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STANDARDS OF PRACTICE AND CARE IN FORENSIC MENTAL HEALTH ASSESSMENT
Legal, Professional, and Principles-Based Considerations

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The specialization of forensic mental health assessment (FMHA) has incorporated important advances during the last two decades. As scientific advances, specialized tools, and relevant ethical guidelines have become core elements of FMHA, however, the question of how to regulate poor practice has assumed increasing importance. One such means of regulation that has been rarely applied to FMHA thus far is malpractice litigation using a clearly defined standard of care. This article focuses on the relationship between standard of practice and standard of care in FMHA. The authors discuss the current absence of a standard of care in FMHA, describing the historical, regulatory, and legal influences that have helped to shape the current state of practice in this specialty area and their relevance to operationalizing a standard of care. The authors address the various sources of authority that the law might consider in defining a standard of care and specify circumstances under which legal regulation using a standard of care would be more useful than would ethical/professional regulation using a standard of practice. Finally, the authors describe the advantages of developing a clearer standard of practice in FMHA, which can then inform the operationalization of a standard of care.

Keywords: FMHA, standard of care, standard of practice

The field of forensic mental health assessment (FMHA) has witnessed significant conceptual and empirical advances over the last 2 decades. These advances have been driven by attention to the law's demands (Melton, Petrila, Poythress, & Slobogin, 1997), the development of empirically validated tools (Frederick, 1997; Grisso & Appelbaum, 1998; Poythress, Monahan, Bonnie, & Hoge, 1999; Rogers, Tillbrook, & Sewell, 2004), and the publication of specialized ethical guidelines (American Psychological Association [APA] Committee on Professional Practice and Standards, 1994; Committee on Ethical Guidelines for Forensic Psychologists, 1991). Despite these advances, however, there remains considerable inconsistency in the quality of forensic assessment practice (Borum & Grisso, 1995; Bow & Quinnell, 2001; Christy, Douglas, Otto, & Petrila, 2004; Hecker & Steinberg, 2002; Heilbrun & Collins, 1995; Horvath, Logan, & Walker, 2002; LaFortune & Nicholson, 1995; Nicholson & Norwood, 2000; Otto & Heilbrun, 2002; Ryba, Cooper, & Zapf, 2003; Skeem & Golding,

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1998; Wettstein, 2005), and there is currently limited substantive or regulatory guidance for many forensic professional activities. Such limited guidance makes it difficult to determine what constitutes minimally satisfactory practice in the area—in the law's terms, a *professional standard of care*.

This article focuses on a standard of care in the area of FMHA and its relationship to a standard of practice. First, we distinguish between the two, as they are sometimes confused. Second, we discuss the apparent absence of a standard of care in FMHA at present. Third, we summarize the historical, regulatory, and legal influences that have helped to shape the current state of practice in this specialty area and their relevance to standard of care. Fourth, we describe the various sources of authority that the law might consider relevant to establishing a professional standard, with particular attention to the ethical, professional, and practical implications of such a standard for the legal community and for the field of forensic psychology. Fifth, we consider the impact of the absence of a standard of care on FMHA as a field. Sixth, we describe the advantages of having such a standard. Recognizing that this is a legal rather than a scientific or clinical prerogative, we consider the various sources of authority that could contribute to a clearer standard of practice in this area, which would in turn inform a standard of care.

Distinguishing Between Standards of Care and Practice

It is important to begin by distinguishing between standards of *care* and standards of *practice*. In this regard, there are four important considerations (summarized in Table 1). The first distinction is definitional. Standards of care are judicial determinations that establish minimally acceptable standards of professional conduct in the context of specific disputes (American Law Institute, 1965). By contrast, standards of practice are generally defined either as the customary way of doing things in a particular field (the "industry standard") or as "best practices" in a particular field (Caldwell & Seamone, 2007). Second, standards of practice are internally established by the field itself. This can occur informally, for instance, when a particular practice becomes "adopted" as the customary way of doing things. It can also occur more formally, for example, through development of practice guidelines applicable to practitioners in the specific field, such as the

