

Establishing Standards for Criminal Forensic Reports: An Empirical Analysis

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Forensic psychologists and forensic psychiatrists (about 80% of whom were certified by a specialty board) were surveyed regarding their beliefs about the necessary and appropriate content for reports on competency to stand trial (CST) (N = 102) and criminal responsibility/not guilty by reason of insanity (CR) (N = 96). Report elements concerning the identification of the defendant and evaluation methods (e.g., names, relevant dates, charges, data sources, notification to defendant of the purpose of the evaluation, and limits on confidentiality) were generally seen as "essential." Clinical data such as psychiatric history, current mental status, and current use of psychotropic medication were also seen as essential, as were data elements specific to each forensic question (e.g., understanding charges/penalties, possible pleas, and roles of trial participants for CST, and collateral information and defendant's description of alleged offense for CR). While most respondents agreed that it was important to provide an opinion about and reasoning for any diagnosis and its relation to the psycholegal question, there was lack of consensus regarding the propriety of offering "ultimate opinions," particularly concerning CR. Although there was general cross-disciplinary agreement regarding the appropriate content for criminal forensic reports, there was some disagreement as to the degree of importance of certain elements. Implications for practice and the development of professional standards are discussed, including advantages and cautions about using these data to influence issues of standards and policy.

The practice of forensic assessment by mental health professionals has grown tremendously in the past 30 years. However, associated with this growth is increasing concern about the quality of

mental health professionals' consultation to the courts.¹⁻⁴ Forensic evaluations have been criticized on a variety of grounds, including failing to address the legally relevant issue, providing conclusory reports without supporting data or reasoning, and failing to collect and communicate relevant information on which to base an opinion.⁵ Recent economic circumstances are causing an increasing number of mental health professionals to include forensic evaluation in their prac-

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tice. However, some of them will not have adequate forensic training, knowledge, or experience required for these tasks.⁶ The consequence of this "could be a gradual erosion of already shaky public and judicial perception(s) of the credibility and competence of mental health professionals as court examiners and expert witnesses."⁶

To address these concerns, specialty guidelines have been developed to improve the quality of forensic practice.⁷ These guidelines, however, are meant only to provide general principles; they must still be translated into the details of actual practice. Moreover, there has been little research to guide these translations for clinical forensic practice.⁸

The present article describes experienced forensic mental health professionals' beliefs about the appropriate content of reports that communicate the results of forensic evaluations in criminal cases. The survey was intended to contribute to the evolution of clearer standards for forensic reports pertaining to the two most frequent evaluation referral questions in criminal law: competence to stand trial (CST) and criminal responsibility (CR) (not guilty by reason of insanity).

Typical or recommended practice by specialized forensic mental health experts does not necessarily define a standard to which all professionals should be held when they offer forensic reports. Nevertheless, the development of guidelines or standards for reports should take into account the practice and recommendations of professionals whose experience and credentials identify them as having special forensic expertise. We sought,

through information gathered in our survey, to identify content areas for which a consensus regarding essential and recommended features of criminal forensic reports has or has not evolved among forensic mental health experts.

At the broadest level, forensic reports should provide three interrelated categories of information: (1) data, (2) clinical and forensic opinions, and (3) some indication concerning how the opinions arise from (are supported by) the data.^{2,5} We know little, however, about professional consensus concerning what is, or at minimum should be, reported within any of these three content categories.

Concerning the first category, only a few studies have examined *types of data* included in forensic reports for CST and CR. Heilbrun *et al.*⁹ found that information about defendants' offenses was used in most cases (about 75%) in their sample of reports, information from mental health records in about one-half of the cases, and information from victims and witnesses only infrequently. Results varied considerably, however, across states* and evaluation settings, and other studies have found that only a minority of criminal forensic reports included data from police reports and mental health records.^{10,11}

Heilbrun and Collins¹² found that only 17 percent of a sample of CST and CR reports included data from psychological testing. Some studies have indicated that

*Some of these between-state differences may be attributed to different methods of data collection. The Florida data were pulled directly from reports, whereas the Virginia data were based on a forensic checklist that clinicians fill out for each case.

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forensic examiners claim to use psychological testing more frequently than that study would suggest.¹³⁻¹⁶ The latter findings, however, are difficult to apply to the present question because they did not pertain specifically to CST and CR evaluations or because they examined only the use of specific tests (e.g., only the Rorschach).

A study conducted by Borum and Grisso,¹⁷ reporting a survey[†] of experienced forensic psychologists and psychiatrists, indicated a two-thirds consensus that psychological testing was important to include in CR evaluations and reports, with about one-half of the respondents indicating its importance for CST evaluations and reports. Psychologists and psychiatrists did not differ in this opinion.

In summary, only a few studies have examined the types of data that are routinely included in criminal forensic reports, and they have been confined to examination of only a very limited number of content variables. Moreover, only one report¹⁷ focused on experts' opinions regarding the types of data that ought to be included, and that report focused narrowly on opinions about psychological testing. Many other authors, however, have offered their individual opinions concerning the types of data that could or should be included in CST and CR reports.^{2, 5, 18-21} Their recommendations were used to form many of the content variables used in the present study.

[†]It should be noted that the data described in Borum and Grisso¹⁷ derive from the same survey and sample that produced the results in the present study. However, the results reported in that article focused entirely on the use of psychological testing, while the results reported here focus on forensic report content.

Concerning the second type of content, the examiner's *clinical/forensic opinions*, three major questions have been raised in past studies and commentary.[‡] First, there has been concern that forensic reports often do not offer opinions of a type that are relevant for the question before the court. For example, studies before 1980 reported that forensic reports for competency questions often provided opinions on mental illness, but no opinions regarding how the defendant's mental illness was related to the legal question of competence.²²⁻²⁴ Some studies suggest that forensic reports have improved in this regard in recent years,^{9, 11} although not in all jurisdictions.²⁵ A second concern has been the tendency of examiners to offer opinions in their reports that are unrelated to the legal question. Some studies have found, for example, that a substantial proportion of forensic reports offered opinions about dangerousness when this prediction was not related to the legal reason for the requested evaluation²² and offered opinions about criminal responsibility when the request was for an evaluation of competence to stand trial.²⁶ The data are too sparse, however, to ascertain the frequency of these problems. Finally, authorities on the subject have argued both for²⁷ and against^{2, 3} the proposition that forensic reports should provide opinions

[‡]Our discussion in this introduction and the subsequent data that we provide in *Results* are directed specifically to the issue of what is or should be included in forensic reports. Two related issues were not assessed directly by this study. These are: (1) what do/should forensic clinicians do to properly assess CST/CR?; and (2) what do/should forensic clinicians testify to? Although our study addressed only report content, there may be some limited implications for practice and testimony, since these different aspects are, to some extent, interrelated.

about the "ultimate legal question" (e.g., "In my opinion, the defendant is incompetent to stand trial"). No studies have examined forensic reports to determine typical practice in this regard, and no studies have reported the consensus of experienced forensic examiners on this issue.

