

UNDERSTANDING FORENSIC PSYCHOLOGISTS' MENTAL STATE AT THE TIME OF
THE OFFENSE EVALUATION PATTERNS:
A MIXED METHODS STUDY

by

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A THESIS

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ABSTRACT

Mental State at the Time of the Offense (MSO) evaluations are used to inform the criminal courts in determinations of criminal responsibility and are an important part of psycholegal practice. Evaluator judgments of defendants' mental state at the time of the offense can significantly influence court determinations, yet research suggests these judgments are not standard across evaluators or jurisdictions and have poor interrater reliability. The current study utilized a mixed methods design to examine patterns of use and acceptability of various aspects of MSO evaluations. Several psychological tests were endorsed as ideal, but not frequently used in practice, while several clinical interview topics are utilized more in practice than recommended by participants. Results may aid legal decision making and inform research regarding MSO evaluation standardization.

DEDICATION

“You should be working on your thesis.”

-Sheila Corrigan, Ph.D.

inspirational psychologist, nagging mother

LIST OF ABBREVIATIONS AND SYMBOLS

ALI	American Law Institute
AP-LS	American Psychology-Law Society
APPIC	Association of Psychology Postdoctoral and Internship Centers
FAI	Forensic Assessment Instrument
<i>M</i>	Mean: The sum of a set of values divided by the number of values in the set
MSO	Mental State at the Time of the Offense
NGRI	Not Guilty by Reason of Insanity
Ph.D.	Doctorate of Philosophy
Psy.D.	Doctorate of Psychology
<i>SD</i>	Standard Deviation: Value of variation from the mean
R-CRAS	Rogers Criminal Responsibility Assessment Scales
<	Less than
>	Greater than
=	Equal to

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I knew from the moment when I first met her and she opened with a *Mean Girls* quote that Jenni Cox was meant to guide me through this graduate school process. What had alluded me then was that I was choosing not only an academic advisor, but a devoted and caring life mentor as well. I have certainly taken advantage of her open-door policy for every research idea and existential crisis that has crossed my mind over the past year and a half and she has encouraged me and validated me through it all. So, first and foremost, thank you, Jenni, for leaving no doubt in my mind that a *Mean Girls* quote could be that start of a wonderful friendship.

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1. INTRODUCTION

Legal theory, dating back thousands of years, requires two components of a criminal act to be present for an offender to be truly culpable: *actus reus*, or “bad act,” and *mens rea*, or “guilty mind.” This means that the mere act of committing a crime is not sufficient for culpability, but the offender must also have intent to perform this act. One such way *mens rea* can be absent is due to a severe mental illness that impairs an individual’s perceptual, cognitive, rational, or other mental abilities to such a degree as to excuse the individual from criminal responsibility. The introduction of this exception to legal culpability also necessitated a consideration of its impact on legal punishment, an idea first introduced in the Hebrew *Mishna* 2,000 years ago (Packer, 2009).

The first formal guidelines for determining criminal responsibility were codified in 18th century England with the “wild beast” standard, which stated that in order to be excused from criminal responsibility one must be “totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute, or a wild beast, such a one is never the object of punishment” (*Rex v. Arnold*, 1724, p. 695). Previously, the absence of *mens rea* had been considered exclusively for mitigation of sentencing, this was the first time it was posed as an exemption from criminal responsibility. Importantly, this standard changed the concept of the insanity defense from that of a moral failing (i.e. good versus evil) to a cognitive failing (Perlin, 1994).

In the majority of the United States, a defendant believed to lack *mens rea* may be found Not Guilty by Reason of Insanity (NGRI). Modern attempts to define legal sanity have resulted

in several similar, yet legally distinct, standards. Adopted from English common law, the M’Naghten standard, the oldest basis for legal insanity in the United States, requires that in order to “establish a defense on the ground of insanity it must be clearly proved, that, at the time of committing the act, the party accused was labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know what he was doing was wrong” (M’Naghten case, 1843, p. 718). Two important precedents in NGRI case law were established with this trial. First, that those found NGRI should be sent to mental health facilities as opposed to jail and, second, that the evidentiary burden of proof to prove insanity is on defendant (Perlin, 1994).

While the M’Naghten standard was adopted by most jurisdictions in the U.S. and is still the most common standard today, it has been criticized for a variety of reasons. One early apprehension was that a literal interpretation of the M’Naghten standard was too strict in that it would exculpate only those “totally deteriorated, drooling hopeless psychotics of longstanding, and congenital idiots” (Zilboorg, 1943, p. 273). Furthermore, many professionals criticize the wrongfulness component of the M’Naghten standard, saying that cognition is only one component of insanity, and that it may not even be the most important aspect (American Law Institute, 1985). These critics believe that the standard focuses too heavily on the cognitive aspect of sanity, mere intellectual knowledge that the act was wrong, and does not consider important emotional controls. In response, some states introduced a volitional criterion, the irresistible impulse standard, to allow for NGRI verdicts if the individual was responding to an overwhelming urge when they committed the crime (Stephen, 1883). Critics of the irresistible impulse standard argue the “irresistible” portion is subjective and hard to quantify, and thus may be susceptible to feigning (*Commonwealth v. Woodhouse*, 1960).

In response to criticisms that the M’Naghten standard was too rigid and mental health professionals were having to narrowly focus legal testimony, the product standard was introduced. In *Durham v. U.S.* (1954), the Court of Appeals for the District of Columbia determined that a defendant could be found NGRI if the criminal act was a “product of a mental disease or defect” (p.874-875), which gave experts the opportunity to provide more comprehensive testimony. However, by expanding the definition of NGRI without stipulating what constituted a mental defect by legal standards, there was inconsistency in both interpretation by evaluators and implementation by courts (Packer, 2009).

Recognizing this, in *McDonald v. United States* (1962) the courts defined “mental defect” as “any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls” (p. 851). This standard refined the legal requirements for being found NGRI by reintroducing the concept of behavioral control, but it did not resolve the debate in the field regarding what constituted a mental disease or provide experts with clear guidelines of how to determine if a behavior is the product of a mental defect (Packer, 2009).

As a comprehensive alternative, the American Law Institute (ALI) standard was proposed in 1962. It stated, “a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacked substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law” (American Law Institute, 1985). The ALI standard consists of two prongs and stipulates that a defendant can be found NGRI if they meet the requirements of either. The cognitive prong differs from the previous legal standards in that it focuses on a defendant’s *appreciation* of the significance of their actions and the moral wrongfulness, as opposed to simply having the

intellectual knowledge their actions were illegal (Fingarette, 1972). This is an important distinction to make given the nature of certain mental illnesses. Consider an individual with severe delusions who believes he must kill a police officer in order to save mankind from the police officer's plot to destroy the world. This individual may be intellectually aware that killing a police officer is wrong, but due to his mental disorder, believes his actions are morally justified.

The volitional prong of the ALI standard shifted focus from the strength of the behavioral impulse emphasized in the irresistible impulse standard to the individual's ability to control the impulse. Supporters of this standard assert that an individual's ability to control an impulse is more observable and quantifiable than the perceived strength of an impulse to an individual (Packer, 2009). As of 2009, 26 states follow the M'Naghten standard or some variant, 20 states have adopted the ALI standard or some variant, and 4 states have no formal insanity defense but still allow for *mens rea* to be considered (Packer, 2009).

Mental State at the Time of the Offense Evaluations

When an offender's mental state at the time of the offense is questioned, the defense, prosecution, or both may retain forensic evaluators, typically psychologists and psychiatrists, to examine the defendant and opine as to the defendant's psychological and cognitive capacity (Packer, 2009). These evaluations, referred to as Mental State at the Time of the Offense (MSO) evaluations, are used to determine criminal responsibility and are an important part of psycholegal practice in that they may be considered by the court when determining a defendant's legal culpability. Additionally, MSO evaluations may inform other legal proceedings, such as plea bargaining and sentencing (Warren, Murrie, Chauhan, Dietz, & Morris, 2004).

The definition of sanity varies by jurisdiction based on the legal standard adopted by that state, as such, the forensic evaluator must focus his or her assessment and testimony on the functional abilities most relevant to the legal standard in the jurisdiction in which they are practicing. For example, in a jurisdiction where the standard focuses on a legal interpretation of wrongfulness, such as one with a M’Naghten variant, an evaluator may seek information through primary and collateral interviews about the defendant’s capacity for reason and reality testing at the time of the offense. If a legal standard emphasizes the defendant’s appreciation of the moral wrongfulness, such as in a jurisdiction with an ALI variant, then an evaluator may ask the defendant if they believed their actions were justified and explore the details of their justification. If a jurisdiction employs only the cognitive prong in its respective legal standard, as most do, then the evaluator does not need to assess the defendant’s previous ability to control his or her behavior (Packer, 2009). As of 2007, only 16 states have legal standards containing the volitional prong, most of which are ALI variants (Steadman et al., 1993). In these jurisdictions, an evaluator may assess the defendant’s capacity to make decisions, ability to delay his or her actions, regard for the possibility he or she would be apprehended, and ability to foresee the possible outcomes (Rogers, 1987). Additionally, most jurisdictions that use the ALI standard or variant only require that the defendant’s cognitive abilities be substantially impaired, as opposed to most M’Naghten jurisdictions which require complete impairment. Thus, evaluators should also be cognizant of the legal degree of impairment required in their jurisdiction when gathering information to form an opinion (Packer, 2009).

The American Psychological Association (2013) published specific guidelines for forensic psychologists to aid in professional development and standardization across jurisdictions. These guidelines instruct evaluators on how to ethically collect information for a

wide variety of forensic evaluations with emphasis placed on impartiality, competency, and logistics. While the guidelines recommend that evaluators provide opinions that are “sufficiently based upon *adequate* scientific foundation” (p. 9; emphasis added), they do not specifically stipulate what information is sufficient for an evaluator to reach an opinion on mental state at the time of the offense. Ethical guidelines encourage acquiring collateral information to supplement data collected and using appropriate assessment instruments. Generally, MSO evaluations primarily include the integration of clinical, collateral, and objective techniques to determine the culpability of the defendant based on their mental state when they allegedly committed the crime (American Psychological Association, 2013; Packer, 2009).

It is critical that these evaluations be valid given the high-stakes nature of the consequences. Should a defendant be determined to have committed the crime and be found culpable, they are subject to subsequent penalties, such as monetary fines and incarceration. However, a defendant determined to be NGRI is considered not responsible for their behavior and not subject to criminal penalty. Despite this, most jurisdictions have mandatory civil commitment statutes for NGRI acquittees, such that defendants found NGRI are generally civilly committed to forensic hospitals for treatment (Ellis, 1986). Often, these judgments contribute to the defendant either receiving punishment or treatment, and denial of the appropriate outcome can deprive the defendant of sorely needed treatment or rehabilitation.

Erroneous conclusions drawn from evaluations can have grave results not only for the offender, but society as well should a truly sane individual bypass the correctional system and tax a mental health facility with already limited resources or, alternatively, a truly insane individual be deprived of adequate treatment in a prison setting and increase their chances of recidivism. These stark differences in outcomes can determine their fate, yet these judgments are

not made in a systematic way across all jurisdictions (Gowensmith, Murrie, & Boccaccini, 2013).

Validity and Reliability Issues in MSO Evaluations

The validity and reliability of MSO evaluations and resulting opinions reflect the credibility of the profession as a whole (Hans, 1986). Research shows lay people in the United States hold negative perceptions of the insanity defense. Several high-profile cases, such as that of Ronald Reagan's failed assassin, John Hinckley, have contributed to the public opinion that the insanity defense is overused (Knoll & Resnick, 2008; Steadman et al., 1993). However, in a review of several studies, Melton et al. (2018) conclude the insanity defense is only utilized in 0.1% of felonies and in only about 25% of those cases is the defendant found NGRI. This public distrust of the insanity defense is based, in part, on the notion that the court's decision relies on a clash of experts testifying to contradictory information derived from a subjective, unreliable process (Hans, 1986).

This perception is somewhat substantiated by previous research concerning how individual biases affect forensic evaluation outcomes (Homant & Kennedy, 1986, 1987a, 1987b). Separate from conscious motivators, such as social justice (Gorman, 1983) and money (Anderten, Staulcup, & Grisso, 1980; Schetky & Colbach, 1982), forensic evaluators can be swayed by unconscious factors as well. One potential threat to the validity of MSO evaluations is what Brodsky (1991) originally labeled the "pull to affiliate," but is more commonly referred to as "adversarial allegiance." Adversarial allegiance occurs when the forensic expert unconsciously pursues evidence that supports a legal outcome congruent with the party by which they are retained (Murrie, Boccaccini, Guarnera, & Rufino, 2013). This effect has been

supported by case law research (DeMatteo et al., 2014) and through empirical manipulations in mock criminal cases (Murrie et al., 2013; Otto, 1989). While this bias is even present in forensic procedures viewed to be the most reliable, such as DNA analysis (Dror & Hampikian, 2011), this practice is contradictory to the expectation that forensic psychologists perform evaluations in a manner that is as objective and accurate as possible (American Psychological Association, 2013).

