THE CONTENT AND QUALITY OF FORENSIC REPORTS OF COMPETENCY TO STAND TRIAL EVALUATIONS

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A Dissertation

Presented to

The Faculty of the Department of Department of Psychology and Philosophy

Sam Houston State University

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In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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by

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August, 2018

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ABSTRACT

Laxton, Kelsey L., *The content and quality of forensic reports of competency to stand trial evaluations*. Doctor of Philosophy (Clinical Psychology), August, 2018, Sam Houston State University, Huntsville, Texas.

Forensic report writing is a complex yet vitally important task for legal decision-makers who rely upon forensic examiners. Empirical evaluations of the content and quality of forensic reports have identified concerning deficiencies in forensic reports through many years and across several jurisdictions. A substantial portion of reports have failed to include proper documentation of the ethical requirement to notify the examinee of the purpose of the evaluation and limits to confidentiality. Another recurring theme is the variable use of third-party information rather than over-reliance on the defendant's self-report. Further, evaluators tend to struggle in the substantiation of their psycholegal opinions and the discussion of competency-related abilities, even when required by statute. The current archival review examined the content and quality of 352 reports of competency to stand trial (CST) evaluations conducted from 2008 to 2016 in an urban jurisdiction of Texas. Reports were authored by 28 psychologists and psychiatrists from ten agencies, hospitals, or practices. Reports were coded by six doctoral-level graduate students with forensic evaluation training and experience. Raters coded the substantiation of clinical and psycholegal opinions, and reports were coded for the presence of factors required by state statute and Principles of Forensic Mental Health Assessment (Heilbrun, 2001). Relative to previous research, results revealed improvements in key areas of documentation of the forensic notification and use of third-party information. While the majority of reports addressed individual functional abilities of CST, comprehensive assessment of these areas was poor. Further, reports were

deficient in connecting impairments in competency-relevant abilities to symptoms of mental illness. Implications for clinical forensic practice are discussed.

KEY WORDS: Forensic evaluation, Report quality, Competency to stand trial, Principles of Forensic Mental Health Assessment

ACKNOWLEDGEMENTS

I would like to thank the American Academy of Forensic Psychology for the Dissertation Grant Award that provided partial funding for this research. I also must express appreciation to the Harris County Public Defender's Office, without whom this research would not have been possible.

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CHAPTER I

Introduction

Legal decision makers frequently rely upon forensic mental health examiners to answer psycholegal questions ranging from criminal and civil competencies to mental condition at the time of the offense and criminal responsibility to civil commitment and other noncriminal adjudication decisions (Melton, Petrila, Poythress, & Slobogin, 2007). In particular, when the issue of a criminal defendant's competency to stand trial (CST) is raised, legal decision makers consistently rely upon and agree with the opinions of forensic mental health examiners (Hart & Hare, 1992; Zapf, Hubbard, Cooper, Wheeles, & Ronan, 2004). Further, the most frequent basis for a court's opinion is not the evaluator's spoken testimony but rather the written report submitted to the court (Heilbrun & Collins, 1995). However, even "the best psychological or psychiatric evaluations will be of little use to courts, attorneys, or others if the findings are not communicated clearly, precisely, and understandably" (Otto, DeMier, & Boccaccini, 2014, p. xii). For these reasons, it is incumbent on the field of forensic psychology to produce and submit accurate, high-quality written reports to the courts (DeMier, 2013).

Until the 2000's, there were few written resources on the content and quality of forensic mental health assessment reports, especially as they differ from general clinical reports. Fortunately, respected scholars have since offered their expert guidance and recommendations for reports of forensic evaluations in a number of journal articles, handbooks, and other books (e.g., Conroy, 2006; DeMier, 2013; Grisso, 2010; Melton et al., 2007; Otto et al., 2014; Witt, 2010). A comprehensive review of these various recommendations is beyond the scope of this paper, but one may seek out the

recommendations from recognized experts in the field of forensic psychology (i.e., certified by the American Board of Forensic Psychology; Conroy, 2006; DeMier, 2013; Grisso, 2010; Heilbrun, 2001; Otto et al., 2014).

Empirical Analyses of Forensic Report Contents and Quality

Although there is a wealth of resources with recommendations for improving the quality of reports and testimony, the empirical research in the area is limited. One of the earliest studies of forensic reports examined the thoroughness and quality of forensic evaluations of CST and legal insanity conducted in Michigan (Petrella & Poythress, 1983). They defined thoroughness as the frequency of contacts to obtain information and the length of clinical evaluation notes and reports. Also, they asked outside raters (an attorney, a trial judge, and a law professor) to judge the quality of a subset of the reports on items regarding clearly stated opinions and basis for those opinions, clinical characterization, use of clear language, inclusion of relevant information, and overall report quality. They found that psychologists' evaluations were deemed more thorough and rated as higher in quality than psychiatrists' evaluations. They concluded that the panel of raters preferred more thorough reports that relied more heavily on multiple, outside sources of information (Petrilla & Poythress, 1983).

Heilbrun and Collins (1995) were the first to characterize the *contents* of forensic reports when they examined a large sample of CST and mental state evaluations conducted in inpatient and outpatient settings in Florida. Only 30% of the reports in this sample included a summary of the notification of purpose of the evaluation, a fundamental tenet of ethical forensic assessment (American Psychological Association [APA], 2013; Melton et al., 2007). Further, the use of third-party information was

variable, with arrest reports (95% of reports), prior mental health evaluations (70%), and interviews with hospital staff (70%) as the most commonly utilized collateral sources (Heilbrun & Collins, 1995). While the six areas of competency mentioned in Florida statute were addressed in nearly all of the hospital reports, the relevant areas were less consistently addressed by community examiners, ranging from 81% to only 61% of reports (Heilbrun & Collins, 1995).

In a multi-jurisdiction sample of CST reports in New Jersey and Nebraska, Robbins, Waters, and Herbert (1997) found major deficits in important information and reasoning as well. Of the 66 reports, over one-third failed to include collateral data, and many reports included extraneous or irrelevant information to legal opinions. Reports typically addressed functional CST abilities, but only 27% elaborated on how psychopathology or symptomology causally affected abilities of CST. Less than half of the reports indicated the procedures or tests used in the evaluation; moreover, of those that did, few described the results or the relationship between the assessment and functional deficits (Robbins et al., 1997). Similarly, critical flaws were also found in reports from evaluations conducted between 1994 and 1997 in Alabama that concluded that the defendant was incompetent to stand trial (Zapf et al., 2004). In this study, reports often (14-98% of reports of incompetent defendants) omitted discussion of vital psycholegal functional areas required by state statute, including the ability to appreciate his or her role in the legal proceedings, to understand the nature of the proceedings, and to be restored to competence.

In another, well-cited study, Skeem and colleagues inspected 100 reports of CST from community examiners in Utah by using a thoroughly-developed coding protocol

drawing from legal, ethical, and professional standards (Skeem, Golding, Cohn, & Berge, 1998). They analyzed the logic presented by examiners in their reports regarding the "degree to which examiners assess[ed] and substantiate[d] any nexus between symptoms of psychopathology and deficits in competence" (Skeem et al., 1998, p. 521). To do this, raters coded each report to reflect whether each of 11 global domains and 31 nested sub-domains of functional CST abilities were addressed by the examiner *and* the extent to which any impairments were linked to the defendant's psychopathology. Results showed that most reports addressed "foundational" CST abilities (i.e., capacities to appreciate charges and potential penalties, to understand the adversary nature of proceedings, and to disclose relevant information to counsel); however, "higher order" CST domains (i.e., capacity for reasoned choice among legal options, capacity to behave appropriately in court, to participate in trial, and to testify relevantly) were addressed in fewer than half of the reports (39% to 24%; Skeem et al., 1998). What is more, slightly over half (53%) of the examiners concluded that the defendant was incompetent, although the average amount of impairment across all CST domains (36%) was substantially lower. Inexplicably, of those that concluded the defendant was incompetent, 15% noted *no* CST impairments, and 36% noted only one or two impairments. Authors also found that reports generally included little data to support their conclusions about CST impairments. In other words, when a competency domain was deemed impaired, the relationship between CST deficits and psychopathology was substantiated in only 10% of reports, whereas the relationship was not described or merely asserted in 70% of reports. Similarly, there was variability in the extent to which CST abilities were described even when the defendant was opined competent (Skeem et al., 1998). Diagnostic opinions

were more often substantiated than psycholegal opinions; most (67%) reports that included diagnoses listed or described multiple or most symptoms to substantiate it, and almost all (94%) of the reports presented symptomatology. Regarding consideration of malingering, most (88%) reports did not describe ruling out the possibility of malingering. However, of the reports that did address malingering, most (75%) supported a finding of malingering with data from records or testing (Skeem et al., 1998). Even though 69% of reports utilized psychological testing of some kind, most examiners (70%) failed to relate testing results to CST abilities, and only 21% utilized testing to address malingering. Compared to the Heilbrun and Collins (1995) study, more reports in the Skeem et al. (1998) study indicated notification of purpose (63%) and limits of confidentiality (47%). Thus, 37%-53% of reports did not document (or did not provide) warning of purpose and disclosure as required by ethical standards (Skeem et al., 1998).

In a rare study of competency evaluations of juveniles, Christy, Douglas, Otto, and Petrila (2004) examined the quality of over 1,300 reports performed by 252 evaluators on 674 juveniles in Florida who had been adjudicated incompetent. Numerous problems were identified in the report sample. Almost half of the reports failed to identify the location of the assessment, and a significant portion of examiners did not reference third-party sources of information in their reports. Christy et al. (2004) also coded reports for the presence of legal competency capacities required by state law. A strong majority (84-91%) of examiners addressed the competency standards in their reports, and all six factors were addressed in 79% of evaluations. To examine the extent to which examiners substantiated their conclusions about the areas of CST, researchers recorded whether specific examples were provided as support or evidence for their

conclusions. Examples were provided in 50 to 63% of reports, meaning that a rationale for an opinion on a particular competency-related capacity was *not* provided in about half of the reports. Moreover, although Florida statute requires that evaluators specifically state the basis of their determination of incompetency, "the basis or predicate condition for the examiner's recommendations of incompetence…could be identified for 847 (62.42%) of the reports" (Christy et al., 2004, p. 386). Over 80% of reports included diagnostic and restorability information, including whether the incapacities could be treated, the length of time needed to restore competency abilities, and the most beneficial location for restorability treatment (Christy et al., 2004).

Similar to Christy et al.'s (2004) comparison of evaluations to state statute, Gray, Black, Fulford, and Owen, (2005) reviewed competency reports of evaluations of state hospital patients for CST factors required for consideration by Texas statute. Citing their personal experiences within the hospital, they described that competency evaluations on many patients committed to their facility consisted of unsatisfactory reports that rarely explained the reasoning behind the psycholegal opinion provided. A new statute pertaining to CST evaluations was added to the Texas Code of Criminal Procedure (Article 46B) in 2004. The statute explicitly identifies factors that must be considered in an examination of CST and specific information that must be included in an examination report (see Table 1). The statute also specified educational and professional training requirements for examiners.

Table 1

Excerpts from the Texas Code of Criminal Procedure, Chapter 46B

Art. 46B.024. Factors Considered in Examination
During an examination under this subchapter and in any report based on that examination, an expert shall consider, in addition to other issues determined relevant by the expert, the following: (1) the capacity of the defendant during criminal proceedings to: (A) rationally understand the charges against the defendant and the potential consequences of the pending criminal proceedings; (B) disclose to counsel pertinent facts, events, and states of mind; (C) engage in a reasoned choice of legal strategies and options; (D) understand the adversarial nature of criminal proceedings; (E) exhibit appropriate courtroom behavior; and (F) testify; (2) as supported by current indications and the defendant's personal history, whether the defendant: (A) is a person with mental illness; or (B) is a person with an intellectual disability; (3) whether the identified condition has lasted or is expected to last continuously for at least one year; (4) the degree of impairment resulting from the mental illness or intellectual disability, if existent, and the specific impact on the defendant's capacity to engage with counsel in a reasonable and rational manner; and (5) if the defendant is taking psychoactive or other medication: (A) whether the medication is necessary to maintain the defendant's competency; and (B) the effect, if any, of the medication on the defendant's appearance, demeanor, or ability to participate in the proceedings.
Art. 46B.025. Expert's Report
An expert's report to the court must state an opinion on a defendant's competency or incompetency to stand trial or explain why the expert is unable to state such an opinion and must also: (1) identify and address specific issues referred to the expert for evaluation; (2) document that the expert explained to the defendant the purpose of the evaluation, the persons to whom a report on the evaluation is provided, and the limits on rules of confidentiality applying to the relationship between the expert and the defendant; (3) in specific terms, describe procedures, techniques, and tests used in the examination, the purpose of each procedure, technique, or test, and the conclusions reached; and

(continued)

(4) state the expert's clinical observations, findings, and opinions on each specific issue referred to the expert by the court, state the specific criteria supporting the expert's diagnosis, and state specifically any issues on which the expert could not provide an opinion.