Table 1
Standards of Care Versus Standards of Practice

Standards of Care	Standards of Practice
1. Judicial determination establishing minimally acceptable standards of professional conduct in a specific context	1. Typical way of doing things in a particular field (i.e., "industry standard") or "best practices" in a particular field
2. Externally established by a court of law	2. Internally established by the field itself
3. Adherence is mandatory	3. Adherence is typically aspirational
4. Breaching a standard of care exposes a professional to liability and monetary damages	4. Breaching a standard of practice may result in sanctions but not civil liability

"Specialty Guidelines for Forensic Psychologists" (Specialty Guidelines; Committee on Ethical Guidelines for Forensic Psychologists, 1991). By contrast, standards of care are externally imposed by a court of law in the context of a specific dispute, established by legislative enactment, or enforced through administrative regulation. Third, although adherence to a standard of care is mandatory, standards of practice are typically considered aspirational in nature. As such, adhering to standards of practice is not mandatory, although usually strongly encouraged. Finally, deviating from a standard of care constitutes negligence, exposing a professional to liability (American Law Institute, 1965). By contrast, deviating from a standard of practice does not result in legal liability, although it may result in the imposition of sanctions from the profession itself, such as through an ethics committee, or the imposition of sanctions by the discipline through an administrative law body, such as a state licensure board.

Current Absence of an Enforceable Standard of Care in FMHA

The U.S. legal system has a well-established malpractice liability system that seeks to provide judicial relief to those injured by substandard professional care. Malpractice litigation involves holding professionals to minimally acceptable standards in the delivery of professional services. It can be based on various legal grounds (e.g., intentional torts, breach of confidentiality, invasion of privacy). However, most malpractice claims are grounded in negligence. The following elements must be proven to establish a negligence claim: (a) a legal duty requiring the professional to conform to a minimal standard of conduct, (b) breach of the standard of care, (c) causal connection between the breach and injury, and (d) legally recognizable damages (Dobbs, Keeton, Owen, & Keeton, 1984).

Despite the seemingly straightforward nature of negligence claims, forensic mental health professionals have largely managed to escape malpractice liability. There are certainly types of misconduct (e.g., breach of confidentiality, sexual misconduct with patients, failure to warn/protect) and particular FMHAs (e.g., child custody evaluations) that are more likely to result in malpractice claims. However, outside of these relatively circumscribed behaviors and evaluations, forensic mental health professionals are apparently sued for malpractice infrequently. We could not find empirical evidence concerning the number of malpractice actions filed against forensic mental health professionals, but several commentators (e.g., Greenberg, Shuman, Feldman, Middleton, & Ewing, 2007; Melton, Petrila, Poythress, & Slobogin, 2007) have noted the difficulty of maintaining a malpractice action in a forensic context. Greenberg et al. (2007) suggested that the risk that a testifying mental health professional may be successfully sued for malpractice as an expert is limited and may have only recently "increased beyond the level of insignificance that once existed" (p. 446).

Melton et al. (2007) concluded that forensic mental health professionals have "little to be concerned about" in terms of malpractice liability (p. 81). However, they also provided a useful framework for considering professional actions in the context of FMHA that conceivably could provide the basis for malpractice litigation: (a) breach of confidentiality (beyond disclosure authorized by the court), (b) failure to protect an identifiable third party from a serious threat of future violence, (c) failure to obtain informed consent, and (d) negligent misdi-

agnosis. Each of these, and the limits of their applicability, is discussed later in this article.

We could not locate empirical research on malpractice actions against mental health professionals in the context of FMHA. If commentators such as Greenberg et al. (2007) and Melton et al. (2007) are correct about the substantial limits of such liability under present law, there may be several reasons for this. First, many criminal defendants have limited financial resources with which to pursue a malpractice claim. Secondly, immunity is often afforded to expert witnesses (see Greenberg et al., 2007); generally, courts grant witnesses (both lay and expert) immunity for defamation claims based on the witnesses' testimony (American Law Institute, 1981). Indeed, some courts have gone beyond immunity for defamation claims and granted absolute immunity for experts (see, e.g., *Bruce v. Bryne-Stevens*, 1989), with the rationale of promoting reliable testimony and ensuring that experts are not deterred from testifying by the threat of liability. Finally, it is difficult to maintain a successful cause of action against a forensic mental health professional in a negligence claim (see Greenberg et al., 2007). To establish liability, a party must prove duty, breach, causation, and damages. Most jurisdictions have held that experts owe a duty to the parties who retained them to provide services with a reasonable degree of professional competence (see, e.g., *Pollock v. Panjabi*, 2000). As such, court-appointed experts, who are not obligated to provide assistance to either party (as opposed to providing assistance to the court more generally), are typically afforded immunity.