If, in practice, MSO evaluations are completely without deviations, forensic psychologists may be considered interchangeable, in that any evaluator would yield the same conclusion on legal sanity. However, previous research does not support this assertion. Gowensmith et al. (2013) examined the outcome of 483 MSO evaluations in Hawaii. The statutory guidelines for felony procedures in Hawaii dictate that three evaluators, one in the public sector and two in the private sector, perform MSO evaluations in each case where the insanity defense is being pursued. These evaluators work independently in that they are retained by the court as opposed to the prosecution or defense. The researchers in this study found that all three evaluators agreed unanimously on the defendant's mental state at the time of the offense in only 55.1% of the cases. Evaluators were more likely to unanimously agree a defendant was sane (38.2% of the time) than insane (17% of the time). When disagreement arose, it was more likely due to one evaluator opining the defendant was insane rather than one evaluator finding the defendant sane. Certain case-specific factors contributed to the level of agreement or disagreement among evaluators. Specifically, if the defendant was under the influence of drugs or alcohol at the time of offense, evaluators tended to disagree on sanity. However, if the defendant had a diagnosable psychotic disorder or was hospitalized shortly before the offense, evaluators were more likely to agree. Still, unanimous agreement only increased to 61.1% when two of the evaluators gave an opinion on sanity and the third did not.

Although adversarial allegiance can be assumed to not have influenced these outcomes due to the independence of the evaluators in Hawaii, other factors, such as personal biases and inadequate evaluation practices, may have driven this effect. These data may generalize to evaluations across the country, given the forensic training and licensing requirements in Hawaii are similar to those in other states (Giorgi-Guarnieri, et al., 2002) and there was no evidence the evaluators' characteristics systematically differed from those in other jurisdictions (Gowensmith et al., 2013).

In practice, there is variation in the frequency of opined insanity by individual evaluators. Murrie and Warren (2005) examined 4,498 evaluations conducted by 59 forensic evaluators and reported that the majority (85%) of evaluators found defendants legally insane only 5-25% of the time. However, a few evaluators were outliers, in that some never found a defendant legally insane and some found the defendant insane over 50% of the time. Considering the aforementioned base rate of legal insanity, these outlying evaluators may be affected by personal biases or adversarial allegiance.

The high stakes of these evaluations, along with the lack of reliability across evaluators, creates a necessity for the standardization of MSO evaluations. This standardization may be achieved through the development of a semi-structured interview with comprehensive psychometric properties. The development of a semi-structured interview would allow for empirical research into its validity and reliability and could help increase the reliability of MSO evaluations across evaluator and jurisdiction. Prior to the development of such a measure, a comprehensive understanding of how these evaluations are conducted in practice is necessary.

Current MSO Evaluation Practices

Although the psychiatric field has published guidelines outlining best practice in MSO evaluations (Janofsky et al., 2014), the field of psychology does not have equivalent guidelines, and little is known about how MSO evaluations are conducted nationwide. The largest study of its kind in this generally understudied field (Packer, 2009) was conducted by Borum and Grisso (1996) via a survey of 96 forensic psychiatrists and psychologists. The researchers asked participants about what they consider to be important aspects of an MSO evaluation report. Concerning the clinical interview portion of the evaluation, they found that respondents considered psychiatric history, substance use history, defendant's account of the offense, and current medication as essential pieces of information. Regarding collateral information, mental health records, police description of defendant's behavior at time of offense, and information from witnesses of the offense were all considered essential or approaching essential. Importantly, only about 25% of evaluators perceived formal psychological testing as essential, though that number could have been affected by the inclusion of psychiatrists, who typically are not trained in psychological assessment. Although comprehensive and informative, this research was conducted over 20 years ago, therefore, little is known as to how these data would generalize to modern practice.

There is reason to believe that our understanding of the dynamic field of forensic psychological evaluations requires constant updating (Lally, 2003; Otto & Heilbrun, 2002). Indeed, as new measures are developed and the legal standards evolve, forensic evaluators' practices must adapt. More recent studies have aimed to determine typical practices of forensic evaluators from different perspectives since the 1996 Borum and Grisso study (Lally, 2003; McLaughlin & Kan, 2014; Warren et al., 2004). One study examined over 5,175 reports from forensic evaluators and focused solely on collateral information obtained. The researchers found

that in over half of the cases forensic evaluators offered insanity opinions without seeing the defendant's criminal history (55%), statements from witnesses (56%), or statements from the defendant (60%). In 14% of cases, evaluators did not even obtain information about the alleged offense (Warren et al., 2004). These practices are especially concerning given alternative perspectives and multiple sources of information are essential to informing mental state at the time of the offense opinions.

When considering standardization of MSO evaluations, including psychological testing may be an avenue for increasing reliability, given the tests used are empirically supported. However, the use of psychological measures in MSO evaluations is still unconventional (Borum & Grisso, 1996; Lally, 2003; McLaughlin & Kan, 2014). Additionally, of all the types of forensic evaluations (e.g. competency to stand trial, nonsexual violence risk), the use of psychological tests is lowest for MSO evaluations (McLaughlin & Kan, 2014). These results are striking considering there have been substantial developments in assessment measures used in forensic settings in recent years, particularly forensic assessment instruments (FAIs; Lally, 2003; Otto & Heilbrun, 2002).

Forensic assessment instruments, measures developed specifically for use within the legal context, are among some of the least used in forensic practice (McLaughlin & Kan, 2014). An example of an FAI relevant to MSO evaluations is the Rogers Criminal Responsibility Assessment Scales (R-CRAS; Rogers, 1984), a tool designed to aid the evaluator in determining legal sanity at the time of the offense (Rogers, 1984). The measure consists of 30 questions which contribute to the five scales: Patient's Reliability, Organicity, Psychopathology at the Time of the Alleged Crime, Cognitive Control, and Behavioral Control. These questions are scored by the evaluator on a 5- or 6-point scale where 0 indicates no available information, 1

indicates no presence of the variable, and 2-6 indicate increasing levels in severity of the variable. The numerical value assigned for each variable requires clinical judgment on behalf of the evaluator with no formal objective scoring criteria provided. Instead, the R-CRAS guides the evaluator through a decision-tree model where the evaluator must first decide if there is evidence of malingering, an organic disorder, or psychiatric disorder before integrating outside information to form an opinion (Rogers, 1984). The R-CRAS has been demonstrated to have good internal validity (Borum, 2003) as well as high interrater reliability (Rogers, 1984; Rogers & Shuman, 2000), however, it is not widely used in practice (Archer, Buffington-Vollum, Stredny, & Handel, 2006). This could be due to criticisms that the R-CRAS does not meet requirements for establishing external validity (Borum, 2003), provide quantifiable guidance for evaluators, or allow for nuanced conclusions (Melton et al., 2018).

Regarding psychological assessment tools developed for general use, McLaughlin and Kan (2014) found that psychological tests were used in only 22% of MSO evaluations, although they were considered acceptable by the majority of participants in the study. Additionally, among those forensic evaluators who do utilize standardized psychological assessment tools in MSO evaluations, multi-scale inventories [e.g. Minnesota Multiphasic Personality Inventory-2, (MMPI-2; Butcher et al., 2001), Personality Assessment Inventory (PAI; Morey, 1991)], are most commonly *used* (McLaughlin & Kan, 2014), however, Lally (2003) found the Wechsler Adult Intelligence Scale – III (WAIS-III; Wechsler, 1997) to be the most *recommended* psychological assessment tool, used by 60% of respondents.

Discrepancies in the quantitative research leave only speculation as to why there is a schism between recommended and actual practices. This trend is not limited to the use of psychological assessment tools, but other aspects of MSO evaluations as well. For example,

mental health records, police descriptions of defendant's behavior at the time of the offense, and information from witnesses were found to be essential by most forensic evaluators (Borum & Grisso, 1996). However, mental health records are only used in about half of evaluation decisions and information from witnesses even less so (Heilbrun, Warren, Rosenfeld, & Collin, 1994). While patterns in MSO evaluations have been examined in many studies (Archer et al., 2006; Borum & Grisso, 1996; Lally, 2003; McLaughlin & Kan, 2014; Warren et al., 2004), previous studies have not directly examined why forensic evaluators do or do not utilize certain psychological tests, clinical interview topics, or sources of collateral information. Previous survey studies did not include open-ended or follow-up questions, although many have identified this as a limitation and recommendation for future research.

2. CURRENT STUDY

The current study concerns the degree to which and reasons why forensic examiners consider certain psychological tests, clinical interview topics, or sources of collateral information when conducting an MSO evaluation. This comprehensive survey-based study addressed all aspects of an MSO evaluation as opposed to previous studies which focused on only one, such as either testing (e.g. McLaughlin & Kan, 2014) or collateral information (e.g. Heilbrun et al., 1994). Additionally, it is the first to directly approach evaluation practices from both an ideal and actual perspective in order to understand the discrepancies in the literature regarding what evaluators recommend and what evaluators do in practice. Importantly, this is the first study to examine forensic evaluators' patterns when conducting MSO evaluations using a mixed methods design. As mentioned above, previous studies have not examined the reasons that evaluators endorse or employ certain psychological measures, sources of collateral information, or clinical interview topics, while not endorsing or utilizing others. Sandelowski, Barroso, & Voils (2007) note that qualitative methods, such as content analysis, can be particularly useful in augmenting quantitative research when researchers are seeking to validate and extend the understanding of the quantitative data. As such, the current study included a quantitative section as well as an elaboration section that were analyzed using content analysis.

The quantitative portion consisted of two sections: endorsement ratings for items that make up all three components of an MSO evaluation (i.e., psychological testing, collateral information, and the clinical interview) and frequency of use ratings for those same items. The

aggregate of the quantitative data allowed for a better understanding of general practices, but not for the evaluators' reasoning behind these recommendations.

The content portion of the survey served to expand and describe the corresponding quantitative data. For every item, participants were tasked with providing written explanations of their responses. This data aided in explaining the results of the quantitative data, considering neither method alone was sufficient for understanding the degree to which, and reasons why, forensic examiners consider certain psychological tests, clinical interview topics, or sources of collateral information when conducting an MSO evaluation.

Based on previous research concerning acceptable and actual MSO evaluation practices, we hypothesized that some discrepancies between *ideal endorsement ratings* and *actual practice ratings* would arise. For example, based on previous research, it was hypothesized that participants would endorse the R-CRAS as more essential but report low use of it in their actual MSO evaluations. Meaning, evaluator average rating of the *R-CRAS ideal* would be statistically higher than evaluator average rating for the *R-CRAS actual*. However, in order to gain a comprehensive understanding of the schism between ideal practices and actual practices, all possible discrepancies were analyzed. As is typical with qualitative research (Creswell & Poth, 2017), no specific hypotheses were made.

3. METHODOLOGY

Design

A convergent parallel mixed methods design was employed for data collection and analyses in order to develop a comprehensive understanding of the research question. Quantitative and content data were collected simultaneously to assess various aspects of the research question. Data from each method was analyzed independently using different methods (i.e., paired-samples t-tests for the quantitative data and content analysis for the content data). Data from the elaboration sections was then integrated with the quantitative data to further explain the quantitative results (Creswell & Poth, 2017; see Figure 1).

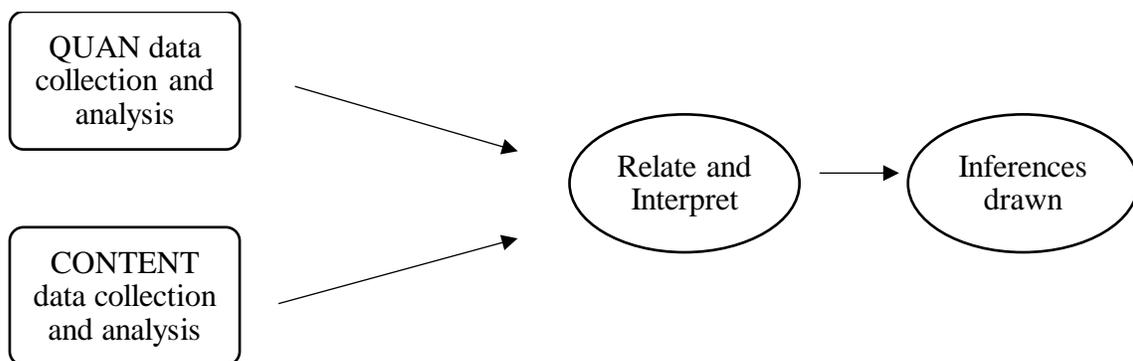


Figure 1. Convergent parallel mixed methods design. Process by which quantitative and content data was collected, analyzed, and integrated.

Participants

Participants included 99 forensic evaluators (52.5% male, $M_{\text{age}} = 50.24$ years, $SD = 14.59$) recruited through solicitation emails sent to members of the American Psychology-Law Society (AP-LS), American Board of Forensic Psychology, and Psy-Law Listservs as well as directors from the Association of Psychology Postdoctoral and Internship Centers (APPIC). Participants have practiced psychology for an average of 16.87 years ($SD = 11.78$ years) in either a private practice (45.5%), a state forensic hospital (24.4%), for the court (8.1%), in a prison (6.1%), a state non-forensic hospital (2%), a private forensic hospital (1%), or other (13.1%). Participants mostly held Ph.D.s (64.6%), while the remainder held Psy.D.s, and have conducted an average of 282.98 ($SD = 599.41$) MSO evaluations. Only psychologists were included in the sample because they are the discipline adherent to the pertinent ethical practices (American Psychological Association, 2013, 2017) and their training and forensic practices differ from those of psychiatrists (Borum & Grisso, 1996; Petrella & Poythress, 1983). All participants had conducted at least one MSO evaluation in the last five years.

