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Mitigation Evaluations: A Survey of Current Practices

Michelle E. Barnett, Stanley L. Brodsky, & Tess M.S. Neal

The University of Alabama

Author Notes

Michelle E. Barnett, Stanley L. Brodsky, and Tess M.S. Neal, Department of Psychology, The University of Alabama. Michelle E. Barnett is now affiliated with the W.G. "Bill" Hefner VA Medical Center, Salisbury, North Carolina.

Correspondence concerning this article should be addressed to Stanley L. Brodsky at Department of Psychology, Box 870348, University of Alabama, Tuscaloosa, AL 35487-0348. E-mail: SB@UA.EDU

Abstract

This study examined the scope and components of mitigation assessments in a first effort to develop some guidelines for conducting mitigation evaluations. Using the Mitigation Evaluations Survey (MES) we developed for this research, we surveyed 266 psychologists about the characteristics and content of mitigation evaluations. A high percentage of participants endorsed each of the 14 content areas presented in the MES as essential or recommended for inclusion in mitigation evaluations. However, when the participants were given a hypothetical open-ended referral question regarding a mitigation evaluation, fewer participants included all 14 content areas in their responses. This discrepancy as well as information regarding the qualifications and expertise of the participants is discussed.

Mitigation Evaluations: A Survey of Current Practices

Mitigation evaluations occupy a unique position within psycholegal topics for several reasons. First, mitigation occurs solely in the sentencing phase of capital murder trials. Capital trials are divided into two separate parts: the guilt-determining phase, and if necessary, the sentencing phase. It is this sentencing phase that sets capital trials apart from other types of criminal and civil litigation, and within this sentencing phase mitigation testimony may become crucial. During the sentencing phase, the jury hears both aggravating and mitigating evidence regarding the case and the defendant, weighs that evidence, and recommends a sentence (Acker & Lanier, 1994).

A second unique element of mitigation work is that it involves a process that carries life or death implications. Jurors who hear the mitigating and aggravating arguments in the sentencing phase of capital trials must rely on that information to arrive at the life-or-death decision they are charged with making. Other psycholegal work psychologists perform (e.g., competency to stand trial, mental state, criminal responsibility) is not directly linked to potential death outcome options.

An additional unique element of mitigation work is the role mental health professionals (MHPs) assume. Decisions regarding the investigation of the case and defendant for potential mitigating circumstances, the selection of mitigation evidence to be presented, and the specific content and depth to which the mitigating factors and circumstances are introduced are ultimately the responsibility of the legal personnel in charge of the defense. However, anecdotal reports indicate that with mitigation evaluations and subsequent mitigation testimony, a principal part of the information gathering, analyzing, conceptualization, and presentation is planned and conducted by mental health experts (Barnett, Brodsky, & Davis, 2004; Schroeder, Guin, Pogue,

& Bordelon, 2006). The broad role mental health experts often assume in mitigation may be due in part to the psychological and biopsychosocial nature of much mitigation evidence; for example, mitigation evidence may range from an overview of a defendant's general upbringing to extensive, detailed, and thorough social histories to specific psychological assessments with associated diagnoses (Connell, 2003). Due to the extensive and nonspecific nature of many mitigating factors and circumstances as well as the nature of capital trials, attorneys may be less able to define the referral question or the exact role for which they have retained the mental health expert during mitigation, in comparison to other psycholegal issues (Connell, 2003; Schroeder, Guin, Pogue, & Bordelon, 2006).

Definition of Mitigating Factors

The legally mandated consideration of mitigating factors, or those factors presented during sentencing that argue for a sentence less than death, was asserted in the 1972 Supreme Court decision in *Furman v. Georgia*, in which the justices addressed the problem of arbitrary and unfair application of the death penalty. The Court's decision in *Lockett v. Ohio* (1978) broadened the requirements set forth in *Furman* (1972) by clarifying the importance of including mitigation factors other than those specifically listed as statutory variables. *Lockett* (1978) specified that "the Eighth and Fourteenth Amendments require that the sentencer, in all but the rarest of capital cases, not be precluded from considering, as a mitigating factor, any aspect of a defendant's character or record and any of the circumstances of the offense that the defendant proffers as a basis for a sentence less than death" (438 U.S., at 604, 98 S.Ct., at 2965. p. 642.). Additional case law lends support to the *Lockett* decision regarding the consideration of mitigating evidence as well as the specific nature and content of such evidence. The case law outlined in *Lockett* (1978), in *Eddings v. Oklahoma* (1982), in *Williams v. Taylor* (2000), and in

Wiggins v. Smith (2003) confirms the necessity of presenting mitigating evidence, especially non-statutory and psychosocial mitigating factors.