If in the opinion of an expert appointed under Article 46B.021 the defendant is incompetent to proceed, the expert shall state in the report:

(1) the symptoms, exact nature, severity, and expected duration of the deficits resulting from the defendant's mental illness or intellectual disability, if any, and the impact of the identified condition on the factors listed in Article 46B.024;

(2) an estimate of the period needed to restore the defendant's competency, including whether the defendant is likely to be restored to competency in the foreseeable future;

(3) and prospective treatment options, if any, for the defendant.

Gray and colleagues (2005) thus wanted to examine the quality of reports relative to the new statutory requirements through comparison of reports to state statute and between points in time (i.e., before and after the new law went into effect in 2004). To do this, they reviewed 103 reports of CST evaluations of defendants found not competent to stand trial and transferred to a maximum-security state hospital for restoration. They found very little difference in quality of evaluations conducted before and after implementation of the then-new statute. In fact, they found that the overall quality of evaluations was "not particularly good" (Gray et al., 2005, p. 20). Specifically, reports addressed an average of only 8 of the 14 components required by statute. Also, less than 5% of the evaluations addressed all the components required by state law, and only 37% addressed 10 or more of the statutory criteria to be considered for CST. Importantly, reports not only failed to document consideration of minor CST abilities (e.g., exhibit courtroom behavior), but also neglected to address *key* components of CST (e.g., capacity to engage in a reasoned choice of legal strategies, to understand the adversarial nature of the court proceedings, and to disclose relevant information to counsel) in 45% to 66% of

the sample. Regarding other information to be contained in a report according to Article 46B, only 67% of reports prescribed treatment options, and less than half of the reports documented the notification of purpose and disclosure (Gray et al., 2005).

While not explicitly intending to examine the contents of forensic reports, Stein, Kan, and Henderson (2016) conducted the only other examination of CST reports in Texas. Stein and colleagues (2016) inquired about the mediating role of psycholegal abilities in the relationship between psychopathology and psycholegal opinions by coding 119 reports from community-based evaluators. However, the researchers' conclusions were limited because several specific psycholegal abilities were infrequently addressed in the reports. Specifically, 42% to 65% of the reports did not address the defendant's capacity to participate in trial, the capacity for appropriate courtroom behavior, and the capacity to testify. More importantly, "only 21 of the 119 reports examined did not have any missing data regarding psycholegal abilities" (Stein et al., 2016, p. 35), and reports were missing an average of two psycholegal abilities required by state statute.

Nicholson and Norwood (2000) suggested that forensic practice fell "far short of professional aspirations for the field" (p. 9) and specifically noted report quality as an area of weakness for the field that warranted further research. Apparently, studies by Christy et al. (2004) and Gray et al. (2005) would suggest that there remains significant room for improvement in forensic report quality since late 1990s. Some years later, Lander and Heilbrun (2009) set forth to examine forensic report quality in a new way: they examined the extent to which 125 forensic evaluation reports from Pennsylvania satisfied the principles of Forensic Mental Health Assessment (FMHA) set forth by Heilbrun (2001; see Table 2).

Table 2

Principles of Forensic Mental Health Assessment (Heilbrun, 2001)

1.	**Identify relevant forensic issues.**
2.	Accept referrals only within area of expertise.
3.	Decline the referral when evaluator impartiality is unlikely.
4.	Clarify the evaluator's role with the attorney.
5.	Clarify financial arrangements.
6.	Obtain appropriate authorization.
7.	Avoid playing the dual roles of therapist and forensic evaluator.
8.	Determine the particular role to be played within forensic assessment if the referral is accepted.
9.	Select the most appropriate model to guide data gathering, interpretation, and communication.
10.	**Use multiple sources of information for each area being assessed.**
11.	Use relevance and reliability (validity) as guides for seeking information and selecting data sources.
12.	**Obtain relevant historical information.**
13.	**Assess clinical characteristics in relevant, reliable, and valid ways.**
14.	**Assess legally relevant behavior.**
15.	Ensure that conditions for evaluation are quiet, private, and distraction-free.
16.	**Provide appropriate notification of purpose and/or obtain appropriate authorization before beginning.**
17.	**Determine whether the individual understands the purpose of the evaluation and the associated limits on confidentiality.**
18.	**Use third party information in assessing response style.**
19.	**Use testing when indicated in assessing response style.**
20.	Use case-specific (idiographic) evidence in assessing clinical condition, functional abilities, and causal connection.
21.	Use nomothetic evidence in assessing clinical condition, functional abilities, and causal connection.
22.	**Use scientific reasoning in assessing causal connection between clinical condition and functional abilities.**
23.	Do not answer the ultimate legal question.
24.	**Describe findings and limits so that they need change little under cross examination.**
25.	**Attribute information to sources.**
26.	**Use plain language; avoid technical jargon.**
27.	Write report in sections, according to model and procedures.
28.	Base testimony on the results of the properly performed FMHA.
29.	Testify effectively.

Note. Principles to be coded from reports and used in the present study appear in bold.

Several important principles of conducting FMHAs include or allude to the use of multiple sources of information (Heilbrun, 2001). However, only 20% of the sample actually cited sources of information; few reports included third-party interviews and less

than 35% of reports referred to the use of previous records (Lander & Heilbrun, 2009). Other principles, as well as Pennsylvania statute, address the use of evidence in assessing clinical condition, functional abilities, and causal connections. In Lander and Heilbrun's (2009) study, the appreciation of charges (93%) and appreciation of potential penalties (67%) were almost always described. However, fewer reports described the capacity to display appropriate courtroom behavior (42%), and far fewer described the capacity to testify relevantly (17%). Other principles were found present to widely varying extents, from 92% (e.g., "use plain language, avoid technical jargon") to just 3.2% (e.g., "use testing, when indicated, in assessing response style;" Lander & Heilbrun, 2009). There is no consensus on these principles in the field, and some have demonstrated more disagreement than others (e.g., "do not answer the ultimate legal question;" e.g., Packer, 2009). However, even principles that do have much higher rates of agreement for necessity or importance in FMHAs were addressed inconsistently in the sample (Lander & Heilbrun, 2009). For example, only 24.8% of reports documented appropriate notification of purpose and limits of confidentiality, and only 3.2% noted whether the individual understands the notification warning. Further, only 21.6% of reports were deemed to have included relevant historical information, and 28.8% were deemed to have assessed clinical characteristics in relevant, reliable, and valid ways (Lander & Heilbrun, 2009). Lander and Heilbrun (2009) further examined the use of the principles by exploring their relationship with ratings of report quality, relevance, and helpfulness by a "Blue Ribbon Panel" of legal experts (i.e., a federal judge, a law professor, a practicing attorney, a forensic psychiatrist, and a forensic psychologist). Results showed modest relationships between the number of principles rated as present in the report and the

overall ratings of quality, helpfulness, and relevance from the experts. The relationship between the presence of individual principles and ratings of quality, helpfulness, and relevance varied, and the strength of these relationships were modest at best (Lander & Heilbrun, 2009).

Robinson and Acklin (2010) examined the quality of 150 reports of 50 adults evaluated for fitness to proceed in Hawaii. They assessed six essential elements of forensic reports: data elements (e.g., identifying information, referral source and information), ethical elements (e.g., notification of purpose), historical or background information elements, collateral information elements, clinical elements (e.g., mental state, diagnostic information), and opinion rationale elements (i.e., information that forms the basis for the forensic opinion) (Robinson & Acklin, 2010). They further attempted to quantify forensic report quality through development of a survey instrument in which each item was rated as 0 (if the item was not included in the report), 1 (if the item was included but incomplete) or 2 (if the item was included and complete). Only one quarter of the reports scored at or above 80% of the maximum possible quality score. The use of various sources of information was more common in this sample than in previous studies, as evaluators reported using four or more separate information sources in 74% of reports, and almost all (98%) the reports included two or more sources. Consistent with previously discussed studies, Robinson and Acklin (2010) concluded that "complying with ethical requirements for disclosure does not appear to be a common practice amongst Hawaii forensic evaluators," (p. 135) as only 24% of reports included complete documentation of disclosure of purpose and confidentiality limits. Regarding rationale/opinion elements, 74% of reports that provided a diagnosis included a complete

rationale for their opinion, and 82% of reports included a complete functional and causal explanation of the defendant's impairment(s) (Robinson & Acklin, 2010).

Apparently, professionals who aim to be experts in forensic psychology are not immune to poor report quality. Grisso (2010) examined a national sample of 62 forensic reports submitted by 36 mental health professionals to reviewers for the American Board of Forensic Psychology. His study highlighted the most common errors found in reports of both criminal and civil referral questions submitted in the board certification process that were not approved by reviewers. The two most common faults with the forensic reports were that (1) major interpretations or opinions were offered without sufficient explanation of the basis of their opinion (56% of reports) and that the legal question or purpose of the evaluation was not stated, not clear, inaccurate, or inappropriate (53% of reports). Further common errors included organization problems (36%), irrelevant data or opinions (31%), failure to consider alternative hypotheses (30%), and inadequate types of data (28%) or over-reliance on a single source of data (22%) (Grisso, 2010).

State of the Field

In a 2000 review, Nicholson and Norwood noted that empirical research "painted a less than flattering portrait of current practices in forensic assessment" (p. 35). Despite key professional developments in forensic psychology, including practice standards and guidelines and creation of training and certification programs in a number of states, they summarized significant deficiencies in forensic practice that did not meet the promise of the Forensic Specialty Guidelines. At the time of their review, they noted several remaining criticisms of forensic evaluations. Specifically, examiners in FMHAs often did not use relevant assessment methods with strong evidence for reliability and validity,

and important sources of third-party information were often underutilized. Across samples from various jurisdictions, Nicholson and Norwood (2000) noted serious concerns about the descriptions of defendants' competency-relevant functional abilities and the evidence upon which the examiners' opinions were based. Moreover, the links between cognitive impairments or psychopathology symptoms and competency-related functional abilities were frequently omitted or discussed poorly in reports. Ten years later, the most common problem cited by Grisso (2010) in "expert" reports was indeed related to the lack of sufficient explanation of major interpretations and conclusions. Similarly, the clear presentation of reasoning that underlies psycholegal opinions and the link between clinical findings and the forensic question is a central point emphasized by DeMier in a 2013 review. Other problems that have been cited across studies relate to elements of forensic reports that are deemed essential yet seemed to be lacking in surveys of actual reports. Specifically, documentation of a discussion with the defendant about the nature and purpose of the evaluation, incorporation of third-party information and testing as needed, and the analysis of functional abilities in addition to the foundational CST abilities are inconsistently addressed in a significant portion of forensic reports (e.g., Christy et al., 2004; Heilbrun & Collins, 1995; Robbins et al., 1997; Skeem & Golding, 1998; Stein et al., 2016).

In some ways, the errors in forensic work product are understandable in light of the difficulty of writing high quality forensic reports, which serve as a culmination of a variety of forensic and psychological skills. A good report first necessitates a good psychiatric and forensic evaluation conducted by a good forensic psychologist (Buchanan & Norko, 2013; DeMier, 2013). As Buchanan and Norko explained in a 2013 research

agenda for forensic evaluation and reporting, report writing entails the organization, interpretation, and presentation of gathered evidence along with understanding the needs of the audience. Throughout the process, practitioners must be aware of a wide range of ethics-related issues at the intersection of clinical psychology and the law. The report is therefore "the most tangible and visible measure of the professionalism of a forensic psychiatrist" (Buchanan & Norko, 2013, p. 359). Fortunately, the field has continued to make improvements with the help of academic scholar-practitioners as well as the professional bodies that represent them and the field as a whole. The combined difficulty and importance of forensic report writing nevertheless deserves continued development and efforts toward quality improvement (Buchanan & Norko, 2013).

The Present Study

Skeem and colleagues (Skeem et al., 1998; Skeem & Golding, 1998), as well as the review by Nicholson and Norwood (2000) noted some improvements in CST reports over early studies of CST evaluations. Major deficits in report content and quality remain in more recent studies as well, especially with respect to necessary ethical documentation (e.g., Robinson & Acklin, 2010), sufficient reasoning or rationale for forensic opinions (e.g., Grisso, 2010), and coverage of statutorily-defined competency areas (e.g., Stein et al., 2016). The current study aimed to advance previous research in several ways. First, this is only the second direct comparison of forensic reports of CST in Texas to state statute, following that of Gray et al. (2005). Further, both Gray et al. (2005) and Stein et al. (2016) included samples that were limited in size and population: Gray et al. (2005) included only reports of those deemed not competent and in need of confinement to a state hospital facility, while Stein et al. (2016) included only reports of a

few community-based examiners. The present study utilized a larger and more representative sample of evaluation reports conducted by examiners from various state agencies, hospitals, and private practice.