An email containing a brief study description and a link to the study website was sent to members of the AP-LS, American Board of Forensic Psychology, Psy-Law, and APPIC organizations. This study used a snowball technique in that participants were recruited through solicitation and word-of-mouth. If they choose to participate, participants remotely clicked on a link that rerouted them to the online platform, Qualtrics, from where they could complete the survey (see Appendix A).

Procedure

Participants viewed an informed consent document prior to beginning the survey. After agreeing to participate, respondents answered a brief demographic questionnaire inquiring about

the jurisdiction in which they practice, the particular insanity standard (e.g., ALI, Durham) in their jurisdiction of practice, their history of MSO evaluations, and number of years since receiving their degree.

Questions Regarding Ideal MSO Evaluation

The first half of the survey was comprised of three separate sections (i.e., Psychological Assessment Tools, Collateral Information, and Clinical Interview Topics) and asked participants to consider only their *ideal evaluation* circumstances (“one that is free from the systematic restraints that may occur in real-world settings”), in order to ascertain which aspects of an MSO evaluation are truly perceived as important to the participant for forming an opinion. In these sections, definitions adapted from the Borum and Grisso (1996) study were provided for each rating in order to ensure collective understanding among participants. “Essential” was defined as “any competent forensic examiner would need to include this item in their evaluation in order to form an opinion on sanity.” “Recommended” was defined as “this item, while not essential, would be collected by a competent forensic examiner in the majority of circumstances.” “Optional” was defined as “assessment of this item would not likely add to an opinion on sanity, but may have the potential to under certain circumstances.” Finally, “unnecessary” was defined as “this item, while one may use it, does not contribute to an opinion on legal sanity; this includes items that may even be contraindicated.”

The first section of this part of the survey provided various psychological assessment tools (e.g., multi-scale personality inventories, intellectual functioning assessments) and prompted participants to rate each test on a four-point scale (3 = essential, 2 = recommended, 1 = optional, 0 = unnecessary). Following each rating participants were asked to explain the

reasoning behind their rating. This section included a total of seven types of psychological tests (see Appendix A).

The next section of the survey prompted participants to rate each source of collateral information (e.g., medical/mental health records, previous arrest records) on a four-point scale as either essential, recommended, optional, or unnecessary. Following each rating, participants were asked to elaborate on their reasoning. There was a total of 10 pieces of collateral information included in this section of the survey (see Appendix A).

The last section of this part of the survey prompted participants to rate each clinical interview topic (e.g. details of current offense, educational history) on a four-point scale as either essential, recommended, optional, or unnecessary. Following each rating participants were asked to elaborate on their reasoning. There was a total of 13 clinical interview topics included in this section of the survey (see Appendix A).

Questions Regarding MSO Evaluation Practices

Finally, the second half of the survey asked participants to consider their *actual practices* in employing the same psychological tests, sources of collateral information, and clinical interview topics when conducting an MSO evaluation. These items were also rated on a four-point scale (3 = very frequently, 2 = frequently, 1 = infrequently, 0 = rarely/never). “Very frequently” was defined as “approximately 75-100% of the time.” “Frequently” was defined as “approximately 50-74% of the time.” “Infrequently” was defined as “approximately 25-49% of the time.” “Rarely/never” was defined as “approximately 0-24% of the time.” All items from the first half of the survey were included in the second half. Additionally, each item included a section for the participant to elaborate on the most important reason why they provided a certain rating (see Appendix A).

4. DATA ANALYSIS

Quantitative Analysis

A mixed methods analysis addressed both the quantitative and content data. For the quantitative analysis, the mean (M) and standard deviations (SD) of *ideal endorsement* and *actual practice* ratings of each item (e.g., multi-scale personality inventories, medical/mental health records, criminal history) within the main sections (e.g., Psychological Assessment Tools, Collateral Information, and Clinical Interview Topics) were calculated. Paired-samples t-tests compared the mean rating for corresponding *ideal endorsement* and *actual practice* ratings for each item. Discrepancies between *ideal endorsement* and *actual practice* ratings were considered significant if the paired-samples t-test resulted in a p -value $< .05$.

Content Analysis

To analyze the elaboration sections of the survey, a content analysis approach was taken. As described by Elo and Kyngäs (2008), inductive content analysis is a process where codes are derived from the data itself through open coding. Open coding involves detailed memoing and identification of keywords in order to describe all aspects of the data. These keywords are then categorized into codes which may be combined, eliminated, or modified throughout the codebook development process. These codes may then be grouped together into categories based not only on their shared characteristics, but also their differences from each other. Further, these categories may be abstracted to formulate a description of the data in relation to the research question, or themes (Elo & Kyngäs, 2008). The validity of the results of content analysis is conventionally established through scientific rigor and trustworthiness, as evidenced by a

thorough and transparent description of the coding application and theme development processes, as well as establishing mechanisms to address reflexivity, such as inter-coder agreement checks (Guest, MacQueen, & Namey, 2012).

Codebook Development

For the current study, the primary researcher submitted the data from the content sections of the survey to NVivo, a program that allows for classifying code and organizing qualitative data. Data was categorized by item and rating type (e.g., *multi-scale personality inventories ideal endorsement*) for analyses. A codebook, a central reference of all codes used in the analysis that ensures consistency in application of codes, was established (see Appendix B). In order to develop a codebook, the primary researcher reviewed a random selection of nine completed surveys, at which point code saturation, where the total range of themes are identified, was likely to have occurred (Hennink, Kaiser, & Marconi, 2017). The primary researcher took a structured coding approach, in that the primary researcher closely read each response to the elaboration section of an item individually. For example, each individual response to the elaboration question of the item *multi-scale personality inventories* in the *ideal endorsement* rating section was coded as a complete text segment. The primary researcher made extensive memos regarding underlying concepts and identified keywords that could be used to develop inductive codes from the data. These memos and keywords were used to develop initial code definitions that included the code name, code description, inclusion criteria, exclusion criteria, and one or more examples of relevant text (see Appendix B).

For an example of the memoing process, while reviewing the *intellectual functioning assessments ideal endorsement* elaboration responses, the primary researcher indicated in a memo that intellectual functioning assessments were being described as helpful, but only in

particular situations, such as when an intellectual disability (ID) was suspected by the evaluator. This memo led to the development of the “ID” code. This code definition developed over the content analysis process to include intellectual disabilities, neurological deficits, or other cognitive disorders. In this instance, the initial code, derived from memoing the *intellectual functioning assessments ideal endorsement* responses, expanded to include other closely related disorders mentioned in elaboration responses to other items (e.g., *neuropsychological evaluation ideal endorsement, current mental status assessment ideal endorsement*).

For an example of the keyword identification process, while reviewing the *employment history ideal endorsement* responses, the primary researcher recognized the keyword phrase “historical functioning” was occurring in multiple individual responses. The primary researcher developed the code name “historical functioning” from the complete response “relevant to historical functioning.” In this instance, the keyword phrase “historical functioning” was an in vivo code, meaning it was labeled using a short phrase taken directly from that section of the data (Given, 2008).

Inter-coder Agreement Process

Reflexivity, individual biases, and interpretation variance can be curtailed by the inclusion of a secondary researcher in the coding process to check for coding reliability and validity (Guest, MacQueen, & Namey, 2012). When conducting inter-coder agreement checks, inconsistencies in coding should be addressed and discussed between the researchers until a consensus is reached, the entire process of which should be documented as part of the overall audit trail (Hennink, Kaiser, & Marconi, 2017). Codes should be modified, integrated, and expanded as necessary to reflect the data, decrease discrepancies in coding, and increase the precision of the codebook. Once these changes have been made following the coding of one

document, the process should be repeated, once again individually coding one randomly selected completed survey, addressing discrepancies, and revising the codebook, if necessary. Inter-coder agreement checks should persist until an acceptable percent agreement of 80% is reached (Guest, MacQueen, & Namey, 2012; Neuendorf, 2002). Responses coded at the beginning of the process may need to be reexamined and potentially recoded in accordance with the final codebook.

In order to establish inter-coder agreement, the primary researcher trained a secondary researcher, a graduate student in the Clinical Psychology department, in general content analysis methods as well as how to organize data and code within NVivo. Using the codebook established by the primary researcher, the primary researcher and secondary researcher separately coded one randomly selected document, *details of current offense actual practice* elaboration responses. Analysis within NVivo calculated inter-coder agreement as represented by percent agreement broken down by each individual code. An average percent agreement across all codes of 97% was attained, which was well above recommended guidelines (Guest, MacQueen, & Namey, 2012; Neuendorf, 2002), however, the smallest percent agreement for an individual code was 57% for the “Informs MSO” code. The primary researcher and secondary researcher discussed the discrepancies in coding and ambiguity of code definitions. This discussion resulted in the modifications of the “Generally informative,” “Informs MSO,” “Informs Offense,” “Practice,” and “Presence of MI or PD” codes. Most notably, the code definitions of “Generally informative” and “Informs MSO” were changed to reflect that responses such as “obvious,” which had previously been indicated to be coded as “Informs MSO,” were to be coded as “Generally informative.” This was done to focus the code definition of “Informs MSO” to items that assess the defendant’s actual mental state around the time of the offense. It was also agreed that such vague comments indicate the evaluator finds the item generally informative, without

reference to how the item is used in the overall opinion, thus making it more appropriate for the “Generally informative” code.

Due to the low percent agreement for the “Informs MSO” code and substantial changes made to the codebook, the primary and secondary researcher decided to perform a second inter-coder agreement check, using the document containing the *medical history ideal endorsement* responses. An average percent agreement across all codes of 96% was attained. Additionally, each individual code had an average percent agreement above the recommended guideline of 80% (Guest, MacQueen, & Namey, 2012; Neuendorf, 2002). After a thorough discussion of minor discrepancies, no modifications were made to the codebook. The primary researcher then recoded the first document, *details of current offense actual practice* responses, in accordance with the adjusted codebook and proceeded to code the remaining documents.

5. RESULTS AND DISCUSSION

Ideal practices

Results of the *ideal endorsement* ratings revealed which psychological assessment tools, sources of collateral information, and clinical interview topics evaluators consider when conducting MSO evaluations, as well as the relative importance of each item to the formulation of the evaluator's opinion. The average *ideal endorsement* ratings of each item are ranked in order of most informative to least informative in an ideal evaluation by the categories of psychological assessment tools (Table 1), sources of collateral information (Table 2), and clinical interview topics (Table 3). Content analysis of the *ideal endorsement* elaboration sections per item revealed the most salient reason evaluators provided for how an item informs an overall opinion on legal sanity. The most common reason is provided in the tables as well.

Table 1
Ideal Endorsement Ratings for Psychological Assessment Tools

Item	<i>M</i>	<i>SD</i>	Reason
Malingering and effort measures (e.g. TOMM, SIMS, VIP, SIRS-2, etc.)	2.12	0.79	Malingering
Multi-scale personality inventories (e.g. PAI, MMPI-II, etc.)	1.44	0.92	Mental Disease/ Malingering
Intellectual functioning assessments (e.g. WAIS-IV, Stanford-Binet, etc.)	1.33	0.77	Mental Defect
Neuropsychological evaluation (e.g. Halstead-Reitan, Luria-Nebraska, etc.)	1.03	0.53	Mental Defect
Rogers Criminal Responsibility Assessment Scales	0.90	0.73	Does Not Inform
Risk assessments/forensically relevant instruments (e.g. PCL-R, HCR-20, etc.)	0.74	0.89	Does Not Inform
Projective tests (e.g. TAT, sentence completion task, Rorschach, etc.)	0.36	0.71	Does Not Inform

Note. The four-point ideal rating scale consisted of 3 = essential, 2 = recommended, 1 = optional, 0 = unnecessary.

Table 2
Ideal Endorsement Ratings for Sources of Collateral Information

Item	<i>M</i>	<i>SD</i>	Reason
Law enforcement's records of offense (e.g. arrest report, supplemental documents, transcripts from patient's interviews with police, etc.)	2.99	0.10	MSO
Medical/mental health records	2.89	0.38	Mental Disease
Pertinent legal documents to the current case (e.g. affidavits, transcripts from prior hearings in this case, etc.)	2.46	0.68	MSO
Interview with witnesses or documented witness statements	2.32	0.81	MSO
Information to inform the justification/reason for the referral	2.31	0.85	Does Not Inform
Previous arrest records	2.18	0.71	Antisocial
Interview with primary caregivers/family members/others known to defendant	2.14	0.75	MSO
Interview with lawyer	1.66	0.92	Does Not Inform
Education records	1.49	0.78	Mental Defect
Miranda waiver	1.39	0.90	MSO

Note. The four-point ideal rating scale consisted of 3 = essential, 2 = recommended, 1 = optional, 0 = unnecessary.

