.

The examiner should record this information, in summary form, in the "Sources of Information" section of the IFI-R and maintain additional notes as needed. As discussed subsequently, the examiner needs to take care in the form of the questions asked and the nature of what is recorded to avoid violating the defendant's rights and attorney-client privilege. While it is necessary to inquire as into the attorney's interactions with the defendant, the nature of the case and the evidence, and so forth, in order to determine a defendant's likely role and hence the psychosocial abilities needed, care must be taken not to record information that is not, or should not be, available to the prosecution.

Prior mental health records

All indications of prior mental health contacts should be pursued before the interview takes place, so that the examiner has as complete a set of mental health records as possible. Obviously, if the defendant has been an inpatient, observational records should be consulted along with all routine psychological reports and test data. This is most easily accomplished through the defense attorney because it will often be most expedient to obtain these records by means of the defendant's signing a release of information. Some attorneys, on account of lack of experience or knowledge of the procedures for pre-trial fitness evaluations, or because of other motives, will be less than cooperative in helping the examiner in obtaining these records or will attempt to block one's access to these records outright. In such situations, should careful explanation of the necessity of this information fail, the examiner should feel no hesitancy in contacting the judge who signed the original evaluation order and using his/her authority to obtain the necessary information.

Prior mental health records are important for several reasons. First, if the defendant does have a significant mental health history, an interview can be conducted more efficiently and validly. That is, the prior information allows the examiner to focus in on the most probable forms of psychopathology, although the examiner must be careful to inquire into other domains as well. In addition, many disordered defendants are not reliable reporters of their own histories, the nature of their prior treatments, and their responses to those treatments. Secondly, the prior information will often contain very complete social and developmental histories, often produced with resources unavailable to the examiner. Again, this enables the examiner to focus on the more salient and relevant aspects of the defendant's social and developmental history, and also saves considerable time. However, because prior mental health records may contain either inaccurate or hearsay evidence, any critical aspect of the defendant's prior record should be corroborated independently, to the extent feasible. Thirdly, prior mental health records comprise perhaps the best evidence that mental health examiners can use in determination of the probability of malingering, exaggeration, or minimization of symptomatology and degree of disturbance. The examiner can compare the nature of the defendant's current self-report and possible test performance to prior data, symptomatology, developmental events, level of education and achievement, etc. and thus be in a better position to evaluate the credibility of current claims. The examiner should record this information, in summary form, in the "Sources of Information" section of the IFI-R and maintain additional notes as needed.

Police reports and prior arrest records

Complete police reports of the alleged crime are necessary, and a past criminal history record helpful, particularly if the defendant has cycled through the criminal justice and mental health systems several times. The police reports are especially critical because they often form the only independent basis for a determination of the defendant's alleged conduct prior to, during, and subsequent to the alleged crime(s). This is not to say that they are accurate; indeed, one of the critical elements in fitness evaluations often has to do with the defendant's ability to challenge the police version of his/her conduct. In addition, the police reports are critical in starting an assessment of the nature and circumstances surrounding the defendant's understanding of his/her Miranda rights, and the conduct of police interrogations [see Section I and below for further discussion of this problem]. In any case, the police reports constitute the "backbone" of the information needed to conduct a competent fitness evaluation, and often contain a wealth of information that will assist in the determination of collateral sources of information that must be consulted.

Prior arrest records often contain information that will assist the examiner in a variety of other ways. The point is not whether the defendant has a long (or short) "criminal career," but rather how he/she has behaved in the past, whether or not he/she has a mental health history, has been previously adjudicated incompetent or evaluated for competency, has been previously civilly committed rather than charged, and so forth. In addition, the defendant's prior experience with the criminal justice system is often a good basis for determining malingered or feigned ignorance of criminal justice procedures. As above, the examiner should record this information, in summary form, in the "Sources of Information" section of the IFI-R and maintain additional notes as needed.

Jail personnel

When a defendant is examined in a jail situation, much good information can be obtained from jail personnel, whether or not the defendant is currently held in a "mental health tier." While not a substitute for the sorts of records kept in an inpatient setting, watch officers and nurses can provide information on the defendant's day-to-day functioning, which can often be significant in determining malingered states. In addition, they can provide information on the nature of medications currently received which "filter" the defendant's behavior in the interview. As above, the examiner should record this information, in summary form, in the "Sources of Information" section of the IFI-R and maintain additional notes as needed.

Finally, the examiner should be aware that pre-trial forensic evaluations occur in the context of "adversarial rules," and hence should maintain an accurate record of all contacts with the defendant, attorneys, collaterals and other mental health professionals. These records are invaluable at later stages if legal tactics designed to confuse or mislead a witness are attempted. Indeed, as described subsequently, there is good reason to advocate that the examiner's actual contact with the defendant, especially in high profile cases, be audiotaped.
METHODOLOGY FOR THE CONDUCT OF FITNESS EVALUATIONS

Having prepared for an examination in this fashion, one can conduct an efficient and comprehensive interview in a short period of time. Most delays in conducting an evaluation and most time spent in an inpatient status can thus be avoided, and a more relevant examination conducted, if these steps are taken.

Recording interviews

As described in detail in Section I, there are many compelling reasons to consider making recordings of pre-trial fitness interviews and to making detailed notes of other contacts, in anticipation of their use in adversarial proceedings. Especially in the context of a likely mental state defense, such recordings provide one of the few glimpses at the defendant's mental state prior to an extensive period of medication and hospitalization. In addition, such recordings are justified on the basis of a higher standard of professional practice. The Committee on Ethical Guidelines for Forensic Psychologists, after considering the issue in considerable detail, advocated the following:

Forensic psychologists have an obligation to document and be prepared to make available, subject to court order or the rules of evidence, all data that form the basis for their evidence or services. The standard to be applied to such documentation or recording anticipates that the detail and quality of such documentation will be subject to reasonable judicial scrutiny; this standard is higher than the normative standard for general clinical practice. When forensic psychologists conduct an examination or engage in the treatment of a party to a legal proceeding with foreknowledge that their professional services will be used in an adjudicative forum, they incur a special responsibility to provide the best documentation possible under the circumstances.

i. Documentation of the data upon which one's evidence is based is subject to the normal rules of discovery, disclosure, confidentiality and privilege that operate in the jurisdiction in which the data were obtained. Forensic psychologists have an obligation to be aware of those rules and to regulate their conduct in accordance with them.

ii. The duties and obligations of forensic psychologists with respect to documentation of data that form the basis for their evidence apply from the moment they know or have a reasonable basis for knowing that their data and evidence derived from it are likely to enter into legally-relevant decisions. [Guideline VI-B(2)]

The Committee had a number of forensic contexts in mind, including, in light of the Byers[99] case, pre-trial fitness interviews. The fundamental concern is with assuring that the evidentiary bases of future expert testimony are sufficiently preserved to avoid undermining the opposing party's constitutional right to effective counsel and confrontation. Recording interviews or otherwise preserving the best evidence available removes the disadvantage of cross-examining an expert who is not only "in control" of the expertise but also of the data to which that expertise is applied. At Byers' trial for murder, an examining psychiatrist testified that, during a pre-trial fitness interview, Byers had told him that his wife had suggested to him that his mental state might have been under the influence of "roots." This statement, if true and not distorted out of context, implied that Byers' "delusions" were suggested to him by his wife. The trial court characterized the testimony as "devastating" and such that it "perhaps will torpedo the (defendant) out of the water." [Byers at 1144] Unfortunately, the psychiatrist had a) destroyed his notes of the interview; b) admitted that he did not record the statement in the destroyed notes because he considered it insignificant; c) did not tell any of his colleagues of the alleged statement, and d) did not allude to it or any aspect of malingering in his report to the court.

The Byers Court rejected his claim that he had been deprived of effective assistance of counsel -- "it is enough that Byers had the opportunity to contest the accuracy of both the details and the conclusion of (the psychiatrist's) analysis by cross-examining him (pointing out ... that the crucial statement on which (he) based his conclusion was not reflected in the psychiatrist's summary of the interview)." [Byers at 1121] Interestingly, the Court concluded, "Recording psychiatric interviews may be a good idea, but not all good ideas have been embodied in the Constitution in general or in the Sixth Amendment in particular." [Byers at 1121]

Judge Bazelon, in his strongly worded dissent, expressed the underlying logic of the Specialty Guidelines clearly when he concluded that

If defense counsel had an accurate, complete record of the clinical interview he could, with the aid of his own experts, attempt to identify the distortions and interactions that may have affected the substance of the interviewer's reports and testimony. But such a complete, accurate record cannot, by virtue of the very effects I have described, be expected to be forthcoming from the interviewer. The accused, moreover, whatever his mental state, cannot be relied upon to fill in the gaps necessary for a complete and accurate assessment. It is therefore clear that ... counsel may be unable to detect distortions or to cross-examine meaningfully the government's expert and rebut his conclusions ... A complete tape recording or videotape of the interview would provide counsel with exactly the sort of objective and precise record that, as I have previously discussed, is often a prerequisite to detection of distortions and to effective cross-examination or rebuttal at trial. As discussed above, such a taped record would facilitate constitutional aims without impairing the interview process itself. [Byers at 1171-1172]

Whether or not such evidentiary rules [i.e., allowing undocumented expert evidence to be admitted, but subject to cross-examination as to their weight] are "wise," it is clear that the standards of practice for forensic psychologists are higher than that required by law and that the forensic examiner must be required to produce carefully documented data upon which such testimony is based. Otherwise, the role of the forensic professional is seriously compromised.

Explaining the limits of confidentiality

Forensic mental health professionals have an ethical obligation not to examine a pre-trial defendant before counsel is appointed and aware of their intended examination [even pursuant to a lawful court order to do so] and also have an obligation to explain the limits of confidentiality to the defendant and to seek his/her assent to the evaluation. The language of the Specialty Guidelines for Forensic Psychologists is instructive and similar to other professional codes:
Forensic psychologists have an obligation to ensure that prospective clients are informed of their legal rights with respect to the anticipated forensic service, of the purposes of any evaluation, of the nature of procedures to be employed, of the intended uses of any product of their services, and of the party who has employed the forensic psychologist.

a) Unless court ordered, forensic psychologists obtain the informed consent of the client or party, or their legal representative, before proceeding with such evaluations and procedures. If the client appears unwilling to proceed after receiving a thorough notification of the purposes, methods, and intended uses of the forensic evaluation, the evaluation should be postponed and the psychologist should take steps to place the client in contact with his/her attorney for the purpose of legal advice on the issue of participation.

b) In situations where the client or party may not have the capacity to provide informed consent to services or the evaluation is pursuant to court order, the forensic psychologist provides reasonable notice to the client's legal representative of the nature of the anticipated forensic service before proceeding. If the client's legal representative objects to the evaluation, the forensic psychologist notifies the court issuing the order and responds as directed. [Guideline IV-E](100)

There has been some confusion as to the qualifier “unless court ordered.” From a technical legal perspective, an examiner does not need the consent or assent of a defendant, if conducting the interview pursuant to court order. However, from a practical, as well as a professional standards perspective, the examiner should attempt to obtain the defendant's consent or assent, and explain the nature of the interview and its limited confidentiality. Under all circumstances, the defendant's counsel should have notice of the interview so that timely motions can be filed. [Guideline IV-E](100)

Informing, or attempting to inform, the defendant of the nature of the fitness evaluation and its limited confidentiality, has a more practical purpose as well. From a legal perspective, the material in such interviews cannot be introduced at a subsequent trial, unless the defendant introduces mental state evidence. [Guideline IV-E](100)

It is often difficult for fully functioning, highly skilled, mental health professionals and attorneys to grasp all of the subtle nuances of this doctrine. However, the basic contours of the rule are rather straightforward and explaining these to the defendant provides a good opportunity to assess the defendant’s ability to comprehend the adversarial nature of criminal proceedings and the role that his/her rights to avoid self-incrimination play in those proceedings. Thus, the process of explaining the “confidentiality limits” and of assessing the defendant’s comprehension of those limits, provides important data on the very issue that forms the basis for the evaluation.

