Should Forensic Patients Be Informed of Evaluators' Opinions Prior to Trial?

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There are several articles in the literature that discuss the problems which occur when persons who have been evaluated by forensic clinicians hear the results of those evaluations for the first time in court. The authors agree that the scenarios presented are problematic but suggest that in many cases the problems can be avoided by sharing the information with the person prior to presenting it in court. They present several case examples to illustrate their point.

Although there is much literature concerning the role of the mental health expert witness, it chiefly addresses issues such as evaluation methodology, effective techniques of giving testimony, or the objectivity/impartiality of experts. As is unfortunately true of many facets of the interface between clinical and legal practice, there has been relatively little attention given to the subject of the evaluation except for abstract discussions about his or her rights. Because of court decisions which address disclosure of information to defendants undergoing evaluation[1] and a defendant's right to have an evaluation provided by the state,[2] there has recently been a greater focus on the relationship between evaluator and evaluatee at the beginning of the examination. A review of the literature, however, still reveals little discussion of the termination phase of the relationship. Because forensic evaluations are frequently discontinuous, particularly those involving competency to stand trial and civil commitment, where a series of evaluations may interrupt ongoing treatment, the way in which termination of the evaluation phase of the relationship is handled may have a significant effect on the treatment phase even if different clinicians are responsible for evaluation and treatment. It is on that termination phase of evaluation which we concentrate in this article.

Several authors have painted grim pictures of the problems which ensue when persons who have undergone forensic evaluations hear the results of the evaluations for the first time in court.[3,4] There have been suggestions that such

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persons be excluded from court when the opinions are presented in order to avoid unduly upsetting them or revealing information for which the person has not been properly prepared to hear. Unfortunately, such suggestions run afoul of the person's legal right to hear all the evidence in the case and have usually been rejected by courts even in cases where the person agrees to waive the right to be present. The previous discussions do not even deal with the common situation in which the report is read into the record and stipulated by both attorneys without any opportunity for the evaluator to explain the findings. We agree that the presentation of clinical material and conclusions in the context of an adversarial courtroom procedure can frequently be harmful clinically to persons who have been evaluated, but we feel that all the alternatives to such disclosure have not been adequately explored. An alternative which has been proposed by one of us,[5] but which has not been discussed in any detail, is to go over the opinion with the person at the time of the evaluation to allow him/her the opportunity to understand what will be said in court and the reasons for the conclusions before the information is presented formally.

Our inpatient Forensic Assessment Unit (FAU) is responsible for providing courts across the state with evaluations for competency to stand trial for male defendants. Wisconsin state law does not permit us to show the actual report to the defendant before it is presented in court.[6] But it has been the policy of the FAU staff to discuss the opinions generated from the evaluation with the defendant before he is returned to court. We present several case examples to illustrate potential advantages of such an approach.

Case 1

Mr. A was charged with two counts of sexual assault. On admission for competency evaluation, he demonstrated loose associations, very disorganized thinking, and said that he had been "tortured psychologically" by everyone at the jail, including his attorney. He said that he knew he was having difficulties in communicating and requested treatment for his problems. Past history revealed a number of psychiatric hospitalizations during which Mr. A had been treated effectively with antipsychotic medication. After the 15-day evaluation period, even after antipsychotic medications had been started at Mr. A's request, he was still sufficiently disorganized and paranoid for us to consider him clearly incompetent to stand trial; Mr. A was informed of our conclusions, and he fully agreed and renewed his request to remain at our facility for treatment. A report containing the opinion that Mr. A was presently incompetent, but could be expected to regain his competency with continued treatment, was sent to the court with copies to the prosecutor and defense attorney, as required by statute, and Mr. A was returned to the county jail to await the competency hearing. Subsequently, the senior author received a subpoena to testify in the hearing; such requests are unusual in our experience unless one of the attorneys has a significant disagreement with the opinion, which we felt to be unlikely in

this case. Contact with Mr. A's attorney revealed that neither he nor the prosecutor disputed the report but that Mr. A himself had requested oral testimony because he thought (as part of his delusional system) that his attorney believed he was not mentally ill and was in collusion with the prosecutor and judge to incarcerate him without treatment. Mr. A indicated at the hearing (at which he was found incompetent and returned to our facility for treatment without objection) that he trusted our staff to advocate for treatment because we had been open with him. On his return to the FAU for treatment to competency, he was appreciative of our support and was quite cooperative with treatment which ultimately resulted in his regaining competency.