Table 3
Ideal Endorsement Ratings for Clinical Interview Topics

Item	<i>M</i>	<i>SD</i>	Reason
Details of current offense	3.00	0.00	MSO
Mental health history	2.91	0.33	Mental Disease
Substance use history	2.81	0.45	Antisocial
Current mental status assessment	2.71	0.50	Mental Disease
Medical History	2.34	0.75	Mental Disease
Family and developmental history	2.24	0.71	Does Not Inform
Criminal history	2.23	0.74	Antisocial
Social history	2.16	0.83	Does Not Inform
Education history	1.94	0.81	Mental Defect
Employment history	1.92	0.76	Contextualization
Sexual history	1.16	0.80	Contextualization
Religious history	1.13	0.69	Contextualization

Note. The four-point ideal rating scale consisted of 3 = essential, 2 = recommended, 1 = optional, 0 = unnecessary.

Mental state at the time of the offense

The construct of an individual's mental state at the time of the offense is inherently difficult to ascertain due to the retrospective nature of MSO evaluations (Melton et al, 2018). Evaluators often have to surmise a defendant's legal sanity or insanity using testing or sources of information indirectly related to the legal construct in order to form their conclusions. However, some sources of collateral information and clinical interview topics were reported to directly inform the evaluator of the defendant's mental state while committing the offense.

Results indicated that inquiring about the defendant's perspective of the offense during the clinical interview is one way to obtain an understanding of their mental state at the time of the offense. Multiple participants (53%) reported that the defendant's self-report uniquely contributes to an opinion because it may allow the evaluator to understand the defendant's internal thoughts and motivations for the behavior, as well as to what degree their thought content was organized and rational. Additionally, this information, as one participant stated, is "imperative in determining the defendant's knowledge of nature and wrongfulness," which often is the legal crux of an MSO evaluation.

Legal documents pertinent to the current case (e.g., affidavits, transcripts from prior hearings in this case, etc.) were also reported by 20% of participants to inform the defendant's mental state at the time of the offense. As summarized by one participant, these documents often provide "information regarding the subject's behavior, statements, etc. regarding the time period surrounding the alleged offense, which is critical to a thorough NGRI evaluation." According to participants, these documents may also provide information regarding the defendant's mental state at the time of the offense as observed by others.

Similarly, 39% of evaluators reported law enforcement's records of the offense, such as the arrest report, supplemental documents, and transcripts from the defendant's interviews with the police, were informative of the defendant's mental state at the time of the offense because they provide an outside perspective of the defendant's behavior, speech, and thinking at that time. Several participants stated that law enforcement records are of particular interest because police officers are often the first members of the criminal justice system to interact with the defendant after the crime. Therefore, these records often contain important information regarding the defendant's mental state proximal to the crime, such as the responding officer's impression of the defendant's mental state. A few evaluators reported that law enforcement officers may have access to audio or video recordings of the defendant immediately following the crime, such as from body cameras on the scene or tape recorders during an interview, which would allow the evaluator to have unfiltered access to the defendant's behavior and statements suggestive of their mental state at that time.

Conducting interviews with witnesses or reviewing documented witness statements may also aid the evaluator in reconstructing the defendant's mental state at the time of the offense according to 32% of participants. Participants suggested that, along with providing information pertinent to the defendant's behavior and speech during and after the offense, which might allude to an insane mental state, witnesses may provide observations directly prior to the offense. Results indicated this information is valuable in that erratic or bizarre behavior, as defined by a third-party witness, directly before the offense may lend further credence to the conclusion that the defendant was truly in a compromised mental state at the time of the crime.

Interviews with primary caregivers, family members, or others closely known to the defendant were reported by 32% of participants to provide valuable information regarding

mental state at the time of the offense as they have a “unique vantage point.” Evaluators indicated that these individuals may provide information regarding the defendant’s mental state and behavior during the days leading up to the offense and notify the evaluator if there was an aberration from typical functioning. However, 25% of participants expressed this information should be pursued with caution, as family members may be biased to either exaggerate or minimize symptoms that might qualify for a NGRI defense or may know very little about the offense itself. Some participants advised that evaluators should make attempts to corroborate any information provided by these individuals.

Required by law, Miranda waivers state the defendant waives his or her right to remain silent and have a lawyer present during questioning by the police (*Miranda v. Arizona*, 1966). In *Miranda v. Arizona* (1966), the Court denoted that the defendant may waive these rights, typically indicated by a signature on the waiver, “provided the waiver is made voluntarily, knowingly, and intelligently” (p. 444). Although there was notable disagreement among evaluators if the Miranda waiver, signed or unsigned, was informative (28% of participants stated it does not inform), those who did find it enlightening (35%) agreed it contributed to conceptualizing the defendant’s mental state at the time of the offense. According to some participants, the Miranda waiver may indicate the defendant’s “thought processes” and “voluntariness” at the time of the police interview, which may be presumed to occur shortly after the offense. According to the results, the Miranda waiver’s informative value is contingent upon how close to the offense it was attained, with more credence afforded to a waiver given directly after the incident. For example, one participant stated “if an individual was thought to be competent to waive his/her Miranda rights after being arrested, that can potentially speak to the defendant's state of mind around the time that the offense was allegedly committed.”

Alternatively, if the waiver is unsigned, suggesting the defendant was uncooperative during the police interview, a few evaluators reported that may indicate the defendant knew the wrongfulness of his or her actions.

Contextualization of Defendant

Responses suggest other items indirectly contribute to an evaluators' opinion on mental state at the time of the offense through various means. While these items do not directly aid the evaluator in reconstructing mental state at the time of the offense, they may, for example, contribute to the evaluator's overall conceptualization of the defendant. Importantly, results indicated that these contextual factors are only situationally relevant, meaning their significance is contingent upon variables related to the case, the defendant, or both.

According to 56% of participants, probing the defendant about their religious beliefs and background can provide a cultural perspective, which allows the evaluator to place the actions of the defendant in a broader context. Of those evaluators, 14% consider this line of questioning during an MSO evaluation to be appropriate for all types of offenses and defendants, as it allows the evaluator to fully understand the defendant in his or her cultural context. In this respect, an evaluator may determine that an individual's actions related to the crime are or are not culturally normative. Conversely, 86% of those evaluators asserted this information is only helpful if religion is somehow related to the defendant's delusions, hallucinations, or other explanations for the criminal act. By inquiring about an individual's religious beliefs, evaluators can better understand, as one participant stated, what is "accepted in that person's religious culture vs. what is delusional, misinterpreted from a religious book, etc.," which may have influenced their mental state at the time of the offense. In these cases, as one participant suggested, evaluators need to "disentangle religious-themed delusions from strongly held religious beliefs." However,

a few evaluators expressed apprehension in utilizing this clinical interview topic because it may prove to be, as one participant stated, “more prejudicial than probative.”

Similarly, according to 65% of participants, the probative value of questioning the defendant about their sexual history during the clinical interview is largely situational and ethically ambiguous. Evaluators indicated that the situations under which this information is more or less necessary to attain would be if the defendant’s sexual attitudes were possibly related to motive (e.g., associated with delusions or hallucinations) or the nature of the crime (e.g., a sexual offense). Overall, 60% of evaluators believe that this information should only be obtained if it has direct relevance to the alleged offense, while 8% reported that even if the crime was sexually-based a detailed sexual history is irrelevant. One participant advised this line of questioning, “would be embarrassing for that person and does not belong in a report unless the report is about sexual issues.”

Evaluators (32%) reported that inquiring about the defendant’s employment history during the clinical interview generally informed the evaluator of their functioning leading up to the offense. The assumption being that if a defendant was functioning relatively well in society historically and leading up to the offense, then the evaluator may consider this as evidence their mental state was not likely impaired during the offense. However, if a defendant was unable to hold a job because, as one participant suggested, “they always got paranoid,” this may indicate their mental state was deteriorating leading up to the offense.

Presence of a Mental Defect

Certain information may indicate a deficit in cognitive or intellectual functioning would be relevant to the legal question in an MSO evaluation. Cognitive deficits are defined as any impairment in cognitive functioning, such as attention, decision-making, memory, judgement,

and others. Many jurisdictions allow for an exemption from criminal responsibility if substantial cognitive deficits contributed to the criminal act (Packer, 2009). For example, Virginia's insanity defense law stipulates a defendant is insane if "at time of the offense, because of mental disease or defect, he/she did not understand the nature, character, and consequences of his/her act, or was unable to distinguish right from wrong, or was driven by an irresistible impulse to commit the act" (Virginia Department of Behavioral Health & Developmental Services, 2003). This standard for insanity is considerably similar to many other jurisdictions in the United States (Packer, 2009), meaning assessing cognitive or intellectual deficits can be a critical part of an MSO evaluation.

Results indicated that items may inform evaluators of an explanation for an altered mental state at the time of the offense based on the defendant's history or current presentation. In this approach, the information, if affirmative, is extrapolated and assumed to apply to the defendant at the time of the offense. For example, participants reported that a defendant's educational history, whether assessed in the clinical interview (38%) or through education records (42%), is relevant to forming their opinions. This includes information such as "level of education," "difficulties with school and school work," and "parental involvement in child's progression," as well as formal transcripts and results of testing. Participants stated that this information may indicate that there is a substantial history of cognitive or intellectual deficits, or lack thereof, which may inform of the defendant's likely cognitive capacity at the time of the offense. Approximately 25% evaluators stated that this information is recommended only if a mental defect is suspected to have contributed to the criminal act. Alternatively, approximately 15% recommend always obtaining this information as it indicates whether more exploration of developmental or intellectual functioning is necessary.

According to 56% of participants, another useful indication of an intellectual disability is formal intelligence testing using measures such as the Wechsler Adult Intelligence Scale (Wechsler, 2008) or Stanford-Binet Intelligence Scales (Roid, 2003). Similarly, 60% of participants reported formal neuropsychological assessment using measures such as the Halstead-Reitan Neuropsychological Test Battery (Reitan & Wolfson, 1993) or Luria-Nebraska Neuropsychological Battery (Golden, Hammeke, & Purisch, 1981) indicate cognitive deficits. These measures may inform the evaluator of the current presence of a cognitive or intellectual disability, as opposed to a history of such disabilities, which can still be presumed to have been present during the offense, according to participants. Results indicated that impairment in intellectual functioning may suggest a defendant meets the intellectual prong of an insanity defense, while neurocognitive impairment may inform the evaluator if the defendant meets the criteria for the volitional prong or irresistible impulse standard. As IQ is relatively stable over time for both average functioning individuals (Wechsler, 2008) and those with intellectual disabilities (Whitaker, 2008), formal testing by the evaluator may be unnecessary if the records indicate the results of previous intelligence testing. A few participants stated that if the evaluator has a justifiable reason to suspect there has been a change in cognitive or intellectual functioning, such as the present level of functioning does not appear commensurate with the defendant's history, then formal testing may need to be given again. Approximately 87% of participants stated if a mental defect is not suspected based on the defendant's record or presentation, then these data are unlikely to inform the evaluator's opinion on the defendant's mental state at the time of the offense.

Presence of a Mental Disease

As clearly stated in the example of the Virginia laws outlining the insanity defense, a “mental disease” can qualify an individual for an insanity plea as long as it impaired the defendant’s understanding of the act or their ability to perceive right from wrong. Indeed, a diagnosed mental illness is one of the greatest predictors that an individual will be found NGRI (Warren et al., 2004). Similar to cognitive deficits, participants reported that evidence the defendant historically exhibited symptoms of a mental illness or is currently suffering from a mental illness is informative to the evaluator in that the evaluator extrapolates that information and looks for any indications those symptoms may have been present during the offense.

According to participants, the defendant’s mental health history, acquired through a review of their records (50%) or during the clinical interview (47%), informs the likelihood of a mental disease leading to impairment at the time of the offense. As reported, “since you did not see the defendant the day of the crime, background can lay the groundwork for a history of mental illness and the likelihood of mental illness at the time of the offense.” As the legal question in MSO evaluations is specific to one narrow timeframe, 11% of evaluators endorsed thoroughly examining those records proximal to the offense as they may be particularly informative of the defendant’s mental state at the time of the offense. Results indicated that while a significant recorded history of mental illness suggests the veracity of the defendant’s claims of a mental illness, a lack of a significant mental health history in the records may denote the defendant is malingering. However, this conclusion would need to be substantiated with other collateral information as it is possible the offense occurred during the defendant’s first signs of a mental illness, although, as one evaluator indicated, “this is not typical.”

Results indicated that a mental status examination, whether formalized, such as the Mini-Mental Status Examination (Folstein, Folstein, & McHugh, 1975), or informal, during the clinical interview may serve a dual role in MSO evaluations. First, 25% of participants stated it indicates to the evaluator if the defendant is able to provide adequate and reliable information during the clinical interview. If a defendant performs poorly on a mental status examination, multiple participants suggested the evaluator should consider this when integrating historical information provided by the defendant during the interview. One participant provided the example: “if they are commenting on current delusional beliefs and do not seem in touch with reality, it would be almost impossible to be sure you got the best information from them about the offense, their own history, etc.” If this were the case, participants suggested the evaluator should attempt to substantiate all information gathered during the interview through collateral sources. According to participants, if a defendant is severely cognitively impaired 7% of evaluators question the ethics of pursuing with a clinical interview, as the defendant cannot rationally give consent to be interviewed. Second, 61% of participants indicated that if an interview with a mental status examination is conducted shortly after the offense, this information can be extrapolated to indirectly inform the defendant’s mental state at the time of the offense. As one participant indicated, “many mental illnesses are persistent, and the presence or absence of current symptoms could be important pieces of information.”