The third and final type of content question pertains to the importance of *describing how one reached an opinion* based on the data used by the examiner. Explaining one's logic often is described as a basic requirement for forensic evaluations.^{2, 5, 28} But no studies have examined reports systematically in this regard, and whether or not there is consensus among experienced forensic examiners about the importance of this type of content for reports is not known.

The present study, therefore, apparently is the first to report the opinions of a national sample of experienced forensic mental health professionals regarding the importance and propriety of a wide range of possible types of content in criminal forensic reports. Where there is a high degree of consensus on such matters, the information may be used to further the development of formal and recognized standards. Where there are disagreements and significant minority opinions, these findings will identify areas that require greater focus for debate in the process of the evolution of standards.

Reports for the two criminal forensic issues (CST and CR) were dealt with separately in the survey; whereas some clinical information is relevant to both of the legal concepts, other types of information may be issue specific. For exam-

ple, CST refers to a defendant's present abilities to understand the nature and object of the proceedings and to rationally assist his/her attorney in preparing a defense. In contrast, CR refers to different mental capacities (e.g., to know/appreciate the wrongfulness/criminality of one's acts, and/or to control one's own behavior) at the time of the alleged offense. Somewhat different types of information may be needed for these two different questions.

The survey included both forensic psychologists and forensic psychiatrists, for several reasons. Many kinds of data needed for forensic evaluations are not specific to the expertise of a particular mental health profession. Nevertheless, some disciplinary differences in opinion about forensic reports might exist as a result of differential attention to certain data sources (e.g., psychological testing, medical history) or because of traditional differences in training.²⁹ If there are interdisciplinary similarities and differences in opinions about the essentials of forensic reports, we should know about them in order to better inform professional associations that may wish to develop standards and guidelines in ways that are as consistent as possible across disciplines.

Method

Participants The sample included respondents who were board certified in forensic psychology or forensic psychiatry, or who had five or more years of experience with forensic evaluation. (Five years was chosen because this is currently the length of experience re-

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quired to be eligible for board certification.)

For the survey of test use in CR evaluations, respondents comprised 53 psychologists (55% of the sample) and 43 psychiatrists (45%). The survey related to CST evaluations included 57 psychologists (56% of the sample) and 45 psychiatrists (44%). Characteristics of these professionals are shown in Tables 1 (CR) and 2 (CST). More than 80 percent were board certified (forensic); they had an average of 17 years of forensic evaluation experience, devoted a little more than half of their practice to forensic evaluations, and frequently conducted examinations on the issues of CST and CR.

Survey Instrument To generate a domain of items that described potential content for CST and/or CR reports, we reviewed (1) major texts in forensic psychology and psychiatry, (2) report-writing manuals that have been developed by state government agencies in a few states for training of forensic mental health professionals, and (3) samples of CST and CR reports from several states. Formal definitions for each item were developed. Several highly experienced forensic mental health professionals in four states reviewed the initial items and definitions, making recommendations and additions. All new suggested items were then included in the list as long as they were not redundant.

A list of the formal definitions of the final 57 items (which we call *elements* of a report) is provided in the *Appendix*. The survey instrument consisted of instructions to the respondents, a form on which respondents could rate each element, and

the glossary of formal definitions of the elements. Some elements were included on both the CST and the CR survey instruments, whereas other elements were specific to CST or CR and therefore appeared on only one survey instrument.

For both surveys, respondents were asked to rate the importance of each element of the report. Importance was rated according to the following scale: Essential—a competent forensic report must include this information (exclusion of the information suggests a report that is below acceptable standards); Recommended—this information is not essential, but will be found in better, more sophisticated forensic reports; Optional—inclusion of this information would not affect the overall quality of the report; Contraindicated—inclusion of this information would negatively influence the quality of the forensic report.

For the CST survey ratings, respondents were asked to assume that they were rating the importance of each report element in the context of cases that involved charges of moderate severity (e.g., larceny, breaking and entering, simple assault and battery). For the CR surveys, respondents were asked to assume that they were rating the importance of each report element in the context of cases in which the charges were relatively serious (e.g., murder, assault with a deadly weapon, rape). These levels of severity were chosen to represent the types of cases in which data on standards of practice might be most critical and relevant. A lower level was used for the CST evaluations because of the relatively greater prevalence of requests for these assess-

Table 1
Demographic and Professional Characteristics of the CR-Responding Sample

	Psychiatrists (N = 43)	Psychologists (N = 53)	Total (N = 96)
Demographics			
Age ^a	(n = 43) 53.5 (9.65)	(n = 49) 46.8 (8.5)	(n = 92) 49.9 (9.64)
Male	(n = 43) 93.0%	(n = 49) 87.8%	(n = 92) 90.2%
Female	7.0%	12.2%	9.8%
Caucasian	(n = 41) 95.1%	(n = 48) 95.8%	(n = 89) 95.5%
Asian-American	4.9%	0.0%	2.2%
African-American	0.0%	4.2%	2.2%
Professional characteristics			
MD only	88.4%	0.0%	39.6%
MD, JD	2.3%	0.0%	1.0%
MD, MLS	2.3%	0.0%	1.0%
MD, PhD	7.0%	0.0%	3.1%
PhD only	0.0%	90.6%	50.0%
PsyD	0.0%	3.8%	2.1%
PhD, JD	0.0%	3.8%	2.1%
EdD	0.0%	1.9%	1.0%
Forensic board certified	95.3%	73.6%	83.3%
Years experience in forensic evaluation ^a	(n = 42) 20.1 (8.90)	(n = 52) 14.8 (6.95)	(n = 94) 17.2 (8.27)
Percentage of practice in forensic evaluation ^a	(n = 42) 45.3 (32.37)	(n = 49) 57.6 (33.55)	(n = 91) 51.9 (33.40)
Number of CR evaluations conducted in past year ^a	(n = 37) 34.9 (33.94)	(n = 45) 35.8 (30.42)	(n = 82) 35.4 (32.18)
Trained others in CR evaluations	(n = 41) 90.2%	(n = 53) 88.7%	(n = 94) 89.4%

^aThe data reported for these variables represent the mean and standard deviation (in parentheses). Data for all other variables represent the percentage of subjects endorsing the item. Also, the reported number of evaluations conducted in the past year has a maximum value of 100.

