What Makes Your Expert Opinion Expert?

Gluing the Evidence Together

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Disclosures

- Seaaira Reedy is employed by CHA and is the Clinical Director for MHM CONREP programs in California
- John Wilson is employed by MHM Services as VP of Clinical Development
- MHM provides CONREP services in 8 locations to the Department of State Hospitals

Workshop Structure

1.State of the "art:"	Empirical evidence regarding quality
2. Key principles:	Formulating expert opinions
3. Small group exercises:	A. One-sentence conclusions B. Case history
4. Large group discussion:	Identification of best practices

1. State of the "Art"

Empirical evidence regarding quality of forensic reports

RS1

Criticisms of Forensic Reports

- Notification of purpose and limits of confidentiality not documented
  - Terms & Conditions suffice
- Structured diagnostic interviews not used
  - Multidisciplinary team, records suffice
- Forensic assessment instruments under-utilized
  - HCR-20 suffices

Nicholson & Norwood (2000)

Criticisms of Forensic Reports

- Psychological testing may be over-utilized
  - Test results not linked to forensic issue
- Collateral information under-utilized
  - Single-source data insufficient, prone to error
- Ultimate issue opinion offered without explicating fact base or rationale
  - Intrudes on province and authority of the court

Nicholson & Norwood (2000)

Criticisms of Forensic Reports

- "Very few reports provided data or reasoning to describe how a defendant's psychopathology compromised abilities" (Skeem et al., 1998)
- "Links between observed deficits in psycholegal abilities and cognitive impairment or symptoms of mental disorder were poorly articulated, if at all" (Nicholson & Norwood, 2000)
- Often fail "to provide specific support…for their conclusions" (Christy et al., 2004)
- "Pervasive mediocrity" (Robinson & Acklin, 2010; Fuger et al., 2014)

Concerns and Challenges

- Content challenges:
  - Incomplete mental status
  - Symptoms introduced at conclusion of report ("surprises")
  - Too much detail (history)
  - Not enough detail (current treatment)
  - Failure to address dangerousness

Identified by MHM CONREP

Concerns and Challenges

- Balance challenges:
  - Painting too rosy a picture, especially with compliant patients
  - Difficulty maintaining objectivity
    - Positive, negative countertransference
  - Using negative, punitive language → interventions sound like punishment

Identified by MHM CONREP

Concerns and Challenges

- Opinion rationale challenges:
  - Concluding patient needs continued treatment without documenting reasoning, examples
  - Failing to link behaviors to dangerousness
  - Failing to draw conclusions – to infer patient needs from behaviors
  - Failing to provide rationale for interventions

Identified by MHM CONREP

Concerns and Challenges

- Opinion rationale challenges:
  - Not integrating risk assessment into report
  - Failing to track risk factors over time = loss of continuity
  - Reports that repeat each other without addressing need for new strategies
  - Not including Penal Code requirements (how client meets criteria for renewal)

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Concerns and Challenges

- Opinion rationale challenges:
  - "Soft" opinions = equivocation
    - Patient "appears" to require continued treatment
  - Half-completed opinions
    - Justify need for continued treatment but not justify ability to receive it in current setting
    - Justify ability to stay in the current setting but not need for treatment/supervision

Identified by MHM CONREP

2. Key Principles

Formulating expert opinions

General Principles

"…The examiner's principal role is to describe the examinee's capacities and deficits relevant to the legal issue at hand, along with the examiner's *inferences* and *reasoning* regarding the causes of the observed deficits."

Nicholson & Norwood (2000) , p. 12, emphasis added

General Principles

- Interview, MSE are foundational elements
- If functional impairments are identified, conduct systematic assessment of possible causes
- If psychological tests are used, results must be linked to issue (risk)
- Link diagnoses to symptoms to functional impairments
- Document rationale for conclusions

Nicholson & Norwood (2000)

Goldilocks Writing

- Too much detail
  - Some clinical details are not relevant to the Court's decision
  - Too many small details makes it difficult to abstract the import, draw a conclusion…
- Not enough detail
  - Important elements of client's presentation missed
  - Evidence supporting opinion absent

See Handout

MSE

- Assessment of client's presentation
- Essential for accurate understanding of functioning, symptomatology, diagnoses
- Important for ongoing monitoring of treatment response
- Provides framework for clinical assessment

MSE

1. Physical appearance
2. Behavior
3. Motor activity
4. Attitude
5. Mood and affect
6. Speech and language
7. Thought and perception
8. Insight and judgment
9. Orientation
10. Attention & concentration
11. Memory
12. Intelligence & abstraction

