

The Use of Third-Party Information in Forensic Assessments: A Two-State Comparison

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There is virtually no research on the normative characteristics of forensic mental health assessment, despite the significant increase in conceptual and empirical attention devoted to such assessment within the last 10 years. The present study addressed this deficit by examining the use of third-party information, a crucial component of forensic mental health assessment, by forensic clinicians in two states: Florida (a total of 277 evaluations on the issues of competency to stand trial and sanity at the time of the offense) and Virginia (316 evaluations addressing the same legal issues). Evaluations in each state were performed in either a community or a hospital setting. Basic information about the offense, records of prior mental health evaluation or treatment, and specific statements by victims or witnesses were the variables examined comprising "third-party information" in this study. More than three fourths of all evaluations across states and settings incorporated this information. There was less consistency in the use of mental health records and victim/witness statements, with significant differences observed across settings and states. Results are discussed in light of potential influences of state, setting, and study methodology.

The literature on forensic mental health assessment has grown enormously in the last 10 years. A number of books have been published.¹⁻⁶ Mainstream journals have increasingly featured articles on forensic assessment, and interdisciplinary journals have been established as sources for publication of articles in this area.

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There has also been significant criticism of the practice of forensic assessment, with some individuals arguing that the entire process is of such limited value that it ought to be banned from the courts until a more solid scientific foundation can be established.⁷⁻¹¹ Others, however, have countered that such criticisms are better characterized as advocacy than scholarship, and hence unbalanced.¹²

One of the ironies of this entire controversy, however, is that such criticisms and responses are made in the absence

of virtually any normative data on the characteristics of forensic mental health assessments. A review of the literature yielded very limited empirical data on the normative aspects of forensic assessment. In one study,¹³ a national survey was used to obtain information on the frequency with which 66 responding psychologists used psychological testing in child custody evaluations; some 75.6 percent reported using testing for the parents, while 74.4 percent noted that they used psychological tests with the children. A second study¹⁴ described ratings of 277 forensic evaluations in Florida addressing the issues of trial competency and sanity at the time of the offense. Characteristics of evaluators (education, licensure, diplomate status, and supervision) and procedures employed in the evaluation (whether notification of purpose was given, psychological testing used, and ultimate legal issue addressed) were described.

One of the more interesting findings of the latter study was the description of the use of third-party information in these evaluations. Third-party information is regarded as one of the most important components distinguishing therapeutic from forensic evaluation.^{1,4} The two most frequently utilized third-party data sources from the Florida study were mental health history and arrest report; each was included more frequently by hospital-based than community-based evaluators.

The present study was designed to provide more information on the use of third-party information in forensic assessment. Forensic evaluations from two

states, Florida and Virginia, were compared in their use of mental health history, offense information, and statements of victims or witnesses. These variables were selected because they are among the most important sources of third-party information in forensic assessment.

Method

Florida Evaluations A total of 277 reports, representing evaluations performed on 277 patients, were randomly selected from the records of patients admitted to the Forensic Service, Florida State Hospital, during calendar year 1989. These reports were selected either from the community (N = 110), where they were performed before the patient's adjudication as either Incompetent for Trial or Not Guilty by Reason of Insanity, or from the hospital (N = 167), where they were performed following the patient's admission to the Forensic Service. Community-based reports addressed the issues of competency to stand trial, mental state at the time of the offense, or both. Hospital evaluations addressed only the issue of trial competency.

Virginia Evaluations All mental health professionals who perform court-ordered evaluations of trial competency or sanity at the time of the offense in Virginia are asked to complete a Forensic Evaluation Information Form, in which the evaluator describes the characteristics of the defendant, the sources of information employed, the time spent on various components of the evalua-

tion, and the conclusions reached.¹⁵ Pre-trial evaluations are performed either in the community or in a hospital. Virginia statutes provide that trial competency and sanity evaluations will be conducted on an outpatient basis whenever possible.

Data from a random sample of 316 Virginia forensic evaluations performed in 1989, and documented by evaluating clinicians in the Forensic Evaluation Information form, were obtained from a database maintained by the Institute of Law, Psychiatry, and Public Policy at the University of Virginia, in consultation with the Supreme Court of the Commonwealth of Virginia. A total of 135 of these evaluations were performed on individuals in a hospital setting; another 181 were done in the community.

Results

As seen in Table 1, the legal issue(s) addressed in the forensic evaluations varied by state. The majority of evaluations done in Florida (77%) addressed only the issue of competency to stand trial, with one percent addressing sanity at the time of the offense and the remaining 18 percent focusing on both issues. By contrast, the majority of Virginia evaluations (66.5%) addressed both trial competency and sanity; 22 percent were devoted to the issue of trial competency alone, and 11 percent addressed only sanity.