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Table 2
Demographic and Professional Characteristics of the CST Responding Sample

	Psychiatrists (N = 45)	Psychologists (N = 57)	Total (N = 102)
Demographics			
Age ^a	(n = 43) 53.5 (9.52)	(n = 54) 46.9 (8.81)	(n = 99) 49.9 (9.68)
Male	(n = 45) 93.3%	(n = 54) 85.2%	(n = 99) 88.9%
Female	6.7%	14.8%	11.1%
Caucasian	(n = 44) 93.2%	(n = 54) 96.3%	(n = 98) 94.9%
Asian-American	6.8%	0.0%	3.1%
African-American	0.0%	3.7%	2.0%
Professional characteristics			
MD only	88.9%	0.0%	39.2%
MD, JD	2.2%	0.0%	1.0%
MD, MLS	2.2%	0.0%	1.0%
MD, PhD	6.6%	0.0%	2.9%
PhD only	0.0%	89.5%	50.0%
PsyD	0.0%	3.5%	2.0%
PhD, JD	0.0%	5.3%	2.9%
EdD	0.0%	1.8%	1.0%
Forensic board certified	93.3%	71.9%	81.4%
Years experience in forensic evaluation ^a	19.9 (8.69)	15.0 (6.86)	17.2 (8.06)
Percentage of practice in forensic evaluation ^a	(n = 43) 47.5 (31.32)	(n = 55) 58.2 (34.00)	(n = 98) 53.5 (33.12)
Number of CST evaluations conducted in past year ^a	(n = 43) 45.7 (37.49)	(n = 47) 39.9 (32.69)	(n = 90) 42.8 (35.09)
Trained others in CST evaluations	(n = 45) 88.9%	(n = 54) 88.8%	(n = 99) 88.9%

^aThe data reported for these variables represent the mean and standard deviation (in parentheses). Data for all other variables represent the number of subjects endorsing the item and the corresponding percentage. Also, the reported number of evaluations conducted in the past year has a maximum value of 100.

ments. Thus, it was believed that information on practices for evaluating defendants on these types of charges would yield results most helpful to mental health professionals, lawyers, and judges in the cases where such data would be used most often.

Procedure

A preliminary inquiry of interest for participating in the study was sent to all psychiatrists certified by the American Board of Forensic Psychiatry who were listed in the 1992 directory of the American Academy of Psychiatry and Law (N = 217), and to all diplomates of the American Board of Forensic Psychology (ABFP) who had listed a specialty in competency/insanity evaluations or criminal assessments and who were listed in the 1993 directory of the ABFP (N = 89). Additional inquiries were sent to specific forensic evaluation centers located in various geographic regions throughout the country.

Individuals who were interested in participating were asked to return a response card with their name and address. Surveys then were sent out to all persons who had returned a response card (N = 165), with a request that they return it by a given date. Approximately 10 additional surveys were sent directly to the staff at two forensic hospitals. With the exception of 6 CST surveys that were sent to a facility where only CST assessments were performed, all potential respondents were sent both the CST and CR survey forms with the order of presentation counterbalanced. No follow-up reminders or follow-up surveys were sent. The overall response rate based on surveys sent

was 69 percent for the CST surveys and 64 percent for the CR surveys.

Results

Tables 3 and 4 show the percent of respondents in each of the four response categories on all elements for the CST and CR reports by forensic psychologists and forensic psychiatrists. On the tables, elements are presented in two major groups: data elements and opinion elements. Within these groups, elements are listed under content subheadings that facilitate their discussion, including separate categories for elements pertaining only to CST or only to CR wherever applicable.⁸

For the following discussion/analysis, we arbitrarily define a *consensus* as having been achieved when an element was endorsed in a particular way by 70 percent or more of the respondents across both disciplines. Our description focuses on three types of results. First, a consensus regarding the *essential* nature of an element would be important when developing standards defining competent practice. Second, we use the sum of an element's essential and recommended percentages to designate an element as *important* (although not necessarily required) if the sum of essential and recommended percentages achieves a consensus (70% or more). This type of consensus might be valuable to consider when developing a higher standard of practice to which clinicians should aspire (for exam-

⁸Elements were not listed on the actual survey forms under the conceptual headings that appear in the tables, because to do so might have influenced respondents' ratings.

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Table 3
Clinicians' Ratings (by Percentage) of the Importance of Components in a Competency to Stand Trial Evaluation Report