Case 2

Mr. B was charged with two counts of armed false imprisonment. He was transferred to our facility for an evaluation for competency to stand trial after he had cut his wrists superficially in the jail. He had been diagnosed on several previous competency evaluations for other criminal charges as malingering to avoid prosecution. On admission, he reported that he was still suicidal; shortly thereafter he claimed to have swallowed two razor blades and a bottle of shampoo containing toxic amounts of zinc. Although there were strong suspicions that he had fabricated the story, he was sent to the emergency room of the university hospital for examination, where he quickly told the staff that he had lied about the suicide attempt. They x-rayed him and pumped his stomach anyway, confirming his recantation. On his return to our facility, he continued to claim to be suicidal until he was informed of the nature of suicide precautions on the unit, which at their most protective include restriction of the patient to the unit dayroom for better observation when not in his room and stripped, locked seclusion when in his room. He immediately experienced a full remission of his depression and claimed no more symptoms during his evaluation period although he remained uncooperative. Our opinion was that there were no indications of any mental incapacity which would cause Mr. B to be found incompetent. (State law at that time placed the burden of proof on the party seeking to establish incompetency; thus such an opinion, if not opposed, would in practice be determinative of competency.) When we shared this opinion with Mr. B, he became quite angry, told us that he had no intentions of being sent back to the jail, and promptly cut his wrists sufficiently to require another trip to the emergency room. After his return to our facility, we told Mr. B that his behavior would be interpreted to the court as yet another effort to delay or avoid prosecution and that continued "suicidal" behavior would not be credited. He quickly stopped acting depressed and was quiet and not disruptive at his competency hearing; after he was found competent, he cooperated fully with his attorney in his defense.

Case 3

Mr. C had been a chronic problem for both the police and the mental health agencies in his home county for years.

He suffered from attention deficit disorder, which had persisted from childhood, and from borderline personality disorder. He had again stopped taking his methylphenidate and was quite agitated and psychotic at the time of his first admission to our facility for evaluation of competency to stand trial on a burglary charge. After reinstitution of methylphenidate with the addition of fluphenazine for his transient psychosis, he gradually regained control over his impulses and was found competent to proceed. During his evaluation, we had shared our opinions of his progress toward competency with him on a regular basis and had told him before he returned to court that we were of the opinion that he was competent. He pled guilty to the burglary charge; while out on bail awaiting sentencing, he again stopped his prescribed medication, substituted a wide variety of street drugs including hallucinogens and was charged with another burglary. He was evaluated in his home county; as he was at the time of arrest very psychotic because of the drugs he had taken, he was found to be incompetent by a different judge than the one who had presided at his previous trial and sent back to our facility for treatment.

His psychosis had resolved even before his admission, as the street drugs had washed out of his system. We placed him back on methylphenidate, and he rapidly returned to his previous level of functioning. We again reported to the court that he had regained competency and again shared that opinion with Mr. C, but the second judge found him to be still incompetent without explanation (either to us or to Mr. C) and sent him back to our facility with instructions that Mr. C's competency would not be reviewed for another three months despite the fact that Wisconsin statutes require the trial judge to schedule a competency hearing as soon as the evaluating facility submits a report indicating that a defendant has been restored to competency.[7] That review was scheduled to be before yet another judge.

Mr. C was understandably confused and upset at this turn of events and was initially very disruptive on the unit, but as we continued to share our opinion that he was in fact as competent as he had been when the first judge found him to be so, he was quite reassured, feeling that at least *someone* in the system was on his side. We were eventually able to work with Mr. C's attorney to get the hearing moved up, and he was returned to court and ultimately released on probation. He contacted us after his release to thank us for "being straight" with him and helping him to get out of the hospital so that he could resolve the charges against him.

Discussion

Although a forensic evaluation does not automatically establish a formal therapist–patient relationship, it is often hard to convince the persons being evaluated that such is not the case.[8] In the case of inpatient competency evaluations, the roles of treater and evaluator are often necessarily combined because of externally imposed statutes or regulations[5,9,10] requiring the clinician to attempt to establish a therapeutic alliance. Forensic evaluations and subse-

quent treatment offer the opportunity to define the exact nature of the relationship at the outset, which is often not possible in purely clinical practice. This opportunity is frequently essential because (unlike private clinical practice) forensic clinicians are often placed in an adversary position with those they evaluate or treat.[8] It thus becomes even more important for clinicians to be as disclosing as possible with forensic patients. Even if the only contact is for evaluation, the precedent which is established may color treatment relationships with subsequent therapists.

It should be pointed out that most relationships with patients in forensic practice, even those involving treatment regarding competency to stand trial, tend to be relatively brief.[10] Thus we have not provided long-term follow-up on the patients presented above because our emphasis is on the effects of sharing forensic opinions on the relationship as it exists in the real world of forensic practice, where the majority of encounters are limited to a few evaluative sessions.