Haney (1995) more fully explained the purpose and scope of mitigating factors by stating, "it is important to emphasize that mitigating evidence…is *not* intended to excuse, justify, or diminish the significance of what they [defendants] have done, but to help explain it, and explain it in a way that has some relevance to the decisions capital jurors must make about sentencing" (p. 560, emphasis in original). Mitigating factors may be statutory (e.g., absence of criminal history, victim consented or was a participant in act, defendant acted under extreme duress or domination, defendant's age at the time of the crime), but are more often of a nonstatutory nature (Acker & Lanier, 1994; American Bar Association, 1994; Domozick, 1983; McPherson, 1995). Nonstatutory mitigating factors are those that are relevant under *Lockett's* (1978) decision that any other relevant influences may be proffered and typically include such circumstances as a defendant's history of mental illness, current emotional disturbance, intellectual impairment, history of childhood abuse or neglect, history of brain injury with neurological impairment, intoxication at time of the offense, or alcohol or drug dependence. It is most often these nonstatutory mitigating factors that mental health experts are called upon to evaluate (Connell, 2003).

Psychological and Biopsychosocial Mitigation Evidence

Mitigation testimony plays an important role within the sentencing phase of capital trials; however, limited empirical evidence exists to address the effectiveness of the presentation of biopsychosocial factors. While theoretical and opinion-based articles have addressed the necessity of effective presentation of such evidence in capital trials, only a handful of empirical studies have investigated the effect on sentencing decisions. The research that has been done

appears to indicate that psychological and psychosocial testimony is frequently applied by jurors as mitigating evidence (Luginbuhl & Middendorf, 1988; McPherson, 1995; Suggs & Berman, 1979; White, 1987). However, research also indicates that jurors occasionally apply psychological and psychosocial testimony presented during mitigation as aggravating evidence (Ellsworth, Bukaty, Cowan, & Thompson, 1984; Schroeder, Guin, Pogue, & Bordelon, 2006). It generally appears that jurors consider and apply circumstances that are perceived to be less controllable by the defendant (e.g., history of childhood physical or sexual abuse, mental retardation, mental illness, extreme emotional distress, age, or history of head injury) as mitigating evidence, while they consider and apply circumstances that are perceived to be more volitional or representative of characterological flaws (e.g., alcohol/drug intoxication, alcohol/drug dependence) as aggravating evidence (Barnett, Brodsky, & Davis, 2004; Barnett, Brodsky, & Price, 2004; Barnett, Brodsky, & Price, 2007).

It is difficult to draw firm conclusions about the effectiveness of specific psychological and psychosocial mitigating circumstances without considering the larger context of capital trials. The jurors who must consider such circumstances have usually participated in the guilt finding phase of the trial, during which they have been exposed to the crime and its impact on victims, considered disturbing evidence, and have little understanding of the defendant except that he perpetrated the horrible crime they considered throughout the trial. These same jurors who develop pre-existing negative feelings toward the defendant during the guilt phase then move to the sentencing phase and must consider and weigh both aggravating and mitigating circumstances when making a sentencing recommendation.

Retaining Mental Health Experts for Mitigation

Mental health experts often fulfill a central role in the mitigation process. This centrality may occur for several reasons. First, much mitigation evidence, especially nonstatutory factors, is psychological or biopsychosocial in nature. Therefore, it would make sense that the gathering and presenting of this evidence would be most appropriately done by mental health experts (Fabian, 2003; Stettler, 1999; Tomes, 1997). These experts are trained in the study of human development, etiology and effects of mental disorders, intellectual impairment, traumatic injury, abuse, and other environmental factors and situations affecting a person's functioning.

Second, the potentially extensive array of mitigating factors, combined with the individual nature of each capital trial and each defendant, may benefit from a professionally trained expert. The training of mental health experts may allow them to combine and analyze many pieces of information relating to the defendant, his or her history, and the individual trial with the goal of developing a cohesive and evidence-based set of conclusions (Connell, 2006; Fabian, 2003; McCoy, 1999; Norton, 1992; Stebbins & Kenney, 1986; Stettler, 1999; Tomes, 1997). Third, defense attorneys are trained to hire appropriate experts, particularly for capital cases. The American Bar Association's (2003) Guidelines for the Appointment and Performance of Defense Counsel in Death Penalty Cases requires that, "Counsel must promptly obtain the investigative resources necessary to prepare for both phases, including at minimum the assistance of a professional investigator and a mitigation specialist, as well as all professional expertise appropriate to the case" (p. 925).