Assuming the elements of duty, causation, and damages can be established, the remaining issue in establishing a negligence claim is determining whether the applicable standard of care was breached. Although in other contexts courts typically determine the presence of a breach by applying the reasonable professional standard (i.e., a reasonable professional acting under similar circumstances), the definition of a "reasonable professional" is not clearly defined in the context of FMHA. It would appear that the absence of a clear standard of care in this context provides a major obstacle to establishing a malpractice claim against a forensic mental health professional.

There are at least three important reasons why there is currently no universally accepted standard of care in FMHA. The first is related to the history of psychology and the debate over the relative importance of empiricism versus theory in psychological assessment and intervention. The second involves regulatory and policy considerations within professional psychology, yielding a limited number of guidelines for psychological practice, including the specialized practice of FMHA, that could inform the legal definition of a standard of care. The final reason relates to certain aspects of negligence jurisprudence and judicial deference to professional custom and self-regulation. Each is discussed briefly next.

Historical Influences on Standard of Care

The development of the discipline of psychology reflects the importance of both theory and empirical data. Differences between theoretical orientations remain substantial, however. Theoretical common ground in the hard sciences, such as biology and chemistry, is less established in psychology. One need only

consider the current debate over the importance of evidence-based assessment and intervention (see, e.g., Barlow, 2005; Edwards, Dattilio, & Bromley, 2004; Hunsley & Mash, 2005; McCabe, 2004; Messer, 2004; Norcross, Beutler, & Levant, 2006) to illustrate the still-active disagreement concerning whether an intervention can be justified on theoretical grounds or whether it should be provided only if it is empirically testable and supported. Such disagreement notwithstanding, there is presently a relatively clear trend toward evidence-based practice throughout most specialties in professional psychology. A similar trend is apparent in other health care professions (McCabe, 2004; Messer, 2004). Cited justifications include cost containment, quality of patient care, professional accountability, and the need for an empirical research base (Barlow, 2005).

The specialty of FMHA has followed a similar developmental trajectory. Psychologists have a long history of providing services to the legal system and legal decision-makers. Early efforts in this area were therapeutic, occurring in the context of a variety of correctional, quasi-correctional, and clinical settings (Otto & Heilbrun, 2002; Travis, 1908). FMHA subsequently came to assume a more prominent role within forensic psychology (Brodsky, 1973; Wrightsman, 2001). The beginning of this enhanced prominence may be traced to the case of *Jenkins v. United States* (1962), in which a federal appellate court held, in part, that psychologists with appropriate training, skills, and expertise were qualified to offer expert testimony on matters of mental disorder.

Following the *Jenkins v. United States* (1962) decision came significant markers of a developing specialization, including the establishment of the American Psychology–Law Society (which later became Division 41 of the APA), the formation of the American Board of Forensic Psychology, and the implementation of multidisciplinary journals. As the developing field became clearer about the nature of forensic assessment, however, the criticisms of some aspects of the practice of FMHA also became more focused. Such criticisms (see, e.g., Grisso, 1986, 2003; Lanyon, 1986; Morse, 1978; Robinson, 1980; *United States v. Downing*, 1985) included the relevance and quality of forensic reports; the limited empirical foundation to foster scientific practice, reasoning, and related conclusions; a lack of specialized forensic assessment instruments; and the absence of standards for forensic practice (Grisso, 1986).