Evaluators expressed the belief that multi-scale personality inventories, such as the Personality Assessment Inventory (Morey, 1991) and Minnesota Multiphasic Personality Inventory-2 (Butcher et al., 2001), inform opinions in MSO evaluations in multiple ways. As such, this item will be discussed again in another section of the paper to more accurately reflect the various ways these tests have probative value. Evaluators (36%) reported that these

inventories may provide information regarding the mental disease contributing to the defendant's defect of reason, especially if assessed proximal to the event. However, evaluators warned that while these inventories may aid in diagnosing current symptomology, they are not designed to assess mental illness in a retrospective manner. As one participant stated, "evaluations often occur well after the alleged offenses, so inventories that test current functioning are not necessary in most cases." A large portion (42%) of evaluators denied the informative value of multi-scale inventories for MSO evaluations, stating the results are absolutely not relevant to the psycholegal question.

Results indicated that evaluators may consider an organic cause, such as a medical or non-illicit drug related reason, for fluctuations in mental state at the time of the offense. A large portion of participants (48%) reported that inquiring about the defendant's medical history during the clinical interview informed them of any conditions which cause alterations in reality testing, such as delirium. According to participants, pertinent medical information would include changes in medication or a history of head injuries or loss of consciousness. Additionally, a few participants stated that inquiring about this information aids the evaluator in ruling in or ruling out the presence of somatic delusions. Some (8%) evaluators believe this information is only necessary if an organic cause for the defendant's impaired mental state is the evaluator's hypothesis.

Antisocial behavior

Antisocial behavior is any behavior that covertly or overtly violates social rules, disregards the rights of others, or defies authority. These behaviors can be criminogenic in nature or aggressive towards others (American Psychiatric Association, 2013). Evaluators (44%) reported that asking defendants about their criminal history during the clinical interview aids in

determining what degree of antisocial behavior the defendant possesses. According to participants, besides being generally informative of the defendant's criminogenic thinking, criminal history informs evaluators if the defendant has been charged with a similar crime in the past. Some evaluators (20%) intimated that if a pattern of similar criminal behavior was present in the defendant's past, then the defendant may be presumed to have known the offense was wrong, thus nullifying an NGRI defense. Other evaluators (8%) indicated this information can be used to assume the presence of an external motivation for the crime if this motivation has been present in the past.

Similarly, 46% of participants reported that previous arrest records aid in informing mental state at the time of the offense indirectly by indicating the defendant's familiarity with the wrongfulness of the alleged crime, should past allegations be similar to the current charges. Some participants placed emphasis on the patterns in previous arrests, not merely the substantial presence or similarities to the current offense. For example, one participant noted:

[Previous arrest records] may be important to establish a pattern of behavior to help rule in or out hypotheses (e.g., this person gets arrested frequently for B&E to a house they delusionally believe is theirs vs. a person who has been arrested for stealing frequently without any claim to NGRI until this event, with no major differences).

A distinction is made between two individuals who have a substantial criminal history similar to the current charges, but one may still be opined as insane at the time of the offense due to repeated insanity, and the other may be opined sane due to the low occurrence of insanity as a contributing factor in their previous crimes.

Results indicated that 48% of evaluators found inquiring about the defendant's substance use during the clinical interview informative of if there is an alternative explanation for the alleged criminal activity besides insanity or criminogenic motives. Evaluators stressed the importance of probing about substance use directly before the alleged offense. Since voluntary intoxication is not a legal exclusion from criminal responsibility (*Kane v. U.S.*, 1968), participants emphasized the importance for evaluators to "rule-in" or "rule-out" the possibility the defendant's actions were primarily driven by the effects of alcohol or a drug. This is particularly critical to assess as intoxication from substance use can mimic the symptoms of mental illness or the mental illness behavior might be a result of substance-induced psychosis, according to participants.

Malingering

Malingering is the deliberate exaggeration or feigning of psychological symptoms for some external gain (American Psychiatric Association, 2013). Where MSO evaluations are concerned, the external gain a defendant might receive from malingering insanity at the time of the offense would be an NGRI acquittal and time spent in a psychiatric hospital as opposed to prison or jail. Many individuals falsely believe that an NGRI acquittal is a legal loophole which allows guilty individuals to avoid jail time (Hans, 1986), however, research shows individuals found NGRI spend more time in psychiatric hospitals than they would in jail for the same offense (Rodriguez, LeWinn, & Perlin, 1983).

There appears to be nearly unanimous agreement (95%) among evaluators that given the heightened incentive for malingering during MSO evaluations, evaluators should always consider this possibility. According to 73% of participants, certain formalized measures, such as the Structured Interview of Reported Symptoms (Rogers, Bagby, & Dickens, 1992) or Test of

Memory Malingering (Tombaugh, 1996), can be used by evaluators to aid in their determination of a defendant's malingering symptoms in order to qualify for a NGRI acquittal. While 22% of evaluators endorsed informal assessment of malingering during MSO evaluations, 27% of participants expressed views similar to a participant who stated, "if there is an indication of malingering or poor effort, it is essential the issue be examined with objective measures, as this issue is directly relevant to the referral question (e.g., diagnosis)." Those who argue against the use of formal malingering measures for every case do not believe it is necessary in cases where there is a substantial history of symptoms or impairment in the defendant's medical or mental health records. Additionally, a few evaluators suggested that unnecessary exposure to malingering measures can affect their test security and validity, an ethical concern made more salient by the deceptive nature of malingering measures.

In addition to measures that exclusively assess malingering, 29% of evaluators reported that multi-scale personality inventories such as the PAI and MMPI, which have imbedded validity indices, indicate if someone is attempting to over or under report symptomology. For example, the PAI has four formal validity scales for assessing inconsistent responding, infrequent responding, negative impression management, and positive impression management (Morey, 1991). Individuals motivated to malingering will likely be indicated by the negative impression management scale, as well as two supplemental scales, the Malingering Index, which assesses effortful negative distortion, and the Roger's Discriminant Function Index, which assesses malingering of mild psychopathology (Edens, Poythress, & Watkins-Clay, 2007). According to some participants, the benefit of using a multi-scale personality measure, as opposed to a stand-alone malingering measure, is that the evaluator can achieve diagnostic clarity and detect possible malingering with one psychological test.

Does Not Inform

Participants in the current study suggested certain conventional aspects of an MSO evaluation do not substantially contribute, either directly or indirectly, to the assessment of a defendant's mental state at the time of the offense. These items do not significantly aid in contextualizing the defendant, informing of antisocial behavior, or indicating the presence of a mental disease or defect. Participants indicated these items, "likely would not provide much information about the defendant's functioning at the time of the crime" or, simply, "[do] not inform."

Asking about the defendant's family and developmental background is, as one participant stated, "good to get general information to understand the defendant, but it is not necessary to go into much detail as most information is not important to a defendant's sanity." This item received a mean rating of 2.24 ($SD = 0.71$), meaning it is at least "recommended" by evaluators in an ideal MSO evaluation, however 40% of evaluators indicated this information is not at all or only minimally informative. This could be due to the general informative value it possesses for establishing a holistic view of the defendant, which was curtailed in the elaboration responses on the usefulness of this item. Alternatively, the inflated rating may be an indicator that evaluators rate this clinical interview topic, regardless of its probative value, as higher based on established practices.

There may be cause for an evaluator to interview the defendant's lawyer as a source of collateral information. However, as one participant indicated, it is only "the exceptional occasion that such an interview would be of any benefit to the opinion on this particular forensic question," and therefore, 30% of participants indicated this item does not typically inform evaluators regarding the defendant's mental state at the time of the offense. According to

participants who agreed an interview may be advantageous, the only information that may aid an evaluator would be the lawyer's justification for suspecting the defendant suffered from a mental disease or defect during the crime. Some participants (27%) stated there are numerous logistical reasons an evaluator would need to be in contact with the defendant's lawyer, such as to determine the referral question, obtain relevant records, and inform the lawyer of the results of the evaluation. Still, beyond logistical matters, there is little justification for a formal interview with the attorney according to most participants. Not only are formal interviews with lawyers generally uninformative, but some evaluators (12%) are concerned they have the potential to bias the evaluator through adversarial allegiance or the acquisition of biased data from an unreliable source. As one participant cautioned, it is "[the lawyer's] duty to zealously defend their client, which constrains their objectivity."

Projective tests are those which employ ambiguous stimuli that allow the test taker to respond in a way that may reveal latent or subtle traits of his or her personality (Cervone & Pervin, 2013). These include psychological assessment tools such as the Rorschach Test (Rorschach, 1981) and Thematic Apperception Test (Murray, 1943). There exists a considerable amount of debate between researchers regarding the validity of such tests for measuring personality constructs, with researchers on both sides holding adamant opinions (Garb, Wood, Lilienfeld, & Nezworski, 2005; Mihura, Meyer, Bombel, & Dumitrascu, 2015; Wood, Garb, Nezworski, Lilienfeld, & Duke, 2015). Importantly, research suggests the Rorschach Test does not meet the legal criteria specified in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1923) for scientific evidence to be admissible in court (Grove, Barden, Garb, & Lilienfeld, 2002, cf. Ritzler, Erard, & Pettigrew, 2002).

It appears similarly strong sentiments are expressed by clinicians and evaluators as well. Projective tests were rated as “unnecessary” ($M = 0.36$, $SD = 0.71$) by evaluators, which is consistent with the results of Lally (2003) where projective tests were viewed as “unacceptable” by evaluators for forensic use. Most evaluators (87%) contended that projective tests do not provide information relevant to the psycholegal question in MSO evaluations. Some participants (12%) stated that at best, projective tests can assess present personality functioning and distorted thinking, but cannot measure these facets retrospectively. According to participants in this study, as opposed to multi-scale personality inventories, projective tests have limited diagnostic value and lack validity indices to assess for malingering. In addition to being viewed as uninformative, the use of projective tests poses a number of ethical and legal concerns as described by participants. First, 22% of participants stated that projective tests are not psychometrically reliable or valid and, therefore, conclusions based on them are likely to be inaccurate. Second, 10% of participants expressed the concern that these tests are not objective and thus susceptible to subjective interpretation by the evaluator. If a projective test is given, some evaluators recommend it only as a collateral source of information to substantiate and expand upon the results of an “objective” personality measure. Third, due to the various admissibility statutes regulating scientific evidence in court (i.e., *Daubert*, *Frye*), 17% of participants stated the results of projective tests would not likely be admitted into evidence. Fourth, even if the results were admitted into evidence, 13% of evaluators are concerned about their ability to competently defend the measures on the stand during cross-examination. In fact, evaluators expressed great apprehension about the idea of having to justify their use of one of these measures, such as stating, “I would die before I had to explain the [Thematic Apperception Test] to a courtroom.” Even those participants who support the use of projective tests in general clinical practice do not

recommend their use in forensic settings, making comments such as, “these tools may assist in diagnosis or symptom profile yet cannot assist in looking at a person’s mental state at the time of the alleged offense.”

Risk assessments and other forensically relevant measures, such as the Psychopathy Checklist-Revised (PCL-R; Hare, 2003) and Historical Clinical Risk Management-20 (HCR-20; Douglas, Hart, Webster, & Belfrage, 2013), were designed specifically for use in forensic populations (McLaughlin & Kan, 2014). While the constructs measured by these assessments, psychopathy (PCL-R) and violence risk (HCR-20), are of interest in many types of forensic evaluations, they do not necessarily translate to MSO evaluations. Therefore, 62% of participants reported that these measures are not informative of mental state at the time of the offense because they were designed to answer other psycholegal questions. However, 11% of participants indicated that in certain jurisdictions an assessment of risk may be court-mandated or required by law in order to determine, as one evaluator stated, “what to do with the person regardless of how the MSO issue turns out.” Even then, there appears to be a logistical issue where two psycholegal questions are being assessed simultaneously, one of which (violence risk) is inherently prospective and the other (MSO) retrospective. Additionally, participants indicated that results of the PCL-R may aid in the assessment of psychopathy. However, according to participants, this information is not necessarily significant given psychopathy alone is not typically an excuse from criminal responsibility, but a defendant may have psychopathic traits and still have been suffering from other symptoms that significantly impaired their ability to understand or appreciate the crime. Furthermore, in the latter cases, 7% of evaluators expressed concerns that it may be prejudicial for an evaluator to establish the defendant as a psychopath, as it may overshadow serious impairment due to other psychiatric symptoms.

As discussed previously, the Rogers Criminal Responsibility Assessment Scales (R-CRAS) is a tool designed to aid the evaluator in determining legal sanity at the time of the offense (Rogers, 1984). The majority of participants (62%) stated this particular psychological assessment tool's utility is limited to structuring information in order to determine an opinion on the defendant's mental state at the time of the offense. Furthermore, the R-CRAS was rated by evaluators in this study as "optional" to "unnecessary" ($M = 0.90$, $SD = 0.73$). According to 32% of participants, the R-CRAS is optional for beginning evaluators as it provides a framework for collecting and organizing data. They went on to explain that more experienced evaluators can obtain the data gathered through the use of the R-CRAS on their own during the clinical interview and collection of collateral information. Consistent with the concerns expressed in Melton et al. (2018), 11% of participants perceived the R-CRAS as constraining when attempting to consider nuanced information or when applying a particular jurisdictional standard of criminal responsibility. Although some studies report good internal validity (Borum, 2003) and interrater reliability (Rogers, 1984; Rogers & Shuman, 2000), a few participants in this study were skeptical of the psychometric properties of the R-CRAS. Consistent with Borum (2003), participants in this study questioned the external validity of the measure.