Components ^a	Psychiatrists (N = 45)				Psychologists (N = 57)			
	E ^b	R	O	C	E	R	O	C
<u>Data elements</u>								
Identification of defendant and evaluation methods								
BASICID	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0
REFSOURC	84.4	15.6	0.0	0.0	91.2	5.3	3.5	0.0
RPTDATE	97.8	2.2	0.0	0.0	100.0	0.0	0.0	0.0
CURCHG	95.6	4.4	0.0	0.0	91.2	8.8	0.0	0.0
EVLPURP	91.1	4.4	4.4	0.0	94.7	3.5	1.8	0.0
LEGLREFCS	27.3	36.4	34.1	2.3	28.1	24.6	47.4	0.0
EVLPLACE	73.3	26.7	0.0	0.0	73.7	21.1	5.3	0.0
EVLDATE	95.5	4.5	0.0	0.0	89.5	7.0	3.5	0.0
LSTSOURC	82.2	13.3	4.4	0.0	73.7	22.8	3.5	0.0
DISCPURP	73.3	17.8	6.7	2.2	66.7	28.1	5.3	0.0
CONPRIV	71.1	22.2	4.4	2.2	59.6	31.6	8.8	0.0
DEFPURP	46.7	40.0	11.1	2.2	57.9	35.1	7.0	0.0
ATYCONT	11.1	35.6	48.9	4.4	21.4	41.1	37.5	0.0
"Clinical" data								
PSYHX	73.3	24.4	2.2	0.0	73.7	17.5	8.8	0.0
MHREC	45.5	36.4	18.2	0.0	52.6	40.4	7.0	0.0
CURNTMS	91.1	6.7	2.2	0.0	96.5	3.5	0.0	0.0
FRMLMSE	75.6	17.8	6.7	0.0	61.4	26.3	12.3	0.0
STATOSET	18.2	61.4	15.9	4.5	33.3	47.4	19.3	0.0
POLINFO	20.5	36.4	25.0	18.2	12.3	31.6	38.6	17.5
PRIORDX	29.5	54.5	13.6	2.3	36.8	42.1	21.1	0.0
MEDS	81.8	13.6	4.5	0.0	84.3	12.3	1.8	1.8
SUBABUSE	43.2	34.1	18.2	4.5	33.3	31.6	29.8	5.3
MEDHX	54.5	34.1	11.4	0.0	33.9	41.1	25.0	0.0
PSYTEST	7.1	35.7	54.8	2.4	21.8	29.1	49.1	0.0
Data elements for CST reports only								
UNDCHRG	100.0	0.0	0.0	0.0	94.7	5.3	0.0	0.0
UNDPLEA	91.1	8.9	0.0	0.0	91.2	7.0	1.8	0.0
APPRGLT	88.9	6.7	4.4	0.0	89.5	8.8	1.8	0.0
UNDPART	88.9	8.9	2.2	0.0	87.7	10.5	1.8	0.0
COMTOATY	86.7	11.1	0.0	2.2	94.7	5.3	0.0	0.0
COLABATY	88.9	8.9	2.2	0.0	86.0	10.5	3.5	0.0
DECMKNG	71.1	22.2	4.4	2.2	77.2	19.3	3.5	0.0
SELFCNTL	57.8	33.3	8.9	0.0	77.2	19.3	3.5	0.0
BXLGLCXT	44.4	40.0	13.3	2.2	42.1	38.6	17.5	1.8
DEFVIEW	31.1	17.8	17.8	33.3	19.3	12.3	15.8	52.6
POLVIEW	13.3	20.0	40.0	26.7	14.0	15.8	26.3	43.9

(Continues)

Table 3—Continued

Components ^a	Psychiatrists (N = 45)				Psychologists (N = 57)			
	E ^b	R	O	C	E	R	O	C
<i>Opinion elements</i>								
MIOPIN	75.6	22.2	2.2	0.0	75.4	19.3	3.5	1.8
DX	53.3	33.3	8.9	4.4	47.4	31.6	17.5	3.5
MIRATION	24.4	51.1	22.2	2.2	36.8	43.9	15.8	3.5
CSTABIL	86.7	8.9	4.4	0.0	91.2	7.0	1.8	0.0
CSTABRAT	46.7	33.3	17.8	2.2	59.6	29.8	10.5	0.0
MITOCST	62.2	31.1	6.7	0.0	77.2	17.5	5.3	0.0
MICSTRAT	40.0	35.6	24.4	0.0	49.1	26.3	24.6	0.0
ADDOPIN	0.0	11.1	20.0	68.9	5.4	1.8	12.5	80.4
ULTOPIN	66.7	11.1	8.9	13.3	50.9	22.8	15.8	10.5
CRINFO	32.6	16.3	18.6	32.6	30.4	14.3	16.1	39.3
SITNCXT	28.9	44.4	22.2	4.4	47.4	35.1	17.5	0.0
ALTEXPL	37.8	37.8	22.2	2.2	50.9	31.6	15.8	1.8

^aSee *Appendix* for identification of terms in this column.

^bE = essential; R = recommended; O = optional; C = contraindicated.

ple, “advanced” practice, or guidelines for programs that train fellows for specialized forensic mental health practice). Third, any elements that are perceived as *contraindicated* by a substantial percentage of respondents (even if less than a consensus) might warrant special scrutiny, since inclusion of those elements in a report would have an increased likelihood to be challenged as “poor practice.”

Following are the results for elements referring to types of data that may be included in reports, then for elements referring to various types of opinions.

Data Elements Surveyed for Both CST and CR Reports. *Identification of Defendant and Evaluation Methods* For both disciplines, and for both CST and CR reports, a consensus was achieved that 10 types of data were *essential* for identifying the defendant and the evaluation process: basic identifying information for the defendant (e.g., name, age,

sex); identification of referral source; current charge(s); statement of purpose of evaluation; date of evaluation; date of report; place of evaluation; list of data sources; description given to defendant concerning purpose of evaluation; and description given to defendant concerning limits of confidentiality and privilege (psychiatrists only for “essential”).

For three other elements in this category, there was not a consensus that they were essential: a description of the defendant’s understanding of the evaluation’s purpose; inclusion of the legal standard for CST or CR; and a statement about actual or attempted contact with the defendant’s lawyer prior to the evaluation. For the first of these, however, there was a consensus regarding the *importance* (“essential” plus “recommended” percentages) of the elements, while for the last two there was not.

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Table 4
Clinicians Ratings (by Percentage) of the Importance of Components in a Criminal Responsibility Evaluation Report