Second, the present study examined a more recent sample of forensic reports, as there appears to be few other empirical studies of forensic report quality since those from 2010 (Grisso; Robinson & Acklin). Research in the field of forensic psychology as a whole has become more aware of pitfalls and errors in the work of forensic examiners. As a result, many resources (journal articles, handbooks, casebooks, training workshops) have become available to improve the quality of FMHA. Furthermore, professional organizations, such as the American Academy of Psychiatry and the Law (AAPL) and the APA in forensic psychology have offered ethical and practice guidelines in forensic evaluation and reports. However, there have been only a handful empirical studies of forensic reports of CST in the past decade. The present study aimed to provide evidence regarding whether forensic examiners have improved in forensic report writing since more recent educational and training resources have come available.

Some assert that a key underlying issue with forensic report writing errors is insufficient training (e.g., DeMier, 2013; Skeem et al., 1998; Skeem & Golding, 1998; Robinson & Acklin, 2010). Thus, a third aim of the current research is to extend previous work by examining a sample of forensic reports in a state that requires forensic examiners of CST to be licensed, doctoral-level psychologists or psychiatrists with appropriate certification or training in addition to recent continuing education (Tex. Code Crim. P. Ann. § 46B.022). Specifically, experts in Texas must be certified by the American Board of Psychiatry and Neurology with added or special qualifications in

forensic psychiatry or by the American Board of Professional Psychology in forensic psychology *or* have at least 24 hours of specialized forensic training relating to incompetency or insanity evaluations *and* at least eight hours of continuing education relating to forensic evaluations completed in the 12 months preceding the court appointment (Tex. Code Crim. P. Ann. § 46B.022). The present study specifically extended the work of Gray et al. (2005), in which the sample was collected only a short time after the state law was modified to include professional requirements for examiners and specific factors to consider in CST examinations. The current sample of reports will span several years following the implementation of the state statute.

To this author's knowledge, no study has attempted to further study the nature and logic of CST reports as thoroughly as Skeem et al. (1998). As such, the present study further investigated the extent to which examiners consider competency-related functional abilities and their relationships, if any, to symptomology and/or psychopathology. Specifically, the present study examined the extent to which evaluators adequately consider competency-related abilities delineated by state statutes and whether they link any deficits in those abilities to psychiatric symptoms or diagnoses.

As a final goal, the present study further examined the validity of Heilbrun's (2001) principles of FMHA in an attempt to extend the work of Lander and Heilbrun (2009). No other work has defined report quality in terms of the presence or absence of specific FMHA principles, nor has any other work attempted to empirically validate these (or other) specific principles. Therefore, a research question posed here is, to what extent are reporters who tend to follow to Heilbrun's (2001) principles also following and adhering to state statutory requirements? And, are those reports that have more principles

present rated as more helpful and of higher quality than those reports who do not document these principles? Empirical examination of forensic practice principles is important to gauge the helpfulness of the guidelines as well as to revise and improve the guidelines as necessary (Buchanan & Norko, 2013).

CHAPTER II

Method

Sample of Reports

An archival review of reports was conducted. Reports were obtained from the Harris County Public Defender's Office (HCPDO) per a data use agreement and institutional review board approval. Because the raw data (i.e., the reports themselves) contained identifying information, the reports remained in the custody and care of the HCPDO, and all coding reviews were conducted on site at the offices of the HCPDO, where the raw data was password-protected. Collected data were de-identified, such that defendant, examiner, and affiliated agency names were replaced by participant identification numbers and letter codes.

A sample of 352 misdemeanant defendants were randomly selected from a pool of approximately 1,500 files of defendants who had been evaluated for CST. Thus, the report sample consisted of 352 reports of CST evaluations conducted between 2010 and 2016. In instances in which defendants received multiple CST evaluations (e.g., CST evaluations on multiple charges at different points in time or re-evaluations after hospitalization), the most recent available report was selected. The reports were authored by 28 examiners from 10 agencies or private practices. The number of reports from each examiner ranged from 1 to 50, with a median of 6 reports per examiner. Reports ranged from 1 to 18 pages, with an average of 5.13 pages (SD = 1.89). Basic report characteristics and defendant demographics are summarized in Table 3.

Table 3

Report Characteristics and Defendant Demographics

Variable	*n* (percent)
Location of Evaluation	
Jail	245 (69.6%)
Inpatient facility	97 (27.6%)
Outpatient setting	8 (2.3%)
Not mentioned	2 (0.6%)
Evaluator Discipline	
Psychologist	274 (77.8%)
Board-Certified Psychologist	41 (11.6%)
Psychiatrist	37 (10.5%)
Evaluator Agency	
Contracted state agency	242 (68.7%)
Psychiatric hospital	88 (25%)
Private practice	22 (6.3%)
Defendant Age	M = 38.61 (SD = 13.15)
Defendant Gender	
Male	271 (77%)
Female	81 (23%)
Defendant Race/Ethnicity	
White/Caucasian	85 (24.1%)
Black/African American	187 (53.1%)
Hispanic/Latino/a	47 (13.4%)
Asian/Asian American	11 (2.8%)
Other	6 (1.7%)
Not mentioned	16 (4.5%)
Defendant Immigration Status	
U.S. born	129 (36.6%)
Immigrant	32 (9.1%)
Not mentioned	191 (54.3%)
Defendant Primary Language	
English	16 (4.5%)
Spanish	7 (2%)
Asian Origin	6 (1.7%)
African Origin	7 (2%)
Other	8 (2.3%)
Not mentioned	308 (87.5%)

Procedures

Coding Protocol. A protocol was carefully developed based on the Texas competency statute and the coding manuals developed and used by Skeem et al. (1998) and Lander and Heilbrun (2009). The coding protocol was modified as necessary during the coder training and reliability stages (described below) with special consideration to minimize rater subjectivity and to emphasize ease of coding and coder reliability. The final coding protocol (see Appendix) included basic report and evaluator information, defendant demographics and historical information, information about the explanation of notification or disclosure, use of collateral sources, testing data (if any), mental health information and diagnoses, psycholegal opinions, recommendations (if any), and overall subjective ratings of report impartiality, language, helpfulness, and quality. The presence or absence of many of Heilbrun's (2001) principles of FMHA were coded based on specific items in the protocol (marked by shaded text boxes and "FMHA Principle" in the coding protocol). As in Lander and Heilbrun's (2009) work, some principles cannot be coded from reports (e.g., "testify relevantly"). When a diagnosis was provided, raters were asked to code the extent to which the evaluator substantiated their diagnostic opinion through description of symptoms to support the diagnosis. Additionally, raters coded whether examiners commented on a defendant's symptom validity or potential for malingering or feigning. Finally, the coding protocol also included the eight competency-related abilities delineated by Texas statute. For each domain, raters coded whether the report fully addressed the CST ability and, if so, whether the defendant was described as impaired on the domain. When an impairment was present, raters also

coded whether the report author articulated a link between the impairment and symptomology.

Training of Report Raters. The primary author and five other doctoral-level graduate students coded the sample of reports. All coders had completed at least one graduate-level course in forensic assessment, had foundational knowledge of CST evaluations, and had observed or conducted court-ordered CST evaluations with a clinical psychologist board certified in forensic psychology. All raters participated in an iterative training process conducted by the primary author to demonstrate and establish proper coding procedure and address coding problems or errors. Raters initially familiarized themselves with the coding protocol and guidelines. All raters subsequently coded one report together and independently coded a second report (not included in analyses), discussing ratings for each item and identifying sources of disagreement or misunderstanding. Next, all raters independently coded five CST reports from the program's community clinic and convened for additional training to address coding discrepancies. This process was repeated for another sample of five community clinic reports (again, not included in analyses). Finally, the raters independently coded seven randomly-selected CST reports from the study sample to establish adequate interrater reliability. Having established acceptable interrater reliability, the remainder of the reports were divided among the raters to code independently. The primary author coded 112 reports, while the number of reports coded by each of the other raters ranged from 18 to 85 (M = 46).

CHAPTER III

Results

Interrater Reliability

To calculate the reliability of coders' ratings, two measures of interrater reliability were calculated: percent agreement and free-marginal multirater kappa. Fleiss' (1971) multirater kappa is an index of agreement based upon Cohen's kappa (Cohen, 1992) for nominal data that corrects for the level of chance agreement; however, Fleiss' kappa is known to be influenced by prevalence bias and is used when raters are restricted in how cases are distributed across categories (Randolph, 2005). Thus, the free-marginal multirater kappa (multirater κ_{free}), used when the quantities of cases that should be distributed into each category is unknown *a priori*, was more appropriate for the current study. Generally, kappa values less than .40 indicate poor agreement, .40 to .59 indicate fair agreement, .60 to .74 indicate good agreement, and values .75 and greater will indicate excellent agreement (Cicchetti & Sparrow, 1981). Using these qualitative categorizations, the raters in the current study reached excellent overall agreement across all considered variables combined (*M* percent agreement = 92.31%; *M* multirater κ_{free} = 0.87). Only seven items across the coding protocol were deemed to have unacceptable agreement (i.e., rater agreement < 75% or multirater $\kappa_{free} < 0.60$). Three of these items were subsequently deleted; the wording of three items was slightly modified; and all items were discussed thoroughly in a final training meeting among the raters to address modifications and discuss discrepancies before proceeding with coding. Across domain psycholegal abilities, mean percent agreement was 89%, and reliability was fair to excellent (ranging from 0.43 to 1.00; *M* multirater κ_{free} = 0.83). Only one domain ability

resulted in a multirater κ_{free} of less than 0.66, and coding of this domain was discussed in the final meeting between the raters to address discrepancies before proceeding with coding. When coding the link between competency impairments and psychopathology, mean rater agreement was 85%, and reliability was good to excellent (*M* multirater κ_{free} = 0.77; range 0.64 to 0.93). Finally, single measures intraclass correlation coefficients (ICCs) for absolute agreement showed acceptable interrater reliability for subjective ratings of helpfulness (ICC = 0.71) and quality (ICC = 0.70) of the report.

Basic Report Contents

The legal issue was clearly stated in almost every report (*n* = 350; 99.4%). Regarding the ethically important forensic warning, 314 reports (89.2%) documented notification of the purpose of the evaluation, while this notification was only vaguely implied or not indicated in 22 reports (6.3%). For the notification of the limits of confidentiality, 325 reports (92.3%) explicitly stated this was provided to the defendant. However, fewer reports (*n* = 258; 73.3%) of reports explicitly described the defendant's understanding of the disclosures. Thirty-three reports (9.4%) implied or indirectly or vaguely mentioned the defendant's understanding, while 45 reports (12.8%) gave no indication whatsoever of the defendant's comprehension of the forensic warning. (It should also be noted 16 defendants refused to participate in the evaluation before the disclosures could be offered by the examiner.)

All 352 reports listed the sources of information for the evaluation, and 311 reports (88.4%) cited at least one collateral source of information in addition to an interview with the defendant. The most common sources of information were court documents (*n* = 330; 93.8%), interviews with the defendant (*n* = 311; 88.4%), law

enforcement records (*n* = 298; 84.7%), mental health records (*n* = 268; 76.1%), and jail records (*n* = 256; 72.7%). Ten reports (2.8%) utilized any types of psychological or forensic testing. Reports rarely cited collateral interviews with family (*n* = 2; 0.6%), jail officers (*n* = 15; 4.3%), mental health personnel (*n* = 2; 0.6%), and attorneys (*n* = 1; 0.3%). One report cited academic records, and 11 reports (3.1%) cited other, miscellaneous sources of information (e.g., letters from prior providers, employment records, and defendant notes to his/her attorney). Despite the widespread use of collateral information, authors discussed comparisons between collateral sources and the defendant's self-report in only 43 reports (12.2%).

Testing

A small portion of reports utilized psychological or forensic testing (*n* = 10; 2.8%). Of these, 9 utilized the Evaluation of Competency to Stand Trial, Revised (ECST-R), one utilized the Inventory of Legal Knowledge, one utilized the Slosson Intelligence Test, Revised, and another utilized various competency and psychological testing instruments.

Diagnostic and Psycholegal Opinions

The vast majority of reports included a diagnostic opinion (334; 94.9%). Of those, 54% (*n* = 190) of reports supported the diagnosis with explicit mentions of most of the symptoms, 35.8% (*n* = 126) listed or described only a few symptoms consistent with the diagnosis provided, and 5.1% (*n* = 18) described no symptoms to substantiate the diagnostic opinion. Put another way, 40.9% of report authors did not adequately support their diagnostic option. Nevertheless, all but seven reports (*n* = 345; 98%) included a full description of mental status. On the other hand, only 11.1% (*n* = 39) of reports addressed

response style, symptom validity, or the possibility of malingering. Of these, 23 defendants were determined unlikely to be feigning, 9 defendants were determined likely to be feigning, and 2 reports did not make a determination regarding feigning.