Discrepancies Between Ideal and Actual Practices¹

Table 4.
Discrepancies between ideal endorsement ratings and actual practice ratings

Item	<i>t</i>	<i>p-value</i>	Cohen's <i>d</i>	Reason
Rogers Criminal Responsibility Assessment Scale	8.56	<.001	.95	Does Not Inform
Employment History	-6.95	<.001	-.81	Standard
Criminal history	-6.59	<.001	-.77	Standard
Social History	-6.37	<.001	-.76	Standard
Family and developmental history	-5.96	<.001	-.70	Standard
Previous arrest records	-5.44	<.001	-.63	Easy Access
Neuropsychological evaluations	5.35	<.001	.59	Incompetence
Education history	-4.06	<.001	-.47	Standard
Medical history	-3.85	<.001	-.45	Standard
Interview with lawyer	-3.18	.002	-.37	Practical
Current mental status assessment	-2.62	.01	-.31	Standard*
Miranda waiver	2.36	.02	.28	Lack of Access

¹ To facilitate clarity and conserve space, only significant discrepancies are reported.

Risk assessments/forensically relevant instruments	2.19	.03	.24	Lack of Access
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Note. Positive t-scores = ideal rating > actual rating. Negative t-scores = actual rating > ideal rating

Psychological assessment tools

Paired-samples t-tests indicated significantly lower *actual practice* ratings than *ideal endorsement* ratings for several psychological assessment tools. This is consistent with previous research (Borum & Grisso, 1996; Lally, 2003; McLaughlin & Kan, 2014), which indicated that the use of psychological assessment tools is uncommon in MSO evaluations. The results of the current study build upon this notion by indicating that, at least for some psychological assessment tools, there is perhaps probative value that is not being obtained due to systematic or logistical constraints.

Neuropsychological evaluations, such as the Halstead-Reitan Neuropsychological Test Battery or Luria-Nebraska Neuropsychological Battery, assist evaluators in determining if the defendant currently exhibits cognitive deficits. However, results indicate that one reason neuropsychological tests are more recommended than they are used is that 33% of participants in this study stated they do not consider themselves competent to administer these measures. Instead, evaluators believe these measures should be given by neuropsychologists or those with specialized training in neurology and psychology. This view is in line with the ethical guidelines for psychologists and forensic examiners, which state psychologists should only provide services in areas where they are competent based on previous training, education, or supervised experience (American Psychological Association, 2013, 2017). However, since these guidelines also clearly stipulate evaluators should take proactive steps to develop their competency, perhaps forensic evaluators should consider taking continuing education credits on cognitive testing or working under the supervision of a neuropsychologist until competence can be established. Conversely, perhaps neuropsychological testing has become too specialized a field for general forensic psychologists to qualify as competent to administer these tests and have them admissible

in court. Without having adequate practice in administering these measures, participants suggested that evaluators should at least refer the defendant for cognitive testing with a specialist if deficits are suspected.

Consistent with previous studies, the R-CRAS is used less frequently than is endorsed (Archer et al., 2006; Lally, 2003), although this study was the first to make this direct comparison. According to participants, the largest factor contributing to its “rare” use ($M = 0.40$, $SD = 0.81$) is that the measure is not considered informative of mental state at the time of the offense for experienced evaluators. Instead, participants reported that knowledgeable evaluators tend to rely on their own ability to gather pertinent information during the clinical interview. Another factor contributing to the low use of this measure in MSO evaluations may be that some evaluators who could potentially find it useful, such as novice evaluators, reported never having been trained on its use or—in some cases—never even having heard of the R-CRAS.

Risk assessments and other forensically relevant instruments were developed to measure constructs such as psychopathy and violence risk and answer other psycholegal questions. Results indicated that although FAIs may be somewhat informative, they are “rarely” used in practice ($M = 0.48$, $SD = 0.85$) due to a lack of access to protocols and manuals in institutions by which many participants are employed. Although viewed as more ideal than utilized, evaluators should consider the biasing effects of these measures, as expressed by participants in the study, before administering them as part of an MSO evaluation. For example, if results of a HCR-20 indicated a likelihood of future violence the evaluator may consciously or subconsciously take this information into account and opine a defendant sane at the time of the offense, particularly if the index offense was violent. Similarly, if the results of the PCL-R were exceedingly high, indicating the presence of many psychopathic traits, then the evaluator may hastily attribute the

defendant's criminal behavior to these psychopathic traits and dismiss the potential presence of symptoms suggestive of a qualifying mental disease or defect. Evaluators may choose to consider instead the research which suggests an appropriate use of results from the PCL-R would be to assess for recidivism and inform the courts of violence risk (DeMatteo & Edens, 2006; DeMatteo et al., 2014).

Collateral information

Paired-samples t-tests indicated significantly lower *ideal endorsement* ratings than *actual practice* ratings for an interview with the defendant's lawyer and previous arrest records. This finding is consistent with the results from the *ideal endorsement* rating section which indicated data collected from interviews with lawyers does not influence evaluators' opinions on the defendant's mental state at the time of the offense. Yet, 26% of participants stated that some contact with the defendant's lawyer is necessary to gather information, such as the referral question and sources of collateral information. Therefore, contact with the defendant's lawyer is based on practical requirement as opposed to actual informative value. However, given the ethical concerns discussed in the previous section on this topic, evaluators should limit communications with the defendant's lawyer, especially if the evaluator is retained by the defense, in order to minimize bias.

The use of arrest records by evaluators is greater than their probative value because, as 38% of evaluators reported, they readily have access to these records or they are provided for them as part of the discovery package. This easy access may be of some concern. Although 46% of participants reported that these records are recommended because they can provide information regarding a defendant's antisocial behavior, some participants indicated they have the potential to be prejudicial. Whether it is unconscious or not, some evaluators may be biased

by the defendant's previous arrest history, or lack thereof, and should consider this before viewing these documents simply because they were provided by the court.

Alternatively, paired-samples t-tests indicated significantly lower *actual practice* ratings than *ideal endorsement* ratings for the defendant's Miranda waiver. As Miranda waivers are required by law to be provided for all defendants at the time of their arrest (*Miranda v. Arizona*, 1966), these should be associated with every criminal case on which an evaluator may be retained to work. However, 22% of participants stated these waivers are "rarely given" to the evaluators by anyone associated with the court. Additionally, a few evaluators reported that they do not think to ask for them. Therefore, some evaluators may benefit from easier access to these waivers or awareness of how this information may be used to inform their MSO opinions.

Clinical interview topics

Paired-samples t-tests indicated significantly lower *ideal endorsement* ratings than *actual practice* ratings for criminal history, education history, family and developmental history, medical history, social history, employment history, and a current mental status assessment. This suggests that half of the topics covered in a typical forensic clinical interview (Packer, 2009) are not significantly informative in constructing an opinion on mental state at the time of the offense, but are still used in practice more frequently. In fact, all these clinical interview topics were at least recommended by participants ($M's > 1.75$). Results indicated this is due to clinicians approaching MSO evaluations with their own "standard comprehensive interview" that they use in a wide variety of contexts.

The question then becomes if it is an acceptable and ethical practice in the field of forensic psychology to knowingly collect personal information about the defendant that is not likely to inform a psycholegal opinion. As discussed previously, due to their sensitive nature,

evaluators only ask about religious and sexual history on a situational basis if the topics are somehow related to the defendant's motivation for the crime or possible psychotic symptoms. However, criminal history, education history, family and developmental history, medical history, and social history do not appear to be considered too personal to be inquired about on a situational basis, still they do not typically provide significant information for the psycholegal question. Evaluators must ask themselves, who decides what potentially sensitive interview topics are relevant? For example, discussing a defendant's criminal history may cause the defendant to become uncomfortable and to perceive the evaluator as judgmental, thus the defendant may become defensive and suspicious of the evaluator. This almost certainly would cause a rupture in the assessment rapport and affect the data collected from that point forward. Such a substantial consequence does not seem worth it, especially given the reportedly limited probative value of the information gleaned and the probable availability of this information from a collateral source, such as arrest records.

Should evaluators be asking only that information which is necessary for contributing to an opinion? Could it be a breach of the defendant's privacy to inquire any further than is absolutely needed? Evaluators cannot know what information a defendant will perceive as too personal, but conversely, cannot avoid all topics which may be necessary to gather information solely out of trepidation. In regards to forensic report writing, there is agreement that only information pertinent to the referral question be included (Conroy, 2006; Grisso, 2010; Melton et al., 2018). There appears to be the requirement for a profession-wide discussion regarding the cost-benefit analysis of the utilization of these topics during the clinical interview itself. If the results of this study are to be relied upon, criminal history, education history, family and developmental history, medical history, social history, and employment history should be

scrutinized for their informative value and considered for inclusion on the list of situational clinical interview topics along with religious history and sexual history.

6. IMPLICATIONS

This study may contribute to researchers' and practitioners' understanding of best practice MSO evaluations. In a field that is continuously developing, it is important to understand how evaluations are being performed as well as the intentions behind those practices. After considering the results of this study, evaluators may gain a better understanding of the practices of their peers and may choose to adapt their methods accordingly. Additionally, the discrepancies addressed by this study may aid in initiating a debate by forensic evaluators regarding what information should and should not be assessed during a MSO evaluation based on a cost-benefit analysis weighing privacy and probative value. Evaluators must also critically evaluate the laws and other procedural constraints dictating their methods or access to certain items that inform or do not inform their opinion on the defendant's mental state at the time of the offense and make modifications as necessary.

The results of this study may also help inform future legal decisions. A 1993 Supreme Court decision determined that, along with other considerations, expert testimony must be based on practices that have gained general acceptance in the given field of expertise (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993). Given this study, in part, examined evaluation practices from an ideal perspective, the *ideal endorsement* ratings indicate the participants' perspectives of the probative value of each item in a typical MSO evaluation. Additionally, the content analysis data summarize the general opinions and reflect the current debates in the field regarding the value of these items. Therefore, the results of this study may inform judges when

determining the admissibility of an expert's testimony in court based on the methods used by that evaluator.

7. LIMITATIONS AND FUTURE DIRECTIONS

The results of this study must be considered within the context of the methodological limitations. Specifically, this study only examined forensic evaluators with Doctorate of Philosophy degrees or Doctorate of Psychology degrees, who are held to specific practice and ethical guidelines (American Psychological Association, 2013, 2017). Therefore, the results of this study should not be presumed to apply to forensic psychiatrists or other forensic evaluators who have received different training and are adherent to other professional guidelines. As may be the case with online survey studies, the quality of the content data was likely diminished relative to if data had been collected through in-person interviews. Additionally, there was a noticeable attrition rate throughout the survey in regards to the elaboration sections, about 50%. This may have impacted the quantity and quality of elaboration responses for items in the *actual practice* sections of the survey. Therefore, conclusions regarding the justification for the discrepancies between ideal and actual practices may not be comprehensive and should be considered with this in mind. Further, the current study did not examine how responses varied by jurisdiction. Based on variance in state laws, there may be reason to believe that evaluators' beliefs about ideal practices and actual practices may vary by jurisdiction.

Regarding future research, these data may inform a more standardized method of conducting MSO evaluations. The acceptability of certain psychological tests, sources of collateral information, and clinical interview topics may help to guide the development of a semi-structured interview to be used in clinical settings based on the informative value of each item. The results identifying the most informative items in an MSO evaluation and how they are

considered in the formulation of an opinion can contribute to the determination of what should be included in such a measure. Additionally, the results indicating several ethical concerns in MSO evaluations may require follow-up studies, for example, surveys examining evaluators' attitudes towards these practices, which may facilitate further profession-wide discussion. Future studies may wish to examine which factors of an MSO evaluation are considered most informative of a defendant's mental state at the time of the offense to legal actors (i.e., judges, lawyers, juries) and the reasons for these determinations. For example, it may be the case that certain legal actors assume family and developmental history is quite informative of a defendant's mental state at the time of the offense and an understanding of their justification may aid in bridging the ideological gap between the psychological and legal fields.

8. CONCLUSION

The results of the present study provide insight into what psychological tests, sources of collateral information, and clinical interview topics forensic evaluators consider informative and how the data obtained contributes to the evaluator's opinion of the defendant's mental state at the time of the offense. Some items, such as the defendant's account of the alleged offense, pertinent legal documents, law enforcement records, witnesses' statements, interviews with the defendant's family, and Miranda waivers, directly inform the evaluator regarding the defendant's mental state at the time of the offense. However, some items, such as the defendant's religious beliefs, sexual history, and employment history, are used by the evaluator to place the defendant in a grander context, while others, such as education history, mental health history, a mental status examination, and results of neurocognitive, intellectual, or multi-scale personality assessments, are used to make assumptions based on the defendant's most likely mental state. Other items, such as substance use history, arrest records, and malingering measures, are used as evidence to consider alternative explanations for the offense that are independent of a defendant's legitimate impairment.