Purpose and Scope of Mitigation Evaluations by Mental Health Experts

Mitigation evaluations are more poorly structured than other types of psycholegal evaluations (see Borum & Grisso, 1995; Borum & Grisso, 1996; Heilbrun, 2001; Melton, Petrila,

Poythress, & Slobogin, 2007; Ryba, Cooper, & Zapf, 2003; Zapf, Boccaccini, & Brodsky, 2003). Many questions can be raised about the quantity and quality of mitigation evaluations conducted by mental health experts: What types of mental health experts are conducting these evaluations (e.g., clinical psychologists, psychiatrists, social workers)? How often are they asked and how often do they accept such a referral? How much experience do they have in conducting mitigation evaluations? What mitigating factors should be considered in such evaluations? What psychological and biopsychosocial factors are actually included in mitigation evaluations? Should specific psychological assessments such as intelligence testing, cognitive functioning, neuropsychological batteries, personality assessments, trauma inventories, and malingering tests be conducted routinely? Should structured interviews be given for diagnostic purposes? Should results from prior psychological evaluations be integrated and included? Should academic records and school achievement scores be included? Should interviews with family members and relatives and other collateral information be included? Should a family genogram be developed? Should causal explanations be included? What elements of mitigation evaluations are essential, recommended, or merely optional for inclusion in a report or testimony?

No specific or consistent guidelines for mitigation evaluations currently exist among capital defense attorneys or mental health professionals who conduct mitigation evaluations (Cunningham & Reidy, 2001; Liebert & Foster, 1994; Marczyk, Heilbrun, DeMatteo, & Bell, 2003). The lack of a clearly defined purpose and scope for mitigation evaluations and for the role of mental health experts within this context may be due to a variety of factors. These factors may range from the variability of potentially mitigating factors in individual capital cases, to a vague and underdefined referral question from a defense attorney, and further to a generally diffuse understanding of what should be considered mitigating evidence given the U. S. Supreme

Court's broad definition of the concept (*Lockett*, 1978). However, given that clinical evaluations are conducted by mental health experts for other psycholegal issues using specific guidelines and purposes, one may reasonably conclude that the potential exists for specific guidelines in mitigation evaluations and testimony.

Goals of the Current Study

Understanding the scope and fundamental components of mitigation assessments is a necessary antecedent to conducting the assessments. It is important to know what content areas and psychological and biopsychosocial factors are addressed in mitigation assessments, as well as who is conducting them. Acquisition of this knowledge base would allow mental health experts to develop an organizing scheme for mitigation evaluations and provide them with content areas about which they would most likely testify. An organized scheme for mitigation evaluations could benefit the defense attorneys who make mitigation evaluation referrals and retain mitigation experts. It would provide attorneys with a clearer picture of what psychological and biopsychosocial evidence typically is or is not provided within a mitigation evaluation.

Specific guidelines may prove useful to mental health professionals conducting such evaluations because it would allow them to approach vague and underdefined referral questions with a clear organizational plan in mind. An organized and thorough evaluation would potentially lead to more effective expert testimony. Although initial data indicate certain types of psychological and biopsychosocial factors are considered to be mitigating, it is difficult to draw firm conclusions due to the lack of knowledge of the factors addressed in mitigation evaluations and testimony. Knowledge of the fundamental components of mitigation assessments and testimony may allow researchers to conduct investigations into the relations between the presentation of biopsychosocial mitigating factors in a defendant's history and the effects of

these factors on sentencing outcome. One of the goals of this study was to elucidate some preliminary standard of practice guidelines for MHPs conducting mitigation evaluations based on the results of our survey.

Specific hypothesis testing was the final goal of this study. Our first hypothesis was that a majority of psychologists who conduct mitigation evaluations will not report utilizing a standard protocol when conducting mitigation evaluations. Our second hypothesis was that, in comparison to the number of items rated as essential or recommended on the MES, psychologists will list fewer procedures and content areas when given a hypothetical open-ended referral question for a mitigation evaluation. Our third hypothesis was that psychologists who report more experience with forensic evaluations and mitigation evaluations will indicate that it is essential or recommended to include a greater number of procedures and content areas when conducting mitigation evaluations than psychologists who report less experience.

Method

Materials

Mitigation Evaluations Survey (MES). The MES was modeled after the surveys conducted by Borum & Grisso (1995, 1996) and Ryba, Cooper, & Zapf (2003). These surveys assessed usage of psychological tests and standards for report writing for competency to stand trial reports and mental state at time of offense reports. Borum & Grisso surveyed psychiatrists and psychologists, and Ryba, Cooper & Zapf surveyed psychologists only. There was considerable overlap in item content between these surveys and the MES, with items such as mental status evaluation and substance abuse history included in all three surveys.

The survey took approximately 15 minutes to complete. The purpose of the survey was to assess the characteristics and content of mitigation evaluations as well as the qualifications and

experience of psychologists conducting mitigation evaluations. Because anecdotal evidence and the mitigation literature suggest psychologists are among the primary MHPs responsible for conducting mitigation evaluations, psychologists appeared to be the appropriate target population for the current survey.