The IFI-R procedure in this regard is as follows: a) the examiner, at the beginning of the interview, explains, in appropriate language, the nature of the limits of confidentiality; and b) then asks the defendant, in his/her own words, to repeat back, after a short pause, the essence of what they understand. The defendant’s own words are recorded in the designated space and the examiner is asked to sign the form attesting to their understanding. The examiner should attempt to first explain the limits in an abstract fashion, and move to increasing concrete examples as necessary. Such a procedure allows the examiner to obtain an early “fix” on the defendant’s functional linguistic and reasoning abilities. One needs to emphasize, however, that the standard of understanding here is not the full set of nuances, but rather the basic elements.

**General procedure for the IFI-R interview**

While this manual and the IFI-R itself provide sample questions and probes, it is not a good practice to conduct an interview in a rigid fashion. One needs to know the rating criteria, the details of the charges against the defendant, the applicable law, and the areas that need to be explored, well enough to conduct an interview smoothly. For example, defendants will frequently provide information in response to one question that is a “lead in” to another area. As long as one ultimately can come back to the original question, one should allow such “smooth transitions” to occur. Establishing rapport is extremely important, and one way to do this is to let defendants know that you’re actively listening to them and are smoothly and logically following their answers. Any real interview will not flow like a checklist, but you need to keep the IFI-R structure and the related criteria in mind.

As stated in the introduction to this manual, “The IFI-R is designed to be utilized by mental health professionals who are already skilled and experienced in clinical evaluation and assessment of mental disorders, especially those involving major impairment in cognitive, affective and social functioning.” Thus, examiners are presumed to know how to conduct a clinical evaluation.

Unfortunately, some licensed examiners, whether they be psychiatrists, psychologists or social workers, conduct the “mental disorder” portions of fitness interviews in highly idiosyncratic ways that are less than optimal in terms of either reliability or validity. Some brief comments about this problem are in order.

Borrowing from Harry Stack Sullivan's well-known terminology, one can conceptualize a comprehensive fitness interview as falling into a series of phases: a) the formal clinical-legal inception; b) the reconnaissance; c) the detailed inquiry of present mental state and present psycholegal abilities; d) the detailed inquiry of mental state at the time of the offense, as needed; e) a reconciliation with other data sources (including consultation with other professionals who have evaluated the defendant), and f) a termination.

**Inception.** In addition to rapport building, the inception requires explaining clearly one’s role to the defendant, focussing on why he/she is being evaluated, to whom the report will be sent, and what limits are placed on the confidentiality of information. It is also good practice to inform a defendant what reports, records, and files have been made available to the examiner, although in cases of suspected malingering an examiner may choose to do otherwise. This is a matter of judgment, however, since it may aid the clinical discovery process to let the defendant tell their “filtered version” first. The examiner may then introduce contradictory evidence at a later point in order to observe the defendant's reaction and to ascertain if the defendant is consciously distorting, having memorial difficulty because of their mental state, or suppressing details that are anxiety arousing, embarrassing or painful to reveal.
Reconnaissance. This is a forensically oriented review of the defendant's history as well as a survey of current level of psychological functioning and awareness of the general nature of the defendant's current legal circumstances [a more detailed inquiry as to psychological status and psychological abilities occurs later]. In the reconnaissance phase of the interview, as well as in the detailed inquiry sections dealing with both psychopathology and psychological abilities, there is much to recommend learning to use sections of standardized or semi-structured interview formats. The clinical practice and research literature over the past two decades has demonstrated, repeatedly, that acceptable levels of reliability and validity in clinical interviews are closely associated with the use of such devices. This is so because the major sources of error can be traced to a) individual differences among clinicians in their ability/skill to be sensitive to certain cues, to be able to interpret in those "proper" weighted or agnostic cues; b) examiner differences in the behavioral referents of psychopathological descriptors ("semantic unreliability"). Thus, diagnostic agreement for major psychopathological categories and symptoms has increased dramatically, especially when explicitly defined criteria are tied to semi-structured elicitation devices. Indeed, semi-structured interviews for practitioners, every psychopathological condition of any popularity are beginning to appear. To be sure, slavish use of complete structured interviews does not guarantee a reliable or valid result. However, as a result of the experience of more than two decades as a professional educator as well as practicing clinician, it is my belief that using such "structuring" devices is a worthy starting place for any forensic examiner, to be modified, over time, as a result of one's critically evaluated clinical experience. In addition, any clinician is subject to unevenness in their performance, and such structuring devices have the added advantage of "smoothing out" normal clinical variability in level of performance.[105] Thus, "seat of the pants" interviews, which result in highly unreliable elicitation and domain coverage, are to be avoided at all costs. In practice, I strongly recommend that interviewers learn how to use at least one such device aimed at lifetime history of disturbance and adjustment (a modified version of the Schedule for Affective Disorders and Schizophrenia, which focuses on the defendant's life-time history of disturbance, treatments received, and general variability in mental condition, has much to recommend it). Regardless of the interviewing technique utilized, of particular importance are:

1) prior mental disorder episodes that have involved criminal charges and/or fitness evaluations, civil commitments and other such dispositions, including the nature of the psychopathology, the pattern of mental state disturbance and its change over time, and the defendant's response to psychotherapeutic and psychopharmacological treatment;

2) other prior mental disorder episodes that have resulted in treatment, hospitalization or significant impairment in social or vocational adjustment, with similar attention to their form, change, and response to treatment (if any);

3) a relevant developmental history including a brief survey of disorder within the family, early developmental events, medical conditions, current and past situational stressors, substance abuse, social and emotional development, etc.

This material should be conveniently summarized in the appropriate "Clinical notes" sections of the IFI-R. As a result of this phase of the interview, along with a careful (prior) review of the defendant's mental health, forensic, and criminal history records, the interviewer should be well-prepared to inquire into a defendant's current mental state, mental state at offense (as appropriate; see below), and current psychological abilities. To re-emphasize what was said earlier, it is critical that the examiner have access to as complete a record of the defendant's history as possible. Many forensic clients, for reasons ranging from level of disturbance retardation to the effects of medication to malingering, are notoriously unreliable informants on their own history. Attempting to gather the needed data from the defendant alone, or without corroboration, is foolish at best.

Detailed inquiries - Present mental state and psychological abilities: mental state at offense. As discussed at length in previously cited works,[106] fitness and criminal responsibility are legally and clinically separable issues. Nevertheless, in actual clinical practice, because many seriously disturbed individuals will be found unfit to stand trial, and then later adjudicated according to their mental state at the time of offense (not guilty by reason of insanity, guilty but mentally ill, diminished capacity), it is often necessary to attempt some sort of mental state evaluation of a defendant at the time of offense as well as their present mental state and current psychological abilities. Section I contains an extended discussion of this problem, particularly in the context of medication, and the change in a defendant's mental state as a result of such medication. Therefore, the detailed inquiry into the defendant's current mental state and their psychopathological abilities should, as appropriate, include some attempt to ascertain their mental state at the time of offense since, if seriously disturbed, they will undoubtedly be medicated and treated for some period of time, making subsequent evaluations of mental state many months or years earlier, in a different psychotic state, much more difficult.

As justified previously, the use of sections of structured and semi-structured interviews to cover the domain of psychopathology in a relatively standardized fashion to improve inter-examiner reliability in the elicitation and coding of information, is strongly advised. Interview formats (or combinations thereof), that I have found most useful in this regard include the Present State Examination,[107] the Schedule for Affective Disorders and Schizophrenia, and the Diagnostic Interview Schedule. From a clinical training perspective, the Present State Examination is probably the most useful for American mental health examiners to learn because it is rooted in the European tradition of a phenomenological approach to severe mental disorder. That is, it structures the interview on the client's subjective experience of their disorder, and hence is a useful complement to the American behavioral tradition. Since the intricacies of a client's reasoning, attributions, perceptions and construals are often at the heart of complex fitness and criminal responsibility issues, learning how to inquire, phenomenologically, into these issues is an important skill in forensic examinations. In addition to learning one of the "main" standardized interviews [well enough that sections can be used, as appropriate, in a dynamically flowing interview context], forensic examiners should also learn a set of "specialized" semi-structured interviews or coding systems,[108] which are, on occasion, necessary to use.

Guidelines for a detailed inquiry into relevant aspects of a defendant's current mental state are discussed below, as are guidelines for use of the IFI-R sections dealing with current psychological abilities. While this manual is concerned with fitness, some comment on the evaluation of mental state of at the time of offense is needed[109] in general, the detailed mental state inquiry with respect to the mental state at the time of the offense must focus on the relationship of the psychopathological elements to the criminal conduct charged. The defendant must be asked to reconstruct his/her thoughts, perceptions, experiences, attitudes and behavior, as well as that of those in the "field of action." Great care must be taken to obtain very detailed information and also to avoid, as far as possible, contamination of the defendant's memories by leading or suggestive questions. Experience has shown that the acknowledged difficulties with retrospective evaluations is frequently translated, at trial, into great "license," with fairly grandiose defense and prosecution theories being advanced with respect to what implications may be drawn from this or that aspect of the defendant's behavior vis-a-vis their mental state. Thus, an abused wife may be claimed to have intended her husband's death because she...
waited three days until attempting to dispose of the body. Detailed inquiry may reveal that her husband may have frequently played "possum" following previous abuse situations when he typically passed out after extreme drug intoxication, and that the wife, disoriented and substantially impaired in reality contact, may have mistakenly appreciated the situation as one in which he was again playing his favorite game instead of being dead from a blow to the head. Lay persons generally assume a greater degree of stability and cross-situational validity of behavior and experience than may be warranted on scientific grounds. The detailed inquiries should enable an examiner, within the limits of current knowledge of psychopathology, to produce a meaningful "psychological autopsy" of the defendant's states of mind during the entire legally significant period.

Reconciliation and termination At the reconciliation/termination phase, the examiner should be prepared to integrate the information available and to inform all parties concerned (the defendant, defense counsel, prosecutor, judge) of his/her observations and tentative conclusions. In complex cases, it is often necessary to obtain further information from collateral sources, especially from prior re-interview of the defendant, in certain "grey-area" cases, there may be legitimate disagreements among experts. It assists the trier of fact if the nature of these disagreements, as well as areas of agreement, are drawn as precisely as possible, with each examiner fully aware and able to comment in advance as to the reasons for disagreement. Such pre-testimony consultations also tend to produce higher quality and more informative strategies for direct and cross-examination.