Importantly, some aspects of a typical MSO evaluation were not particularly informative of the defendant's mental state at the time of the offense. The inclusion of these items should be critically evaluated from a practical and ethical perspective. Several significant discrepancies arose between ideal and actual practices, suggesting mechanisms to facilitate the use of informative items, for example, encouraging competency training for neuropsychological assessment or disseminating information on the value of the R-CRAS for beginning evaluators.

Additionally, some discrepancies highlighted possible ethical considerations in MSO evaluations, for example, the acquisition of potentially sensitive or pejorative information through the clinical interview which may not inform the overall opinion. These results and discrepancies may facilitate a profession-wide discussion on a standardized practice of MSO evaluations.

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APPENDIX A: Qualtrics Survey

Demographic Questionnaire

For demographic purposes, please answer the following:

1. Please identify your sex.
 - Male
 - Female
 - Other: _____

2. Please identify your age. _____

3. Which is the highest degree you have attained?
 - Doctorate of Philosophy (Ph.D.)
 - Doctorate of Psychology (Psy.D.)
 - Other: _____

4. What year did you attain your degree? _____

5. Which type of institution do you work for?
 - State forensic hospital
 - State non-forensic hospital
 - Prison/jail
 - Private forensic hospital
 - Private practice
 - Court
 - Other: _____

6. By which side are you usually retained
 - Defense
 - Prosecution/state
 - Both
 - The court

7. Which standard is used to determine a Not Guilty by Reason of Insanity verdict in your jurisdiction?
- M’Naghten Standard (or variant)
 - American Law Institute Standard (or variant)
 - Durham Standard (product standard)
 - Other: _____
8. Approximately how many years have you actively worked as a forensic examiner (in formal employment and/or training conducting forensic evaluations)? _____
9. How many evaluations have you conducted in your career where the referral question focused primarily, or in part, on a defendant’s Mental State at the Time of the Offense (MSO; e.g., Not Guilty by Reason of Insanity/NGRI)? _____

Ideal Questions

Psychological Assessment Tools

For the following questions consider only your opinion on the **importance** of each item in an **ideal** Mental State at the Time of the Offense (MSO)/Not Guilty by Reason of Insanity (NGRI) evaluation. **Do not** consider personal or situational constraints, such as time, resource availability, or similar limitations. Please indicate using the scale if each item is **ESSENTIAL**, **RECOMMENDED**, **OPTIONAL**, or **UNNECESSARY** when conducting an MSO/NGRI evaluation. Additionally, for each item please briefly provide the **most important reason** you gave that rating. For example, if you rated an item “essential” you might say how it informs your opinion or if you rated an item “unnecessary” you might explain how it does not inform your opinion or is otherwise inappropriate.

Essential: any competent forensic examiner would need to include this item in their evaluation in order to form an opinion on sanity

Recommended: this item, while not essential, would be collected by a competent forensic examiner in the majority of circumstances

Optional: assessment of this item would not likely add to an opinion on sanity, but may have the potential to under certain circumstances

Unnecessary: this item, while one may use it, does not contribute to an opinion on legal sanity; this includes items that may even be contraindicated

1. Multi-scale personality inventories (e.g. PAI, MMPI-II, etc.)
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

2. Intellectual functioning assessments (e.g. WAIS-IV, WASI, Stanford-Binet, etc.)

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

3. Neuropsychological evaluation (e.g. Halstead-Reitan, Luria-Nebraska, etc.)

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

4. Projective tests (e.g. TAT, sentence completion task, Rorschach, etc.)

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

5. Malingering and effort measures (e.g. TOMM, SIMS, VIP, SIRS-2, M-FAST, etc.)

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

6. Rogers Criminal Responsibility Assessment Scales

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

7. Risk assessments and other forensically relevant instruments (e.g. PCL-R, HCR-20, etc.)

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

Collateral Information

Please remember to consider only your opinion on the **importance** of each item in an **ideal** MSO evaluation that is free from personal or situational constraints, such as time, resource availability, or similar limitations.

Essential: any competent forensic examiner would need to include this item in their evaluation in order to form an opinion on sanity

Recommended: this item, while not essential, would be collected by a competent forensic examiner in the majority of circumstances

Optional: assessment of this item would not likely add to an opinion on sanity, but may have the potential to under certain circumstances

Unnecessary: this item, while one may use it, does not contribute to an opinion on legal sanity; this includes items that may even be contraindicated

1. Medical/mental health records
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

2. Law enforcement's records of offense (e.g. arrest report, supplemental documents, transcripts from patient's interviews with police, etc.)
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

3. Interview with primary caregivers, family members, or others closely known to the defendant
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

4. Interview with lawyer
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

5. Previous arrest records
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

6. Pertinent legal documents to the current case (e.g. affidavits, transcripts from prior hearings in this case, etc.)
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

7. Interview with witnesses or documented witness statements
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

8. Miranda waiver
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

9. Information to inform the justification/reason for the referral (e.g., provided by the defense attorney or by the motion for the MSO evaluation)
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

10. Education records
Essential-----Recommended-----Optional-----Unnecessary
Please provide the most important reason why you gave that rating:

Clinical Interview Topics

Please remember to consider only your opinion on the **importance** of each item in an **ideal** MSO evaluation that is free from personal or situational constraints, such as time, resource availability, or similar limitations.

Essential: any competent forensic examiner would need to include this item in their evaluation in order to form an opinion on sanity

Recommended: this item, while not essential, would be collected by a competent forensic examiner in the majority of circumstances

Optional: assessment of this item would not likely add to an opinion on sanity, but may have the potential to under certain circumstances

Unnecessary: this item, while one may use it, does not contribute to an opinion on legal sanity; this includes items that may even be contraindicated

1. Criminal history
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

2. Details of current offense
Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

3. Educational history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

4. Employment history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

5. Family and developmental history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

6. Medical history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

7. Mental health history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

8. Religious history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

9. Sexual history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

10. Social history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

11. Substance use history

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

12. Current mental status assessment

Essential-----Recommended-----Optional-----Unnecessary

Please provide the most important reason why you gave that rating:

13. What other clinical interview topics do you consider essential in an ideal MSO evaluation?

Practice Questions

Psychological Assessment Tools

For the following questions consider only **your actual practice** when conducting an MSO/NGRI evaluation. Please indicate using the scale if each item is used in **your actual practice** VERY FREQUENTLY, FREQUENTLY, INFREQUENTLY, or RARELY/NEVER when conducting an MSO/NGRI evaluation. Additionally, for each item please indicate why you scored it such a way, for example, if you rated an item “frequently” you might say it is essential for forming your opinion or if you rated an item “rarely/never” you might explain that is because of certain systemic factors or unreliability of the item. Please answer the following questions in accordance with **your actual practice**.

Very Frequently: approximately 75-100% of the time

Frequently: approximately 50-74% of the time

Infrequently: approximately 25-49% of the time

Rarely/Never: approximately 0-24% of the time

1. Multi-scale personality inventories (e.g. PAI, MMPI-II, etc.)

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

2. Intellectual functioning assessments (e.g. WAIS-IV, WASI, Stanford-Binet, etc.)
Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

3. Neuropsychological evaluation (e.g. Halstead-Reitan, Luria-Nebraska, etc.)
Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

4. Projective tests (e.g. TAT, sentence completion task, Rorschach, etc.)
Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

5. Malingering and effort measures (e.g. TOMM, SIMS, VIP, SIRS-2, M-FAST, etc.)
Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

6. Rogers Criminal Responsibility Assessment Scales
Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

7. Risk assessments and other forensically relevant instruments (e.g. PCL-R, HCR-20, etc.)
Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

Collateral Information

Remember to consider only **your actual practice** when conducting an MSO/NGRI evaluation.

Very Frequently: approximately 75-100% of the time

Frequently: approximately 50-74% of the time

Infrequently: approximately 25-49% of the time

Rarely/Never: approximately 0-24% of the time

1. Medical/mental health records

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

2. Law enforcement's records of offense (e.g. arrest report, supplemental documents, transcripts from patient's interviews with police, etc.)

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

3. Interview with primary caregivers, family members, or others closely known to the defendant

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

4. Interview with lawyer

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

5. Previous arrest records

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

6. Pertinent legal documents to the current case (e.g. affidavits, transcripts from prior hearings in this case, etc.)

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

7. Interview with witnesses or documented witness statements

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

8. Miranda waiver

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

9. Information to inform the justification/reason for the referral (e.g., provided by the defense attorney or by the motion for the MSO evaluation)

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

10. Education records

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

Clinical Interview Topics

Remember to consider only **your actual practice** when conducting an MSO/NGRI evaluation.

Very Frequently: approximately 75-100% of the time

Frequently: approximately 50-74% of the time

Infrequently: approximately 25-49% of the time

Rarely/Never: approximately 0-24% of the time

1. Criminal history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

2. Details of current offense

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

3. Educational history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

4. Employment history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

5. Family and developmental history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

6. Medical history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

7. Mental health history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

8. Religious history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

9. Sexual history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

10. Social history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

11. Substance use history

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

12. Current mental status assessment

Very Frequently-----Frequently-----Infrequently-----Rarely/Never

Please indicate the most important reason contributing to your frequency of use of this item: _____

APPENDIX B: Codebook

Code Name	Definition	Examples
Antisocial behavior	Any response that indicates the item informs the evaluator of the defendant’s antisocial behavior (i.e. criminality, gang-affiliation, drug use, etc.). This includes statements antisocial behavior was somehow the cause of the offense.	“to rule out voluntary intoxication as basis for mental state at the time of the alleged offense”
Constraining	Any response that indicates an item is not used because it is constraining or otherwise limiting for the evaluator. This includes statements the item is not appropriate for the evaluator’s jurisdiction.	“even somewhat constraining once one has been doing this for a while”
Corroborative	Any response that indicates an item is informative as it is used to corroborate other secondary documents or statements made by the defendant. Includes references to item leading to sources of corroborative information. This does not include responses that indicate the item aids in determinations that the defendant is being untruthful or is providing discrepancies.	“may allow for comparison to earlier/other testing & records” “also provides a check on intelligence tests” “To corroborate”
Court ordered	Any response that indicates an item is typically requested by the court or a member of the court (lawyer, etc.). This includes responses that the item is only used when requested by the court. This includes any statement the item is used by the evaluator due to pressures from the court/the law.	“when requested by the court” “Unless specifically asked by court.” “Necessary per state law.”
Cultural context	Any response that indicates an item may inform the evaluator of the defendant’s cultural background and thus possible explanations for mental state at the time of the offense.	“could provide cultural perspective” “If relevant to evaluatee personally or culturally.”

Demographic concerns	Any response that indicates an item is more or less appropriate or informative for a certain population based on a demographic factor of that population. This does not include responses that indicate the item is more or less helpful for a certain population based on psychiatric factors.	“the population i work with is primarily Spanish speaking, we use other assessment tools”
Does not inform	Any response that indicates an item does not inform the referral question neither directly nor indirectly. This includes statements that the item is irrelevant. This includes statements that the item does not typically provide information above and beyond other sources. This does not include responses that indicate the item would be informative under certain circumstances.	“usually not relevant” “Not required to form diagnoses or opinions in the majority of cases.” “Irrelevant to referral question” “Unlikely to inform MSO”
Ethical concern	Any response that addresses an ethical concern or dilemma that may arise by use of an item. This includes violation of the principle of do no harm, which may be violated by an evaluator giving excessive tests or gathering unnecessary information.	“you may only use tools if they assist in answering a specific question” “may potentially bias the evaluator”
Generally informative	Any response that indicates the item is informative for the evaluator when opining on mental state at the time of the offense, without reference to how the item informs. This includes responses to vague to be coded otherwise. This includes normally ambiguous comments such as “obvious.” This does not include responses that insinuate specific ways in which the item informs an evaluator’s opinion.	“Better understanding of the individual so I can render and opinion.” “Important, but not necessarily essential” “Good to go over.”
Guidance	Any response that indicates an item is primarily used as a guide for the evaluator. This includes statements the item may be a guide for initial clinicians.	“this is a helpful tool for structuring thinking on this particular forensic issue”
Historical functioning	Any response that insinuates the item informs the evaluator of the defendant’s past (historical) functioning. This does not include responses that are explicitly referencing historical functioning related to mental illness alone.	“relevant to historical functioning” “changes in the weeks/months leading up to the offense”
History of mental illness	Any response that indicates the item informs MSO indirectly through establishing the defendant has a history of mental illness. This includes responses about an organic cause. This does not include responses stating the item informs mental	“Goes to establishment of history of mental illness” “Can help describe course and length of symptoms.”