There was a difference in evaluation setting between the Florida and Virginia data. The majority of Florida evaluations (60.3%) were done on an inpatient

basis, while only 43 percent of Virginia evaluations were hospital based. However, this difference is a result of sampling methodology. Evaluations in Florida were randomly selected from among postadjudication defendants who had been hospitalized as incompetent for trial. In Virginia, the evaluations were randomly selected from the preadjudication evaluations performed in 1989.

A higher proportion of evaluators in each state were doctoral-level psychologists (relative to psychiatrists), and the majority of clinicians in each state were licensed (80.1% in Virginia; 69.3% in Florida). A very small percentage of clinicians were certified by the American Board of Psychiatry and Neurology or the American Board of Professional Psychology (1.6% in Virginia; 6.9% in Florida).

Utilization of third-party information varied according to both setting and state, as seen in Table 2. Offense information was consistently incorporated into forensic evaluations, suggesting that evaluators performing forensic assessments clearly saw this as important information. However, an analysis of within-state differences revealed significant differences in the use of offense information across community and inpatient settings. Significantly more hospital than community evaluations in Florida incorporated offense information ($X^2 = 82.0, p < .00001$), whereas a significant difference in the opposite direction may be seen for Virginia evaluations ($X^2 = 15.9, p < .0001$).

Table 1
Characteristics of Forensic Evaluations in 1989 and Mental Health Professionals, by State*

	State			
	Florida (N = 277)		Virginia (N = 316)	
	N	%	N	%
Legal Issue(s)				
Trial Competency	226	81.5	71	22.5
Sanity	3	1.1	35	11.1
Both	48	18.0	210	66.5
Setting of Evaluation				
Inpatient	167	60.3	113	35.8
Hospital Outpatient	0	0.0	22	7.0
Community	110	39.7	181	57.3
Education				
M.D. (Psychiatrist)	53	19.1	119	37.7
Ph.D. (Psychologist)	159	57.4	149	47.2
Other	65	23.5	48	15.2
Licensure Status				
Licensed	192	69.3	250	79.1
Unlicensed	82	29.6	50	15.8
Uncertain	3	1.1	16	5.1
Diplomate Status				
Yes	19	6.8	5	1.6
No	257	92.7	311	98.4
Uncertain	1	0.4	0	0.0

* The unit of analysis for this table is the forensic evaluation. Each evaluation is considered to be a separate data point, so "evaluator characteristics" reflect heavier weighting for clinicians performing multiple evaluations.

Table 2
Utilization Frequency of Third-Party Information in Forensic Evaluations, by Setting and State

	Florida (N = 277)		Virginia (N = 316)	
	N	%	N	%
Offense Information ^c				
Community (N = 291)	53	48.8	155 ^a	86.6
Hospital (N = 302)	160 ^b	95.8	91 ^{a,b}	67.9
Mental Health Records ^c				
Community	44	40.0	86	50.0
Hospital	144 ^b	86.2	46	34.6
Victim/Witness Statements ^c				
Community	2	1.8	61 ^a	35.7
Hospital	1	0.6	24 ^{a,b}	18.0

^a Within row chi-square comparison significant at $p < .01$.

^b Within column chi-square comparison significant at $p < .01$.

^c Overall chi-square comparison significant at $p < .01$.

Mental health records were utilized less frequently, although they were incorporated into 68 percent of Florida evaluations and 43 percent of Virginia evaluations. There was one exception: a

very high percentage of hospital evaluations in Florida (86.2%) included prior mental health data. These results suggested that information describing prior mental health history is sought with

some frequency by clinicians, but almost always used when it is highly accessible (as is the case in Florida forensic hospitals). Statements from victims or witnesses to the offense were utilized relatively infrequently in Virginia, with 36 percent of community evaluations and 18 percent of hospital evaluations incorporating this information. However, victim/witness statements were virtually uncited in Florida evaluations; only three of the total 277 evaluations used them. Even though the differences between states were significantly different for both settings, it would be accurate to conclude that in neither state was the use of victim/witness statements sufficiently frequent to describe their inclusion as normative practice.

Discussion

The study of forensic evaluations can provide a revealing profile of the practice of forensic assessment in a given state. Until fairly recently, maximum security hospitals were frequently used for preadjudication as well as postadjudication evaluations.¹⁶ In Virginia, the random sampling of preadjudication evaluations reflects the transition from hospital to community for such evaluations, with the majority now being performed in the community.