This is also the time to deal with the defendant's response to inconsistencies in the information available. One advantage of this openness is that it allows the defendant to produce any additional information which might explain or clarify discrepancies or other problems, and it helps prevent an uninformed "battle of the experts." In any case, the defendant, at some point in the process, has a right to hear the nature of the examiner's conclusions, however tentative. The defendant's reactions to such feedback are often most informative about their mental state and their psychosocial reasoning abilities.

**USING THE IFI-R TO ASSESS CURRENT PSYCHOLEGAL ABILITIES AND FUNCTIONAL MENTAL STATE**

In a "smoothly" conducted IFI-R interview, there is no sharp boundary between the assessment of current psychological abilities and functional mental state. Usually, a review of the defendant's past psychological difficulties flows naturally into an evaluation of his mental state at the timet of arrest and the alleged criminal conduct, and then to current mental status in the context of current legal situation. Thus, there are no firm guidelines as to how to make the transition to this, most critical, phase of the interview. Before discussing the major psychosocial sections of the IFI-R, however, some comments as to the principal areas of current psychopathological signs and symptoms which need to be addressed are in order, as are comments about the role of psychological tests in this assessment.

A significant body of empirical data points to the conclusion that traditional psychological tests bear little relationship to a defendant's competency status, while tests that directly assess a defendant's functional psychological abilities are empirically related to ultimate competency decisions.

Therefore, instruments like the IFI-R focus upon a direct assessment of aspects of psychopathology that have proven most critical to the impairment of specific psychological abilities. The following sub-sections described the major domains of disturbance which should be examined, at a minimum, in the IFI-R interview, and recorded in the "Current Clinical Condition" section. Each sub-section also contains some clinical examples of interview methodology, but are not substitutes for supervised clinical experience or advanced training as a forensic mental health examiner. The order in which symptom/disturbance domains are discussed is based upon Nicholson & Kugler's empirical summary, modeled after the original IFI categories, of domains most-to-least associated with ultimate determinations of incompetency. In using this section of the IFI-R pertaining to domains of psychopathology, you are asked, for each major domain of psychopathological sign or symptom, to first make a dichotomous present or absent decision. The level of pathology in each area necessary to justify a "present" rating is described briefly in each of the sub-sections below. If you have decided that one or more instances of a particular type of pathology is present, your next task is to give brief, but descriptive example(s) of the specific concerns that are relevant to the defendant's fitness. These examples are of critical importance because they need to be tied, in some functional manner, to the severity of their impact on the defendant's psychosocial abilities. Always err on the side of more rather than less description. Finally, the right hand column of the rating form, in the "Current Clinical Condition" section asks you to judge the relevance or importance of the type of symptom to this defendant's fitness to stand trial in this particular case. A rating of 0 should automatically be used if the symptom type is absent. It should also be used if the symptom is present, but does not in your opinion bear significantly on the defendant's fitness. A rating of "1" implies that, while the symptom is present and would affect a defendant's fitness, the effect is insufficient to allow a trial to proceed, even though the witness's presence with special precautions being taken by the defense or by the Court [such special precautions or arrangements, if they form the basis for your ratings, should be summarized in the "Other factors relevant to opinion" section of the "Summary Report." A rating of "2" implies that the symptom is likely to interfere seriously with a defendant's fitness. However, a rating of "2" on any particular item does not imply automatically that your final overall judgment is that the defendant is unfit.

**ASSESSMENT OF CURRENT LEVEL OF PSYCHOLOGICAL FUNCTIONING**

**Attention/Consciousness**

Disturbances of attention and consciousness can range from the extremes of clouded consciousness (diminished awareness of the external world), disorientation, and complete stupor to significant difficulties in concentration, "thinking straight" and so forth. Many of the more severe difficulties in this domain will usually be apparent because of their manifestations in a defendant's speech, moment-to-moment attention to the examiner, and so forth. However, more moderate, but significant difficulties in concentration and thinking, which accompany severe depression as well as some psychotic states, may require particular probing. If disorientation or diminished awareness of the external world is suspected, standard probes from mental status examinations include asking for the defendant's age, whereabouts, month and day, and so forth. Because some of the more traditional probes (current and recent presidents, serial 7's, etc.) are rather obvious and are easily seen as an opportunity to appear "out of it" by defendants wishing to "fake bad," there is much to recommend approaching basic attention and concentration more indirectly. Thus, I usually start my interview by being a bit disorganized and asking the defendant's help with spelling his/her name, asking his date of birth and trying to figure out how old he/she is relative to the current date, inquiring into highest level of education by asking when they were last in school, asking about how long they have been in jail, and other similar probes [name of their attorney, for example]. Most defendants seeking to malinger state of consciousness or attention will not be so crude as to claim they don't know basic information about themselves and their recent experience, although if put in an obvious "test format" (name the last presidents, etc.) will see it as a test to be failed. If the defendant does appear to be so disoriented/stuporous/inattentive as to be unable to answer such simple questions, then the examiner should immediately seek collateral information from jail personnel as to their observations, current medication condition [e.g. detoxification status, head injury during arrest, and so forth].
While there is nothing "wrong" with using standard mental status probes, it has been my experience that contextualizing orientation and consciousness into simple and relevant questions is more effective.

Difficulty in thinking or concentrating as a function of affective disturbance or psychotic processes (which will usually be spontaneously raised by the defendant), can be probed more directly with, "Do your thoughts seem muddled or slow?"; "Do you have trouble making decisions lately?"; "Can you think clearly about your situation?"; "Do your thoughts frequently drift off, making it difficult to stay on one topic?" While defendants will rarely be experiencing such decisional/concentration/thinking difficulties for the first time, it is more usual that this has been a consistent pattern associated with prior depressive or psychotic episodes. Such information is critical in the analysis of malingering.

Obviously, a severely disoriented/stuporous defendant will not be able to comprehend the nature of judicial proceedings. Even evidence of general disorientation, however, must be extended to the specifics of the defendant's case before a rating of "2" is justified. The more difficult decisions, of course, are the ones in the middle where a case could be made either way. This will most frequently occur with severe depression where the defendant's ability to concentrate and think clearly is quite reduced, but is also quite variable and/or situational.

Delusions

Delusions are belief systems that are highly irrational and idiosyncratic, and are not shared with others as part of a religious or subcultural belief system. In pre-trial forensic interviews, delusional processes usually become apparent when asking about the nature of the alleged crime, or relationship with attorneys, trial strategy or the roles of court personnel. Usually the defendant's mental health history will also contain either overt statements about delusional processes or substantial hints. The examiner, thus, may have a smooth transition to inquiry about the defendant's current degree of belief in prior ideas that may be relevant to his/her fitness. If such obvious transitions are not available, a good starting probe for delusional beliefs is, "Do you have any ideas about things that other people don't seem to understand?"; or, "Does your imagination seem to play tricks on you?"; or, "Have you any ideas about things that you're afraid to talk about because other people will think they're strange or weird?" (In many cases, the delusional processes themselves may make the defendant unwilling to trust an interviewer, but you'll find yourself "suspecting" that such cognitive processes are in operation because of particularly cryptic allusions or nonverbal indices of suspicion and fearfulness. Unless the defendant willingly describes his thoughts and beliefs in sufficient detail, you won't be able to rate this symptom constellation as present. Make a note of your hunches and the cues upon which they're based in the "Other observations" section.)

Delusional processes come in a variety of forms. The most common delusional processes involve control (one's will or will power is controlled by an external force or agency), persecution (someone or something seeking to harm, poison or kill), grandiosity (one has special status or prominence), influence (one is being affected by X-rays, microwave transmitters), reference (people say or do things that have special significance or contain "double messages") and religion (one has special religious powers, identity or connection to God). While the presence of delusional processes is of great importance in traditional psychodiagnosis, it may have little impact on a defendant's fitness for trial if it doesn't functionally interfere with his or her ability to communicate effectively, understand the charges and judicial process, and so forth. For example, a defendant may have committed an unlawful entry into a home because the "color of the house" and the "shape of the driveway" meant that the person who lived there belonged to the same secret society as the defendant. Such a belief system would be of great importance concerning the defendant's criminal responsibility, but would not interfere with fitness if he were able to relate the relevant facts of his behavior and thinking and if he understood why trespass and unlawful entry were crimes and what he had to do to counter the prosecutor's case. On the other hand, a religious delusion (that one was acting on the direct orders of God) might influence a defendant's fitness if one of the consequences of the delusion were that one was not permitted to talk to one's lawyer unless God ordered it -- and He hadn't.

A word of caution about the "diagnosis" of delusion. Mental health examiners have a strong tendency to overdiagnose delusions because they fail to inquire into the client's degree of subjective belief in the idiosyncratic idea. Disturbed individuals, like everyone else, try to make sense of their phenomenological world, and hence entertain various ideas that help to justify their perceptions and feelings, and make things seem more sensible. Thus, the client may entertain the notion that someone else is controlling his mind because thoughts come to him that he himself finds disturbing. Thus, one needs to distinguish between full and partial delusions, or between beliefs maintained with delusional intensity versus highly overvalued ideas. As above, if one adopts an inquiring and non-judgmental stance, the client is usually quite willing to explore his/her belief system and degree of belief in great detail. Finally, one needs to note that in cases where the defendant is accused of some rather horrific crime, strange ideas [the victim is not dead, there is a conspiracy, it will be riveway" meant that the person who lived there like everyone else, try to make sense of their phenomenological world, and hence entertain various ideas that help to justify their perceptions and feelings, and make things seem more sensible. Thus, the client may entertain the notion that someone else is controlling his mind because thoughts come to him that he himself finds disturbing. Thus, one needs to distinguish between full and partial delusions, or between beliefs maintained with delusional intensity versus highly overvalued ideas. As above, if one adopts an inquiring and non-judgmental stance, the client is usually quite willing to explore his/her belief system and degree of belief in great detail. Finally, one needs to note that in cases where the defendant is accused of some rather horrific crime, strange ideas [the victim is not dead, there is a conspiracy, his/it will be riveway"

Hallucinations

Like delusional processes, hallucinations can occur in a variety of forms, the more common being auditory and visual, although disorders of taste, smell, touch and other bodily senses occur as well. Good probe questions, if hallucinations are suspected, are, "Has there ever been a time when things looked or sounded funny to you?"; or, "Have you ever seen or heard something that other people around you couldn't see or hear?" While hallucinations per se may be unrelated to fitness, their psychological consequences may be. For example, a defendant who hears voices may experience the voices as telling him not to trust his attorney, or something of that ilk. On the other hand, voices that promise "hell and damnation" to a disturbed murderer may make him or her emotionally labile and difficult to handle in court, but they are unlikely to lead to impaired communication with his attorney unless, say, the defendant believes that he or she ought to "fry" for the murder and is unwilling to explore possible defenses.

As is the case with other symptoms, if you suspect that the defendant may be hallucinating, or hallucinates on occasion, you should carefully examine the parameters of the symptom. Auditory hallucinations are the most common form of malingering in forensic situations. A very detailed inquiry into the client's experiences should be undertaken if hallucinations are claimed or thought to be present. Among the more common issues to be explored are: a) association with delusional beliefs; b) hearing voices inside one's head versus through the ears; c) degree of compliance and resistance [to command hallucinations]; d) identity of the voices, clarity of what is said, and situational characteristics of the experience; e) nature of the client's attempts to diminish or avoid the voices; and e) unusual symptom combinations. In general, the onset of hallucinatory experiences with the alleged criminal conduct and adjudicatory processes should be viewed with great suspicion, although in younger clients there may be no prior
detection or record of such difficulties. Self-reports of such symptoms should also be compared with observational data from jail personnel or ward staff.