FMHA has been strengthened substantially in its clarity and scientific foundation during the last 15 years (Borum & Otto, 2000). There has been substantial growth in research, scholarship, and practice-related literature (e.g., Goldstein, 2003, 2007a; Heilbrun, 2001; Heilbrun, Marczyk, & DeMatteo, 2002; Melton et al., 1997; Monahan et al., 2001; Rogers, 1997; Rogers & Shuman, 2000), and the development of specialized forensic assessment instruments (e.g., Frederick, 1997; Grisso, 1998; Hare, 1991; Poythress et al., 1999; Quinsey, Harris, Rice, & Cormier, 2006; Rogers, 1992). There has also been considerable expansion in professional organizations that focus on the intersection of psychology and law (e.g., American Psychology–Law Society, American Board of Forensic Psychology). Such organizations foster collaboration and the development of specialized practice knowledge and expertise (Otto & Heilbrun, 2002). As well, there has been a steady increase in the availability of specialized training opportunities (Bersoff et al., 1997; Packer & Borum, 2003), which can also increase the uniformity and quality of specialized practice. Finally, there has been increased

emphasis on the scientific foundation of expert testimony (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993).

There has been more limited progress in the development of forensic practice guidelines (APA Committee on Professional Practice and Standards, 1994, 1998; Otto & Heilbrun, 2002). Despite these advances from mostly theoretical to more balanced (theoretical *and* evidence-based) guidelines, there is still considerable variability in the quality of forensic assessment practice (Borum & Grisso, 1995; Bow & Quinnell, 2001; Christy et al., 2004; Hecker & Steinberg, 2002; Heilbrun & Collins, 1995; Horvath et al., 2002; LaFortune & Nicholson, 1995; Nicholson & Norwood, 2000; Otto & Heilbrun, 2002; Ryba et al., 2003; Skeem & Golding, 1998; Wettstein, 2005). The historical tendency to attribute theoretical value to unvalidated measures when such validation is possible may have limited the development of evidence-based practice guidelines that could help inform FMHA standards of care.

Regulatory and Policy Influences on Standard of Care

Applied psychology has changed substantially over the last 20 years as a result of advances in conceptual thinking, greater emphasis on evidence-based practice, and a variety of political, regulatory, and economic influences (see Barlow, 2005; Messer, 2004; Norcross et al., 2006). Psychologists now practice in a wider variety of settings and with more diverse populations than ever before, consistent with the expanded number of applied specialty areas endorsed by the APA.

This expansion into new practice areas has challenged the ability of relevant professional organizations to keep pace. As psychologists continue to venture into nontraditional settings, leading professional organizations are faced with the difficult task of promulgating practice guidelines to assist psychologists in meeting appropriate standards of conduct in these settings. However, there may be a considerable lag between when psychologists enter a specialty area and the promulgation of relevant guidelines, if such guidelines are even published. As a result, psychologists often face demands on their expertise in new environments without practice guidelines to help inform their professional conduct. Although the "Ethical Principles of Psychologists and Code of Conduct" (APA Ethics Code; APA, 2002c) is a source of broad professional guidance, it cannot address many of the specific situations that psychologists encounter in specialized practice environments (APA, 2002c). As a result, some APA specialties have established more specific guidelines to supplement the APA Ethics Code. For example, the Society for Industrial and Organizational Psychology (APA Division 14; 2003) promulgated the *Principles for the Validation and Use of Personnel Selection Procedures* (now in its 4th edition); Mental Retardation and Developmental Disabilities (APA Division 33, 2007) promulgated the "Guidelines on Effective Behavioral Treatment for Persons with Mental Retardation and Developmental Disabilities"; and Counseling Psychology (APA Division 17) and the Society for the Psychological Study of Ethnic Minority Issues (APA Division 45) jointly drafted the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, which was subsequently adopted and published by the American Psychological Association (2002d).

This expanded range of practice areas suggests that practice guidelines will continue to play an important role in shaping professional conduct. However, under current APA policy, the development of practice guidelines that are endorsed by APA is an arduous process. The APA Council of Representatives approved as APA policy the "Criteria for Practice Guideline Development and Evaluation" in 2001 (APA, 2002b, 2005). The "Criteria for Practice Guideline Development and Evaluation" elaborates on Section 2.2 of the guideline development and evaluation criteria, which suggest that practice guidelines be considered and written only when there is a documented need for such guidance (APA, 1995, 2002a, 2005).