The first section of the survey presented a referral question for a mitigation evaluation to the psychologist completing the survey. The psychologist was asked to read the referral information and list or briefly describe assessment techniques s/he would use for the evaluation and content areas s/he would covered within the evaluation. Specifically, the open-ended referral question was:

> Joe Smith has been referred to you for a mitigation evaluation. Joe has been found guilty of capital murder and his attorney believes there may be potential mitigating circumstances in Joe's background that could be presented during the upcoming sentencing phase of the trial. The attorney has retained you as a mental health expert to evaluate Joe; you may need to testify about your findings during sentencing. The attorney provided you with the following information: Reportedly, Joe (age 33) had a hard childhood and was raised in a rough home environment. He received poor grades and dropped out at the end of 9th grade. Joe has never held a full-time job, but he has maintained periods of steady part-time employment at a service station. Joe told his attorney that he has been psychiatrically hospitalized twice.

The remainder of the survey (second and third sections) was modeled from surveys found in the forensic assessment literature. These surveys investigated psychological test usage and the establishment of standards for report writing in competency to stand trial and criminal responsibility evaluations (Borum & Grisso, 1995, 1996; Ryba et al., 2003).

The second section of the MES consisted of demographic questions regarding the respondents' age, gender, ethnicity, location, profession, educational background, years in practice, experience conducting forensic evaluations, and experience conducting mitigation evaluations. In the third section of the survey, respondents were asked to rate 14 items according to each item's perceived importance in mitigation evaluations. On the survey, each item was listed in a bold font followed by a description. Respondents were asked to rate each item as follows:

(E) Essential: Must be included; Exclusion would be unacceptable

(R) Recommended: Not essential, but would be found in better mitigation evaluations

(O) Optional: Inclusion would not affect overall quality of mitigation evaluations

(C) Contraindicated: Inclusion would negatively affect quality of mitigation evaluations.

Participants

Psychologists. The Mitigation Evaluations Survey (MES) was sent to a subset of members of the American Psychological Association (APA) through the use of the mailing label service available through the APA Research Office. The mailing label service required the investigator specify a major field of interest (we chose Clinical Psychology), specify additional areas of interest (Forensic Psychology and Psychology & Law), and request a specific sample size (up to N = 2,000). This request resulted in a complete roster of the 1,295 APA members who identified these major field and interest areas when submitting their yearly membership information.

Of the 1,295 mailed surveys, 266 complete or partially complete surveys were returned for a response rate of 20.5%. The participants were 65% male and 34% female and ranged in age from 30 to 72 years with a mean age of 53.5 (SD = 8.3). The sample was predominantly

Caucasian (93%) with the remaining participants reporting their ethnicity as Hispanic (2.6%), American Indian/Alaskan Native (1.1%), African American (0.8%), Asian (0.4%), and Other (2.1%). The highest academic degrees held by participants were Ph.D. (80%), Psy.D. (13%), Ph.D./J.D. (3.2%), Ed.D. (3.2%), and M.A. (0.6%). Participants reported practicing in 45 states and the District of Columbia (excluding Alaska, Mississippi, Montana, New Hampshire, and South Dakota). Although participants noted a variety of areas of specialization or additional credentialing, 30 participants (9%) specifically reported certification by the American Board of Professional Psychology (ABPP).

Several questions were asked about the experience level and expertise of the participants. The responses suggested the participants surveyed represent a diverse group of practitioners, especially in regard to mitigation evaluations. The participants had an average of 17 years of forensic evaluation experience and 10 years of experience conducting mitigation evaluations. The participants indicated that on average 49% of their practice was devoted to forensic evaluations and approximately 8% of their practice involved mitigation evaluations. On average, the participants reported having conducted five mitigation evaluations in the past year and 51 mitigation evaluations over the course of their career. It was noted that 30% of participants reported never having conducted a mitigation evaluation. These data surely reflect, at least in part, participants practicing in some states that do not have the death penalty.

Given the sizable portion of participants who indicated little or no experience with mitigation evaluations, the questions regarding experience level and expertise were re-analyzed after separating those who indicated they had conducted a number of mitigation evaluations in their career (at least five) from those who indicated they had never conducted a mitigation evaluation. Those participants possessing experience with mitigation evaluations reported

practicing five years longer (M = 24.4) than those reporting no experience with mitigation evaluations (M = 19.7), t (143) = 8.46, $p < .001$. Mitigation-experienced participants indicated more experience in forensic evaluations (M = 19.9 years) than those reporting no experience (M = 13.2 years), t (144) = 10.5, $p < .001$, and mitigation-experienced participants also indicated a greater percent of their practice was committed to forensic evaluations (M = 55.89%) than those reporting no experience (M = 37.96%), t (145) = 6.00, $p < .001$.

Procedure

The MES was accompanied by: 1) a cover letter detailing the purpose of the study, documenting IRB approval, assuring anonymity in participation, and providing the investigator's contact information; 2) a pre-addressed and stamped return envelope; and 3) a form indicating that the investigator would donate $2.00 to one of three listed organizations of the respondent's choice (The Susan G. Komen Breast Cancer Foundation; Habitat for Humanity International; UNICEF) should the respondent return a completed survey form. This form also provided a section for the respondent to provide his/her contact information should he/she want a summary of the results upon the completion of the project. Three weeks after initially mailing the survey, the participants were sent a postcard reminder to complete and return the survey.