	illness/symptoms during offense (this is also different from MSO) or current mental illness/symptoms.	“to help determine the prevalence and effect of their symptoms.”
ID, neuro, cog disorders	Any response that indicates an item informs the evaluator about previous or current intellectual disabilities, neurological deficits, or other cognitive disorders. This includes responses that insinuate the item is only useful in situations in which ID/neuro/cognitive abilities are questioned. This does not include responses that indicate an item is only relevant if the offense occurred within a school setting.	“This information is helpful in determining whether a defendant was ever diagnosed with an intellectual disability.” “if there is cognitive impairment”
Incompetent	Any responses that indicates the participant does not feel competent to utilize the item. This includes statements that the target population is irrelevant to the participant. This does not include responses related to the legal matter of competency to stand trial.	“I refer to testing experts when the tests are relevant” “Don’t often have ID cases” “No experience in using these instruments.”
Informs MSO	Any response that states the item directly informs the defendant’s mental state at the time they committed the offense. This does not include items that inform MSO indirectly, such as through informing the historical context of the defendant, potential diagnoses, etc.	“pertinent to the questions of sanity” “determine what symptomology they may have been experiencing at the time”
Informs offense	Any response that indicates that item gives relevant information about the alleged offense itself. As in, informs evaluator of the facts of the alleged crime without explicit focus on defendant. This does not include responses that reference the defendant’s mental state or behavior at the time of the offense.	“essential to know what happened” “Helps with reconstructing state of mind at the time of the offense” “knowledge of wrongfulness”
Insufficient data	Any response that indicates an item is primarily used when there is insufficient data on the issue addressed by the item.	“limited diagnostic info in record”
Irrelevant response	Any response that is entirely irrelevant or indecipherable. This includes responses that are “salty” (i.e. “This survey is too long”). This does not include responses that indicate the item is irrelevant to the referral question.	“This survey is too long” “N/A” “We are psychologists, aren’t we?”
Lack of access	Any response that indicates an item is typically inaccessible or difficult for the evaluator to procure. This includes statements that insinuate the item is usually unavailable, such as “if available”	“they are not frequently available” “harder to get”

Legal strategy	Any response that indicates an item may inform the evaluator that the defendant has used/is using NGRI as a legal strategy in in the past or present. This includes comments about clarifying reasons for referral question.	“Have there been prior NGIs etc.” “Attorneys can inform you about the reason for the referral”
Logistics	Any response that insinuates an item aids in an MSO evaluation by helping the evaluator with logistical processes for the evaluation.	“helps clarify referral question”
Malingering	Any response that indicates the item aids in the evaluator’s determination that the defendant is malingering insanity. This includes references to checking consistency of defendant and his/her responses. This does not include corroboration across multiple sources.	“determine consistency of defendant’s report” “Can be useful for determining malingering exaggeration of reported behaviors”
Money	Any response that indicates an item is not used due to limited finances or other financial concerns.	“I may not have funding to do it in detail.”
Objectivity	Any response that indicates an item is a source of objective information for the evaluator to form an opinion. This includes statements the item is unbiased or empirically based. This does not include responses that indicate the item assesses for reliability.	“objective evaluation” “Objective Personally and validity scales” “Without it, eval is subjective.”
Obsolete	Any response that an item is not used because it is considered obsolete or outdated.	“a bit outdated”
Organic cause	Any response that indicates an item informs MSO by informing the evaluator of an organic or medical cause for the defendant’s mental state during the alleged crime. This includes responses related to heritability, family causes. This does not include responses that indicate an item informs the presence of mental illness/symptoms.	“there could be medical reasons for mental state fluctuations” “risk for heritable illness.” “Could show organic cause if mental illness”
Personal	Any response that indicates an item is used or not used based on personal preferences of the evaluator with no other justification provided.	“not my favorite measure”
Practice	Any response that indicates an item is used mainly/solely because it is standard/common practice. This includes responses that state an item was used because the evaluator was trained to do so (i.e. “I did what my supervisor told me to do”) or is required by law. This includes statements the evaluator does this because they always have. This includes the evaluator using the item because it is available	“I always ask details of the alleged offense” “part of comprehensive evaluation” “i get this standard on all evaluations” “It is an essential part of the clinical history.”

Presence of MI or PD	Any response that indicates the item informs MSO indirectly through establishing the defendant currently suffers or recently suffered from a mental illness/diagnosis or describes the symptoms. This may be coded along with “Informs MSO” code, but doesn’t have to be if response does not insinuate relationship to legal insanity determination. This does not include responses stating the item informs past mental illness or a history of symptoms.	“establishment of presence of mental illness” “Can offer useful information for diagnostic purposes” “Helps look at current state of mind” “But may be related to mental illness or defect”
Second Opinion	Any response that indicates an item is informative when the evaluator is offering a second opinion.	“in second opinion cases”
Situational	Any response that generally indicates the item is only useful in certain situations or cases. This does not include responses that provide a context in which the item would be useful (i.e. when indicated that it would be useful when an intellectual disability may be an issue).	“when needed” “depends on the case” “Only if directly relevant” “Might be Germaine”
Situational constraints	Any response that indicates the participant would utilize this item more but there are situational constraints.	“depending on situational constraints”
Situational juveniles	Any response that indicates an item is mainly/solely informative when evaluating child offenders.	“essential for children and juveniles”
Situational school	Any response that indicates the item is only informative when the alleged offense occurred during school-aged years or was somehow related to the defendant’s school. This does not include responses that indicate an item informs the evaluator regarding intellectual disabilities.	“unless crime was at school or related to school” “while the defendant was a student or at the defendant's school.”
Situational time	Any response that indicates an item is more or less informative depending on how quickly it occurs after the offense.	“could be important if close to time of the offense”
Time limitations	Any response that indicates an item is either difficult or infeasible due to time restraints. This does not include situational responses that indicate an item is more or less useful if obtained at a certain time.	“time consuming” “lengthy” “time demands” “Time constraints”
Treatment	Any response that indicates an item is used to inform treatment for the defendant.	“informs tx recommendations”
Unreliable	Any response that indicates the source of the information or the information itself is not trustworthy or is inaccurate. This includes statements that the item is used to inform the evaluator if the source of information is or is not reliable.	“self report is often inaccurate” “must be considered in light of motivations”

APPENDIX C: IRB Approval



June 28, 2017

Lauren Meaux
Department of Psychology
College of Arts and Sciences
Box 870348

Re: IRB # 17-OR-216, "Understanding Forensic Psychologists' Mental State at the Time of the Offense Evaluation Patterns: A Mixed Methods Study"

Dear Ms. Meaux:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. You have also been granted the requested waiver of written documentation of informed consent. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on June 27, 2018. If your research will continue beyond this date, please complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, please complete the Modification of an Approved Protocol form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the Request for Study Closure form.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,



Carpinato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer
Office for Research Compliance

**UNIVERSITY OF ALABAMA
 INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN SUBJECTS
 REQUEST FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS**

I. Identifying information

	Principal Investigator	Second Investigator
Name:	Lauren Meaux, B.S., B.A.	Jennifer Cox, Ph.D.
Department:	Psychology	Psychology
College:	Arts and Sciences	Arts and Sciences
University:	The University of Alabama	The University of Alabama
Address:	Box 870348, Tuscaloosa, AL	Box 870348, Tuscaloosa, AL
Telephone:	(985) 373-5901	(205) 348-7908
FAX:	(205) 348-8648	(205) 348-8648
E-mail:	lmeaux@crimson.ua.edu	

Title of Research Project: Understanding Forensic Psychologists' Mental State at the Time of the Offense
 Evaluation Patterns: A Mixed Methods Study

Date Submitted: June 5, 2017
 Funding Source: none

Type of Proposal: New Revision Renewal Completed Exempt

Please attach a renewal application

Please attach a continuing review of studies form

Please enter the original IRB # at the top of the page

UA faculty or staff member signature:

II. NOTIFICATION OF IRB ACTION (to be completed by IRB):

Type of Review: Full board Expedited
 IRB Action:

<input type="checkbox"/> Rejected	Date: _____
<input type="checkbox"/> Tabled Pending Revisions	Date: _____
<input type="checkbox"/> Approved Pending Revisions	Date: _____

Approved—this proposal complies with University and federal regulations for the protection of human subjects.

Approval is effective until the following date: 6-27-18

Items approved:	<input checked="" type="checkbox"/> Research protocol:	dated <u>6-28-17</u>
	<input checked="" type="checkbox"/> Informed consent:	dated <u>6-28-17</u>
	<input type="checkbox"/> Recruitment materials:	dated _____
	<input type="checkbox"/> Other:	dated _____

Approval signature: Date: 6/28/2017

Informed Consent

Study title: Understanding Forensic Psychologists' Mental State at the Time of the Offense Evaluation Patterns: A Mixed Methods Study

Principle Investigator: Lauren Meaux, B.A., B.S., Graduate Student

You are being asked to take part in the research study, *Understanding Forensic Psychologists' Mental State at the Time of the Offense Evaluation Patterns: A Mixed Methods Study*. The study is being done by Lauren Meaux, who is a graduate student in Clinical Psychology at the University of Alabama, and Jennifer Cox, Ph.D., who is an Assistant Professor at the University of Alabama.

What is this study about? What is the investigator trying to learn?

This study is being done to find out which psychological tests, pieces of collateral information, and clinical interview topics should inform an evaluator's opinion during an examination of a defendant's mental state at the time of the offense (MSO).

Why is this study important or useful?

This knowledge is important because research suggests MSO evaluation practices vary greatly by evaluator. A thorough understanding of practices, as well as perceptions of "best practices" may inform standardization of practice.

Why have I been asked to be in this study?

As a forensic evaluator who has conducted an MSO evaluation within the last five years, you are in a unique position to provide information on your experiences and opinions regarding MSO evaluations.

How many people will be in this study?

About 60 other forensic evaluators will be in this study.

What will I be asked to do in this study?

If you agree to participate in this study you will be asked to fill out a questionnaire that asks you about yourself including your demographic background. You will then be asked to answer a survey regarding the degree to which you consider certain psychological tests, collateral information, and clinical interview topics essential if you were conducting an MSO evaluation free from common practical restraints. Then you will be asked about your actual practices when conducting MSO evaluations.

How much time will I spend being this study?

Participation in this study will take approximately 15 minutes.

Will being in this study cost me anything?

The only cost to you is your time.

Will I be compensated for being in this study?

Although your participation will be appreciated, you will not be compensated.

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Approval date: 6-28-17
Expiration date: 6-27-18

Can the investigator take me out of this study?

This entire study is conducted online and the investigator will have no direct contact with you.

What are the risks (dangers or harms) to me if I am in this study?

Potential risks associated with your participation include potential anxiety or discomfort while answering questions about yourself or your practices. You have the right to stop at any time without any punishment or penalty. Additionally, you may skip any question you do not wish to answer.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits for you. However, you may indirectly benefit by critically reviewing and considering your ideal and actual practice during MSO evaluations.

What are the benefits to science or society?

This study may give society a better understanding of the psychological tests, collateral information, and clinical interview topics most informative in an MSO evaluation. This may lead to the development of a semi-structured interview for MSO evaluations that can help standardize practices and decrease variability across evaluators.

How will my privacy and confidentiality be protected?

As a potential participant in this study, it is your decision to participate. If you choose to participate, you will click on the button below and be directed to the survey website. At this time, it is your decision whether or not to access this link and participate voluntarily. Investigators have no direct access to prospective participants and there will be no recruitment reminders or follow-ups. In addition, you will complete the study in a time and location of your choice. You may withdraw from the study at any time.

This study is confidential and we will keep information private to every extent possible. Your responses will be downloaded and kept in a password protected file. Only the Primary Investigator and co-investigator will have access to this file. No identifying information, including your name, will be recorded. No personal information will be included in any sort of report that might be published.

What are the alternatives to being in this study? Do I have other choices?

The alternative to being in this study is to not take part in it.

What are my rights as a participant in this study?

Taking part in this study is voluntary. It is your free choice. You can refuse to be in it at all. If you start the study, you can stop at any time. There will be no effect on your relations with the University of Alabama.

The University of Alabama Institutional Review Board ("the IRB") is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

UA IRB Approved Document

Approval date: 6-28-17

Expiration date: 6-27-18

Who do I call if I have questions or problems?

If you have questions, concerns, or complaints about the study please call Lauren Meaux @ (205) 348-5083 or email at lmeaux@crimson.ua.edu.

If you have questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email the Research Compliance office at participantoutreach@bama.ua.edu.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website at <http://osp.ua.edu/site/IRBGrid.html>.

Clicking the button below confirms that I have read this consent form. I understand the nature of this study and I understand what I will be asked to do. I freely agree to take part in the study.

UA IRB Approved Document

Approval date: 6-28-17

Expiration date: 6-27-18

Debriefing Form

**Debriefing: Understanding Forensic Psychologists' Mental State at the Time of the Offense
Evaluation Patterns: A Mixed Methods Study**

Thank you for your time and participation.

This study investigated the degree to which and reasons why forensic examiners consider certain psychological tests, clinical interview topics, or pieces of collateral information when conducting a Mental State at the Time of the Offense (MSO) evaluation.

The investigators hope that this research can provide insight into ideal and actual MSO practices and the reasoning of the evaluators conducting those practices.

Please forward the email including the study description and link to other forensic psychologists who have conducted an MSO evaluation in the last five years.

You may email or call the researcher, Lauren Meaux, at lmeaux@crimson.ua.edu or (205) 348-5000 if you have any questions.

You may also contact Ms. Tanta Myles, Research Compliance Officer at the University of Alabama at (205) 348-8461. She can answer any questions or concerns about your rights as you take part in this study. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email us at participantoutreach@bama.ua.edu. After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the University Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

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