As is the case with other psychotic symptoms, the forensic examiner must carefully distinguish between presence of psychotic symptoms and fitness. Ratings of "2" should only be given when the nature of the hallucination and the defendant's response to it are such that there is clear evidence that it significantly diminishes a contextualized psychosocial ability.

**Thought disorder: Impaired reasoning and judgment**

While symptoms in this domain are often associated with various specific delusions and hallucinations, they also can occur independently. The domain includes what is traditionally called "formal thought disorder" as well as the speech, communication and reasoning difficulties commonly referred to as "thought disorder." Regardless of designation, they reflect a fundamental disorganization of cognitive and communicative processes. Examples of formal thought disorder include thought withdrawal or blocking (a sudden cessation of thought not coincident with the anxiety), thought insertion (the subject experiences thoughts, which he identifies as not his own, being inserted into his mind), thought broadcasting (one's thoughts occur aloud and can be heard by others), or thought echo (one's thoughts are repeated or echoed). Occasionally, defendants will volunteer information about these types of symptoms without any questions (in the context, say, of discussing what they were thinking about on the day of the alleged crime). A good routine question for all defendants is something like, "Have you had any difficulty in being able to think clearly?", or "Have you been able to think about your situation pretty clearly; or does anything interfere with your thoughts?" Defendants will usually respond with some mention of anxiety or preoccupation (see below), but occasionally, in a disordered defendant, this will give rise to an answer that implies formal thought disorder. If you suspect that this may be the case, follow up with specific questions about insertion, withdrawal and the like. These symptoms are quite rare, even in psychotic individuals.

When present, the full range of the defendant's thought processes that relate to his or her fitness (as opposed to responsibility) should be carefully examined. For example, a defendant may believe that his thoughts are being picked up by a concealed microphone and broadcast to the judge or jury. Whether or not this would justifiably a rating of "1" or "2" depends upon the extent and consequences of this belief.

This domain also includes the speech and communication disturbances more commonly called "thought disorder." Rare forms of this include neologisms (client makes up nonsense words or uses words in bizarre ways), incoherent speech (seriously distorted grammar, and lack of logical connection between words, phrases or sentences -- not to be confused with poor education), nonsocial speech (as opposed to incoherent speech, which is at least responsive to the social demands of the interview situation, the defendant talks to himself, or to other people, or "voices" not present), and muteness (the defendant rarely responds, and then with only minimal speech or grunting sounds -- do not confuse with apparent uncooperativeness or unwillingness to answer). These symptoms are indicative of severe pathology and are likely to interfere seriously with a defendant's fitness because they render him inaccessible to an attorney and obviously unable to communicate effectively with an attorney. Nevertheless, these are not "all or none" phenomena, and sometimes will not be so severe as to render a defendant unfit. Also, defendants with these symptoms are sometimes quite responsive to medication and/or to persistent but empathic attempts to understand them. These symptoms of thought and communication disorder are usually rated on the basis of observation, and no special questions are necessary to elicit information. However, if such primary speech disturbances are occurring, one must be careful to examine their character. For example, if a defendant's speech is incoherent or neologistic, some attempt must be made to see if the defendant realizes this and can produce more conventional speech. Also, one must be mindful of cultural or educational factors (highly colloquial or idiomatic speech is not incoherent speech).

Other, more common, speech and communication disturbances include various characteristics of speech that interfere with communication, but not as severely. These include poverty of content (extremely vague speech in spite of actual number of words used), reduced quantity (very short responses coupled with a great deal of difficulty in maintaining a "conversational flow"), illogical thinking or tangentiality or loosening of associations or derailment (less severe forms of incoherence but similar in that the front of thought is either idiosyncratic, distorted, illogical or obscure), pressured speech (rapid, accelerated speech), or slow speech (the opposite), or flight of ideas (frequently accompanies pressured speech; while the "associations" are understandable, topics are rapidly changed and frequently represent irrelevant themes) or odd speech (metonymic speech, paraphasia, word approximations). These symptoms are also usually apparent without the need for elicitation. Their relevance to fitness depends upon how modifiable the defendant's speech patterns are, the type of defense envisioned, and how seriously they would interfere with a skilled attorney's ability to communicate with such a person. Such symptoms are frequently highly situational and time-bound.

This sub-section also includes general impairment of judgement/right. Some defendants may not manifest particular, concrete symptoms of thought disorder or delusions/hallucinations that render them unfit, but may think or perceive the world in highly idiosyncratic or nonconsensual ways, or may have belief systems that can only be described as "very screwy". If defendants manifest such an insight/judgment impairment, it may influence their fitness to stand trial on a particular set of charges. To assess this item one should first assess the extent of impaired or diminished judgment, and then attempt to relate the nature of this impairment to the case at hand. This is an "open" category and should be used carefully. Many disturbed individuals think in idiosyncratic ways that don't reach the extremes of a "symptom", but are "significant" in their impact on the ability to evaluate the nature of their situation. The most common example are individuals who reject the idea that they are mentally ill, despite considerable evidence to the contrary. This will most often directly influence their reasoning abilities vis-a-vis defense strategies [see psychosocial abilities sections, below]. Be sure to describe carefully the characteristics of defendants for whom this sub-category is used.

**Cognitive impairment: impaired memory**

This domain includes impairments in cognitive functioning that arise because of retardation, physical disease or injury, amnesias, and other disorders of functional memory. It is one of the most commonly misunderstood and misused grounds for determining a defendant's fitness.

**Impaired memory**

Almost all courts have consistently applied Dusky to situations involving claimed amnesia or impaired memory and concluded that amnesia by itself is not a sufficient basis for a finding of incompetency. The judicial reluctance to accept amnesia is partially
based upon well-justified skepticism—-the frequency with which defendants claim "not to remember" and the admitted scientific and clinical difficulty in distinguishing feigned from genuine amnesia or memory loss in a criminal context. It is also based upon jurisprudential reasoning, to wit, inability to remember specific details may not hinder the development of a defense, depending upon the circumstances. An important case addressing the relevance of amnesia to fitness is Wilson v. United States. The defendant, Wilson, had permanent retrograde amnesia and appealed his conviction on the grounds that his amnesia deprived him of his right to a fair trial. The Wilson court held that if a defendant has amnesia, the trial judge must make a prediction, prior to any legal proceedings, of the defendant's ability to participate. Further, if the case proceeds, the trial judge must also determine at the conclusion of the proceedings and prior to sentencing whether the amnesia had an effect on the proceedings. If it did, the trial judge could find that the conviction should not stand and the case would have to be retried. In the retrial, the government must be able to overcome the unfairness; if not, the indictment would be dismissed. The Wilson court suggested six factors which should be considered by the trial judge:

(1) The extent to which the amnesia affected the defendant's ability to consult with and assist his lawyer;

(2) The extent to which the amnesia affected the defendant's ability to testify on his own behalf;

(3) The extent to which the evidence ... could be extrinsically reconstructed in view of the defendant's amnesia; such evidence would include evidence relating to the crime itself as well as any reasonably possible alibi;

(4) The extent to which the Government assisted the defendant and his counsel in that reconstruction;

(5) The strength of the prosecution's case. Most important here will be whether the Government's case is such as to negate all reasonable hypotheses of innocence. If there is any substantial possibility that the accused could, but for his amnesia, establish an alibi or other defense, it should be presumed that he would have been able to do so;

(6) Any other factors and circumstances that would indicate whether or not the defendant had a fair trial. [Wilson at 463-464]

Many courts have rejected this case-by-case approach, relying instead on a simple rejection of amnesia claims unless it can be shown that the defendant's loss of memory obscures the search for truth. Nevertheless, the Wilson criteria provide a sensible set of guidelines for a forensic examiner in assessing the extent to which a defendant's claims, in light of the particular context of his case, the evidence, and the trial strategy, are relevant to fitness. Careful review of these guidelines makes it clear that only very rarely will amnestic claims rise to the level of severe disadvantage at trial (usually because of the strength of the prosecution's case). Thus, most amnesia claims a) are based upon the credibility of the defendant who has every reason to be self-serving, b) occur in contexts where the state's case could be proved by strong physical or circumstantial evidence and the amnesia is not convincingly related to ability to consult with one's attorney in relationship to disputed issues at trial, and c) are the result of the defendant's own actions during the alleged criminal act or are a consequence of self-induced intoxication or substance abuse.

While amnesia claims need to be carefully examined with a healthy dose of skepticism, this does not mean not taking a defendant's claim of amnesia seriously. This is required in forensic examinations, especially when mental state issues are involved and the loss of memory claim is related to psychotic episodes and dissociation. A clinical case illustrates this pointedly. The defendant, charged with sexual assault and murder, had a long history of drug and alcohol abuse, and a verifiable history of dissociative tendencies, schizotypal personality and suicidality. On initial interview, he claimed "patchy" amnesia and a desire for the state to "get it over with" (i.e., execute him). A clinical decision, supported by the court, to engage in brief therapy with an aim to deal with his suicidal ideation and to facilitate reconstruction of his memory, prior to an opinion about his amnesia and competency, was made. After three sessions, he revealed that the murder had occurred in a context quite different from that alleged by the prosecution, although certain aspects of his memory remained "patchy." Nevertheless, it was discovered that a sexual assault had not taken place, but rather the young girl had solicited sex for money, and had then threatened reporting him to the police if he did not pay more. The murderous assault occurred in this context. His defense counsel disclosed this information to the prosecution and the police were able to discover evidence which corroborated his version of the solicitation. He pled to second degree murder, and the sexual assault charge was dropped. Otherwise, it could have been a death penalty case.

Cognitive impairment

While a precise assessment of level of intellectual functioning requires extensive psychological testing, a reasonable estimate can be made from a defendant's general verbal ability and fund of knowledge. The more exact intellectual level of a criminal defendant is of no great concern unless there is evidence of severe retardation. In general, one will easily detect significant problems in this area on the basis of the defendant's inability to understand either formal English or "street" language, and a general difficulty in communication and comprehension. One of the most common mistakes in pretrial fitness evaluations is using standardized intellective assessment measures as a principal basis for determining fitness in defendants suspected of mental retardation. This is a mistake for several reasons. First, and perhaps foremost, such devices are of very limited utility in making functional assessments of the relationship between retardation and specific psycholegal deficits. If retardation is suspected as an issue, the examiner is better off using instruments or techniques specifically designed for this purpose. Second, scores on intellective assessment devices have been rejected, uniformly, as a per se basis for determining fitness. Thirdly, on a pragmatic basis, empirical evidence has consistently demonstrated very low and nonsignificant correlations between IQ measures and fitness. The issue is the defendant's functional abilities, and this needs to be assessed with an instrument designed for the purpose and on the basis of specific cognitive abilities relevant to the case. This is not to say that standardized intellective measures may not be a useful supplement, particularly to examine the details of a defendant's reasoning and verbal abilities in a non-forensic context. One must be careful, as well, not to use inappropriate standards. A defendant is not required to have a good grasp of the language or to be educated normatively in order to be fit to stand trial. He is, however, required to have a sufficient grasp, however slow, of the nature of his situation and the consequences of various actions he might take to defend himself. Interview based evidence for retardation should be appropriately noted, as should psychological tests of whatever nature.
As discussed in great detail in Section I, the most common problem has to do with understanding and applying one’s Miranda rights and resisting coercive police interrogation techniques. If there are any data to indicate retardation or mental disorder and reason to suspect the nature of the defendant's comprehension of Miranda rights or the nature of police custodial behavior, the examiner should take immediate steps to inform defense counsel and conduct a thorough inquiry.