Results

The first purpose of the study was to estimate the characteristics and content of mitigation evaluations as well as the qualifications and experience of psychologists conducting such evaluations. Results from the MES indicated a high percentage of participants endorsed each of the 14 content areas as essential or recommended for inclusion in a mitigation evaluation (see Table 1). Twelve of the 14 content areas were endorsed as essential or recommended by greater than 80% of participants and the remaining three areas (i.e., collateral interviews with other

informants, neuropsychological testing, and causal explanation) were so endorsed by 74%, 63%, and 75% of the participants, respectively. It is notable that 13 of the 14 content areas were rated as contraindicated by almost none of the participants; however, 7.9% of participants rated causal explanation as contraindicated.

The results were further examined after separating those participants who reported experience conducting mitigation evaluations (n = 145) from those who reported no mitigation evaluation experience (n = 106). The "experienced" participants (those who had done at least 5 evaluations) endorsed 12 of the 14 content areas as essential or recommended at a significantly greater rate than the "no experience" participants (one-tailed binomial tests, $p < .01$). Two of the content areas (i.e., collateral interviews with others and neuropsychological testing) had no significant difference in endorsement rate between the "experienced" versus "no experience" participants, (one-tailed binomial tests, $p > .01$).

To analyze the qualitative responses provided in the survey, the investigators categorized each of the responses into one of the 14 content areas of the survey. If a response from the open-ended referral question did not fit into any of the 14 content areas, it was placed in the "Other" category. The categorization process was completed by the first author. The 14 content areas were well-defined (see Table 1) and decisions about what content area a response fell into were straightforward (e.g., substance abuse history, neuropsychological testing, etc.). If a response did not clearly fit into one of the 13 defined content areas, it was categorized in the "other" content area which was the 14th category.

The percentage of participants indicating inclusion of each content area was calculated. In contrast to the results from the third section of the survey, results from the open-ended referral question indicated a lower number of participants who included the various content areas in their

response (see Table 1). Many participants provided assessment techniques or content areas that were placed in the "Other" category. The most frequently occurring of these responses were the following: interview/clinical interview (49.2%), social history (32.0%), record review (27.1%), malingering assessment (19.9%), and obtaining collateral information (13.9%). Some of the "Other" responses appeared to bridge multiple *a priori* categories and in a few cases it unclear whether they should be included or excluded from the 14 main categories.

The results from the open-ended referral section were also examined after separating those participants who reported experience conducting mitigation evaluations (n = 145) from those participants who reported no experience conducting mitigation evaluations (n = 103) (see Table 2). A total of eight content areas were included by the "experienced" participants significantly more often (one-tailed binomial tests, $p < .01$) than the "no experience" participants: review of criminal/police records, medical history, substance abuse history, collateral interviews with family, collateral interviews with others, intellectual/ cognitive testing, neuropsychological testing, and personality/emotional functioning assessment.

We also analyzed the data to assess our three *a priori* hypotheses. The first hypothesis, that a majority of psychologists conducting mitigation evaluations would report not utilizing a standard protocol for these evaluations, was not supported. The majority (55.5%) of participants who indicated having experience conducting mitigation evaluations reported they do utilize a standard protocol when conducting mitigation evaluations.

Our second hypothesis, that psychologists would generate fewer procedures and content areas when given an open-ended referral in comparison to the number of items rated as essential or recommended in a list form on the MES, was supported. We categorized each of the qualitative responses into one of the 14 content areas listed. If a response from did not fit into

any of the 14 content areas, it was placed in the "Other" category. The percentage of participants indicating inclusion of each content area was calculated. These percentages were compared to the percentage of participants who indicated a content area was essential or recommended in the third section of the survey. For all 14 content areas, a higher percentage of participants indicated the content area was recommended or essential as compared to the percentage of participants who included the content area when given an open-ended referral question. This result holds true for the group of participants who reported experience conducting mitigation evaluations and the group of participants who reported no experience conducting mitigation evaluations.

The third hypothesis was not supported. We predicted that psychologists reporting more experience with forensic evaluations and mitigation evaluations would indicate it was essential or recommended to include a greater number of procedures and content areas when conducting mitigation evaluations than would psychologists who reported less experience with forensic and mitigation evaluations. A multiple linear regression was conducted to test this hypothesis, with number of content areas rated as essential or recommended as the dependent variable. The independent variables include years of experience in forensic evaluations, years of experience in mitigation evaluations, and number of mitigation evaluations conducted. The overall model was not able to account for a significant amount of the variance in the dependent variable, $F(3, 223) = 8.83$, $p = 0.39$, $R^2 = .014$. A large majority of participants (both those with and without experience conducting mitigation evaluations) indicated it was essential or recommended to include all the content areas presented in the MES.