Components ^a	Psychiatrists (N = 43)				Psychologists (N = 53)			
	E ^b	R	O	C	E	R	O	C
<u>Data elements</u>								
Identification of defendant and evaluation methods								
BASICID	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0
REFSOURC	95.3	4.7	0.0	0.0	92.5	5.7	0.0	1.9
RPTDATE	97.7	2.3	0.0	0.0	100.0	0.0	0.0	0.0
CURCHG	95.3	4.7	0.0	0.0	96.2	3.8	0.0	0.0
EVLPURP	93.0	7.0	4.4	0.0	96.2	3.8	0.0	0.0
LEGLREFCR	35.7	21.4	40.5	2.4	30.2	28.3	41.5	0.0
EVLPLACE	76.7	20.9	2.3	0.0	73.6	22.6	3.8	0.0
EVLDATE	93.0	7.0	0.0	0.0	90.6	7.5	1.9	0.0
LSTSOURC	90.7	7.0	2.3	0.0	84.9	15.1	0.0	0.0
DISCPURP	74.4	18.6	7.0	0.0	71.7	24.5	3.8	0.0
CONPRIV	79.1	16.3	4.7	0.0	67.9	24.5	7.5	0.0
DEFPURP	62.8	27.9	9.3	0.0	62.3	30.2	7.5	0.0
ATYCONT	19.0	38.1	40.5	2.4	20.8	39.6	37.7	1.9
Clinical Data								
PSYHX	90.7	9.3	0.0	0.0	90.6	9.4	0.0	0.0
MHREC	78.6	19.0	2.4	0.0	77.4	22.6	0.0	0.0
CURNTMS	88.4	9.3	2.3	0.0	92.5	7.5	0.0	0.0
FRMLMSE	76.7	18.6	2.3	2.3	64.2	22.6	13.2	0.0
STATOSET	20.9	60.5	16.3	2.3	47.2	37.7	15.1	0.0
POLINFO	72.1	25.6	0.0	2.3	75.5	18.9	5.7	0.0
PRIORDX	73.8	26.2	0.0	0.0	66.0	30.2	3.8	0.0
PSYMEDS	81.0	19.0	0.0	0.0	79.2	18.9	1.9	0.0
SUBABUSE	74.4	23.3	0.0	2.3	73.6	17.0	5.7	3.8
MEDHX	64.3	33.3	0.0	2.4	64.2	26.4	9.4	0.0
PSYTEST	16.2	45.9	37.8	0.0	29.4	39.2	31.4	0.0
Data elements for CR reports only								
DEFDISC	88.4	9.3	0.0	2.3	79.2	13.2	1.9	5.7
COLATDES	65.9	26.8	2.4	4.9	67.3	28.8	1.9	1.9
<u>Opinion elements</u>								
MIOPIN	93.0	4.7	0.0	2.3	96.2	3.8	0.0	0.0
DX	74.4	18.6	4.7	2.3	60.4	26.4	11.3	1.9
MIRATION	62.8	23.3	14.0	0.0	64.2	22.6	13.2	0.0
MITOCR	95.3	4.7	0.0	0.0	100.0	0.0	0.0	0.0
MICRRAT	65.1	23.3	11.6	0.0	69.8	17.0	13.2	0.0
ADDOPIN	0.0	4.7	30.2	65.1	5.7	5.7	11.3	77.4
ULTOPIN	58.5	12.2	9.8	19.5	40.4	15.4	26.9	17.3
MENTDZS	28.6	19.0	21.4	31.0	32.7	25.0	21.2	21.2
CSTINFO	35.7	21.4	14.3	28.6	34.0	13.2	18.9	34.0
MALING	36.6	31.7	29.3	2.4	50.0	32.7	17.3	0.0

^aSee *Appendix* for identification of terms in this column.

^bE = essential; R = recommended; O = optional; C = contraindicated.

ment, 9 of the 11 elements in this category were seen as important for both CST and CR reports. The two exceptions were psychological testing and police information about the defendant's behavior when arrested (viewed as *important* for CR only).

Consensual agreement as to whether or not the clinical data elements were *essential* varied somewhat for the two types of evaluations. Elements seen as *essential* for both CST and CR evaluations were: psychiatric history; current mental status; information from a formal mental status examination; and current use of psychotropic medication. Elements seen as *essential* for CR but not CST evaluations were: information reviewed in past mental health records; police information about defendant's behavior at time of alleged offense; information about prior psychiatric diagnoses; and information about presence/absence of substance abuse.

About one-half of the respondents endorsed psychological testing as being either "essential" or "recommended" (more so for CR than CST reports). But the sum of these combined ratings did not achieve the 70 percent criterion for consensus as *important*, and only about one-quarter of psychologists perceived psychological testing as *essential* for CST or CR evaluations.

Data Elements Surveyed for CST Reports Only Certain data-based elements were surveyed for CST reports alone, because they pertained to the assessment of specific abilities associated with a defendant's capacity to understand and participate in the trial process. Respondents

reached a consensus that 9 of these 11 elements were at least *important*. Moreover, 7 of the 9 elements were seen as *essential* by both professions for adequate description in CST reports: understanding of charges/penalties; understanding of possible pleas; appreciation of consequences of a guilty plea and accepting a plea bargain; understanding of roles of trial participants; ability to communicate with legal counsel; ability to consider advice (collaborate with) counsel; and ability to make decisions (process information) without distortion due to mental illness.

The elements in this category that were not seen as important for inclusion in CST reports were the descriptions of the alleged offense by the defendant and by the police. There was particular disagreement among respondents concerning the propriety of including the defendant's own description of events in CST reports. About one-half of the psychologists and one-third of the psychiatrists believed that this was *contraindicated*, while a substantial proportion (about one-half of the psychiatrists) felt that it was *important* to include. Concerning the police view of the alleged offense, roughly one-third of both professions rated it as *important* to include, while about 27 percent of psychiatrists and 44 percent of psychologists believed it was *contraindicated*.

Data Elements Surveyed for CR Reports Only The defendant's description of events surrounding the time of the alleged offense was considered *essential* by consensus for CR reports. Information from witnesses or other collateral sources

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was seen as *important* and nearly reached consensus as *essential*.

Opinion Elements The following types of opinion statements reached consensus as being *important* for both CST and CR reports: opinion about presence or absence of mental illness/mental retardation (MI/MR); opinion about formal MI/MR diagnosis (i.e., DSM-IV); explanation of reasoning for opinion about MI/MR; opinion about relation between defendant's MI/MR and capacities relevant for the question of CST or CR; and explanation of reasoning concerning the relationship between defendant's MI/MR and capacities relevant for the question of CST or CR. However, only two of these opinion statements achieved a consensus as *essential*: an opinion about presence or absence of MI/MR; and an opinion concerning the relation between the defendant's MI/MR and the capacities relevant for the CST or CR question.

Four other types of opinion statements were included in the survey. First, the survey defined an "ultimate opinion" as a clinical opinion as to whether or not the defendant "is competent to stand trial" or "was insane at the time of the offense, was criminally responsible, or is recommended as NGRI." A general statement of the results would conclude that there was consensual agreement that ultimate opinions were *important* for both types of reports, with about one-half of respondents perceiving them as *essential*. The exception arose for CR reports as perceived by psychologists, for whom an ultimate opinion was seen as *important* by less than a consensus (55%). Only a relatively small percentage of respon-

dents believed that ultimate opinions by clinicians were *contraindicated* for CST reports (10–13%) or for CR reports (17–19%).