Even with psychotic defendants who can be treated involuntarily with medication, it is preferable both clinically and legally to secure cooperation with treatment in order to facilitate its continuation after return to court, as demonstrated in the case of Mr. A. In states which provide a right to refuse treatment for patients found incompetent to stand trial,[11] it becomes even more important to establish trust with such patients.

One important way to foster a therapeutic alliance is to be as open as possible with patients, especially in the adversarial context of a criminal forensic inpatient evaluation, where many defendants perceive the clinicians (not without reason) to be part of the state apparatus arrayed against them. As demonstrated with Mr. A and Mr. C, the therapeutic alliances which were established depended in part on our willingness to share our ongoing opinions of their competency with them throughout their evaluations; those alliances were important in convincing the patients to continue on the medication which helped to maintain their competency throughout the subsequent legal procedures. We have reported elsewhere[12] that sharing the medical records generated during hospitalization can be very useful in alleviating forensic patients' fantasies and paranoid fears about what is being said about them by staff. Even if they have access to the records after discharge (as is the case in Wisconsin and in a growing number of other states), proactively offering to share the records with them when the information is fresh and the staff that has done the charting is available to discuss its entries with patients is typically seen by patients as a good faith effort and is successful in the great majority of cases in defusing unnecessary tension and suspicion.

This principle can easily be extended to forensic opinions, which are clearly the part of the records which will have the most immediate impact on patients. Unlike the medical records, patients will usually hear those opinions whether they want to or not, and it makes sense to share the information before it is presented in the often hostile environment of a court with adversarial presentation

and cross-examination and without the opportunity for the patient to have what is being said about him clarified. As the majority of evaluations for competency to stand trial are presented without *viva voce* testimony by the evaluating clinician,[13] it is even more important in such cases to allow the patient a chance to hear and understand the opinions. The United States Supreme Court[1] has required that defendants be made aware of the purpose of forensic evaluations and also that defense attorneys be aware of forensic evaluations performed on their clients. Defense attorneys also usually (by law in Wisconsin for court-ordered evaluations) have access to the reports themselves prior to their entry into evidence. Even if legally authorized, as we have argued previously,[12] it makes little sense to share any part of a medical record, including forensic reports, with agents of a patient without giving the patient himself the same opportunity.

Judges who order competency evaluation expect more than a simple opinion on competency[14]; they also need predictions about how defendants will do after return to jail and court and how best to deal with their behavior in those settings. The defendant's reaction to the opinion itself may be important information for the evaluator to have in preparing such recommendations. For example, had Mr. B not been told the evaluator's opinion that he was competent while still at the hospital, he would probably have gone through his "suicidal" routine in court, as he had done in previous cases, resulting in another, unnecessary hospitalization for further evaluation. We have found that by sharing opinions with which patients strongly disagree, we can often help them to resolve their negative feelings before they return to court, forestalling unexpected and unnecessary disruptive courtroom behavior. And for those who remain angry, we can at least forewarn the attorneys and judge what to expect.

We do not argue that the results of forensic evaluations should *always* be shared with patients. As in other clinical situations, professional judgment must be exercised. We have at times refrained from sharing the results of our evaluations with defendants when our own opinions have been unclear and where such information would only serve to further confuse an already disorganized patient and thus complicate the task of treatment.

Competency evaluations are typically the simplest of forensic evaluations and usually require less extensive examination of past and family history than evaluations for criminal responsibility or psychic trauma. They therefore pose less danger of revealing information or conclusions which might be udnuly upsetting to patients.

In situations different from those under which our evaluations are carried out, different approaches may be necessary. Strasburger[15] has pointed out that in the case of private evaluations done at the request of the prosecution in criminal cases, or the adversarial attorney in civil cases, the requesting attorney may not want the evaluator's opinions shared with the person being evaluated in advance of trial for strategic reasons. In such situations, although the patient should clearly be told before the evalu-

ation for whom the evaluation is being done and the potential impact of any opinions resulting from the evaluation,[16] it may not be possible to provide disclosure of the final opinions to the patient. The development of a therapeutic alliance is usually less essential in such evaluations because the evaluator is rarely called upon to provide subsequent treatment. Therefore, loss of some of the benefits of disclosure that we have outlined above would be less important in these cases.

We suggest only that each patient be considered individually and that where it appears that no harm would ensue from disclosure and the opportunity for the patient to more fully understand the opinions and their bases, forensic clinicians strongly consider discussing with patients as much of their opinions and reasoning as possible.

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