Discussion

Scope and Fundamental Components of Mitigation Assessments

One noteworthy result is the high percentage of participants who endorsed each of the 14 content areas presented in the survey as essential or recommended for inclusion in mitigation evaluations. All of the content areas were endorsed as essential or recommended by at least 65% of participants; 12 of the 14 content areas were endorsed as essential or recommended by greater than 80% of participants. Although it is possible this high level of endorsement reflects an acquiescence response set, the last six content areas received the lowest endorsement from participants, which suggests participants were thoughtfully responding to the survey items.

Fewer participants included the 14 content areas in their responses when given a hypothetical open-ended referral question regarding the techniques and content areas they would use in a mitigation evaluation. Eleven of the content areas were listed by many participants with two content areas (i.e., intellectual/cognitive testing and personality/emotional functioning assessment) included at slightly greater rates and one area (i.e., causal explanation) included by far fewer participants. This finding indicates a discrepancy between the content areas participants believe should be covered in a mitigation evaluation and the content areas participants might actually include if conducting a mitigation evaluation. Although these findings indicate a discrepancy between “should” and “would” include in a mitigation assessment, the finding is consistent with what would be expected based on memory; that is, that the recognition-based task elicited higher rates of endorsement than did the recall-based task (Ebbinghaus, 1913).

The two content areas with the smallest discrepancy between the open-ended referral section and the list of content areas in the third section of the survey are broad (i.e., intellectual/cognitive testing and personality/emotional functioning assessment). This finding

suggests participants may have included general techniques with which they were familiar in their responses. For another content area (i.e., causal explanation), the discrepancy is larger. It is likely many participants did not include this area in response to the open-ended referral question because it is not typically assessed with general clinical techniques (e.g., a clinical interview, record review, etc.) or a specific psychometric test. It appears participants find it important to include a causal explanation in a mitigation evaluation; however, they did not spontaneously suggest this type of explanation should occur during the evaluation proper. Conclusions about causal explanations may be drawn in a written report, communicated during verbal feedback with the attorney, or presented during mitigation testimony (Heilbrun, 2001; Melton et al., 2007).

Few participants rated any of the 14 content areas presented as contraindicated. However, 7.4% of participants rated causal explanation as contraindicated. It needs to be remembered that one of the major theoretical purposes of presenting mitigating factors during sentencing is to help explain to jurors in a relevant and contextual way what the defendant has done and how the mitigating factors relate to sentencing (Haney, 1995). Written comments by several participants provided insight into this puzzling finding. Several participants noted they would not provide a *causal* explanation as to why any particular defendant committed a particular crime, but would provide a general, contextual framework of how such an event might have occurred. One participant noted he/she would not want to be in the position of having to provide testimony regarding a *causal* explanation, when no one could be absolutely certain of why any particular defendant committed any particular crime. Replacing the phrase "causal explanation" with "explanatory framework" or "contextual explanation" is suggested for future research.

A different explanation for this finding was provided by an insightful reviewer of this article. The reviewer noted that a causal explanation can only be given where the defendant is

admitting to at least some activity in connection with the crime. However, it is not uncommon for evaluations to be conducted with defendants who consistently claim innocence. It may not be possible for the psychologist to provide a causal explanation unless s/he accepts the jury verdict over the defendant's ongoing protests. This reviewer suggested causal explanation therefore is not an element which invariably ought to be present, but one that should be essayed on a discretionary basis and presented in some cases. It may be appropriate for psychologists to report that the defendant maintained his/her innocence, acknowledge the jury's decision, and indicate the importance for the jury to consider certain relevant factors in coming to their sentencing decision. Some factors may be presented as hypothetical in that they may both explain aspects of the defendant's behavior, presuming the accuracy of the verdict but simultaneously acknowledging the ongoing protest of innocence. The use of discretion in deciding whether to address the complex issue of causal explanation is important in this work.

In addition to determining what content areas and biopsychosocial factors are addressed in mitigation evaluations, this project sought to investigate the qualifications and expertise of psychologists conducting such evaluations. A sizable portion of participants indicated little or no experience. This result is not surprising because mitigation evaluations represent a circumscribed area within the broader field of forensic assessment and the general field of clinical assessment. Given the specific nature of mitigation evaluations, it was not expected that all individuals with forensic interests would have experience conducting mitigation evaluations.

The participants who indicated experience conducting mitigation evaluations also reported significantly more years practicing, more years of experience in forensic evaluations, and a higher percent of practice currently committed to forensic evaluation than participants who reported no experience conducting mitigation evaluations. These results indicate practitioners

tend not to receive mitigation evaluation referrals until their practice is well-established or that less experienced practitioners turn down such referrals, possibly due to a lack of experience or training associated with mitigation evaluations.