See Handout

Methods of Assessing Mental Status

- Observation:
  - No cooperation required
  - "Thin slices" reveal a great deal
    - Gait, facial expression, age, level of alertness, psychomotor activity level, eye contact, tics or abnormal movements, grooming, odor, dress, cleanliness, tattoos, scars, weight, height, posture, attitude, mood, affect, and responsiveness
  - Convert automatic observation to hypotheses
    - Fast and slow processing

e.g., Oltmanns, Friedman, Fiedler & Turkheimer (2004); see also Croskerry (2006); Gladwell (2005)

Methods of Assessing Mental Status

- Conversation:
  - Open-ended questioning
  - "Small talk" may be "big"
  - Responses provide data regarding multiple domains
    - Mood, affect, speech, thought processes, thought content, attitude, engagement, insight, judgment, orientation, attention, concentration, memory
  - Do not need to be directive

Methods of Assessing Mental Status

- Exploration:
  - Ask direct, directive, and pointed questions
    - "I'm not sure I understood what you meant when you said…"
  - Follow up on symptoms, signs, behaviors
  - Inquire about domains not assessed through "softer" methods of observation or conversation

Formulating the Report

- Gather data, complete a review of historical records
  - Look for inconsistences and consistencies in patient's report in treatment versus the historical record
  - Explore inconsistences with patient
  - If possible, review the police report with the patient as a form of reality testing, take notes on where the patient's view of the crime and his/her illness differs from records
  - Take note of the patient's behaviors at the time of the offense to link to any recent behaviors

Formulating the Report

- Review the patient's most recent report
  - Interview client, focus on areas where client has improved since last report, and/or areas where client has remained stagnant or regressed
  - Ensure part of the interview is structured so the same areas from the previous reporting period are assessed (insight into mental illness, substance abuse, crime, risk, etc.)

Formulating the Report

- Review treatment plan with patient, assess progress made during the most recent reporting period, and/or over the last year
- Discuss, from the patient's perspective, the progress he/she thinks has been achieved, and any new goals

Formulating the Report

- Review recent clinical notes
  - Speak with other treatment providers to assess the patient's progress in other areas of treatment (group, home visit, day socialization)
- Speak with patient's collateral contacts, verify client's progress or lack thereof

Formulating the Report

- Review the patient's risk assessment; be prepared to speak to the factors that elevate the patient's risk. Incorporate these factors into your report, but also speak to protective factors.
- Review most recent psychological testing and incorporate findings into report

Writing the Report

- Consider the legal criteria being addressed
- Do the data (from current and historical records, patient interview, collateral contacts, and overall progress in treatment) support continuing the patient in treatment?
  - Based on the data, does patient meet legal criteria for continuation of treatment?
  - Do you not have sufficient data? Feel yourself stretching, but still opine the patient is dangerous? Consider reevaluating level of care.

Writing the Report

- Author your report keeping the legal criteria in mind, actively addressing it
  - APA Specialty Guideline 10.01: Focus on legally relevant factors
- Systematically address areas that the patient has improved in over the last reporting period
  - "Mr. Doe has increased his insight into his addiction as evidenced by his ability to speak to his triggers to usage, as well as his increased AA attendance and completion of the 12-Steps. Likewise, he is able to admit a potential for relapse."

APA (2013) Specialty Guidelines for Forensic Psychology

Writing the Report

- Assess areas in which the patient needs to improve,
- Analyze the patient's current behavior, and
- Make links to behavior exhibited at the time of the crime, during times of past dangerousness, and/or at times of decompensation

Writing the Report

- "While Mr. Doe has made considerable progress this quarter, he continues to minimize the role that auditory hallucinations played in the commission of his instant offense. This is significant given that he continues to experience voices telling him to look for his mother, which he experienced preceding his crime and led to his violent assault of his mother. As he is unable to acknowledge the role auditory hallucinations played in his crime, and how these hallucinations increase his risk for dangerous behavior, he is unable to manage his mental illness and potential for dangerousness, and thus, we must do so for him."

Writing the Report

- Don't be afraid to give the patient credit for the progress he/she has made
- You should be an unbiased evaluator, and acknowledging progress, helps establish your credibility

The Rationale

- Have your rationale in mind prior to beginning to write; author your report to support your rationale
- Restate the legal criteria/criterion the patient satisfies
- Summarize the data that supports your conclusion
- Do not introduce any new information in the rationale; no surprises!

What Makes an Expert Opinion Expert?