Regarding the ultimate opinion, 135 defendants (38.4%) were deemed competent to stand trial, and 217 defendants (61.6%) were deemed incompetent to stand trial. Reports indicated an initial competency evaluation in 251 cases (71.3%), whereas 99 evaluations (28.1%) indicated a re-evaluation following a period of restoration efforts. For the following analyses, reports where the defendant did not participate in the interview were excluded. Table 4 lists the competency-related domains and displays the frequency with which reports addressed each domain (column 2), the proportion of reports that described the defendant as unimpaired or impaired on each domain, given that the domain was addressed (columns 3 and 4), and the proportion of reports that linked noted impairments in competency abilities to mental illness or symptomology (columns 5 and 6). As the Table reveals, each CST domain was addressed in a majority of reports. However, only 187 reports (60.9%) addressed all eight CST domains, and 52 reports (16.9%) addressed six or fewer domains. Overall, 120 reports (39.1%) neglected to address at least one of the CST factors required by statute. Additionally, there were significant differences in the number of CST domains addressed for defendants deemed competent versus incompetent to proceed, t (349.87) = 4.914, $p < .01$, $d = 0.51$. Interestingly, report authors addressed a higher number of CST domains for defendants opined competent to proceed ($M = 7.48$, $SD = 1.09$) than for defendants opined incompetent to proceed ($M = 6.73$, $SD = 1.79$).

Table 4

Competency Domains and Related Impairments

CST Domain	Domain addressed	Given domain addressed,		Given impairment, link to mental illness	
		Unimpaired	Impaired	Yes	No
Rationally understand the charges against him/her	284 (92.5%)	159 (51.8%)	125 (40.7%)	71 (56.8%)	54 (43.2%)
Rationally understand the consequences of criminal proceedings	263 (85.7%)	154 (50.2%)	109 (35.5%)	57 (52.3%)	52 (47.7%)
Disclose to counsel pertinent facts, events, and states of mind	294 (95.8%)	125 (40.7%)	169 (55%)	133 (78.7%)	36 (21.3%)
Engage in a reasoned choice of legal strategies and options	288 (93.8%)	133 (43.3%)	155 (50.5%)	110 (70.1%)	45 (29%)
Understand the adversarial nature of criminal proceedings	269 (87.6%)	154 (50.2%)	115 (37.5%)	67 (58.2%)	48 (41.7%)
Exhibit appropriate courtroom behavior	296 (96.4%)	160 (52.1%)	136 (44.3%)	111 (81.6%)	25 (18.4%)
Testify relevantly	299 (97.4%)	122 (39.7%)	177 (57.7%)	161 (90.1%)	16 (9%)
Consult with attorney with reasonable degree of understanding	251 (81.8%)	110 (35.8%)	141 (45.9%)	123 (87.2%)	18 (12.8%)

Note. $N = 307$, the number of reports where the defendant agreed to participate in the interview.

Drawing on Skeem et al. (1998), associations between competency domain impairments and ultimate CST opinion were examined using phi coefficients. As seen in Table 5 and Table 6, impairment on CST domains were strongly related to examiners' ultimate CST opinions. Table 5 depicts the portion of defendants who were deemed incompetent (IST) and competent (CST) when a competency domain was noted to be impaired or unimpaired. For example, 100% of defendants with an impairment in the capacity to rationally understand the charges against him or her were opined incompetent to stand trial, while 0% of the impaired defendants were deemed competent. Also, 77.9% of defendants without such an impairment were opined competent to proceed. Overall, when defendants were described as impaired with respect to any of these major competency-related domains, they were almost always (98.5-100%) deemed incompetent to stand trial. Table 6 depicts the portion of defendants found incompetent or competent to proceed that demonstrated an impairment on the domain. For example, 80.1% of defendants opined incompetent to proceed were noted to have an impairment in the capacity to rationally understand the charges against him or her, while 19.9% of those opined incompetent to stand trial did not demonstrate such an impairment. On the other hand, 0% of defendants opined competent to proceed were noted to have an impairment in the ability to rationally understand the charges, while 100% of those opined competent did not demonstrate the impairment.

Table 5

Percent of Defendants Opined Incompetent or Competent when Domain is Impaired vs. Unimpaired

			Of those with impairment,		Of those without impairment,	
CST Domain	*n* [a]	ϕ	Opined IST	Opined CST	Opined IST	Opined CST
Rationally understand the charges against him/her	308	.79*	100%	0%	22.1%	77.9%
Rationally understand the consequences of criminal proceedings	281	.78*	99.2%	0.8%	21.9%	78.1%
Disclose to counsel pertinent facts, events, and states of mind	329	.98*	98.5%	0.5%	2.3%	97.7%
Engage in a reasoned choice of legal strategies and options	316	.96*	99.4%	0.6%	4.4%	95.6%
Understand the adversarial nature of criminal proceedings	287	.82*	100%	0%	18.4%	81.6%
Exhibit appropriate courtroom behavior	335	.79*	99.4%	0.6%	22%	78%
Testify relevantly	333	.99*	99.5%	0.5%	0%	100%
Consult with attorney with reasonable degree of understanding	281	.96*	99.4%	0.6%	0.9%	99.1%

Note. [a] Sample size varies for each domain based on cases for which the domain was addressed.
*$p < .01$

Table 6

Percent of Defendants with or without a Domain Impairment when Opined Incompetent vs. Competent

CST Domain	*N* [a]	ϕ	Of those opined incompetent, Impaired	Of those opined incompetent, Unimpaired	Of those opined competent, Impaired	Of those opined competent, Unimpaired
Rationally understand the charges against him/her	308	.79*	80.1%	19.9%	0%	100%
Rationally understand the consequences of criminal proceedings	281	.78*	78.6%	21.4%	0.8%	99.2%
Disclose to counsel pertinent facts, events, and states of mind	329	.98*	98.5%	1.5%	0.8%	99.2%
Engage in a reasoned choice of legal strategies and options	316	.96*	96.7%	3.3%	0.8%	99.2%
Understand the adversarial nature of criminal proceedings	287	.82*	81.6%	18.4%	0%	100%
Exhibit appropriate courtroom behavior	335	.79*	81.8%	18.2%	0.8%	99.2%
Testify relevantly	333	.99*	100%	0%	0.8%	99.2%
Consult with attorney with reasonable degree of understanding	281	.96*	99.4%	0.6%	0.9%	99.1%

Note. [a] Sample size varies for each domain based on cases for which the domain was addressed.
*$p < .01$

Other Statutory Elements

Texas statute states that an expert should consider the effects of psychiatric medication on the defendant's competency and demeanor. There were 261 defendants noted to be taking psychiatric medications at the time of the evaluation. Of these, 208 reports (79.7%) mentioned the effect of medications on the defendant's "appearance, demeanor, and ability to participate in the proceedings." Also, 212 reports (81.2%) noted that medications were necessary to maintain the defendant's competency.

If a defendant in Texas is opined incompetent to proceed, the statute further requires the expert to address the restorability of the defendant to competency, an estimate of the time needed to do so, and appropriate prospective treatment options. Of the 217 defendants found incompetent to proceed, 203 reports (93.5%) asserted an opinion regarding the defendant's ability to be restored to competency. Of these, 43 defendants (21.2%) were deemed not likely to be restored; 160 defendants (78.8%) were deemed likely to be restored. Only 9 reports (4.1%) did not provide a time frame (i.e., "the forseeable future"). Of those found incompetent to proceed, 202 reports (93.1%) provided prospective treatment recommendations. Unsurprisingly, the most commonly cited recommendation was psychiatric medications (*n* = 170; 78.3%), followed by inpatient hospitalization (*n* = 114; 52.5%), psychotherapy or psychoeducation (*n* = 102; 47%), further evaluation (*n* = 45; 20.7%), and outpatient treatment (*n* = 19; 8.8%). (Note that these treatment recommendations were not mutually exclusive.)

Overall Report Quality

Report raters provided subjective ratings of report quality. The majority of reports were noted to reflect an impartial tone (*n* = 334; 94.9%) and plain language (*n* =

267; 75.9%). On a Likert scale from 1 (not at all) to 5 (extremely), 30.4% (n = 107) of reports were rated as only somewhat, slightly, or not at all helpful to the trier of fact. On a Likert scale from 1 (poor) to 5 (excellent), 21% (n = 74) of reports were rated as only fair or poor, while 51.4% (n = 181) of reports were rated as very good or excellent. As expected, subjective ratings of helpfulness correlated significantly with subjective ratings of overall quality (r = .798, p < .01). Report length was also modestly yet significantly correlated with ratings of helpfulness (r = .274, p < .01) and overall quality (r = .245, p < .01). Furthermore, the number of CST domains address per report correlated significantly with ratings of helpfulness (r = .560, p < .01) and quality (r = .537, p < .01).

Forensic Mental Health Assessment Principles

Table 7 lists the 15 of the 29 principles of FMHA (Heilbrun, 2001) that were able to be coded from reports, along with the number and percentages of reports that adhered to each principle. The number of principles present in each report ranged from 5 to 13 (M = 9.8, SD = 1.4). The total number of principles present in each report correlated positively and significantly with subjective ratings of overall helpfulness (r = .415, p < .01) and quality (r = .428, p < .01). The number of principles present in each report also correlated significantly and positively with the total number of CST domains addressed in each report, (r = .555, p < .01). Notably, reports rendering an opinion of competent to proceed versus incompetent to proceed differed significantly with respect to adherence to principles of FMHA, t (350) = 4.299, p < .01, d = 0.49. Specifically, reports including an opinion of competency demonstrated a mean of 10.19 principles of FMHA (SD = 0.97), whereas reports including an opinion of incompetency demonstrated a mean of 9.55 principles of FMHA (SD = 1.55).

Table 7

Frequency of Use of Principles of Forensic Mental Health Assessment (Heilbrun, 2001)

Principle	*n* (%)
P1. Identify relevant forensic issues.	352 (100%)
P10. Use multiple sources of information for each area being assessed.	311 (88.4%)
P12. Obtain relevant historical information.	345 (98%)
P13. Assess clinical characteristics in relevant, reliable, and valid ways.	336 (95.5%)
P14. Assess legally relevant behavior.	198 (56.3%)
P16. Provide appropriate notification of purpose and/or obtain appropriate authorization before beginning.	314 (89.2%)
P17. Determine whether the individual understands the purpose of the evaluation and the associated limits on confidentiality.	258 (73.3%)
P18. Use third party information in assessing response style.	43 (12.2%)
P19. Use testing when indicated in assessing response style.	2 (0.6%)
P22. Use scientific reasoning in assessing causal connection between clinical condition and functional abilities.	28 (8%)
P23. Do not answer the ultimate legal question.[a]	0 (0%)
P24. Describe findings and limits so that they need change little under cross-examination.	342 (97.2%)
P25. Attribute information to sources.	301 (85.5%)
P26. Use plain language; avoid technical jargon.	267 (75.9%)
P27. Write report in sections, according to model and procedures.	352 (100%)

Note. [a] *Texas statute requires an ultimate opinion be provided.*

Agency Comparisons

Analyses of Variance were conducted to make comparisons between reports from private practitioners, evaluators in inpatient psychiatric facilities, and evaluators employed by a contracted state agency. There were no significant differences across

agencies with respect to the application of principles of FMHA, $F(2,349) = 2.73$, $p = .066$, partial $\eta^2 = .015$, the number of CST domains addressed, $F(2,349) = 2.01$, $p = .135$, partial $\eta^2 = .011$, subjective ratings of helpfulness, $F(2,349) = 1.55$, $p = .213$, partial $\eta^2 = .009$, or subjective ratings of overall report quality, $F(2,349) = 2.24$, $p = .108$, partial $\eta^2 = .013$. With only one psychiatrist evaluator in the sample, comparisons between professional disciplines (i.e., psychologists versus psychiatrists) could not be completed.

CHAPTER IV

Discussion

The current study examined adherence to statutory guidelines and to the principles of forensic report-writing outlined by Heilbrun (2001) in a sample of 352 reports of competency to stand trial evaluations in a southern, urban jurisdiction. Overall, the findings showed some improvements in report components deemed essential in the field (e.g., the forensic warning, uses of third-party information). Also, half of the reports were subjectively rated as very good or excellent, and nearly a quarter of reports were subjectively rated as at least moderately helpful to the trier of fact. On the other hand, notable deficits, especially in regard to substantiation of psycholegal opinions, continue to be observed in this sample. Furthermore, overall adherence to the principles of FMHA was quite variable, with each principle being addressed in 0-100% of reports.

In regards to essential report components, such as the documentation of the forensic warning, results showed improvements over previous studies. In the current sample, 89% of reports documented a notification of the purpose of the evaluation – an improvement over prior findings of 30% (Heilbrun & Collins, 1995) and 63% (Skeem et al., 1995). Similarly, 92% of reports in the current sample documented notification of the limits of confidentiality, compared to 24% (Robinson & Acklin, 2010) and 47% (Skeem et al., 1995). Nearly a quarter of the reports in the current sample included some indication of the defendant's understanding of the forensic disclosures. While these findings show a large improvement from 3.2% of reports in Lander and Heilbrun (2009), one could argue this ethical element of forensic evaluation should be more commonly documented.