Participants with mitigation evaluation experience tended to include more of the 14 content areas and more frequently endorsed the 14 content areas as essential or recommended than those without experience. It is possible that participants with experience recalled specific mitigation evaluations they conducted and used those experiences to shape their responses. Participants without experience would have no direct experience on which to base their responses, which may have resulted in less complete responses. It is also likely that participants with experience would have acquired more factual and academic knowledge regarding conducting mitigations evaluations than those with no experience.

Psychologists' lack of experience conducting mitigation evaluations or a lack of interest in such work might have contributed to the low response rates (20.5%). Previous research regarding mail surveys has indicated that a typical response rate is around 30% (Morrison, Thomson, & Petticrew, 2003) and response rates vary widely from 21-78% (Erwin, 2002; Kittleson, 1995). Therefore, in the context of other mail survey research, the response rates obtained for this study do not appear abnormally low.

Towards Guidelines for Conducting Mitigation Evaluations

In addition to the rationale provided in the introduction, the study provides several additional reasons why it might be beneficial to establish a set of guidelines for mitigation evaluations. First, a discrepancy exists between what psychologists indicate should be included in a mitigation evaluation and the content areas they include when given a hypothetical open-ended referral question. A set of guidelines for conducting mitigation evaluations should assist in

closing the potential gap between suggested and actual clinical practice. Second, a set of guidelines for conducting mitigation evaluations may help ensure mental health experts are conducting thorough evaluations and subsequently testifying about relevant content areas. In a similar vein, a set of guidelines may assist mental health experts in explaining relevant content areas in mitigation testimony to the retaining attorneys. Third, a sizable portion of the participants indicated they have never conducted a mitigation evaluation. A set of working guidelines for conducting mitigation evaluations would be especially beneficial to those professionals who have no previous experience performing this type of evaluation. Finally, a significant portion (45.5%) of participants indicated they do not use a standard protocol when conducting mitigation evaluations. It is likely that some of these professionals do not use a standard protocol simply because no such protocol or standard guidelines currently exist within forensic assessment literature (Cunningham & Reidy, 2001; Marczyk et al., 2003).

A preliminary set of guidelines for conducting mitigation evaluations derived from the empirical information collected is presented below. These guidelines are not intended to represent a final product, but rather to open for discussion the essential issues to be considered in preparing mitigation guidelines.

Guideline 1: Psychologists conducting a mitigation evaluation should consider and/or evaluate each of the 14 content areas presented in the MES. A high percentage of participants endorsed each of the 14 content areas presented in the MES as essential or recommended for inclusion in a mitigation evaluation. These guidelines are also consistent with written comments provided by participants who indicated they include “everything I can think of” or utilize “a kitchen sink approach” when conducting mitigation evaluations. It is also important to note that with the exception of “causal explanation,” none of the content areas were

rated as contraindicated by a notable number of participants. Possible reasons for this finding have been discussed, and it is recommended that in the future this content area be referred to as "explanatory framework" or "contextual explanation."

Particular attention also appears warranted for the three content areas (i.e., intellectual/ cognitive testing, neuropsychological testing, and assessment of personality/emotional functioning) that involve specialized psychological assessment and specific psychometric tests. In completing the MES, several participants noted they would include the three aforementioned content areas "if necessary" or "as clinically indicated." As with any type of evaluation, it is important that psychologists conducting mitigation evaluations consider the necessity of including these three content areas. In many cases, specialized assessment or psychometric testing might be warranted; however, such testing should not automatically be conducted.

To reiterate this final point: it is essential that the assessment process and the gathering of data in mitigation evaluations is case-driven and must reflect the unique aspects of each situation. Evaluators should consider each of the 14 MES content areas to be sure they do not inadvertently leave something out of consideration; however, we do not mean to imply that all 14 content areas are necessary for inclusion. Rather, we hope psychologists consider and discard any content area that would not make sense in the particular case in which they are working. Flexibility in terms of determining what information is available and relevant is a necessary skill for practitioners doing this kind of work.

Guideline 2: Psychologists should conduct a thorough clinical interview with the defendant, obtain a detailed social history, and perform a comprehensive review of available records when conducting mitigation evaluations. As indicated by the results from the MES, use of these three techniques will provide much of the information necessary to

evaluate the 14 content areas included in the MES. These techniques should also assist the MHP in making relevant decisions regarding the need for specialized assessment or specific psychometric testing. It is also possible these techniques will lead the psychologist or other MHP to important family members, friends, or other informants who can serve as collateral contacts.

Guideline 3: Psychologists should evaluate the need to include any additional content areas or assessment techniques. Clinicians may find assessments of adaptive functioning or malingering are warranted. In other cases, it may be useful to complete a family genogram or explore additional content areas such as military history or general social functioning. On occasion, psychologists may wish to obtain professional consultations, such as a referral for a neurological examination or medical neuroimaging.