- Not the expert's credentials!
- Procedures used to formulate opinion +
- Body of knowledge used as foundation for procedures
  - If accumulated knowledge in field is not used, opinion is not an expert opinion

    …even if opinion holder is an expert!

Martindale (2001);
APA (2013) Specialty Guidelines for Forensic Psychology

Three Categories of Information

1. Clinical data
2. Inferences or opinions
3. Rationale explaining relationships between data and opinions
   - Clearly distinguish among categories
   - Know when to provide each category

Clinical Data

- What you observe or read
  - Historical records
  - Interview behavior
  - Interview content
  - Test performance
- Focus on what is relevant for forensic issue

Clinical Data

- Selectively include relevant information
  - Data that supports your opinion
  - Data that supports an alternative conclusion
- Maximize clarity through organization
- Avoid over-describing history
  - Ensure essential elements are included

Inferences and Opinions

- Interpretations of clinical data
  - Functional impairments
  - Presence of psychosis, symptoms
  - Lack/presence of insight, extent of insight (awareness/understanding for MDOs)
  - Diagnoses
  - Risks, opinion regarding psycholegal issue

3. Small Group Exercises

A. Short exercise: Developing conclusions
B. Longer exercise: Developing recommendations

A. Short Exercise: Drawing Conclusions

- Break into small groups
- Review short paragraphs summarizing treatment
- Half the room works with Mr. King, half with Mrs. Queen
- Develop one-sentence conclusions based on clinical data for each paragraph
- Debrief

See Handout

B. Longer Exercise: Developing Recommendations

- Break into small groups
- Read case history, treatment plan, HCR-20, Individual Risk Profile
- Develop summary paragraph
- Develop recommendation paragraph
- Be ready to debrief

See Handout

4. Large Group Discussion

Best Practices

Large Group Discussion

- What are your best practices? What works for you?
  - Who is your audience?
  - What do you want to achieve?
  - What do you want to avoid?

Large Group Discussion

- What are your challenges? What is hard for you?
  - Balance between risk and recovery?
  - Boundary setting?
  - Compassion fatigue?
  - Time management?

Pointers

- Report length should be balanced
  - Too short, and clinical details will be missing or rationale will be unsupported
  - Too long, and details will be irrelevant, courts won't read
- One size *doesn't* fit all
- Focus on your reasoning, not just data

Five Decisions in Report Writing

1. What information to include or exclude
2. Where to place the information
3. How to emphasize information
4. What vocabulary and writing style to use
5. How long the report should be
   - …Each decision has implications for report quality

Griffith et al., 2010; Goodman-Delahunty & Dhami (2013)

Document Rationale

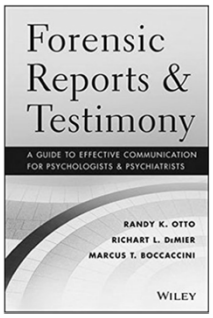
- Logic explaining relation between data and opinions
  - Anchor opinion in historical/clinical data
  - Explicate reasoning that links data to opinion
  - Link past behavior to probable future behavior
  - Link anticipated situations to situations in which client was violent in the past

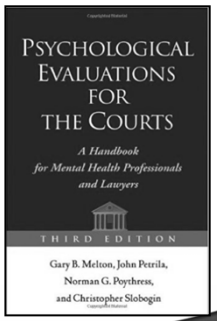
Recommendations for Quality Improvement

- Self-monitoring/bench marking
- Feedback from the Court
- Peer Review
- Forensic report checklist as *aide memoir*
- Training, templates that support:
  - Standardized processes, third-party data, assessment of relevant factors, linkages between clinical data and legal questions, etc.

Fuger et al. (2014)

Resources





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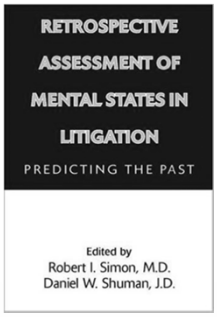

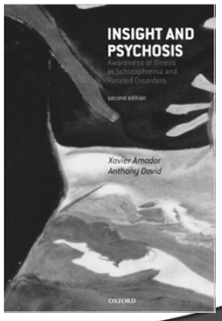

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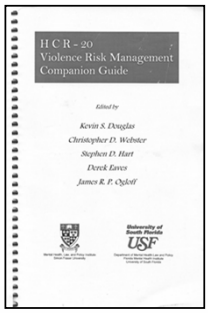

- http://members.psyc.sfu.ca/labs/mhlpi/publications.htm
- Corresponds to Version 2
- Matches interventions to *HCR-20* findings
- 2001 publication
- $70.00