The term *guideline* has a specific meaning under APA policy. It refers to statements that recommend specific professional behavior, endeavor, or conduct for psychologists (APA, 2005, p. 976). APA policy also distinguishes between *guidelines* and the more specific term *practice guidelines*, with the latter intended to provide guidance to professionals concerning conduct and decisions in particular areas of practice. More specific practice guidelines include an emphasis on providing high quality psychological services, practical guidance, continuing education in particular practice areas, and informing the public of desirable professional practices (APA, 2002b, 2005). Practice guidelines are aspirational, not mandatory, and thus not intended to supersede the judgment of psychologists or be promulgated as a means of establishing a specialty area of psychology or excluding psychologists from practicing in any given area (APA, 2005). Although this may keep practice guidelines from interfering with practice opportunities, it also limits the regulatory impact of such guidelines—and the extent to which they can influence a standard of care.

APA (2005) policy cites three broad justifications for the development of practice guidelines. The first notes that practice guidelines may be developed in response to legal and regulatory considerations. These include changes in regulatory laws, administrative systems, court decisions and case law, and the importance of psychology serving the legal system in the most effective and ethical manner possible. The second suggests that practice guidelines are appropriate when they benefit the public. Specific examples include improved service delivery in treatment and evaluation, avoidance of harm and discrimination, meeting the needs of traditionally underserved populations, and responding to public policy initiatives. The third indicates that practice guidelines are also appropriate for providing professional guidance. The development of new technology, expansion of multidisciplinary roles, advances in theory and science, and professional risk management are all identified as justifications for the ongoing development of practice guidelines.

APA policy also notes that the need for practice guidelines should be well-established, relevant to a significant segment of APA membership, supported by specific evidence and documentation, and should integrate multiple perspectives. Documentation and evidence are stressed because they promote the evaluation of the guidelines by the profession and other interested parties. Proposed practice guidelines must be approved by every division within APA and undergo a period of public review as well before they are formally adopted by APA. Supporting evidence can include empirical data, professional consensus, and/or expert agreement (APA, 2005).

The development of forensic practice guidelines is relevant to this discussion. During the 1990s, APA promulgated two sets of general guidelines relevant to forensic practice: "Guidelines for Child Custody Evaluations in Divorce Proceedings" (APA Committee on Professional Practice and Standards, 1994) and *Guidelines for Psychological Evaluations in Child Protection Matters* (APA Committee on Professional Practice and Standards, 1998). Both sets of guidelines are aspirational, aiming to promote good practice by psychologists in each of these areas. Both focus more on the process of conducting these types of evaluations and less on the specific content (Otto & Heilbrun, 2002). Although these documents provide some guidance on matters such as record keeping, informed consent, and confidentiality, they do little to establish substantive assessment guidelines. Accordingly, they have few implications for substantive aspects of standard of care (Otto & Heilbrun, 2002).

In 1991, the American Academy of Forensic Psychology and the American Psychology–Law Society published the Specialty Guidelines (Committee on Ethical Guidelines for Forensic Psychologists, 1991). These guidelines offer more specific guidance on the substantive aspects of competent forensic practice than do the "Guidelines for Child Custody Evaluations in Divorce Proceedings" or the *Guidelines for Psychological Evaluations in Child Protection Matters*. As the specialty of forensic psychological assessment has developed further since 1991, however, the need for specific practice guidelines has become clearer. Except for the three sets of guidelines just discussed, there is currently little formal practice guidance for FMHA conducted by psychologists (Otto & Heilbrun, 2002). This is problematic in light of the apparent inconsistency in the quality of forensic psychological assessment cited by numerous investigators and scholars (e.g., Bow & Quinnell, 2001; Christy et al., 2004; Hecker & Steinberg, 2002; Heilbrun & Collins, 1995; Horvath et al., 2002; Nicholson & Norwood, 2000; Ryba et al., 2003; Skeem & Golding, 1998). Specific problems cited include the absence of collateral sources; the use of psychological tests that are irrelevant, psychometrically unsound, or outdated; and the failure to link data, reasoning, and conclusions. Practice guidelines addressing such areas could help inform a standard of care in FMHA.