Mood and affect

This domain contains a diverse set of affective disturbances ranging from severe anxiety and panic attacks, through severe depression and suicidal ideation or behavior, to more psychotic manifestations of affective disturbance. Many defendants are "upset" during judicial proceedings. Obviously, merely being anxious, distraught or depressed at the thought of serving jail time is not sufficient to warrant rating this category. Anxiety, if rated, should be sufficiently extreme and debilitating to make normal interactions and/or communication almost impossible (for example, panic attacks). Likewise, depressive symptoms must reach the point of seriously interfering with a defendant's abilities to assist at trial. A significant number of defendants are deeply depressed and feel their future is hopeless -- nevertheless, they are willing, with some encouragement, to help their lawyers. Some individuals, however, experience levels of depression far beyond this, and begin to stop talking, or contemplate (or attempt) suicide. Depression at this level of intensity should be noted, although its bearing on fitness is, as always, a matter of functional relationship. The problem with severe depression is not only that a defendant may become mute (or severely agitated), or will attempt suicide -- such individuals may also be highly irrational in their appraisal of their situation and may be overwhelmed by their hopelessness.

Other manifestations of affective disturbance included in this sub-section are depressive hallucinations [if not recorded elsewhere], blunting of affect (flat affect, apathy, expressionlessness), incongruous or inappropriate affect; hypomanic affect [or outright mania], or extreme suspiciousness. Most of the symptoms in this category are based upon observation and need no formal probes. However, as is always the case, any indications should be explored once they are detected. Therefore, a seriously depressed defendant should be closely questioned about reasons for the depression, the depth of the depression, the presence of suicidal plans or other forms of self-destructiveness (sabotage of their own defense, for example). The significance of symptoms in this category for trial fitness is highly context-dependent. Manic defendants, for example, who may exhibit serious affective disturbance, as well as delusions of grandiosity and communicational disturbances, may be fit if they retain a reasonable ability to relate to an attorney and to recognize what is required for the defense. On the other hand, such defendants may be unfit if their mania renders them unable to provide relevant details or to testify on their own behalf (if necessary).

Defendants whose high levels of anxiety disorganize their thought processes should not be determined to be unfit without attempting an intervention by means of rapidly acting anti-anxiety medications and brief, supportive therapy. Individuals at the extremes of the depression-mania continuum, whose affective state, as well as often accompanying delusions, render them unfit (because these seriously interfere with present psychosocial abilities), are likely to need a brief period of hospitalization. The same is true of psychotically depressed defendants who are unable to cooperate with the forensic interviewing process.

Other observations and notable symptoms

This is a mixed category that includes behaviors observed during the interview or behaviors that seem highly probable in the future. Examples include hostile or destructive outbursts, odd mannerisms and/or catatonic posturing, embarrassing behavior, behaving as if hallucinating [while denying hallucinations], stereotypic behavior and the like. The importance of such behavior to a defendant's fitness is highly dependent upon the situation. For example, a defendant who has violent outbursts may be quite fit and can even be separated from the actual courtroom to follow the proceedings by television. Defendants who have a tendency to expose themselves may disrupt the trial proceedings, but this may be dealt with in similar ways. On the other hand, the defendant's embarrassing behavior may not be so easily controlled, in that it may be a product of chaotic thought processes that render a defendant unable to comprehend realistically what is occurring around them. Careful questioning, assessment, and examples are necessary to justify using this category. It is also meant to include any other observations or symptoms that do not easily fit in the domains above, but which are cause for serious concern in evaluating the defendant's fitness.

ASSESSMENT OF PSYCHOLEGAL ABILITIES

The next sections of the IFI-R concern specific psychosocial abilities, and the relationship of any psychopathology determined to exist, to those psychosocial abilities. There are four general sections: a) Capacity to appreciate charges and to disclose pertinent facts, events and motives; b) Courtroom demeanor and capacity to understand the adversarial nature of proceedings; c) Quantity of relationship with attorney; and d) Appreciation of, and reasoned choice with respect to, legal options and consequences. Each section will be discussed in turn. For each of the four sections, the examiner is asked, at the end of the section, to indicate the degree of incapacity on a three point scale. A rating of 0 should be used if there is no or minimal incapacity. A rating of 1 is used if there is moderate incapacity, and a rating of 2 is reserved for substantial incapacity. Please keep in mind, in terms of final judgments, that, while substantial incapacity may be apparent in a particular area, the specifics of the case may not require a high degree of capacity in that area. For example, a defendant may not be able to appreciate the nature of a plea bargain, but it is known that the defense wishes to proceed with a jury trial if the defendant is found fit. Thus, the finding that the defendant is incapacitated in this area may not have much influence on your overall evaluation of fitness. Please note that each section requires you to indicate the concerns you noted about the defendant in explicit psycholegal terms. Also please note that each section and sub-section contains sample probes and comments. As in the psychopathology section, defendants will frequently provide information for one section in response to questions from another section. The interviewer has the responsibility to allow such transitions to flow smoothly and to keep track of unanswered questions or areas that need further exploration.

Capacity to appreciate charges/disclose pertinent facts, events and motives

In order to effectively assist in one's own defense, it goes without saying that one must comprehend the charges and be able to provide a competent attorney with pertinent exculpating facts, mitigating circumstances, and the like. This broad capacity involves five distinguishable sub-areas: a) appreciating the nature of the alleged charges; b) ability to provide a reasonable account of one’s own behavior prior to, during, and subsequent to, the alleged crime; c) ability to provide an account of the behavior of relevant others during the same time period; d) ability to provide information about the behavior of the police during the time of apprehension, arrest and interrogation; and e) ability to provide relevant information about one’s own state of mind at the time, including intentions, feelings and cognitions.
One begins to examine this aspect of fitness with a set of general questions about the nature of the alleged crime. For example, "What did the police say you did?"; "Why do you think you were arrested?"; "What are you charged with?" This probe can then be followed with specific questions appropriate to the first five sub-areas. It is best to attempt to get a fairly detailed account of the circumstances through the eyes of the defendant. Many times, the first responses of a defendant, especially one who has some degree of psychological disturbance or confusion, will be less than satisfactory. This can also occur because of a lack of trust or rapport. It is therefore necessary to "stay with it" for as long as is required to reach a realistic judgment. Often one may go over the same material two or three times, asking more and more detailed questions appropriate to the circumstances.

After the defendant has given his/her first response to the opening probe question, one can ask a series of more specific follow-up questions, such as:

What does it mean to be charged with X? Is that what you think you actually did, or did you do something else? What was on your mind at the time? What were you feeling at the time? Did you intend to do X? How did it happen? What happened next?, etc.

Unlike a police interrogation, it is absolutely necessary that you take a position of wanting to understand the circumstances through the eyes of the defendant. It is critical during this stage of the examination that you ask the sorts of questions to which a competent defense attorney would need answers for an appropriate defense. You will have to consult with the defense attorney or have the expertise to know which facets are most pertinent to a defense to the alleged crime. One must also realize that many defendants are not lawyers or even "jailhouse" lawyers, and may not have an understanding of the nuances of charges. If a defendant does not understand the nature of the charge, for example, it is permissible to attempt to explain this. After a suitable pause, one should then re-inquire to see if the defendant now understands, or if there are psychopathological/cognitive impairments which prevent understanding even when explained.

Within the context of the Wilson factors [discussed above], it is obvious that a defendant must have an appropriate functional memory of the events that happened to him/her before, during, and after the time period during which the alleged crime occurred. Complete unbiased memory is not necessary. Under most circumstances, defendants must surely have access to some details of their behavior at the time of the alleged crime, but what is required depends upon the defenses potentially available. The degree and quality of memory necessary is context-dependent and cannot be evaluated without consultation with defense and prosecution counsel. Under some circumstances, it may be critical that the defendant be able to remember intentions, motives and other feeling states, as well as physical details, sequences and the like.

After one has probed the nature and circumstances of the alleged crime and the defendant's ability to provide pertinent facts and information about his/her own mental state, one can then ask about the behavior of others who might have been involved or are witnesses, as well as conduct a detailed inquiry with respect to the behavior of the police during the arrest process. The questions to be asked depend upon the circumstances, but particularly relevant are details related to the circumstances of arrest and custody, how evidence was obtained, the nature and comprehension of Miranda warnings, and the detailed circumstances surrounding interrogation. Regrettably, my experience in several jurisdictions is that the police account of their behavior during custodial interrogation is often at variance with independent evidence. A defendant's ability to recognize distortion in the testimony of police officers, especially where interrogation interviews are not recorded, can be essential. A full discussion of these issues is found in Section I.

Courtroom demeanor and appreciating the adversarial nature of proceedings

The section pertains to several issues, all of which are related to a defendant's ability to appreciate his/her role and those of others in adversarial proceedings and to understand and appreciate the "ground rules" of the adversarial process. This section involves four distinguishable sub-areas: a) appreciation of the major roles of court personnel, b) appreciation of appropriate courtroom behavior and trial conduct, c) capacity to testify relevantly, and d) capacity to testify, observe and participate on current medication.

A significant subgroup of defendants do not understand the roles of court personnel (judge, jury, prosecutor, etc.). One must distinguish between not understanding because of lack of information or experience, and distorted views of these roles attributable to psychopathology. In the former case, brief education, often during the course of the interview, is all that is needed. If tied to delusory processes, however, the defendant may not be able to proceed without more sustained psychotherapeutic or psychopharmacological interventions. A defendant who believes that the judge is an agent of a conspiracy, based upon a delusional belief system, will be seriously disadvantaged at trial and in his/her willingness to cooperate with defense counsel, who is often seen as part of the conspiracy.