Second, there was consensus or near consensus that offering opinions in the report about legal or forensic issues other than those requested by the court (e.g., "danger to others") were *contraindicated*. Third, there was no consensus regarding the appropriateness of including CST opinions and CR opinions in the same report for those instances in which both evaluation requests were made at the same time. In fact, respondents were quite divided on the matter; about one-third believed that this practice was *essential*, while one-third believed that it was *contraindicated*.

Finally, by a consensus, the respondents considered it *important* for the report to include an opinion as to whether or not the defendant's legally relevant mental state deficits might be related to causes other than mental illness or mental retardation (for CR, malingering; for CST, other reasons such as simple lack of knowledge of trial procedures). However, this was not seen as *essential* for CST or CR reports.

Opinion Elements Surveyed for CST Reports Only Respondents expressed a consensus that it was *important* for examiners to offer opinions in the report about the nature and degree of any deficits in abilities relevant for CST, as well as an explanation concerning how the opinion was reached. Only the first of these, however, was considered *essential* by consensus. Respondents also expressed a consensus that it was *important* (but *not*

essential) for reports to offer an opinion about situational circumstances (e.g., anticipated demands of this defendant's trial) in which the defendant's deficits might be more or less likely to compromise the defendant's trial participation.

Opinion Elements Surveyed for CR Reports Only No consensus was reached concerning whether the CR report should offer an opinion that a defendant's DSM diagnosis does or does not meet the legal criteria for "mental disease or defect," as this might apply to the issue of criminal responsibility. Approximately 21 percent to 31 percent of respondents believed that this was *contraindicated*, which was almost the same as the percentage of those who believed that it was *essential* (28–32%).¹¹

Summary of Differences Between Disciplines Differences were found between the ratings of the psychiatrists and the psychologists on several items. We chose a difference level of 15 percent to identify these items and focused on the differences in essential and contraindicated ratings. These items included: whether or not a medical history is *essential* in CST evaluations (psychiatrists, 55%; psychologists, 34%); whether a description of the defendant's capacity for self control is *essential* in CST evaluations (psychiatrists, 57%; psychologists, 77%); whether it is *essential* to describe situational trial contexts as they relate to the defendant's CST deficits (psychia-

trists, 29%; psychologists, 47%); whether including a defendant's view of the offense in CST reports is *contraindicated* (psychiatrists, 33%; psychologists, 53%); and whether the defendant's behavior in settings outside the interview is *essential* to observe and describe (CST: psychiatrists, 18%; psychologists, 33%; CR: psychiatrists, 21%; psychologists, 47%).

Finally, there were some differences observed concerning whether an ultimate opinion is *essential* for criminal forensic evaluations. For CST assessments, about two-thirds (67%) of the psychiatrists rated this *essential*, while only one-half (51%) of the psychologists assigned this rating. However, for the CR evaluations the *essential* ratings dropped to 59 percent for the psychiatrists and 40 percent for the psychologists.

Discussion

This is the first article to report areas of consensus and disagreement among a national sample of forensic mental health professionals concerning the necessary and appropriate contents of criminal forensic reports. The respondents, most of them diplomates in forensic psychiatry or forensic psychology, were highly experienced and specialized in criminal forensic evaluations. The survey and sampling procedures offer no reason to believe that the opinions of these respondents as a group are not representative of the domain of forensic mental health diplomates. Therefore, their opinions provide a valuable base of information to consider in any efforts to develop explicit standards and guidelines for criminal forensic reports.

¹¹Two items not reported in Tables 3 and 4 inquired about the importance of organizing the report in a particular sequence and of citing legal statutes or cases where relevant. Neither of these were considered as *important* by consensus.

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Such efforts may arise for varied purposes: (1) developing formal standards for endorsement by professional forensic mental health organizations; (2) establishing quality assurance policies in public sector forensic evaluation systems; (3) assisting attorneys and courts in their scrutiny of the quality of forensic examiners' reports; (4) developing curricula and training objectives in pre- and postdoctoral forensic psychology programs, forensic psychiatry fellowships, and continuing education programs; and (5) identifying criteria that may be used by researchers to define and assess the quality of forensic evaluations and reports. The following discussion focuses on the values and limitations of our survey results for these potential objectives.

First, our results suggest that a consensus has evolved among forensic mental health professionals concerning many essential types of content in CST and CR reports. Moreover, there was general agreement between forensic psychologists and forensic psychiatrists regarding the appropriate content for criminal forensic reports. It is likely that standards regarding much of the content of CST and CR reports could be developed jointly by the two disciplines without significant controversy or conceptual conflict.

Second, while revealing a sense of agreement on most matters, the results also identify some issues for which there appears not to be a consensus concerning the propriety of certain types of content. Such disagreement may occur for a variety of substantive (e.g., real disagreement about evaluation practices), strategic (e.g., believing that extremely brief re-

ports provide more protection from cross-examination), and contextual reasons (e.g., different practices may be suggested by different specific cases or by the demands of different systems).

Considerable diversity in viewpoints within both disciplines—including directly opposing positions—arose especially in response to questions about the proper form or inclusion of certain types of expert opinions in the report. For example, among psychologists, there was a notable lack of consensus regarding the propriety of offering expert clinical opinions on the ultimate legal CR question in the report. There were three positions on the matter. A little more than one-half of them endorsed the practice, while about one-fifth condemned it. The third position, taken by about one-quarter of the psychologists in the survey, was that offering or not offering ultimate opinions was of no great consequence, presumably because legal fact-finders are in no way obligated to accept the expert's opinion. Respondents also were divided about including opinions in the report as to whether a defendant's diagnosis meets legal criteria for mental disease or defect. Unfortunately, we could not determine the rationale for respondents' choices, which would have helped us to understand the diversity of opinion on these issues. For example, some of those who rated these elements as *essential* might have done so because it is required by law or compelled by judges in their jurisdiction, while others may have made this rating because they believed that inclusion of these elements is *essential* in principle. Nevertheless, these results identify

some questions that should continue to be the focus of debate among forensic mental health professionals in order to move the field toward consensus on those matters.

Third, while we believe that our findings may be of considerable use to those who wish to form standards and guidelines, the results do not offer a blueprint. We urge careful reflection, rather than automatic use of the results, when applying them to questions of standards of practice.¹ Several cautions should be exercised when using the results of our survey to address questions of policy.

