"Reasonable Medical Certainty": Can We Meet *Daubert* Standards in Insanity Cases?

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When mental health professionals testify in insanity defense cases (more generally, about mental state at the time of the offense [MSO]), opinion testimony is generally solicited after the prefatory question as to whether the forthcoming opinions are held with "reasonable medical certainty" (psychiatrists) or "reasonable scientific certainty" (nonmedical experts). The question and its answer—almost inevitably a "Yes"—are a virtual mantra with which most readers of this Journal are probably quite familiar. In this brief editorial, I discuss what can, arguably should, and in the worst (or perhaps, best) case scenario, may have to be done in light of evolving standards for admissibility of expert testimony.

Prior to *Daubert v. Merrell Dow Pharmaceuticals Inc.*[1] expert testimony was generally governed by the "general acceptance" test established under *Frye v. U.S.*[2] As *Frye* was generally applied, expert witnesses were on safe ground so long as they had employed methods generally accepted in their field for gathering the information on which their opinions were based. As Simon noted, "*Daubert* shifted the focus from the general acceptance of the conclusion of expert testimony to the underlying reasonableness or soundness of the methodology" (Ref. 3, p 4). With its emphasis on (along with "acceptability") the testability of scientific knowledge, peer review, and publication history and factors affecting potential error rates, *Daubert* directed trial judges to evaluate the potential validity of experts' methods, not merely their acceptability.

In the context of MSO evaluations, this is a rough gauntlet thrown in the face of the mental health professions. Simon[3] noted further, "A standard methodology for the retrospective determination of an individual's mental state does not exist . . .[and that]. . .good validity studies [of MSO evaluations] are practically nonexistent" (citation omitted) (Ref. 3, p 5). Accepting Simon's disturbing, but I think accurate, appraisal of the current state of affairs, one wonders what expert witnesses in *Daubert* jurisdictions might be thinking in claiming, willy-nilly, "reasonable medical/scientific certainty" in MSO cases (but see Poythress,[4] for what may happen if they answer otherwise).

Must/Should/Can the Validity of MSO Evaluations be Investigated?

One question is what *must* be done by the mental health professions sitting on the horns of the dilemma created by *Daubert* expectations on the one hand and the vacuum in our literature regarding the validity of MSO judgments on the other. At present, one answer to the "must" question is to do nothing. We may hope that inertia is on our side and that courts will continue their acceptance, in the MSO context, of expert testimony grounded in little more than the claim that our credentials and our "clinical experience" assure that our reconstructive judgments are valid. Perhaps the *Daubert* mandate will disturb the courts' inertia only (or mainly) in cases involving novel or suspected "junk science." Unless and until *Daubert* is brought to bear specifically in the MSO context, we can sit and wait.

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What we should do is another matter, one that invokes value choices and forces us to confront the realistic limitations on what we can do, should we opt to do anything. I will assert here that, on grounds of professional responsibility, we (the mental health professions) should not take shelter in the courts' inertia and long-standing acceptance of expert testimony based on methods whose validity has gone largely, if not completely, unexamined. We should be about the business of developing the best evidence that we can with respect to the validity of retrospective forensic assessments.

The Time-Lapse Design

The question of what we can do is a daunting one. To assess the validity (accuracy) of a retrospective MSO forensic evaluation, a primary challenge is to establish a plausible baseline representing a defendant's "true" mental state at the time of the offense. The best research design for validating retrospective judgments involves a time-lapse model, described by Rogers as "an adaptation of test-retest reliability that is applied to the reproducibility of retrospective diagnosis and symptoms" (Ref. 5, p 293). In essence, one must be able to conduct forensic MSO assessments of defendants very close in time to the alleged offense. Of course, even these evaluations are also retrospective ones, but the smaller the time window between the crime and the baseline evaluation, the less opportunity for factors such as natural fluctuations in symptomatology, intervening treatment, prolonged detention in a depressing jail environment, or psychological reactions (if any) to the offense itself, to influence (change) the defendant's mental presentation. Such evaluations would provide the "ground truth" against which the accuracy of subsequent (more retrospective) assessments would be compared.