For those defendants who will likely stand trial or who need to participate in various hearings on pre-trial motions (as opposed to plea bargain), one needs to assess their ability to conduct themselves properly in a courtroom and to be active participants in the adjudicatory process. A defendant must not act in such a manner as to disrupt the decorum of trial proceedings. Thus, one needs to inquire about how the defendant would respond to various stresses at trial, including witnesses saying things that are upsetting or wrong, questions from the judge, and so forth. The examiner must be careful to distinguish the degree of voluntariness involved in the defendant's predicted behavior at trial or hearings. Defendants who might have an angry or volatile temperament or who might seek to disrupt a trial with angry outbursts or obscene language would not be considered until if there were evidence that they were capable of controlling their behavior. In such a case, the trial could proceed even under the extreme circumstances of the defendant being removed to an isolation room where they could follow the proceedings via a television monitor. However, if the outbursts were a function of rather severe psychopathology, one might seriously question a defendant's fitness. For example, an acutely disturbed schizophrenic defendant, who otherwise might be fit, would be at least temporarily unfit if, during the stress of a trial at the point where witnesses were testifying, he began to hallucinate or had a rather severely dissociated state of consciousness. Under such a circumstance, the issue of fitness would revolve around the question of whether or not a temporary recess or suspension would solve the problem. If a defendant were able to retain his capacity to "track" the proceedings, then one would decide in favor of fitness with special precautions and attention given to the defendant's moment-to-moment state of mind. A defendant whose behavior at trial might be embarrassing (e.g., public masturbation, grimacing, posting) poses a different set of problems. The court would have the option of removing the defendant to an isolation room, but the critical issue would be the defendant's cognitive capacities, the untoward behavior notwithstanding. This would pose a difficult assessment question. One would need to examine the defendant quite carefully to determine if the bizarre behavior co-varied with a significant diminution of awareness and comprehension.
Another issue has to do with the ability of a defendant to participate in (and remember) defense strategy, to testify relevantly and coherently, and so forth. While this situation will occur only rarely, if it will be necessary for the defendant to testify, the defendant's bizarre behavior or communication disturbances should not be such as to render him impossible to understand or to destroy his credibility. A defendant who must testify for a proper defense, but who is currently unable to carry out such a task, would most likely be unfit to stand trial. As discussed at length in Section I, however, this is a complex issue. A disordered individual whose defense concerns her mental state must be able to convey the nature of her cognitive, intentional and affective disturbance at the time of the alleged crime in an accurate manner, but must be able to do so, at the current time, in a relatively coherent manner. As suggested in Section I, this "knot" can be partially unravelled by the defense insisting on making a videorecording of the defendant, in his/her highly disordered state, prior to the use of medication/psychotherapy to restore the defendant to fitness (and hence, greater coherence). In addition, it has been my experience that brief conjoint interviews with defendants and their counsel, with the aim of teaching counsel how to communicate with thought disordered individuals, can result in the ability of counsel to "handshake" the defendant's testimony in a reasonable fashion [see, also, attorney relationship section, below]. The "caught between a rock and a hard place" aspect of this situation is obvious.

A related issue in this area has to do with drug-induced behavioral appropriateness. If many of the defendant's psychopathological symptoms (overt behavior as well as thought processes and affect) are under the control of medication, most jurisdictions will allow a trial to proceed. However, one must be alert to the possibility that such competency restoration in one sense may produce iatrogenic incompetency in another sense. The level of medication involved or the defendant's individual reactions to the medication may have dramatic effects on the individual's demeanor, level of sedation, emotional blunting, cognitive abilities or ability to accurately remember one's mental state at the time of offense. The legal problems posed in such situations are discussed at length in Section I, particularly in the context of the Riggins case. Difficult as it may be, the forensic examiner must attempt to estimate the degree of impact of the defendant's current total medications on his/her capacity to function at trial, the extent to which the "material evidence" of the trial has been altered by the medication, and so forth.

In addition to the probe questions suggested, the examiner needs to use the behavior sample during one's interview with the defendant as a guide to predicting future behavior. Also, if drug-induced fitness is an issue, one would need reports from the defendant, as well as others, concerning prior response to medication or other treatment and its cessation. If the defendant is currently medicated, at levels that approximate what would occur at trial, then the examiner, in the context of what may be anticipated at trial, needs to carefully describe and evaluate the situation. Thus, in a Riggins situation, where the defendant's degree of remorse, affect, and attitude will be critical in a jury's death penalty decision-making, the examiner will need to evaluate the extent to which the defendant's emotional flatness is attributable to medication versus his/her premedicated (*normal*) personality.

Quality of the relationship with attorney

The concern here is that defendants should have the capacity to consult and communicate with their attorney in an effective manner. Defendants who have the capacity to disclose pertinent facts must, of course, be willing to share that information with their attorney. The defendant should understand and appreciate that the responsibility of the defense attorney is to protect the interests of a client. A lack of trust in an attorney may result in the withholding of important information. Some defendants may believe, in a paranoid fashion, that the legal system is unfair or out to get them, and that the defense attorney is simply working for the system. Operating from this belief, defendants may feel quite reluctant to divulge information, on the assumption that any disclosure will be used against them. The lack of trust may also result in a defendant rejecting sound legal advice.

The quality of a relationship with an attorney should be evaluated both specifically with a particular attorney if the defendant already has representation, as well as more generally, in terms of potential relationships with other attorneys. It is possible, and indeed has happened not infrequently in my experience, that a defendant could be unfit with one attorney but fit with another. An analogy to psychotherapy may help clarify this point. Some clients are virtually unaffected by treatment by a therapist who uses one therapeutic technique but would respond quite positively to another therapist and/or technique. There has been considerable research in this area demonstrating that the match between client, therapist and technique is of critical importance in maximizing a successful outcome. The match between client and attorney may be of equal importance. Some attorneys may work quite effectively with highly anxious clients; others may work well with paranoid individuals. Thus, in some cases, the distinction between fitness with a particular attorney and fitness with attorneys in general may be a significant one in your judgment about fitness. As a consequence, you are asked to indicate separately in your ratings impairment in the relationship with a particular attorney and "other factors" that may imply that the difficulty may generalize to all attorneys. If there are other factors (such as ethnic or linguistic subgroup) which imply that the impairment with the specific attorney would not generalize to all attorneys, then you should note those factors. If the impairment is likely to generalize across attorneys, you should note the reasons why and consider that it your judgment of degree of impairment on the appropriate scale. You should be particularly alert to what it would be like to work with this defendant and what skills would be needed to interact with this defendant in ways which would increase the level and type of communication.

If defendants have already had considerable contact with their attorney, some specific questions about the nature of their discussion and their confidence in the attorney should be asked. Did they disclose pertinent facts regarding the circumstances of the alleged crime? Are they comfortable in discussing things with their attorney? Do they trust their attorney? Do they think the attorney is looking out for their best interests? Do they believe the attorney will do a good job for them? Do they understand why the attorney raised the fitness issue? Do they understand or agree with the defense counsel's defense strategy? On what issues do they disagree?

For defendants who have not yet had any substantive discussions with an attorney, these same questions can be asked in a hypothetical manner. What do you think is the role of a defense attorney? Would you be willing to cooperate with a defense attorney? Do you think there is a difference between public defenders and private attorneys? Do you believe the attorney appointed will try to do a good job for you?

One of the most frustrating aspects of fitness evaluations or fitness restoration programs has to do with the high level of variability in attorney skill and involvement with disturbed defendants. Some attorneys are remarkably skilled, given the dearth of attention to such training in law school, in interacting with disturbed defendants. Others are easily frustrated and often cold and hostile. The forensic examiner must be willing to assess and differentiate difficulties in the attorney-client relationship that are situational from those that are mostly attributable to the defendant's psychopathology per se. The defendant must be able to effectively assist a competent attorney. Obviously, difficulty eliciting cooperation from a defendant may be a problem of the attorney, not of the defendant. Assuming modal interpersonal skills, a defendant must be able to give sufficient trust to an attorney to make an
effective defense possible. This is not to say that a young black man, for example, would be incompetent if he refused to cooperate with an insensitive, court-appointed, white lawyer who didn't have much of a conception of the defendant's life position. However, if the young man's suspiciousness were so great that he suspected collusion even by the most obviously sympathetic source (a young black lawyer with a reputation in the youth's own community), one might realistically suspect that fitness would be an issue. One must be careful not to encourage “splitting” between an attorney and client. With the permission of the parties, and sometimes the court, I have found it useful in such situations to conduct joint interviews in order to assess the extent of certain problems, and to give an attorney an opportunity to learn some of the clinical skills often needed to work with certain “problem” clients.

Appreciation/reasoned choice of legal options and consequences

The primary concern in this section is that a defendant should have the capacity to evaluate and appreciate defense options and other related matters (jury trial, bench trial, plea bargaining, insanity defense) and make a “reasoned choice” on the most appropriate and realistic course of action. The examiner must consider responses to questions in this area in the context of the realities of the defendant's case, the defendant's demographic characteristics, and the defendant's level of intellectual sophistication, experience, and psychosocial and psychopathological adjustment.

As made clear in Section I, this is not to say that “reasoned choice” for a defendant should be equated with willingness to accept an attorney's advice. Rather, the concern is that the desire for another option is based on a rational assessment of the advice and the likely consequences of various options. A defendant may want to proceed with a jury trial, rather than plea bargain, even when there is a compelling argument that this could result in a much longer sentence, if convicted. Nevertheless, such a defendant must be given the right to exercise the right to a jury trial, unless there is reason to believe that the decision is based upon irrational, perhaps even psychotic, thought processes. An example would be a murder case where an insanity defense appears to be the only legal option realistically available. If the defendant dismisses the attorney's advice, stating the belief that a jury will understand that he was simply acting on God's command that the victim should be destroyed and further that the jury would find him innocent and would in fact praise him for his actions, one has probable grounds, assuming other data, for determining that the choice is “not reasoned” and the result of mental illness. As another example, one of the most difficult decision points is presented by a defendant who acknowledges his guilt at the outset and states an intention to plead guilty even though his defense attorney is convinced that a good defense or plea bargaining would result in acquittal or a lighter sentence. While some would regard such behavior as a priori evidence of unfitness, it is merely an indication for further probing on the part of the examiner. Admission of guilt can be part of a delusional system that may leave real doubt whether a crime was ever committed by the defendant. It may be related to overwhelming guilt feelings about quite different issues that color the defendant's perception of his part in the present alleged crime, or it may be the result of a firmly held personal value system that demands expiation for wrongful acts. Each of these motives can have a different effect on the assessor's final judgment about fitness.

In any case, the simple statement of an intention to plead guilty, or represent oneself, or waive an insanity defense, should not be taken at face value. Detailed examination of the defendant's reasoning processes, and a careful distinction between idiosyncratic thought processes and psychopathologically influenced thought processes, is necessary. A variety of sample probes are given, but the examiner must use his/her own judgment as to how to proceed given the circumstances of the case.

A final issue in this section has to do with the problem of defendant's appraisal of their mental condition and their choices as to treatment. While this overlaps, to some extent, with impaired judgment and insight [above], the focus here is not simply on acknowledging one's mental condition, but on how the defendant would like to deal with the fact that others view him/her as needing treatment and the likely form of that treatment. Some individuals will wish to contest their being adjudicated unfit on the basis of mental disorder. The examiner must probe the nature of the defendant's reasoning (on very rare occasions defendants, usually with strong paranoid personalities, have had their idiosyncratic beliefs inappropriately judged delusional). In a similar fashion, the examiner must explore a defendant's reasoning about choice [or non-choice] of treatment. Scholarly and clinical commentators on this issue have repeatedly stressed the complexity of this determination, but seem to agree that, at a minimum, the examiner should focus on:

- a) the degree to which the client has been or can be informed about the nature of the proposed treatment and its relative benefits and risks, along with likely outcomes;
- b) the ability of the client to understand the information relevant to the choice;
- c) the ability of the client to communicate his/her choice;
- d) the ability of the client to appreciate the nature of their situation and the likely consequences of various choices.