Another essential report component is the use of collateral or third-party information. In the current study, the large majority (88%) of reports referenced at least one collateral source of information in addition to the interview with the defendant, with court and law enforcement records and mental health records being the most commonly cited sources. Notably, the use of psychological or forensic testing was rare in this sample. In comparing these results to those in the literature, previous studies have reported widely varied rates of the use of collateral information. Some studies have noted substantial portions of reports that failed to reference third-party information (Christy et al., 2004; Lander & Heilbrun, 2009; Robbins et al., 1997), particularly in reports by community examiners (Heilbrun & Collins, 1995). One more recent study found that 74% of reports included four or more sources of information and 98% of reports referenced two or more sources of data (Robinson & Acklin, 2010). However, Grisso (2010) reported that 28% of reports continued to evidence inadequate data and 22% of reports relied too heavily on a single source of data (e.g., clinical interview). The results in the current study might suggest that forensic mental health examiners have become increasingly aware of the dangers of relying solely on the defendant's self-report. One caveat could be that the mental health and court records were easily accessible from the state mental health agencies and hospitals with whom the evaluators were employed.

An area of deficiency observed in the current study, which has also been observed in earlier research, is the lack of substantiation of diagnostic and psycholegal opinions. In the current sample, only about half of the reports (54%) were judged to adequately support the provided diagnosis, and the possibility of or rule out of malingering, feigning, or exaggeration was rarely articulated. In prior studies, diagnostic opinions have been

adequately supported in 67% (Skeem et al., 1998) and 74% (Robinson & Acklin, 2010) of reports. The current results suggest that, even after 20 years, mental health professionals continue to fail to adequately articulate the reasoning for their clinical opinions.

One way that examiners can support their ultimate opinions of competent or incompetent to proceed is to articulate and consider functional capacities related to competency. In Texas, the statute delineates which of these functional domains should be considered in an evaluation. In the current sample, individual competency-related domains required by statute were addressed in 82% to 97% of reports. The most commonly addressed domains were the capacity to testify relevantly and to exhibit courtroom behavior, while the least commonly addressed domains were the capacity to consult with one's attorney with a reasonable degree of understanding and to rationally understand the consequences of the criminal proceedings. Interestingly, the former domains may be more commonly addressed because they are more easily described or assessed, as they signify more concrete abilities, as compared to the more abstract or complex capacities to "consult" or "rationally understand." While 92% of reports addressed six or more domains, only 61% of reports addressed all eight domains. These findings are largely in line with results from previous research. Heilbrun and Collins (1995) noted that nearly all hospital evaluators but only 61-81% of community evaluators addressed functional competency abilities, while these abilities were only addressed in half the reports in a sample from Robbins and colleagues (1997). In other samples, the portions of reports that addressed each of the functional competency abilities ranged from 24-85% (Skeem et al., 1995), 14-98% (Zapf et al., 2004), to 84-91% (Christy et al. 2004).

Notably, however, the findings from the current study show improvements over prior samples from the same state, which found that 82% of community-based reports were missing at least one psycholegal ability defined by law (Stein et al., 2016), and specific competency domains were addressed in 30 to 85% of reports from a Texas state hospital (Gray et al., 2005). In the latter sample, less than 5% of reports addressed all competency factors required by statute.

An additional important aspect of substantiating psycholegal opinions is to link specific CST domain impairments to psychopathology. In the current sample, impairments in CST domains were adequately linked to psychopathology in only 52% to 90% of reports, depending on the domain. Impairments in the capacities to rationally understand the consequences of the proceedings and the charges were least likely to be linked to symptomology, while impairment in the capacity to testify relevantly was most likely to be associated with mental illness. As noted, these results suggest that more concrete abilities are more easily tied to psychopathology, whereas identifying symptoms that interfere with the capacity to rationally understand is a comparatively abstract process. Results from the current study are in line with the variable results from the literature. In earlier studies, 27% (Robbins et al., 1997) to 90% (Skeem et al., 1998) of reports failed to substantiate a link between psychopathology or symptoms and functional competency-relevant domains. Still, later studies found that a rationale for opinions was only provided in 50-63% of reports (Christy et al., 2004; Gray et al., 2005). More recently, Robinson and Acklin (2010) noted that 82% of reports provided a functional explanation of the defendant's impairment. Indeed, Grisso (2010) reported that the most common error in submitted reports was that major interpretations or opinions were

offered without sufficient explanation of the basis for their opinion (56% of reports). Evidently, evaluators continue to show difficulty substantiating their pycholegal opinions.

Not only were evaluators in the current study neglecting to address competency-related factors required by statute and to adequately support their opinions, but some reports failed to include other information required by law. For example, about 20% of reports did not address the effects of medications on competency or demeanor. Fortunately, many reports included an opinion of whether a defendant was likely to be restored to competency, and the large majority noted whether restoration was likely in the "foreseeable future" required by in statute. The large majority provided treatment recommendations for restoration, as well.

As mentioned, adherence to principles of FMHA was quite variable, with each principle being addressed in 0-100% of reports. Fortunately, results revealed that a large majority of evaluators are using multiple sources of information to obtain relevant historical data and to "assess clinical characteristics in relevant, reliable, and valid ways," and most authors attribute the information to sources from which it is obtained (principles 10, 12, 13, and 25). Also, while approximately 90% of evaluators document providing a notification of purpose and limits of confidentiality, about a quarter of evaluators failed to document whether the defendant understood these disclosures. Previous authors have presumed the lack of documentation to reflect a lack of ethical practices in this regard, and communication of this ethical function is vital. Principles 18 and 19 refer to assessing response style, and these principles were present in only a minimal number of reports. This is an alarming finding, given that there are increased threats to the validity

of information provided by a defendant in a forensic evaluation (Melton et al., 2007). Forensic examinees often have much to gain from the outcome of an evaluation. Further, accuracy is vital in forensic examination, the psycholegal methods and opinions are often given a high level of scrutiny (Melton et al., 2007). Finally, perhaps most concerning is the minimal adherence to principle 22: "Use scientific reasoning in assessing causal connection between clinical condition and functional abilities." In other words, only 28 of 352 reports articulated a link between each noted impairment in a competency-relevant area to mental health symptoms.

Regarding overall quality ratings, the majority of reports were rated to have an impartial tone and plain language, and about half of the reports were rated to have above-average quality. Importantly, 70% of reports were described as moderately to extremely helpful to the trier of fact. Longer reports, especially reports that addressed a greater number of CST domains, were rated as more helpful and of greater quality. Reports that adhered to more Principles of FMHA (Heilbrun, 2001) were rated as more helpful and of greater quality, as well. Unfortunately, because there have been a variety of methods to operationally define report quality (e.g., subjective ratings, Blue Ribbon panels, quantitatively calculated scores), comparisons in report quality across time and jurisdictions are unable to be made.

Implications for Practice

All reports in the current sample adhered to the FMHA Principle, "Write reports in sections." Over 68% of the sample was drawn from a state agency that utilized a uniform report template across evaluators. This may be the product of a "Template for Competency Evaluations" that was released by the Texas Correctional Office on

Offenders with Medical or Mental Impairments (TCOOMMI, n.d.). Perhaps as a result, almost all of the reports were structured according to the Texas state statute, such that each competency-relevant factor was provided a separate section and heading. It should be noted though, that this template was produced as guidance, rather than any legal requirement (Texas Health and Safety Code, Chapter 614, 2005), and forensic mental health evaluators remain free to deviate from this template. Nevertheless, the use of report templates could be one explanation for the findings that individual CST domains were addressed in such a majority of reports. Thus, reports of evaluations of competency to stand trial may document more comprehensive assessments of functional abilities with the "reminder" to address each particular domain in its own section of the report. Alternatively, the use of "checklists" has been proposed (Witt, 2010). A good example of a specific and thorough report checklist can be found on the website of the University of Massachusetts Medical School (Designated Forensic Professional Training and Certification Committee, n.d.). Of course, future research should further address this hypothesis.

Another hypothesis for the noted improvements in report quality in the current sample is the state's requirements for training and continuing education for forensic examiners. As mentioned, forensic examiners in the state of Texas are required to be licensed, doctoral-level psychologists or psychiatrists with 24 hours of specialized forensic training and at least eight hours of continuing education related to forensic evaluation in the prior 12 months. Indeed, Skeem and Golding (1998) concluded that insufficient training was the underlying issue to poor forensic report quality. Ideally, these training requirements contribute to higher quality forensic evaluations, but a causal

association cannot be asserted based on the current data. However, some research supports the hypothesis that training improves the quality of reports. Melton, Weithorn, and Slobogin (1985) found that reports by evaluators who attended a comprehensive, 50-hour training were rated more favorably by legal professionals. While Skeem and colleagues (1998) found that an annual, two-day training did not improve aspects of report quality, Robinson and Acklin (2010) found a significant improvement in report quality by community evaluators who attended an annual training. Skeem and Golding (1998) concluded that brief trainings were insufficient and advocated for more comprehensive and focused programs of training. Future research should continue to explore the impact of training on report writing, especially to determine the amount of training or qualifications necessary to produce higher quality and statutorily-compliant reports.

Limitations and Future Directions

The current study examined how the content and quality of forensic reports of competency to stand trial align with ethical and statutory guidelines as well as Principles of FMHA. Report raters subjectively coded overall report quality and helpfulness, but it is unclear how these ratings would compare to ratings of report quality by judges reading the reports and making the ultimate legal decisions. Similarly, future research should address to what extent judges expect and consider specific functional abilities related to competency to stand trial. For example, do judges also perceive reports that address these domains as more helpful and better in quality? Also research has not addressed to what extent judges agree with the Principles of FMHA.

The current study attempted to build upon a key study by Skeem and colleagues (1998). The author intended to examine subdomains of broader, foundational competency-related abilities in a similar manner to Skeem and colleagues (1998). However, efforts to achieve inter-rater reliability required the subdomains to be eliminated from the coding protocol. Additionally, comparisons between this sample and prior study samples were made, but unique elements of each jurisdiction limit the generalizability of the findings and comparisons. Further, the results from this urban jurisdiction with predominantly agency- or hospital-based evaluators may not generalize to more rural areas or areas with a higher proportion of evaluators in private practice.

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APPENDIX

Defendant Participant ID_____
Evaluator Letter_____
Rater Name_____

CST REPORT CODING PROTOCOL

Code UA for unavailable, NA for not applicable, or NM for not mentioned. DO NOT LEAVE ANYTHING BLANK!

BASIC REPORT/EVALUATOR INFORMATION

__/__/_____ Date of *Current* Offense
__/__/_____ Date of Arrest (could be the same as above)
__/__/_____ Date entered jail (could also be the same as above)
__/__/_____ Date transferred to other location (or *N/A*)
Indicate where:
_____ Inpatient secure facility
_____ Outpatient setting
_____ Other, specify: _____
__/__/_____ Date released to community, *if released prior to CST eval*
__/__/_____ Date of *original* motion for CST evaluation
__/__/_____ Date of *original* court order or referral for CST evaluation
__/__/_____ Date of Evaluation
__/__/_____ Date of Report
__/__/_____ Date of CST hearing/ ruling
Title(s) of *current* offense(s): _____
_____
_____ Length of Report (*in approximate .5 pages*)
_____ Location of Evaluation
1 = jail or other correctional facility
2 = inpatient secure facility
3 = Non-secure outpatient setting
4 = Other, Specify: _____
_____ Evaluator Discipline (or *NM*) (*usually found in signature block or heading*)
1 = Psychologist
2 = Board Certified Psychologist (*i.e., ABPP*)
3 = Psychiatrist
4 = Other, Specify: _____
_____ Is the legal question(s)/forensic issue(s) identified by the report?
0 = No, the legal question is unclear
1 = No, but the forensic purpose is readily inferred by the reader
2 = Yes, author clearly states/cites legal question/issue/standard at issue

FMHA Principle #1

EXPLANATION OF NOTIFICATION/DISCLOSURE

_____ Does the author include documentation that the defendant was given an explanation of the **purpose of the evaluation** prior to the interview? (*or N/A in rare cases*)
0 = No, no indication that it was provided/addressed
1 = Implied, vaguely noted
2 = Yes, it is explicitly/concretely stated

FMHA Principle #16

_____ Does the author include documentation that the defendant was given an explanation of the **limits of confidentiality** prior to the interview? (*or N/A in rare cases*)
0 = No, no indication that it was provided/addressed
1 = Implied, vaguely noted
2 = Yes, it is explicitly/concretely stated

_____ If yes, does the author *describe* the defendant's (perceived) **understanding** of the purpose of the evaluation and the limits of confidentiality? (*or N/A in rare cases*)
0 = No, no indication of understanding (or lack of) *whatsoever, at all*
1 = Implied, indirect or vague mention of understanding (or lack of)
2 = Yes, *explicitly* stating the defendant understood or providing evidence of *how/what* the defendant understood

FMHA Principle #17

DEFENDANT DEMOGRAPHICS ***Do not make any assumptions.*** *Code as NM if not mentioned.***

_____ Age, in years (at the time of the evaluation; may need to calculate from DOB)

_____ Sex, as reported by evaluator (0 = male, 1 = female)

_____ Race/Ethnicity, as reported by evaluator

0 = White/Caucasian
1 = Black/African American
2 = Hispanic/Latino/a, Specify nationality: _____
3 = Asian/Asian American, Specify nationality: _____
4 = Other, Specify: _____

_____ Immigrant status (***Don't assume!***)

0 = U.S. Born (e.g., "*born* in City, State")
1 = Immigrated >10 years prior to eval
2 = Immigrated 5-10 years prior to eval
3 = Immigrated <5 years prior to eval

If immigrated, specify country of origin: _____

_____ Primary language spoken by defendant (***Don't assume!***)

0 = English
1 = Spanish
2 = Asian Origin, Specify: _____
3 = African Origin, Specify: _____
4 = Other, Specify: _____

_____ IF primary language not English, in which language was evaluation conducted? (*or N/A*)

1 = Defendant's primary language spoken by evaluator
2 = Defendant's primary language with an interpreter
3 = Defendant's secondary language

_____ Highest level of education

0 = Did not graduate HS
1 = HS Graduate (Diploma or GED)
2 = Some College/Associate's Degree/Other certification
3 = Bachelor's Degree
4 = Graduate Degree

_____ Employment Status (***Don't assume!***)

0 = Unemployed
1 = Employed/self-employed/earning money through non-criminal means

HISTORICAL INFORMATION INCLUDED IN THE REPORT

Does the report *contain* the defendant's . . . (0 = No, 1 = Yes; not whether one exists, but whether it is mentioned in report; may be statement that the defendant has *no* history of X)

_____ Family of origin/upbringing/social history?
_____ Education history?
_____ Employment history?
_____ Medical history?
_____ **Psychiatric/Mental health history?** **FMHA Principle #12**
_____ Substance Use/Abuse history?
_____ Military history?
_____ Criminal/legal history?