1. We used 70 percent agreement to define a consensus. Standard-setting bodies should decide whether they wish to accept this definition or to identify a more or less rigorous definition of consensus. Changing the percentage cut-off, of course, will produce different conclusions regarding which of the content categories in the study may be essential and therefore potentially appropriate to represent a standard for competent report writing practice.

2. A consensus of experts concerning minimal standards of practice in report writing does not necessarily define cor-

rect practice. In addition to the experts' consensus, one should consider law, professional ethical standards, and other sources of criteria that make authoritative demands on professional practice and presentation of reports. When these other authoritative sources are in conflict with the experts' consensus, the latter should not automatically be used to define "adequate" practice. For example, Section VI of the Specialty Guidelines for Forensic Psychologists⁷ may be interpreted to obligate experts to explain clearly the reasons for any opinions they may offer, so that the trier of fact may assess their foundation. Yet our respondents did not express a consensus that it was *essential* for reports to explain clinicians' reasons for their opinions that deficits in a particular defendant's cognitive abilities were relevant for the question of CST. In this instance, and perhaps others, standard-setting bodies might wish to contradict the consensus of the experienced forensic mental health professionals in this study.

3. It is quite possible that the opinions of a national panel of experts could be misleading when developing standards for professionals in a specific jurisdiction. Certain states may have unique legal and administrative demands that would be in conflict with general practice nationwide. For example, experts in this study reached a consensus that for CST and CR evaluation reports, it was inappropriate for examiners to offer opinions on other legal issues such as "dangerousness." In Massachusetts, however, examiners are required to address defendants' "need for care and treatment" in all pretrial mental health evaluations (Massachusetts Gen-

¹We reiterate that our survey asked only about report content and did not inquire directly about evaluation practice and testimony. Although most report content addresses something done during the assessment and most clinicians will probably be willing to testify to something that has already been included in the report, there may be important distinctions in the degree of importance assigned to each element. For example, one might consider it essential to do something in practice—like giving notice on the limits of confidentiality—but believe that its inclusion in a report or testimony was somewhat less important. Thus, since our data only report respondents' beliefs about report content, any implications drawn for evaluation practice and testimony must be done with caution.

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eral Laws, c 123, s 15(c)). This often requires addressing the potential need for psychiatric hospital commitment during the pretrial period, which in Massachusetts requires that the defendant meet criteria similar to those in civil commitment. "Danger to others" is one of those commitment criteria. Therefore, the practice that this national panel of experts considered to be *contraindicated* is appropriate in Massachusetts. Similarly, there may be some types of content that the experts considered *essential* that would be inappropriate in some jurisdictions. Standard-setting bodies must be careful to understand and weigh such conflicts rather than automatically adopting a national opinion consensus.

4. Standard-setting bodies, or persons using the results of this study to evaluate the quality of an expert's report, should remember that we surveyed experienced forensic mental health professionals' opinions, not their behavior. The results, therefore, are interpreted appropriately as the respondents' beliefs about adequate report writing practice. They should not be interpreted as representing the actual report writing practice of experienced forensic mental health professionals, for which very limited data currently are available.⁹

Finally, we encourage researchers to use the *data* and *opinion* elements in this study to examine the quality of forensic evaluations and reports, especially in relation to examiners' training, their experience, and the characteristics of legal systems and public sector forensic mental health systems in which pretrial evaluations are performed. *Quality*, however,

may have many definitions and may require consideration of a variety of report characteristics (e.g., organization, length, and clarity of communication), as well as less formal aspects of the communication (e.g., how well the report attends to the clinical needs of the defendant as well as the informational needs of the legal system). Researchers should recognize that report content—the sole focus of the present study—is but one among many important characteristics of reports that might be worthy of consideration when establishing criteria with which to evaluate report quality.

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Appendix: Survey Definitions for Elements of Forensic Reports

I. Data Elements

Identification of Defendant and Evaluation Methods

BASICID: Basic Identifiers: such as defendant's name and date of birth, name of examiner.

REFSOURC: Referral Source: identification of the party requesting the evaluation (e.g., which court or name of attorney).

RPTDATE: Report Date: date of report.

CURCHRG: Current Charges: identification of offense(s) and offense dates for which the defendant currently is being charged.

EVLPURP: Purpose of Evaluation: statement of purpose for performing the evaluation.

LGLREFCS: Legal Reference to CST: a legal citation providing a definition of competence to stand trial in that jurisdiction.

EVLPLACE: Place of Evaluation: identification of the location where the evaluation was conducted (e.g., hospital, mental health center, jail).

EVLDATE: Evaluation Dates: identification of the date(s) on which the examiner met with the defendant for purposes of direct assessment procedures (e.g., interview, testing) and amount of time spent in direct contact for assessment.

LSTSOURC: Listing of Other Data Sources: listing of any sources of information obtained by the examiner other than through direct clinical/forensic interview with defendant (e.g., mental health records, police reports, interviews with relatives/witnesses, psychological or medical tests).

DISCPURP: Disclosure of Purpose: statement indicating that defendant was told the purpose of the evaluation prior to interview/testing.

CONPRIV: Confidentiality/Privilege: statement indicating that defendant was given explanation of the limits of confidentiality/privilege prior to interview/testing.

DEFPURP: Defendant's Understanding of Purpose: statement commenting on defendant's understanding of the purpose of the evaluation.

ATYCONT: Attorney Contact: statement indicating that examiner contacted defendant's attorney prior to evaluation or that an attempt was made to do so.

Clinical Data

PSYHX: Psychiatric History: information that addresses whether or not defendant has a history of mental illness (or mental retardation).

MHREC: Mental Health Records: includes a statement indicating that some document(s) from previous mental health evaluation/treatment was reviewed by examiner, or that such records were not available when an attempt was made to obtain them.

CURNTMS: Current Mental Status: information (data) about defendant's current mental status, derived at least in part from direct observation of defendant by examiner (must be a description of mental state at the time of the evaluation); for example, describing delusions or other symptoms, describing thoughts or thought processes, describing level of intelligence at present time.

FRMLMSE: Formal Mental Status Exam: description of mental status that comments on the following: orientation; memory; emotion; behavior; thought.

STATOSET: Current Status in Other Settings (if available): observations (data) about defen-

dant's current mental state as observed by examiner or others in a current setting other than the interview (e.g., hospital or jail) in the days just prior to or during the evaluation.