Almost all of the issues in this section deal with fundamental constitutional rights, and the examiner should study the material in Section I with respect to these issues carefully. The ultimate goal is to assess the relationship between the individual's intellectual and psychological capacities and impairments, on the one hand, and their psychosocial ability to voluntarily, knowingly and competently choose to waive these fundamental rights by pursuing trial strategies and defenses, on the other.

COMMUNICATING RESULTS TO FITNESS EVALUATION

The "Summary Report" section of the IFI-R has been designed to summarize the nature of one's findings. It is not a substitute for the formal forensic report, but is useful in those jurisdictions where mental health administrators wish to track the nature of forensic evaluations performed and their essential results. Please note that several sub-areas ask for information which may have been implicit in other sections but is addressed explicitly here. First among these is “Assessment of malingering potential.” All final reports should include, whenever there is any doubt, an assessment of the potential for malingering. Recommendations that involve a defendant's unfitness should never be based solely upon the defendant's self-report or neuropsychological evaluations; it is imperative that the results be corroborated by other means [history, records, collaterals, etc.]. If prior records and other means of corroborate are not available, the examiner should use the indeterminate category and identify a strategy that will help to resolve the issue. On the other side, if the examiner suspects malingering (in either direction) but does not have the data needed to substantiate the suspicion, the indeterminate category should be use and a resolution strategy [e.g., inpatient observation].
suggested. In any case, the malingering potential associated with any pre-trial evaluation should always be addressed, unless it is obvious from the record and history that the defendant's self-report is consistent with his/her non-forensic mental health history. While the movement to conduct pre-trial forensic examinations on an outpatient basis is well justified on legal, clinical and economic grounds, its "weak link" is that adequate records of past mental health history, often critical to an evaluation of malingering, are not readily available and intensive observation of the defendant is often not possible. Therefore, the forensic examiner should not hesitate to obtain as much record and observational data for corroborative purposes as possible. It follows that if such a substantial potential exists, but cannot be ruled out, the examiner should refrain from a final recommendation, and communicate the reasons for indeterminacy to the court.

The "Summary Report" also requests that the examiner address factors relevant to the probability of restorability. One needs to acknowledge, immediately, that the empirical basis for firm predictions of restorability is shaky at best. Firm clinical predictions of restorability are not the purpose of this section. Rather, based upon the examiner's clinical findings and review of the defendant's record, especially prior treatment history and treatment response, the examiner should identify whatever factors he/she feels are relevant for the judge and subsequent treatment personnel. For example, treatment refusal or resistance rarely occurs in a vacuum; it develops as an interaction between the defendant, the disorder and previous interactions with mental health professionals. The nature of its development is an important "factor" because it lays the groundwork for possible psychotherapeutic intervention. Other possible examples include evidence of clearly progressive dementia, evidence of a lack of attempting meaningful psychotherapeutic interventions in defendants refusing medication, appropriateness of prior psychopharmacological treatments, and so forth.

This manual is not the appropriate place to discuss the nature of how to write forensic reports for the courts. Excellent discussion of the pros and cons of various approaches can be found in a variety of sources. However, in the context of the philosophy of test construction that has guided the I-FI-R, several short comments are appropriate. First, forensic reports that concern a defendant's fitness are not like ordinary psychological evaluations. It is necessary to present sufficient social, developmental and current psychological data to give the recipient (judge, defense counsel, etc.) an accurate view of the defendant, but in the context of the issue at hand, not a general psychological evaluation. Second, the structure of the I-FI-R particularly the psychosocial section [as reflected in the "Summary"] provides a convenient structure for the organization of a functional evaluation of a particular defendant, contextualized to the particulars of his/her current charges, evidence, trial strategies, and so forth. Indeed, one of the advantages of the I-FI-R methodology is that it leads quite naturally to a communication to the court that is "framed" in legally appropriate and useful ways. Third, the report writer should be always cognizant of the fact that these communications to the court are essentially non-confidential [except when produced in a privately retained capacity]. The principles of Estelle and the Federal Rules of Evidence notwithstanding, it is always good practice to write reports that respect the right of the defendant to avoid self-incrimination and the right to maintain attorney-client privilege. It is important to avoid placing information not known to the police or prosecutors into fitness reports. Finally, and above all else, it is important that reports contain contextualized information that will be useful, not only to judicial authorities, who must make the final decision, but also to treatment personnel. Especially in reports that are framed in terms of a defendant’s unfitness, it is important to give detailed and specific reasons as to the basis for one's conclusions. These will form the backbone of a competency restoration plan, if one's recommendations are accepted, and are the most valuable part of one's expertise in any case.

1. The original Interdisciplinary Fitness Interview was authored in 1981 by Stephen Golding and Ronald Roesch as part of a grant from the National Institutes of Mental Health (R01-MH33690). The Interdisciplinary Fitness Interview - Revised represents a substantive revision based upon research and clinical experience using the instrument over the past decade, Copyright 1993 Portions of this manual, or the complete manual, MAY NOT BE REPRODUCED OR CITED WITHOUT PERMISSION from the author. Copies of the I-FI-R itself may be obtained, for use by licensed psychologists, psychiatrists, or social workers only, at the rate of $1.50 per instrument copy. Additional copies of the manual are also available for $15.00 per copy.

2. On technical and semantic grounds, "fitness" is the preferred term; however, “competency” is the more traditional usage.


12. Such cost estimates include not only professional evaluation fees, but also administrative and court costs, attorney fees, and the increased costs associated with added "detention-days" while the defendant's trial is postponed. For defendants appropriately found incompetent, such costs also include lengthy inpatient hospitalizations.


14. Hale, in his History of the Pleas of the Crown (1736) observed that "If a man in his sound memory commits a capital offense, and before his arraignment he becomes absolutely mad, he ought not by law to be arraigned during his phrenzy, but be remitted to prison until that incapacity be removed; the reason is, because he cannot advisedly plead to the indictment." [Quoted in Silten, P. & Tullis, R. (1977). Mental competency in criminal proceedings. Hastings Law Journal, 28, 1053-1074 at p. 1053]. Hale actually included not only competency to plead at arraignment, but also competency at trial, judgment, sentencing or possible execution.


17. "Nature of proceedings" implies a variety of things including court processes and personnel, the nature of charges, evidence that will be deemed relevant, and the possible consequences of conviction.


19. For example, in Roesch and Golding's (1980) study [supra n15] of 270 defendants referred for competency evaluations, 87 percent of those found incompetent were either psychotic or mentally retarded, whereas only 17 percent of the competent defendants received such diagnoses. A recent meta-analysis of thirty studies of incompetent defendants reached essentially the same conclusion [Nicholson, R. & Kugler, K. (1991). Competent and incompetent criminal defendants. Psychological Bulletin, 109, 355-370].

20. See Golding & Roesch and Roesch & Golding supra n15 for a review of these cases.

21. The equation of psychosis/retardation with incompetency is empirically erroneous because the conditional probability that a defendant who is incompetent is also psychotic is not the same that a defendant who is psychotic is also incompetent (See Golding et al., supra n12). Given the nature of the Dusky standard, it is almost a certainty that most individuals who are adjudicated incompetent are also psychotic or severely retarded. On the other hand, the proportion of psychotic defendants who are also incompetent is dramatically lower; many mentally ill individuals meet the Dusky standard for competency.

22. Roesch and Golding, supra n15; see also American Bar Association. (1984). Criminal Justice Mental Health Standards. Chicago, Ill: Author. After extensive commentary and debate, the ABA endorsed leaving this standard in its open form, rejecting proposals to develop more specific "checklists" or operational definitions of the construct.


24. Florida Rules of Criminal Procedure, §3.211, 1991; the similarity between this structure and the IFI-R is not coincidental. A modified form of the IFI is in use in Florida. McGarry's Competency Assessment Instrument [McGarry, L. et al. (1973). Competency to stand trial and mental illness. National Institutes for Mental Health, Center for Studies of Crime and Delinquency, DHFW 73-9103] was the original pattern for both the Florida rules and the IFI, although the IFI goes on to require the relationship between mental disturbance and each psycholegal ability, as well as the specific concerns in each area.


27. 67 C.A. 2d 272 (1967).


32. Cal. Pen. Code Ann. §1369(f) (West 1982) provides "It shall be presumed that the defendant is mentally competent unless it is proved by a preponderance of the evidence that the defendant is mentally incompetent".


37. 302 F. 2d 214 (Eighth Cir., 1962).

38. 304 U.S. 458 (1938).


40. supra n2 at 444, emphasis added.


42. 361 U. S. 199 (1960).


44. A series of cases in the area of confessions explore the implications of which circumstances count and which do not. See United States v. Rouco (11th Cir., 1985) [nervousness and depression are not sufficient to doubt voluntariness, but incompetency or insanity would be]; Corn v. Zant 708 F. 2d 549 (11th Cir., 1983), cert. denied 104 S. Ct. 2670 (1984) [a history of low intelligence and 'mere emotional disturbance' will not render a confession involuntary, but incompetency and/or insanity at the time would]; United States v. Waxman 572 F. Supp. 1196 (E.D. Penn., 1983) [mere personality disorder, high dosages of tranquilizer and anxiety insufficient]; Gladden v. Unsworth 396 F. 2d 373 (9th Cir., 1968), [holding that, with respect to voluntariness, the confession must not be the result of mental illness]; and Gibbs v. Warden of Georgia State Penitentiary, 450 F. Supp. 242 (M.D. Ga., 1978) [confession is admissible, even if defendant was psychotic, because it was not substantially induced by the psychosis; 'a confession is inadmissible if it would not have been obtained but for the effects of the confessor's psychosis' (emphasis added, at 244)].


47. Competency to be executed certainly merits discussion, but it rarely arises and is beyond the scope of this manual.


49. 478 F. 2d 211 (9th Cir. 1973).

50. 423 F. 2d 1183 (9th Cir. 1970).

51. 422 U. S. 806 (1975).

52. 384 U.S. 150 (1965).


54. 3 All E. R. 523 (1961).

56. 507 F. 2d 1148 (D.C. Cir. 1974).

57. 408 A. 2d. 364 (D.C.Cir. 1979).

58. 940 F. 2d 1543, 1547 (D.C. Cir. 1991).


60. *supra* n40.


63. See "Validity or admissibility, under Federal Constitution, of accused's pretrial confession as affected by accused's mental illness or impairment at time of confession--Supreme Court cases," 93 L. Ed. 2d 1078; and "Mental subnormality of accused as affecting voluntariness or admissibility of confession," 8 A.L.R. 4th 16.


66. A spate of such cases have occurred in Arizona, and all appear attributable to interrogators trained at the same "school" and relying upon variants of the Inbau-Reid methods. In one such set of cases, the police were investigating a mass murder and robbery at a Buddhist temple outside Phoenix. Acting upon a tip, they arrested five individuals, all of whom gave detailed and identical confessions, and who claimed afterwards to have been psychologically coerced. Some months later, by accident, the real perpetrators were arrested and found in possession of the weapon which matched the murders. There was absolutely no connection between the two sets of individuals. In addition, one of the boys actually involved in the "Temple" murders confessed to another killing, which the police had "solved" the prior year by the confession of a mentally disordered Vietnam veteran, who also was completely innocent.

67. As Gudjonsson (among others) has noted, the most disturbing cases of all involve individuals who gave false confessions and who do not appear to be mentally ill, retarded, or obviously vulnerable.

68. *supra* n50.