_____ Does the defendant have any prior arrests, convictions, or trouble with the law? (0 = No, 1 = Yes)

_____ Does the author detail sources of information used (in list/paragraph)? (0 = No, 1 = Yes)

_____ Does the author note collateral information was *requested* but unavailable? (0 = No, 1 = Yes)

Which **sources of information** are cited as reviewed in the evaluation? 0 = No, 1 = Yes, or N/A (e.g., defendant has no prior criminal history or was not detained); *use best judgment to assign to category or use "other"*

FMHA Principle #10

_____ Interview with the defendant
_____ Court documents/records
_____ Law enforcement records (e.g., arrest/offese reports, prior arrests)
_____ Jail/correctional records (e.g., booking, jail medical/MH records, probationary records)
_____ **General or forensic mental health records (e.g., CST/MSO reports, forensic hospitalizations psychiatric hospitalizations, treatment records, testing/evaluation reports, physical medical records)**

FMHA Principle #13

_____ School/Academic Records
_____ Collateral interview with family member/spouse/guardian/significant other
_____ Collateral interview with detention/jail officers/jail medical staff
_____ Collateral interview with current or prior mental health care provider/hospital personnel
_____ Collateral interview with defense or prosecuting attorney
_____ Other or Unsure, Specify: -

_____

FMHA Principle #25

_____ Throughout the report, how often is information *attributed to* sources (including the defendant) or collateral records (besides the initial listing)? (0 = Rarely, 1 = Sometimes, **2 = Often or almost always**)

ASSESSMENT OF MALINGERING/FEIGNING OF SYMPTOMS

_____ Does the author *explicitly address* response style, symptom validity, effort, malingering/feigning or exaggerating symptoms? (0 = No, 1 = Yes)

_____ Did the author administer a symptom validity or malingering measure, or test of effort?

FMHA Principle #19

0 = No
1 = Yes, Specify instrument/test(s): _____

_____ Does the author *explicitly* discuss comparisons between collateral sources/presentation and the defendant's self-report *in order to address symptom validity or malinger/feigning/exaggeration?*

FMHA Principle #18

0 = No
1 = Yes

_____ If addressed, what did the author *explicitly* conclude? (***Not*** *the reader's inference.*)

0 = the defendant is *unlikely* to be malingering/feigning or exaggerating symptoms
1 = the defendant is *likely* to be malingering/feigning or exaggerating symptoms

MENTAL HEALTH INFORMATION

_____ *How well* does the author describe the defendant's mental status/behavioral observations at the time of the evaluation? (e.g., orientation, thought process, speech, mood/affect, concentration, memory, A/VH, thoughts of harm)

0 = Mental status (exam) is not mentioned or addressed in a limited fashion
_____ 1 = Mental status (exam) is fully addressed (e.g., in a separate paragraph, section heading)

_____ Does the author provide a diagnostic opinion (including "no diagnosis," "by history," "provisional," or "rule-out")? (0 = No, 1 = Yes) (*If diagnosis is deferred, code as 0.)*

If yes, check which category(ies) of mental illness, according to *DSM* (*Code each axis independently if DSM-IV-TR*).

_____ No diagnosis (*Only code this if "NO diagnosis" is the actual opinion.*)
_____ Neurodevelopmental disorder (including ID, ADHD, ASD, and BIF)
_____ Schizophrenia spectrum and other psychotic disorder
_____ Bipolar and related disorder
_____ Depressive disorder
_____ Anxiety disorder (including obsessive-compulsive and related disorder)
_____ Trauma- and stressor-related disorder
_____ Substance-related disorder
_____ Neurocognitive disorder (including impairment due to TBI or medical condition)
_____ Personality disorder
_____ Disruptive, impulse-control, and conduct disorder
_____ Other, Specify: _____

Considering **ALL** the information contained in the report, how well does the author back up his/her diagnostic opinion? (*or NA*)
(*If multiple diagnoses were considered or listed, give the highest score appropriate.*)

0 = Author describes ***no*** symptoms, simply lists the diagnosis
1 = Author presents a ***few*** symptoms
2 = Author explicitly mentions *most* symptoms to meet diagnostic criteria

FMHA Principle #13

Has the defendant had any prior psychiatric hospitalizations? (*or NM*)

0 = No indication of any prior hospitalizations
1 = Yes: **How many** admissions/stays? (*or NM*) _____

Is defendant currently prescribed any psychiatric medication(s)? (*or NM*)

0 = No
1 = Yes: **List medication(s)**: _____
_____

Is there any indication that the defendant has previously been evaluated for CST?
(*make an educated guess if necessary*)

0 = No
1 = Yes: **How many?** _____

Is the current evaluation a re-evaluation for CST for the instant offense?
(*make educated guess if necessary)* (0 = No, 1 = Yes)

FMHA Principle #14 **FMHA Principle #22**

STATUTORY REQUIREMENTS

1. Does the author describe the defendant's abilities/impairments related to his/her ***capacity to rationally understand the charges against him/her***?

(Abilities in this domain include, but are not limited to: Factual knowledge of his/her charges and their labels, Knowledge of the meaning of the charges or the behaviors to which the charges refer, Comprehension of the police version of events)

0 = No, this domain is not addressed
1 = Yes, the domain is addressed, and the defendant IS NOT impaired on this domain
2 = Yes, the domain is addressed, and the defendant IS impaired on this domain

1a. IF there is impairment in this domain, does the author explain how the defendant's mental illness or symptoms affect his/her ***capacity to rationally understand the charges***?

N/A = No impairment was noted
0 = No, the author fails to relate the impairment to mental illness/mental illness symptoms ***at all***
1 = Yes, the author provides a partial, implied, or explicit link between mental illness and/or symptoms and the impairment *in this domain*

2. Does the author describe the defendant's abilities/impairments related to his/her ***Capacity to rationally understand the potential consequences of the pending criminal proceedings***?

(Abilities in this domain include, but are not limited to: Knowledge of potential penalties that could be imposed, Comprehension of the seriousness of potential sentences)

0 = No, this domain is not addressed
1 = Yes, the domain is addressed, and the defendant IS NOT impaired on this domain
2 = Yes, the domain is addressed, and the defendant IS impaired on this domain

2a. IF there is impairment in this domain, does the author explain how the defendant's mental illness or symptoms affect his/her ***capacity to rationally understand the potential consequences of the proceedings***?

N/A = No impairment was noted
0 = No, the author fails to relate the impairment to mental illness/mental illness symptoms ***at all***
1 = Yes, the author provides a partial, implied, or explicit link between mental illness and/or symptoms and the impairment in *this domain*

_____ **3.** Does the author describe the defendant's abilities/impairments related to his/her ***Capacity to disclose to counsel pertinent facts, events, and states of mind***?

(Abilities in this domain include, but are not limited to: Ability to provide a reasonable account of own behavior prior to, during, and subsequent to the alleged crime; ability to provide information about states of mind, including intentions, feelings, cognitions; behavior of others/police surrounding the alleged crime, comprehension of Miranda warning, confession behaviors)

0 = No, this domain is not addressed
1 = Yes, the domain is addressed, and the defendant IS NOT impaired on this domain
2 = Yes, the domain is addressed, and the defendant IS impaired on this domain

_____ **3a.** IF there is impairment in this domain, does the author explain how the defendant's mental illness or symptoms affect his ***capacity to disclose pertinent facts, events, and states of mind***?

N/A = No impairment was noted
0 = No, the author fails to relate the impairment to mental illness/mental illness symptoms ***at all***
1 = Yes, the author provides a partial, implied, or explicit link between mental illness and/or symptoms and the impairment *in this domain*

_____ **4.** Does the author describe the defendant's abilities/impairments related to his/her ***Capacity to engage in a reasoned choice of legal strategies and options***?

(Abilities in this domain include, but are not limited to: Understanding of pleas (factual knowledge and understanding of guilty, not guilty, no contest, insane, etc.); Knowledge and understanding of the plea bargaining process and the implications of a guilty plea or plea bargain; Capacity to participate in planning a defense strategy and to make a reasoned about defense options (e.g., plea, plea bargain) without distortion due to mental illness)

0 = No, this domain is not addressed
1 = Yes, the domain is addressed, and the defendant IS NOT impaired on this domain
2 = Yes, the domain is addressed, and the defendant IS impaired on this domain

_____ **4a.** IF there is impairment in this domain, does the author explain how the defendant's mental illness or symptoms affect his/her ***capacity to engage in a reasoned choice of legal strategies/options***?

N/A = No impairment was noted
0 = No, the author fails to relate the impairment to mental illness/mental illness symptoms ***at all***
1 = Yes, the author provides a partial, implied, or explicit link between mental illness and/or symptoms and the impairment *in this domain*

_____ **5.** Does the author describe the defendant's abilities/impairments related to his/her ***Capacity to understand the adversarial nature of criminal proceedings***?

(Abilities in this domain include, but are not limited to: Understanding of the functions of trial participants (e.g., defense, prosecution, etc.); Understanding of court procedures (e.g., basic sequence of events, how key players interact, basic processes, etc.)

0 = No, this domain is not addressed
1 = Yes, the domain is addressed, and the defendant IS NOT impaired on this domain
2 = Yes, the domain is addressed, and the defendant IS impaired on this domain

_____ **5a.** IF there is impairment in this domain, does the author explain how the defendant's mental illness or symptoms affect his/her ***capacity to understand the adversarial nature of the criminal proceedings***?

N/A = No impairment was noted
0 = No, the author fails to relate the impairment to mental illness/mental illness symptoms ***at all***
1 = Yes, the author provides a partial, implied, or explicit link between mental illness and/or symptoms and the impairment *in this domain*

_____ **6.** Does the author describe the defendant's abilities/impairments related to his/her ***Capacity to exhibit appropriate courtroom behavior***?

(Abilities in this domain include, but are not limited to: Appreciation of appropriate courtroom behavior, Ability to manage behavior/ emotion in courtroom, Ability to track events as they unfold)

0 = No, this domain is not addressed
1 = Yes, the domain is addressed, and the defendant IS NOT impaired on this domain
2 = Yes, the domain is addressed, and the defendant IS impaired on this domain

_____ **6a.** IF there is impairment in this domain, does the author explain how the defendant's mental illness or symptoms affect his/her ***capacity to exhibit appropriate court behavior***?

N/A = No impairment was noted
0 = No, the author fails to relate the impairment to mental illness/mental illness symptoms ***at all***
1 = Yes, the author provides a partial, implied, or explicit link between mental illness and/or symptoms and the impairment *in this domain*

_____ **7.** Does the author describe the defendants' abilities/impairments related to his/her ***capacity to testify relevantly***?

0 = No, this domain is not addressed
1 = Yes, the domain is addressed, and the defendant IS NOT impaired on this domain
2 = Yes, the domain is addressed, and the defendant IS impaired on this domain

_____ **7a.** IF there is impairment in this domain, does the author explain how the defendant's mental illness or symptoms affect his/her ***capacity to testify relevantly***?

N/A = No impairment was noted
0 = No, the author fails to relate the impairment to mental illness/mental illness symptoms ***at all***
1 = Yes, the author provides a partial, implied, or explicit link between the mental illness and/or mental illness symptoms and the impairment in the *capacity to testify relevantly*

_____ **8.** Does the author describe the defendant's abilities/impairments related to his/her ***Sufficient present ability to consult with the person's lawyer with a reasonable degree of rational understanding?***

(Note that abilities in this domain cut across multiple other broad domains)

0 = No, this domain is not addressed
1 = Yes, the domain is addressed, and the defendant IS NOT impaired on this domain
2 = Yes, the domain is addressed, and the defendant IS impaired on this domain

_____ **8a.** IF there is impairment in this domain, does the author explain how the defendant's mental illness or symptoms affect his/her ***sufficient ability to consult with counsel in a reasonable, rational manner***?