POLINFO: Information from Police: description of information (data) from police concerning defendant's behavior at time of arrest OR statement indicating that the examiner made an effort to obtain information from police, but such information was not made available to the examiner.

PRIORDX: Prior Diagnosis: statement indicating a diagnosis from earlier medical or psychiatric treatment or indicating the absence of earlier diagnosis or treatment history.

PSYMEDS: Psychotropic Medication: statement identifying defendant's current use of psychotropic medication (since time of arrest and at time of evaluation) or absence of it.

SUBABUSE: Alcohol/Substance Abuse: statement identifying presence and degree, or absence, of alcohol or other substance abuse in the past (prior to current charges).

MEDHX: Medical History: statement identifying presence and degree, or absence, of any past or current significant illnesses or medication use.

PSYTEST: Psychological Testing: use and reporting of intellectual, objective or projective tests/instruments designed for clinical evaluation (e.g., WAIS-R, MMPI, Rorschach, Beck, etc.).

Data Elements for CST Reports Only

UNDCHRG: Understanding of Charges or Penalties: data describing what the defendant understands about the charges or potential penalties.

UNDPLEA: Understanding Pleas: data describing the defendant's degree of understanding of pleas available to defendants (e.g., guilty, not guilty, not guilty by reason of insanity).

APPRGLT: Appreciation of Guilty Plea: data describing defendant's understanding and appreciation of information specifically related to entering a guilty plea or accepting a "plea bargain" (e.g., giving up certain rights).

UNDPART: Understanding of Trial Participants: data describing what the defendant understands about the roles of participants in the formal trial process (e.g., prosecutor, defense attorney).

COMTOATY: Communication to Counsel: data describing the degree to which defendant is able to provide defense counsel with coherent description of the alleged offense (or of events within that time).

COLABATY: Collaborating with Counsel:

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data describing the degree to which defendant is able to consider advice of counsel.

DECMAKNG: Decision Making: data describing defendant's abilities for making decisions (processing information) without distortion due to mental illness.

SELFCNTL: Self Control: data describing defendant's ability to manage his/her behavior or emotion in courtroom.

BXLGLCXT: Demeanor in Legal Context: a description of defendant's behavior in recent interactions with his/her attorney or within recent court proceedings.

DEFVIEW: Report of Defendant's View of Offense: inclusion of information describing the alleged offense or the time surrounding it, derived from the defendant's description.

POLVIEW: Police View of Offense: inclusion of detailed description of the alleged offense, based on data derived from police or other informants.

Data Elements for CR Reports Only

LGLREFCR: Legal Reference to CR: a legal citation providing a definition of insanity/criminal responsibility in that jurisdiction.

DEFDISC: Defendant's Disclosure: information (data) about defendant's behavior at time of the alleged offense based on the defendant's own report; OR statement indicating that the examiner made an effort to obtain the information, but defendant was not willing or able to provide a description of behavior and events at time of alleged offense.

COLATDES: Collateral Description: information (data) from interview with witness(es) concerning defendant's behavior at time of the alleged offense, or from others who encountered the defendant soon before or after the alleged offense; OR statement that no persons are known to have had contact with the defendant immediately before, during or after the alleged offense, or that potential informants were contacted by the examiner but were either unwilling or unable to provide relevant information.

II. Opinion Elements

Opinion Elements for both CST and CR

MIOPIN: Mental Illness Opinion: statement of examiner's opinion concerning presence and degree, or absence, of current mental illness or mental retardation.

DX: Diagnosis: statement of opinion regarding

formal (DSM-III-R) diagnosis (if mental illness exists).

MIRATION: Mental Illness Rationale: a description of how the examiner reached an opinion about the presence an degree, or absence of mental illness.

SEQORGZ: Sequential Organization: report uses subheadings with content proceeding in the following sequence: identification and purpose, method, data, interpretations.

LEGCITN: Legal Citation: inclusion of references or citations to statutes or legal cases bearing on forensic questions.

ADDOPIN: Additional Clinical Opinions: report offers opinions also on defendant's current dangerousness and other matters that may be relevant for sentencing, but for which there is no legal (statutory) requirement to address.

Opinion Elements for CST Only

CSTABIL: CST Abilities: statement of examiner's opinion concerning presence, absence, or degree of deficits in abilities relevant for the question of competence to stand trial.

CSTABRAT: CST Abilities Rationale: a clear description of how the examiner arrived at the opinion about CST abilities.

MITOCST: Relation of Mental Illness and CST Abilities: if mentally ill and deficits in CST abilities, explanation of relationship between them, if any.

MICSTRAT: Rationale for Relation of Mental Illness to CST Abilities: if mental illness existed, a description of how the examiner reached the opinion about the relation of mental illness to CST abilities.

ULTOPIN: Ultimate Opinion: report includes the examiner's clinical opinion concerning whether or not the defendant is competent to stand trial.

CRINFO: Criminal Responsibility (CR): if the evaluation referral called for a CR evaluation at the same time as the CST evaluation, inclusion of data and opinions on the question of criminal responsibility along with CST results in the same report.

SITCNXT: Situational Context: description of situational circumstances (e.g., conditions of trial) in which the defendant's functional deficits are or are not likely to compromise the defendant's trial participation.

ALTEXPL: Alternative Explanations: discussion of any reasons other than mental illness that

could explain deficiencies in defendant's performance during assessment of CST abilities.

Opinion Elements for CR Only

MITOCR: Opinion about Relation of Mental Illness to CR: if mental illness existed at time of alleged offense, a statement of examiner's opinion concerning the degree to which it did or did not influence the defendant's capacities associated with the legal definition of criminal responsibility.

MICRRAT: Rationale for Relation of Mental Illness to CR: if mental illness existed, a description of how the examiner reached the opinion about the relation of mental illness to CR.

MENTDZS: Mental Disease or Defect: report includes an opinion about whether a DSM-III-R diagnosis does or does not meet the legal criteria for "mental disease or defect."

CSTINFO: Competence to Stand Trial (CST): if the evaluation referral called for a CST evaluation at the same time as the CR evaluation, inclusion of data and opinions on the question of competence along with CR results in the same report.

MALING: Malingering: a statement addressing the question of malingering of mental illness at the time of the evaluation, or dissimulation by defendant when providing information about mental state at the time of the alleged offense.

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