69. Justice Blackmun, in his dissent, characterized the majority's position as one conferring a constitution right to make a fool of himself upon the defendant.

70. *supra* n21.


73. 972 F. 2d 263 (9th Cir. 1992), cert. granted 113 S. Ct. 810 (12/14/92).


76. Interestingly, the American Bar Association, in their Criminal Justice Mental Health Standards, comes down on the side of the State's interests. "A person determined to be incompetent to stand trial and detained or committed for treatment or habilitation or ordered to appear for outpatient treatment or habilitation should have no right to refuse ordinary and reasonable treatment or habilitation designed to effect competence. However, a defendant should have the right to refuse any treatment or habilitation which may impair the defendant's ability to prepare a defense to the charge, which is experimental or which has an unreasonable risk of serious, hazardous or irreversible side effects."[Standard 7-4.10(c).]

78. In addition to considering the "Riggins" factors, Judge Winder, in Woodland considered a) whether or not there was reasonable medical certainty that forcible medication would render the defendant competent; b) the likelihood of medication side-effects; c) the likelihood that medication would alter the defendant's demeanor at trial and hence make a "fair and accurate" trial unlikely; and d) the State's interest in trying the case, given the likelihood that the defendant would remain hospitalized.

79. Most defendants returned from competency restoration have been heavily medicated for a significant period of time, and many are ordered to continue on medication during trial. Roesch & Golding (supra n15) in one sample found that 37% of defendants were on medication during their trials. Recent data imply that this may be a serious underestimate. Another study found that nearly all their sample were on continuing medication following their competency restoration [Golding, S., Eaves, D., & Kowaz, A. (1989). The assessment, treatment and community outcome of insanity acquittees: Forensic history and response to treatment. International Journal of Law and Psychiatry, 12, 149-179].


81. These guidelines are incorporated into the structure of the IFI-R, discussed in Section II. It is convenient to describe them here.

82. The basic concern amongst side-effects is tardive dyskinesia which may develop in patients treated with commonly prescribed anti-psychotic medications such as Haldol, Prolixin, Stelazine, Thorazine and others. There is considerable debate in the professional community, but the majority opinion is that the disorder may be irreversible in chronic patients and may be detected quite early in treatment if properly assessed [Gardos, G. E. & Cole, J. O. (1983). The prognosis of tardive dyskinesia. Journal of Clinical Psychiatry, 44, 177-179]. This class of side-effects, which involves abnormal motor movements of the limbs, face, tongue and mouth, as well as other side effects which involve feelings of apathy, listlessness, cognitive slowing, shaking, muscular discomfort and often anxiety, provide a genuine basis for treatment refusal. Indeed, they are the primary reasons for non-compliance with medication among psychiatric patients.

83. Under Jackson v. Indiana, a pre-trial defendant may not be held indefinitely for competency restoration. Some defendants, including those who are malinger mental illness as well as those with "real" mental illnesses, may "rationally" understand that by refusing treatment they may hasten either their outright release or their civil (as opposed to criminal) commitment under Jackson.

84. From a professional mental health perspective, one of the problems with many court decisions in this area is a presumption of generality of side-effects in all individuals, based upon data that they occur in some individuals. Given the great variability of individual differences, a person-specific analysis seems warranted.

85. That is, assuming that the result of a "Riggins" hearing is that the State prevails, or that the defendant agrees to trial while medicated and the hearing judge determines that fundamental fairness will not be compromised.

86. All courts that have considered the issue agree that expert testimony is the minimum required. Riggins can be read as questioning whether this is sufficient. "We also are persuaded that allowing Riggins to present expert evidence about the effect of Mellaril on his demeanor did nothing to cure the possibility that the substance of his own testimony, his interaction with counsel, or his comprehension at trial were compromised ..." supra n78.


89. 406 U. S. 715 (1972)


92. Golding supra n10.

93. Ibid.

95. Davis, D. L. (1985). Treatment planning for the patient who is incompetent to stand trial. Hospital & Community Psychiatry, 36, 268-271; "the assessment and treatment planning process must proceed on the same specific and functional basis as the original competency assessment. For example, a delusion that the patient's attorney is a member of the KGB and cannot be trusted would clearly have the potential to prevent the patient from participating in his or her defense. However, a poor self image may have little relationship to the patient's competency. Similarly, a patient's lack of a high school diploma and his lack of knowledge about the legal system would have differing treatment priorities. The first concern is not relevant to competency, while the second would have clear implications" (p. 269).

96. For example, many jail-based evaluations are conducted under less than optimal conditions (i.e., attorney-client contact rooms, through glass walls, etc.). Often, especially when particularly difficult or disturbed defendants are anticipated, special arrangements can be made. The examiner must be careful not to arrogantly insist on "bringing the defendant to my office," since this is costly and often not necessary, though under certain circumstances and anticipated testing situations, may be needed.

97. The Speciality Guidelines for Forensic Psychologists, supra n30, provides, at Guideline VI(F), that "Forensic psychologists are aware that hearsay exceptions and other rules governing expert testimony place a special ethical burden upon them. When hearsay or otherwise inadmissible evidence forms the basis of their opinion, evidence or professional product, they seek to minimize sole reliance upon such evidence. Where circumstances reasonably permit, forensic psychologists seek to obtain independent and personal verification of data relied upon as part of their professional services to the court or to a party to a legal proceeding."

98. Speciality Guidelines for Forensic Psychologists, supra n30.


100. Speciality Guidelines for Forensic Psychologists, supra n30; see also relevant sections of the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (1992) regarding the obtaining of "assent" from those presumably incompetent to give "consent."

101. In some jurisdictions, particularly Texas, the prosecution has attempted, repeatedly, to use pre-trial fitness evaluations as a context to obtain information which it may not be entitled to later use in the death-penalty phase of trials. Such tactics have been repeatedly struck down by the Supreme Court, but the professional code of conduct in this matter is designed to prevent such tactics or to make them known to the defense prior to the interview occurring.

102. The clearest statement of this rule is given in the Federal Rules of Criminal Procedure:

No statement made by the defendant in the course of any (forensic) examination ... with or without the consent of the defendant, no testimony by the expert based upon such statement, and no other fruits of the statement shall be admitted in evidence against the defendant ... in any criminal proceeding except on an issue respecting mental condition on which the defendant has introduced testimony (Federal Rules of Criminal Procedure, Rule 12.2(c), 1985).

103. For example, a statement such as "I will be asking you to tell me what actually happened, as best you remember it. While my report will be read by your defense attorney, the prosecutor and the judge, neither the judge nor the prosecutor can use your statements to me as evidence at trial that you are guilty. Your statements to me can only come up at trial if you and your defense attorney agree that you should plead guilty or agree that you should plead that you did [alleged crime] but you did it because of your mental or physical condition;" versus "Suppose you tell me that you did point the gun at Jane's head and pulled the trigger. Unless you and Ms. Smith, your attorney, agree that you should say that at trial, the prosecutor can't use your telling me as evidence against you. He would have to prove it some other way. For example, he could ask Jane's boyfriend what he saw, but he can't ask you unless you agree to take the stand, and he can't use what's in my report unless you agree to it."


105. From a professional practice standpoint, the use of structured or semi-structured interviews would seem almost mandatory in high profile cases, where extremely rigorous cross-examination of an examiner's competence and the adequacy of the database upon which he/she relies can be routinely expected.


108. See Hesselbrock, V., Stabenau, J., & Hesselbrock, M. (1982). A comparison of two interview schedules - The Schedule for Affective Disorders and Schizophrenia-Lifetime and the National Institute for Mental Health Diagnostic Interview Schedule. Archives of General Psychiatry, 39, 674-677 for an evaluation of early forms of these schedules; these interview schedules, and many like them, are constantly subject to revision. Hence, forensic examiners in choosing which to use should consult the empirical and scholarly literature before making a decision.

109. As a matter of clinical sophistication, the importance of communicating to a mentally disordered individual that one genuinely wants to understand their experience of their world cannot be overemphasized. The difference in the type and quality of clinical material elicited by this simple interpersonal stance is often quite amazing. This type of rapport, with the examiner seen as being non-judgmentally open to trying to understand the client's experience, is essential. Under such interviewing conditions, even very
paranoid, thought disordered, or hostile clients will explore the details of their thought, affective and perceptual processes; lacking such a context, the examiner will not be able to obtain the data necessary for a competent evaluation of their true mental state.


112. See Nicholson & Kugler, supra n18, for details.

113. The original IFI focussed upon what was termed a) primary disturbance of thought, b) primary disturbance of communication, c) secondary disturbance of communication, d) delusional processes, e) hallucinations, f) unmanageable or disturbing behavior, g) affective disturbances, h) disturbance of consciousness or orientation, i) disturbances of memory/ amnesia, j) severe mental retardation and k) general impairment of judgment or insight. Based upon both empirical research and more than a decade of experience with the instrument, I have somewhat simplified and restructured the psychopathological portion of the IFI-R.

114. Supra n18.

115. Distinguishing religious delusions from idiosyncratic subcultural beliefs, especially when the defendant has been raised in a religious sect that accepts personal revelation, is a difficult matter. However, one rarely encounters completely encapsulated religious delusional beliefs. More commonly, the delusory beliefs extend, upon careful inquiry, into other non-religious areas and/or other signs of disordered or disorganized thinking are present.


117. In the original IFI, these categories were separated into primary and secondary disturbances of thought and communication, as well as impaired judgment.


120. 391 F. 2d 460 [D.C. Cir. 1968].


123. See relevant sections as well as n45, supra.

124. This may require the assistance of outside specialists in these matters, as well as interviews with the arresting or interrogating officers, obtaining documentation of the Miranda procedures and interview notes, recordings, etc.

125. Often “street-wise” defendants or members of extremist political, social or religious subgroups will opine that the attorneys and judges are in collusion with each other. These are often idiosyncratic or perhaps overvalued ideas, but rarely are the result of a true delusory system rooted in individual psychopathology as opposed to subgroup or subcultural belief systems that may seem quite “wacky.”
126. Clinicians experienced with interviews of severely disordered individuals over a longitudinal sequence, on and off medication, will immediately recognize the problem. It is not uncommon for medicated clients to have great difficulty remembering and relating the phenomenological details of the pre-medicated psychotic experiences.

127. In similar contexts, this is a place where devices such as The Hare Psychopathy Checklist - Revised [Toronto : Multi-Health Systems, 1991] are invaluable. Many examiners, unfortunately like the lay public, equate chronic antisocial behavior with true antisocial personality disorder and hence evaluate a behaviorally antisocial defendant's seemingly "flat affect" as an indicator of psychopathy. Because personality disorders [particularly antisocial, borderline, narcissistic, and schizotypal] often overlap with each other and with psychotic conditions, careful differentiation of the disorder(s) and the effects of medication is necessary.


129. As discussed previously, detection of malingering is an evolving art and science. Richard Roger's edited book, (1988). Clinical assessment of malingering and deception. New York: Guilford Press is a useful starting place, as are the references at n115 and n118 supra. The literature on detection of malingering, especially in forensic contexts, is growing rapidly.

130. See Golding, supra n10; Carbonnel, Heilbrun & Friedman, supra n90 and accompanying text for why this is so.

131. See, for example, Melton et al., supra n110 and references contained therein.