N/A = No impairment was noted
0 = No, the author fails to relate the impairment to mental illness/mental illness symptoms ***at all***
1 = Yes, the author provides a partial, implied, or explicit link between mental illness and/or symptoms and the impairment *in this domain*

MEDICATION AND CST (*If no medications prescribed, check here and move to next section.*) ☐

_____ Does the author address whether or not the medication has an effect on the defendant's appearance, demeanor, ability to participate in or "track" the proceedings, or any emotional/cognitive/memory deficits attributable to medications?

0 = No, Author does not describe any effects of the medication on the defendant
1 = Yes, Author mentions *some* effects of the medication on the defendant

_____ Does the author address whether or not the medication is necessary to maintain CST *or* the potential impact of discontinuing medication on CST? (0 = No, 1 = Yes)

PSYCHOLEGAL OPINIONS

_____ Does the report include the defendant's own *detailed* description of the alleged offense (i.e., self-reported crime details that might violate his or her 5th amendment rights)? (0 = No, 1 = Yes)

_____ Indicate the author's opinion:

0 = Competent to stand trial
1 = Not competent to stand trial
2 = Indeterminate/the author does not offer an opinion

FMHA Principle #23

_____ Does the author make an ***explicit*** reference to evidence contrary to their psycholegal opinion? (e.g., "*While the defendant demonstrates a factual knowledge of the charges against him, he lacks a sufficient ability to consult with his attorney.*")

0 = No
1 = Yes

FMHA Principle #24

_____ Does the author address criminal responsibility or mental state at the time of the offense?
0 = No
1 = Yes, pursuant to a court order that this also be evaluated
2 = Yes, but there is no indication that the court requested this be evaluated

TREATMENT – ***IF opined incompetent*** *(If declared CST, check here and move to next section.)* ☐
Which types of treatment are recommended, if any? *Code each separately; Not mutually exclusive.* (0 = No, 1 = Yes)

_____ Medication(s)
_____ Psychotherapy or psychoeducation
_____ Treatment in an outpatient setting
_____ Treatment in an inpatient setting
_____ Future/further evaluation

_____ Does the author ***address*** whether or not the defendant can/is likely to be restored to competency? (0 = No, 1= Yes)

_____ If yes, what does the author ***opine*** regarding the defendant's restorability?
0 = The defendant cannot/is NOT likely to be restored
1 = The defendant can/is likely to be restored, but the author offers ***no*** time frame *whatsoever*
2 = The defendant can/is likely to be restored ***and*** can be restored in the forseeable future and/***or*** provides a more **specific** timeline for how long it will take

OVERALL SUBJCTIVE RATINGS *(Rather than any criteria, rate according to your overall impression of the report.)*

_____ Does the tone and language of the report generally reflect impartiality?
0 = No, or largely no
1 = Somewhat or mixed
2 = Yes, or largely yes
FMHA Principle #24

_____ Does the tone and language of the report generally reflect plain language?
0 = Mostly no
1 = Somewhat or mixed
2 = Mostly yes
FMHA Principle #26

_____ Does this report *provide the necessary information* to assist a judge in making a decision?
1 = Not at all helpful
2 = Slightly helpful
3 = Somewhat helpful
4 = Moderately helpful
5 = Extremely helpful

_____ Give your subjective judgment of the ***overall quality*** of this report.
1 = Poor
2 = Fair
3 = Good
4 = Very good
5 = Excellent

If any testing data is used, continue to next page.
If no testing is used, check here. ☐

TESTING DATA

_____ Was a **forensic assessment instrument** (i.e., test of competency-related abilities) used in the evaluation?

FMHA Principle #21

0 = No
1 = Yes, Specify Test(s): _____

_____ Was **psychological testing** (i.e., testing *not* derived for use in forensic mental health assessments) used at all in the evaluation? (0 = No, 1 = Yes)

If yes, which ***category*** of psychological testing is used? (0 = No, 1 = Yes)
(If unsure, consult this database: Buros' "Mental measurement yearbook with tests in print".)

FMHA Principles #13, 21

_____ Was a measure of ***intelligence*** used in the evaluation?

0 = No
1 = Yes, Specify Test(s): _____

_____ Was a measure of ***achievement*** used in the evaluation?

0 = No
1 = Yes, Specify Test(s): _____

_____ Was a ***neuropsychological*** measure used in the evaluation (including ***memory***)?

0 = No
1 = Yes, Specify Test(s): _____

_____ Was an ***objective measure of personality/psychopathology*** used in the evaluation?

0 = No
1 = Yes, Specify Test(s): _____

_____ If yes, does the author note/discuss the validity of the results (e.g. inventory validity scales)?

0 = No
1 = Yes

_____ Was a ***projective*** instrument used in the evaluation?

0 = No
1 = Yes, Specify Test(s): _____

_____ Does the author use testing results to justify, support, or substantiate the diagnostic opinion if any? Or, are testing results discussed in the diagnostic formulation?
*(Note: Consider **ALL** information contained throughout the report, not just "testing" section.)*

0 = The author **does not** link between test results and diagnostic opinion.
1 = The author **does** relate the test results to particular diagnostic opinion.

FMHA Principle #21

_____ Does the author use testing results to describe the defendant's competency-related abilities (i.e., the competency domains on p. 6-7).
*(Note: Consider **ALL** information contained throughout the report, not just "testing" section.)*

0 = The author **does not** link test results to any specific functional ability involved in CST or even to CST in general. The author generally uses the tests solely for describing dimensions of psychopathology/cognitive deficits and may simply summarize results without discussing implications for CST. *Ex: "The defendant's score on the paired associates portion of the WMS were far below average, suggesting impaired short-term memory."*
1 = The author **does** provide a description of the implications of test results for a defendant's CST. The author may relate results to the concept of CST in general, or specifically to particular functional ability(ies). *Ex: "The defendant's score on the paired associates portion of the WMS were far below average, suggesting impaired short-term memory, which may damage his understanding of the proceedings and ability to assist defense."*

VITA

KELSEY L. LAXTON, M.A.
Sam Houston State University

EDUCATION

August 2012 – Present
Doctor of Philosophy, Clinical Psychology with Forensic Emphasis (Candidate)
Sam Houston State University, Huntsville, Texas
Dissertation: *The Content and Quality of Forensic Mental Health Examiners' Reports of Competency to Stand Trial*
Chair: Jorge G. Varela, Ph.D.

December 2014
Master of Arts, Clinical Psychology with Forensic Emphasis
Sam Houston State University, Huntsville, Texas
Thesis: *Does distance make the heart grow fonder, or does distance make the eyes wander? Long-distance relationships, attention to alternatives, and infidelity*
Chair: Rowland S. Miller, Ph.D.

August 2008 – May 2012
Bachelor of Arts, Psychology with a Minor in Criminal Justice
Summa Cum Laude with Honors Distinction
University of Tennessee at Martin, Martin, Tennessee

CLINICAL & PRACTICA EXPERIENCE

August 2017 – Present
Pre-doctoral Clinical Intern
Inpatient Forensic Training Track
Federal Bureau of Prisons, Federal Correctional Complex – Butner
Butner, North Carolina

Setting/Population: Adult males committed, hospitalized, or incarcerated at a federal correctional compound

Responsibilities:
- Full-time, six-month rotation in inpatient forensic evaluation
  - Conduct forensic evaluations of competency to stand trial, mental state at the time of the offense, and dangerousness risk assessments
  - Provide inpatient treatment, including medication monitoring, behavioral management, daily rounds in extended secure housing, and participate in interdisciplinary treatment team meetings
  - Conduct and document suicide risk assessments
  - Facilitate competency restoration groups for committed pre-trial defendants

  - Administer tests of personality, malingering and cognitive screening instruments in a group testing clinic
- Half-time, six-month rotation in the Bureau of Prisons' Commitment and Treatment Program for Sexually Dangerous Persons
  - Facilitate and provide holistic, multidimensional, cognitive-behavioral treatment to reduce sexual dangerousness and criminal recidivism potential
  - Co-facilitate psychoeducational and/or process-oriented treatment groups
  - Contribute to multidisciplinary treatment team meetings
  - Participate in the residential, modified therapeutic community
- Half-time, six-month rotation providing services to the general inmate population
  - Conduct and document intake screenings, suicide risk assessments, and diagnostic evaluations as needed
  - Provide individual therapy and brief, supportive counseling
  - Facilitate empirically-supported psychotherapy groups
  - Provide consultation to medical, educational, psychiatry, and correctional staff as needed

Primary Supervisors: Evan S. Du Bois, Psy.D.; Robert Cochrane, Psy.D., ABPP, Training Director; Kara Holden, Ph.D.; Michelle Rissling, Ph.D.

August 2016 – July 2017

Practicum Student
Federal Bureau of Prisons, Federal Prison Camp – Bryan
Bryan, Texas

Setting/Population: Adult female offenders incarcerated in a minimum security federal correctional compound

Responsibilities:
- Co-facilitated group therapy within the Non-Residential Drug Abuse Program (DAP) and the Resolve Trauma Program
  - Screened individuals for eligibility for the Residential DAP
  - Assessed individuals for eligibility/appropriateness for participation in specific treatment groups
  - Engaged in treatment planning
  - Conducted psychoeducational workshops on trauma-related stress disorders
- Participated in multidisciplinary treatment team meetings
- Attended RDAP therapeutic community meetings
- Conducted brief individual therapy

Supervisors: Ashley Noble, Psy.D., Chief Psychologist; Leana Talbott, Psy. D., Drug Abuse Program Coordinator; Deanna Berg, Psy,D., Staff Psychologist; Melissa Arrieta, Psy.D., Resolve Trauma Program Coordinators

August 2015 – September 2016 ***Student Clinician and Co-Therapist***
Sex Offender Treatment Program
Livingston, Texas

Setting/Population: Primarily low-income, rural adult males (two groups) and females (one group) on probation or parole for sexual offenses

Responsibilities:
- Co-facilitated bi-monthly, mandated, evidence-based, manualized group treatment with a Licensed Sex Offender Treatment Provider
- Provided individual, evidenced-based psychotherapy for group members whose needs extended beyond the group context
  - Engaged in treatment and discharge planning
  - Assessed/managed risk for self-harm, suicide, and deviant sexual behavior
- Participated in external social support meetings, including chaperon training

Supervisor: Holly A. Miller, Ph.D., Licensed Sex Offender Treatment Provider

August 2015 ***Assistant Behavioral Abnormality Evaluator***
Contractor, Texas Department of Criminal Justice (TDCJ)

Setting/Population: Adult male offender convicted of multiple sexual offenses incarcerated in state correctional facility

Responsibilities:
- Participated in a behavioral abnormality and risk assessment of an inmate being considered for civil commitment as a Sexually Violent Predator
- Assisted with administration, scoring, and interpretation of risk assessment measures (i.e., Static-99R, Psychopathy Checklist-Revised)
- Formulated case conceptualizations and diagnoses
- Assisted with written evaluation report for TDCJ

Supervisor: Jorge G. Varela, Ph.D.

June 2015 – July 2016 ***Clinic Coordinator***
Psychological Services Center at Sam Houston State University
Huntsville, Texas

Setting/Population: Community mental health clinic servicing a primarily low-income, rural population of adults, adolescents, and children

Responsibilities:
- Completed telephone intake interviews of potential clients
- Facilitated and arranged services from outside referral agencies to the clinic
- Led weekly meetings of clinicians and supervisors to assign cases and facilitate group discussion of clinical/ethical issues
- Mediated clinic concerns between student clinicians, staff, and supervisors
- Supervised peers in clinic policy, procedure, and record-keeping
- Monitored clinical case assignments and updated client waiting lists
- Conducted Quality Assurance reviews of clinic case files each semester
- Advertised services to the community and planned an Open House Event
- Assisted in day-to-day operations and administration

Supervisor: Mary Alice Conroy, Ph.D., ABPP, Clinic Director

October 2014 – July 2017 ***Student Forensic Evaluator***
Psychological Services Center at Sam Houston State University
Huntsville, Texas

Setting/Population: Male and female adults and adolescents involved in the justice system in several rural counties; evaluations conducted in jails or in outpatient clinic

Responsibilities:
- Conduct court-ordered, pre-trial evaluations (i.e., competency to stand trial and mental state at the time of the offense for adults; fitness to proceed, criminal responsibility, and certification to adult court for juveniles) under the direct supervision of a board-certified forensic examiner
- Co-author forensic evaluation reports for the courts

Supervisor: Mary Alice Conroy, Ph.D., ABPP

October 2014 – July 2016 ***Student Forensic Evaluator***
Psychological Services Center at Sam Houston State University
Huntsville, Texas

Setting/Population: Male and female adolescents involved in the justice system in several rural counties; evaluations conducted in detention center or clinic

Responsibilities:
- Conduct court-ordered or probation-referred psychodiagnostic evaluations of justice-involved youth
  - Administer, score, and interpret abbreviated and comprehensive measures of intellectual and achievement abilities, behavior, and personality

- Co-author integrated reports documenting clinical findings and recommendations
  - Provide treatment recommendations to referral agencies to assist departments in placement and probation requirement decisions

Supervisor: Darryl Johnson, Ph.D.