This criterion of access to defendants as soon as possible after the alleged offense places some practical limitations on prospective investigators. First, such research will probably have to be conducted in cooperation with a public defender, through whom appropriate cases (e.g., those in which MSO issues may be relevant) can be identified early (e.g., within a few days of arrest) and from whom legal authority to approach defendants for baseline research assessments can be obtained. Needless to say, there are myriad problems that must be resolved relating to work product, privilege, and the potential use of research MSO assessments at trial. Ecological validity concerns dictate that these research MSO evaluations be conducted under as realistic conditions as possible. Consideration must be given to providing appropriate fees to both the "baseline" and "retrospective" experts and to the possible need to convince institutional review boards to waive informed consent requirements for the defendants so that they view these as "real" forensic assessments.

Several variations in design and measurement could lead to interesting, if not important, findings. These include manipulating the time window between the baseline and retrospective evaluation (are retrospective evaluations more accurate after 2 months than after 4 months?), professional discipline of evaluators (do medical and nonmedical examiners produce comparably accurate retrospective profiles?), or the examiners' level of professional/forensic experience (do experienced and relatively novel examiners produce comparably accurate retrospective profiles?). Does the accuracy of retrospective judgments differ across domains of information to be reconstructed—that is, does accuracy vary across reconstructions of clinical symptoms, full diagnoses, or perceived motives; reasons that animated the alleged criminal behavior; or clinical attributions about linkages, or lack thereof, between symptoms and elements of the offense in light of the prevailing insanity test?

The needed research is likely to be expensive, requiring considerable external funding. Pending sufficient resources to conduct adequate MSO validation research using the time-lapse design with real defendants, an interim approach might be to conduct smaller scale, analogue studies in other contexts, whose parameters approximate, in important ways, at least some of those present in criminal forensic contexts. Civil commitment settings afford the opportunity for such analogue studies.

People who are involuntarily hospitalized have active mental disorders that may have contributed to the behavior giving rise to their commitment (e.g., evidence of harm to others), and the window of time between the behavior that justifies commitment and commitment is usually very small. With appropriate human subject research protections, baseline (at the time of involuntary commitment) and retrospective (scheduled for a designated period after commitment) mock-MSO evaluations could be conducted by clinicians trained in MSO assessments. Petitions

for commitment provide an analogue to the police "information" in criminal cases, and the community petitioners could be interviewed as "witnesses" might be in the criminal context.

Admittedly, the analogue is imperfect; the committed individuals are (usually) not charged with offenses, they are not facing criminal trial with representation by criminal defense attorneys, and the range of behavior that justifies their commitment will probably fall well short of the serious felony offenses in which true MSO evaluations are sought. Assuming that agency staff (perhaps on their own time) may be performing the mock-MSO evaluations, the absence of attorney-expert consultation and remuneration for services could also influence study results. Nevertheless, the parallels to the criminal context may be sufficient to generate research findings that, if not compelling, are at least informative with respect to the accuracy (validity) of retrospective clinical judgments about MSO issues.

Professional Lobbying for Funding Initiatives

The judicial system has long operated under the (perhaps implicit) assumption that the knowledge and methods of general psychiatry and clinical psychology would translate easily and directly into the legal forum. The professions of psychiatry and psychology have developed forensic subspecialties, with methods and bodies of knowledge that may differ in important ways from the methods used in general clinical practice. In many applications, MSO evaluations among them, scientific research has not kept pace with the changes in practice. Yet, now the courts, as in *Daubert*, are demanding evidence of validity that exceeds what the professions can muster.

The clinical professions, purely on their own, have little need to examine the validity of psycholegal methods and judgments. It is the courts' use of clinical experts to help resolve legal disputes and the demand for opinions that inform legal inferences (i.e., criminal responsibility) that creates the need for evidence regarding the scientific validity (or absence thereof) of such methods and judgments. MSO and other reconstructive forensic evaluations are important, even necessary, components in a variety of mental health law contexts and thus warrant the resources necessary to conduct the validation studies needed to meet the courts' mandate in *Daubert*. Extensive federal funding has been made available to support research on clinical diagnoses. In light of these needs, perhaps professional mental health organizations, such as the American Psychiatric Association and American Psychological Association, should lobby for federal research initiatives to support investigations of the validity of MSO and other forensic evaluations.

References

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