The data described in this study suggest several conclusions regarding the use of third-party information. First, the frequent use of offense information in forensic evaluations is encouraging because it is so important for inclusion in a thorough criminal forensic evaluation.⁴ There is also an "accessibility ef-

fect" that is readily apparent. In Florida, defendants adjudicated incompetent for trial are not admitted to a forensic hospital until an information packet, which includes the arrest report and the preadjudication forensic evaluations, is provided to the mental health department. Thus, any Florida hospital evaluator who did not use the arrest report simply failed to review information that was readily available. In Florida communities, by contrast, an evaluator must seek such information from the defense attorney and/or prosecutor, perhaps accounting for the least frequent usage of offense information seen in either state. Obtaining offense information as part of a forensic evaluation in Virginia is of intermediate difficulty. While the Commonwealth's Attorney (in a trial competency evaluation) or the attorney making the motion (in a sanity evaluation) is required by Virginia Code to provide the evaluator with information about the offense, this does not always occur and may require a follow-up request from the evaluator.

The same "accessibility effect" is even more apparent in Florida evaluators' use of mental health records. Information about previous mental health contacts or evaluations, which is readily available to hospital-based forensic evaluators, was used by a very high (86.2%) proportion of hospital clinicians in Florida. However, its utilization frequency dropped considerably (to 40%) in the community. Evaluations of sanity (but not trial competency) done in Virginia are facilitated by the provision of "available psychiatric, psychological, medical, or social records that are deemed rele-

vant" (Virginia Code 19.2-169.5) from the attorney making the motion. This should make access to this information somewhat easier for clinicians in Virginia; some 50 percent of Virginia community evaluations do incorporate these records. However, "accessibility" does not explain the puzzling (and disconcerting) finding that only 34.6 percent of hospital evaluators in Virginia reported using prior mental health information.

Finally, statements made by victims or witnesses, obtained either from documentation or direct interview by the clinician, were utilized relatively infrequently in Virginia but almost never in Florida. There may be two explanations for this. First, such statements are not routinely included in the information provided to Florida forensic hospitals before defendant's admission. Accessibility is therefore low, whether Florida clinicians are performing hospital- or community-based evaluations. Such accessibility may be higher in Virginia, where "transcripts of preliminary hearings, if any" are included in the materials to be provided to the clinician (Virginia Code 19.2-169.5). A second possible explanation for these findings is the higher proportion of evaluations in Virginia that addressed the issue of sanity may explain the greater need for information relevant to reconstruction of mental state at the time of the offense, and thus the more frequent use of direct observations of victims or witnesses.

It is also disconcerting that victim/witness statements, which are clearly relevant in certain kinds of forensic evalu-

ation, are collected less frequently than other data that are less relevant but more easily obtained. For example, community-based evaluators in Florida administered psychological tests such as the Draw a Person test (6% of cases) and the Wide Range Achievement Test in (6% of cases),¹⁴ but interviewed a victim or witness in only two percent of their evaluations. The limited contribution of these particular instruments,¹⁷ when contrasted with the potentially invaluable perceptions of those directly observing the defendant, should yield a very different pattern of use.

The present study suggests that some elements of third-party information—offense descriptions and mental health records—are incorporated fairly routinely into criminal forensic evaluations. The "accessibility effect" for such information can help to explain their utilization frequency in both hospital and community settings: the more readily available the information, the more likely that it will be incorporated into the forensic evaluation.

It is possible that some third-party information was sought by evaluators but never obtained. Alternatively, it may be that some evaluators in the present study did not fully appreciate the differences between forensic and "therapeutic" evaluation, and the associated need to treat information obtained in the former as constituting "hypotheses to be verified" through third-party information.^{4, 17} However, Virginia has provided training in forensic evaluation through the Institute of Law, Psychiatry, and Public Policy since the 1970s. Florida

has provided such training since 1986, delivered through the Florida Mental Health Institute. Since specialized training has been shown to improve the quality of forensic evaluations,^{16, 18} it seems quite possible that evaluators in the present study were more cognizant of the importance of third-party information in forensic evaluation than they would be in states without such training.

The comparisons between Florida and Virginia in this study must be considered with some caution because of the different methods of data collection. It is not clear whether direct rating of reports and evaluators' responses on a checklist will produce comparable results, and the present study does not address this question. It would be an important area for further investigation, however. Research comparing the results of indirect (clinician-reported) and direct (report rated) methods of characterizing forensic mental health evaluations can provide valuable information on the quality of forensic reports as well as the accuracy of self-reported information.

The need for further research in forensic assessment, particularly its normative characteristics and use of third-party information, is pressing. Empirical investigation has not kept pace with the conceptual advances and accelerated practice witnessed during the last decade. Further research should allow critics and advocates of forensic assessment to ground their arguments empirically, if they are so inclined.

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