June 2014 – May 2015

Practicum Student
Intensive Outpatient Program
National Smart Healthcare
Houston, Texas

Setting/Population: Managed care intensive outpatient therapy program servicing low-income, sometimes homeless or indigent, urban adult males and females with chronic and severe mental illnesses

Responsibilities:
- Facilitated group therapy for clients with severe mental illnesses
- Collaborated with case managers and IOP staff to ensure continuum of care
- Assessed suicide risk assessment and developed risk management plans
- Conducted integrative psychodiagnostic assessments to inform treatment needs, treatment plans, and appropriateness of services
  - Administered, scored, and interpreted abbreviated and comprehensive measures of intellectual functioning and achievement, adaptive behavior, personality, and psychopathology
- Authored integrated reports documenting clinical findings and recommendations
  - Provided feedback and recommendations to treatment teams

Supervisor: Frank Fee, Ph.D.

August 2013 – October 2016

Student Clinician
Psychological Services Center at Sam Houston State University
Huntsville, Texas

Setting/Population: Community mental health clinic servicing a low-income, rural population of adults, adolescents, and children with diagnoses of serious and persistent mental illness, substance use, mood and anxiety disorders, personality disorders, family and academic stress

Responsibilities:
- Conducted intake evaluations
- Provided individual, evidence-based psychotherapy services
  - Engaged in suicide risk assessment and management

- Engaged in treatment planning with clients, monitor treatment goals, and author treatment summary reports
- Consulted with community providers and agencies to ensure client safety and continuity of care

- Conducted comprehensive psychodiagnostic and psychoeducational evaluations
- Authored integrated reports documenting clinical findings
  - Provided feedback and recommendations to clients and referral agencies
- Attended and participated in group supervision/clinical case conferences

Supervisors: Jorge G. Varela, Ph.D.; Adam T. Schmidt, Ph.D.; Lisa Kan, Ph.D.; Craig Henderson, Ph.D.; David V. Nelson, Ph.D., ABPP, Wendy Elliott, Ph.D.

March 2011 – August 2012

Applied Behavioral Analysis (ABA) Technician
Children's Treatment Center for Children with Autism and Other Developmental Disorders
Martin, Tennessee

Setting/Population: Private practice community clinic serving rural children with pervasive developmental disorders and their families

Responsibilities:

- Provided individual, applied behavioral therapeutic services to modify unwanted behavior and to enhance learning and skills in academic and social settings
- Utilized iPad, computer applications as a key treatment tools

Supervisor: Gary Brown, Ph.D., Health Service Provider in Psychology

SUPERVISORY EXPERIENCE

Sept 2014 – May 2016

Peer Supervisor
Capstone Practicum Course
Sam Houston State University, Huntsville, Texas

Setting/Population: Junior doctoral student clinicians conducting psychotherapy and psychoeducational evaluations in a community mental health clinic. Clients were low-income, rural adults and adolescents with mood and anxiety disorders, personality disorders, and family and academic stress

Responsibilities:

- Co-facilitated supervision sessions with licensed staff psychologist
- Reviewed therapy and assessment session videos with supervisees

- Reviewed and provided feedback on clinical documentation and case presentation materials for the Capstone comprehensive exam

Supervisors: Darryl Johnson, Ph.D., Wendy Elliott, Ph.D.

TEACHING EXPERIENCE

August 2016 – May 2017

Graduate Teaching Assistant and Peer Supervisor
Assessment of Personality and Psychopathology (Graduate Course)
Sam Houston State University, Huntsville, Texas

Responsibilities:
- Supervised junior masters'- and doctoral-level student clinicians learning to conduct clinical interviews and assess personality
- Supervised the administration, scoring, interpretation, and write-up of objective personality measures (MMPI-2, MMPI-2-RF, PAI)
- Reviewed and provided feedback on written assignments including mock reports of personality assessment

Supervisory Professor: Jaime L. Anderson, Ph.D.

August 2013 – May 2014

Graduate Teaching Assistant
Introduction to Research Methods – Laboratory (Undergraduate Courses)
Sam Houston State University, Huntsville, Texas

Responsibilities:
- Designed course syllabus and planned course experiment in collaboration with lecture course instructor
- Instructed and assisted students in three sections in writing a full-length manuscript for a pre-determined experiment
- Provided instruction on research methods in psychology, APA writing and citation style, plagiarism, hypothesis testing, and basics of SPSS and data analysis/interpretation as related to a course experiment

Supervisory Professor: John de Castro, Ph.D.

August 2011 – December 2012

Undergraduate Supplemental Instructor
Experimental Psychology (Undergraduate Course)
University of Tennessee at Martin, Martin, Tennessee

Responsibilities:
- Selected by primary course instructor based on performance in the course
- Provided supplemental course instruction and assistance with material to experimental psychology students

Supervisory Professor: Colin W. Key, Ph.D.

RESEARCH

PUBLICATIONS

Cramer, R. J., **Laxton, K. L**., Chandler, J. F., Kehn, A., Bate, B. P., Clark, J. W. (2017). Political identity, type of victim, and hate crime-related beliefs as predictors of views concerning hate crime penalty enhancement laws. *Analyses of Social Issues and Public Policy, 17*, 262-285. doi:10.1111/asap.12140

WORKSHOP PRESENTATIONS

Laxton, K. L. & Bate, B. P. (2016, July). *Criminal Responsibility and Forensic Report Writing: A summary of* American Academy of Forensic Psychology *Continuing Education workshops.* Invited seminar presented in Graduate Student Seminar Series, Sam Houston State University, Huntsville, TX.

Kan, L. Miller, D., Bias, J., Wechsler, H., **Laxton, K. L.,** Mathew, A., & Henderson, C. (2015, November). *Campus rape and Title IX: Ethical and Clinical Issues.* Continuing Education Workshop presented at the Annual Meeting of the Texas Psychological Association, San Antonio, TX.

Henderson, C., Dowda, R., Henderson, S., Kan, L., Wechsler, H., **Laxton, K. L.**, Li, C. (2014, November). *Zen and Baseball: The Supervisory Relationship in Strength-Based Supervision*. Continuing Education Workshop presented at the annual meeting of the Texas Psychological Association, Dallas, TX.

CONFERENCE PRESENTATIONS

Laxton, K. L., Varela, J. G., Bryson, C. N., Mattos, L. A., Reinhard, E. E., Holdren, S. M., Lawrence, J., & Minor, B. R. (2018, March). *Content and quality of forensic reports of competency to stand trial evaluations.* Paper presented at the annual conference of the American Psychology-Law Society, Memphis, TN.

Bryson, C. N., Boccaccini, M. T., Gowensmith, W. N., **Laxton, K. L.**, Mattos, L. A., Reinhard, E. E., Holdren, S. M., & Lawrence, J. (2018, March). *Time matters in competency to stand trial evaluations.* Poster presented at the annual conference of the American Psychology-Law Society, Memphis, TN.

Vera, L., Boccaccini, M., **Laxton, K. L,** Bryson, C., Pennington, C., Ridge, B. (2017, August). *The influence of empathy on the accuracy of evaluator ratings of Psychopathy*. Poster presented at the annual conference of the American Psychological Association, Washington, D.C.

Vera, L., Boccaccini, M., **Laxton, K. L,** Bryson, C., Pennington, C., Ridge, B. (2017, March). *Evaluator empathy in psychopathy interviews*. Poster presented at the annual conference of the American Psychology-Law Society, Seattle, WA.

Lawrence, J., Varela, J. G., **Laxton, K. L.**, Arellano, M., Colbourn, S., Munoz, C., Barrera, H. (2015, May). *The influence of interpreted testimony on mock jurors' decision making and perceptions of criminal defendants*. Poster presented at the annual conference of the American Society of Trial Consultants, Nashville, TN.

Laxton, K.L., Schmidt, A.T., Hoskowitz, N.A. (2015, March). *A multicultural revision of the Sensitivity to Punishment and Sensitivity to Reward Questionnaire – Child Version*. Poster presented at the annual conference of the American Psychology-Law Society, San Diego, CA.

Lawrence, J., Varela, J. G., **Laxton, K. L.**, Arellano, M., Colbourn, S., Munoz, C., Barrera, H. (2015, May). *The influence of interpreted testimony on mock jurors' decision making and perceptions of criminal defendants*. Poster presented at the annual conference of the American Psychology-Law Society, San Diego, CA.

Noland, R. M., Lamb, G. L., Pelayo, J., **Laxton, K. L.,** & Henderson, V. (2015, February). *Perfect Practice Makes Perfect: Improving Graduate Students Individualized Testing Competency*. Poster presented at the annual meeting of the National Association of School Psychologists, Orlando, FL.

Laxton, K. L. (2014, June*). A call for training programs in trial consultation: Implications for practice and ethics*. Poster presented at the annual conference of the American Society of Trial Consultants, Asheville, NC.

Laxton, K. L., Cramer, R. J., Bate, B. P., Kehn, A., Clark, J. W. (2014, March). *Should we punish hate? An examination of factors in support or opposition of hate crime penalty enhancements*. Poster presented at the annual conference of the American Psychology-Law Society, New Orleans, LA.

Colbourn, S. L., Henderson, C. E., **Laxton, K. L.** (2013, August). *Evidence-based substance abuse treatment and the criminal adolescent: Positive long term effects*. Poster presented at the annual conference of the American Psychological Association, Honolulu, HI.

Miller, A. K., **Laxton, K. L.,** Duncan, J. M., Pennington, J. N., & Gemberling, T. M. (2013, March). *Expertise only for the enrapt: Need for cognition moderates utilization of culpability-diminishing insanity opinion*. Poster presented at the annual conference of the American Psychology-Law Society, Portland, OR.

Miller, A. K., Gemberling, T. M., Gardner, B. O., Burks, A. C., Rodriguez, D., & **Laxton, K. L.** (2013, March). *Clarifying the personality roots of jury-biasing social cognitions: On right-wing authoritarianism*. Poster presented at the annual conference of the American Psychology-Law Society, Portland, OR.

Miller, A. K., Duncan, J. M., Taslitz, A. E., Gardner, B. O., Pennington, C. R., Kline, S. A., Burks, A. C., Pennington, J. N., Duhon, D. A., Rodriguez, D., Stein, M. L., Gemberling, T. M., & **Laxton, K. L.** (2013, March). *A personality-and-attitude-change model of jury NGRI verdicts: The pivotal role of perspective taking*. Poster presented at the annual conference of the American Psychology-Law Society, Portland, OR.

Merwin, M. M., Buckelew, S., & **Laxton, K. L.** (2011, August). *The Insanity of Mary Todd Lincoln: An exemplar case study for teaching elements and integration of the biopsychosocial model*. Poster presented at the annual conference of the American Psychological Association, Washington, D. C.

Laxton, K. L., Taylor, J., Little, A. W., Sneed, A. (2011, March). *At the end of your rope, what's next? The Effects of stress on motivation in college students.* Poster presented at the annual conference of the Southeastern Psychological Association, Jacksonville, FL.

Laxton, K. L., Taylor, J., Little, A. W., Sneed, A. (2010, November). *At the end of your rope, what's next? The Effects of stress on motivation in college students*. Paper presented at the annual Experimental Psychology Research Symposium, University of Tennessee at Martin, Martin, TN.

Laxton, K. L., Little, A. W., Sneed, A., Taylor, J., & Wheeler, K. (2010, November). *Analyses of alcohol use and other risk behaviors among adolescents at the Martin Housing Authority's Crossroads Teen Center*. Paper presented at the annual Experimental Psychology Research Symposium, University of Tennessee at Martin, Martin, TN.

HONORS, AWARDS, & SCHOLARSHIPS

March 2017	American Academy of Forensic Psychology Dissertation Grant ($1000)
2014 – 2017	Goodlark Educational Foundation Anne Deason Healthcare Scholarship
2013 – 2014	Goodlark Educational Foundation Graduate Student Scholarship
May 2012	Summa Cum Laude Honors Graduate, University of Tennessee at Martin
Spring 2011	Outstanding Psychology Student Award
Spring 2011	Outstanding University Service Award
2009 –2010; 2011 –2012	Stephen & Karen Wright Loyalty Scholarship, Alpha Delta Pi Sorority
2008 – 2012	Honors Seminar Program Participant and Chancellor's Scholarship Recipient
2008 – 2010	Academic Competitiveness Scholarship
Fall 2008	Nemak Inc. Private Scholarship

PROFESSIONAL AFFILIATIONS

2012 – Present	American Psychology-Law Society
2014 – 2017	American Society of Trial Consultants
2014 – 2017	Texas Psychological Association and Sam Houston Area Psychological Association (Local Area Society)
2012 – 2017	Graduate Student Psychology Organization, Sam Houston State University
2011 – 2016	American Psychological Association