The three guidelines above are an initial attempt to provide a set of guidelines for conducting mitigation evaluations. Therefore, it is important to recognize they are preliminary guidelines and should be revised, improved, and corrected in a manner consistent with the findings of future research and implementation in clinical practice. Furthermore, much of the family history and background is often obtained by social workers, and the process of developing guidelines certainly calls for collaboration with our fellow professionals.

Future Research on the Effectiveness of Mitigation Assessments

The current project was designed to provide an empirical basis regarding the scope and components of mitigation evaluations. This study has several strengths, including a large sample size for survey research (266 participants), recruited from a list of all APA members who indicated interest or expertise in forensic psychology. Previous research with both APA members and those who are not APA members indicate APA membership is representative of all doctoral-level clinicians with respect to demographic characteristics, education, and employment

(Center for Mental Health Services, 1996; Howard et al., 1986, Stapp, Tucker, & VandenBos, 1985). Stapp, Tucker, and VandenBos concluded that the APA membership database is sufficiently representative of licensed clinicians to use the member database for policy research.

Although the study has several strengths, there are also limitations. For example, we cannot be certain that our sample of respondents is fully representative of the larger population of mental health professionals who conduct capital mitigation assessments. A second potential limitation is that we developed the MES specifically for this study; and therefore there is limited information available to evaluate the quality of the MES as a measurement tool. Future research that builds upon this foundational study may work to further develop or validate the MES.

A third limitation is that the method this study used was able to deduce standards of practice, but not necessarily "best practice" guidelines. Ideally, the field will move toward developing "best practice" guidelines for work in this area; however, the first step we took was to gather information about widespread standards of practice in mitigation evaluations and derive some basic standard guidelines for practitioners in this area. Standards of practice are the prevailing ways of approaching assessments, but that does not necessarily mean they are the *best* practices. Future work should look toward devising best practice guidelines for practitioners who conduct mitigation assessments in capital trials.

Future research investigating mitigation evaluations might focus on testing and revising the working guidelines presented in this discussion. For example, inquiry could investigate the utility of including each of the 14 content areas when conducting a mitigation evaluation, the necessity of using all three suggested techniques (i.e., clinical interview, social history, and record review), and the need to include additional content areas or assessment strategies. Future work could also look to transcripts from existing mitigation testimony to compile information

about standards of practice in mitigation testimony, which would complement the findings of this study. Finally, it would also be useful to assemble a task force of MHPs who possess expertise and professional involvement specific to mitigation evaluations and forensic assessment. The task force could assist in further developing the proposed set of working guidelines into a "gold standard" for conducting mitigation evaluations.

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Table 1

*Participants (*N*=266) Indicating Content Areas in the Open-Ended Referral Section (Part I) and % of Content Areas Rated Essential, Recommended, Optional, or Contraindicated in Part III*

	Part I	Part III (%)			
Content Area	%	E	R	O	C
Review of criminal records	45.5	83.5	6.8	0.8	1.1
Current mental status	27.1	80.1	11.3	0.8	0.4
Medical history	39.5	77.8	13.5	0.8	0.0
Mental health history	54.5	91.0	1.5	0.0	0.0
Academic history	50.0	65.0	24.8	1.5	0.0
Employment history	32.0	57.9	32.0	1.5	0.0
Substance abuse history	39.1	82.3	9.4	0.4	0.0
Developmental/Family history	53.0	73.7	18.0	0.4	0.0
Collateral interviews w/ family	28.2	40.2	42.5	8.6	0.4
Collateral interviews w/ others	24.8	31.2	42.9	17.7	0.4
Intellectual/Cognitive testing	71.1	55.3	28.9	8.3	0.0
Neuropsychological testing	36.5	27.4	36.8	25.9	0.4
Personality/Emotional	70.3	59.0	24.4	7.9	1.1
Causal explanation	2.3	55.3	19.9	6.4	7.9

Table 2

Differences between Participants with and without Mitigation Evaluation Experience Regarding Inclusion of Content Areas

		% Included		
Content Area	*n*	Exp.	No exp.	One-tailed binomial[a]
Review of criminal/police records	106	51.7	37.7	.003**
Current mental status	106	30.3	25.5	.165
Medical history	106	45.5	32.1	.000**
Mental health history	106	56.6	50.0	.102
Academic history	106	57.2	38.7	.224
Employment history	106	35.9	28.3	.063
Substance abuse history	106	46.2	30.2	.001**
Developmental/Family history	106	56.6	50.0	.102
Collateral interviews w/ family	106	28.3	30.2	.000**
Collateral interviews w/ others	106	24.1	25.5	.000**
Intellectual/Cognitive testing	106	78.6	59.4	.000**
Neuropsychological testing	106	45.5	25.5	.000**
Personality/Emotional functioning	106	75.2	62.3	.000**
Causal explanation	106	2.8	1.9	.391

Note. [a] Calculated using % of experienced group as test proportion. ** $p<.01$.