The Influence of Legal Authority on a Standard of Care

The third reason for the absence of a clear standard of care in FMHA relates to certain aspects of negligence jurisprudence, particularly judicial deference to professional custom and self-regulation. Few legal cases directly address the negligence of mental health professionals in making diagnostic and treatment decisions, and we were unable to locate cases that cited negligence in the context of assessment (excluding failure to diagnose), or more specifically, forensic assessment (Klerman, 1990; Reisner, Slobogin, & Rai, 2004). Accordingly, the law that might apply to forensic assessment must be analogized from its application to medicine and similar professions. Any professional practitioner must conform to a standard of care, skill, and technical proficiency normally exercised by others practicing in the same field. Although the standard of care can vary from jurisdiction to jurisdiction, courts will usually seek guidance from the nationally accepted or customary standards of the professional's particular area of practice.

In addition, mental health professionals holding themselves out as specialists are held to a specialist's standard of care, as are those in other professions (Marczyk & Wertheimer, 2001).

In formulating a standard of care, courts look to common law, state statutes, applicable codes of ethics, relevant scientific research, and standards of practice (often presented to the court in the form of expert testimony), all of which contribute to defining nationally accepted or customary standards (Peters, 2000). Depending on the jurisdiction, the standard of care is defined either in terms of a local standard, a customary practice standard, or a national standard (Blumstein, 2002). This approach to establishing standards of care reflects courts' unwillingness to choose among conflicting schools of thought within a discipline or profession and a preference for these same bodies to regulate the conduct and practice of its members (Peters, 2000). This stance effectively allows professions to set their own standards of practice. When professions fail to do so, this can mean that methods which are obsolete, irrelevant, or suboptimal may nevertheless remain within accepted boundaries of practice (Blumstein, 2002; Dobbs et al., 1984).

The Absence of an Enforceable Standard of Care

What are the customary or national standards in the specialty of FMHA? Despite more traditional guidelines established by ethics codes, statutes, and professional organizations, mental health professionals have traditionally been afforded significant discretion in treatment, diagnostic, and assessment decisions, depending on the case-specific circumstances and the practitioners' theoretical orientation. The same is true in the context of FMHA, which is currently a practice area noteworthy for the variety of approaches that practitioners from different disciplines (e.g., psychology, psychiatry, social work) use in conducting FMHA across a wide range of criminal and civil issues (Melton et al., 2007). For example, psychiatrists and social workers might rely more heavily on clinical interviewing strategies, whereas a psychologist might prefer an approach that integrates clinical interviewing with psychological testing. Although psychologists might typically incorporate more formal and structured assessment strategies, they also show differing opinions on the nature of acceptable assessment instruments and strategies across a broad range of forensic issues (Lally, 2003).

Such differing views are related to another reason for the absence of an enforceable standard of care in the context of FMHA: the "respectable minority doctrine" or "two schools of thought rule" (Peters, 2000, p. 166). Under this legal doctrine, a defense to negligence can be established by showing that a respectable minority of those practicing in the field supports a particular psychological approach or procedure (Smith, 1991). Accordingly, a claim of negligence brought against a mental health professional or forensic clinician will typically be evaluated using the standard of how members of the profession or specialty would customarily act under the circumstances. Under the respectable minority doctrine, the approach to conducting FMHA can be "customary" even if it is not used by a majority of practitioners. Given the number of existing approaches to conducting FMHA, the respectable minority doctrine can be a strong defense against liability in the broader mental health and specific FMHA context. In effect, it

allows a forensic practitioner to choose a course of action that might not necessarily reflect best practice, and might even be unreasonable or negligent, but avoid liability if this approach is endorsed by a respectable minority of forensic practitioners.[1]

At present, the state of the law in this area seems to reflect a judicial preference for customary standards of practice and their related defenses (Blumstein, 2002). Some commentators (e.g., Peters, 2000) have noted, however, that a growing number of jurisdictions are moving away from the majority position and toward a reasonableness standard (Peters, 2000). Under this standard, the appropriate analysis shifts from what is customary practice to what is reasonable—specifically, what would a reasonable professional in this discipline do in such a case? The court would look to various sources of authority to determine the standard. The most likely sources of this authority for FMHA are common law, state statutes, applicable codes of ethics, relevant scientific research, and standards of practice. On a related note, one scholar (Shuman, 1997) noted an increased willingness of courts to enforce clinical practice guidelines as standards of care in medical malpractice actions and the potential importance of practice guidelines for establishing standards of care. He observed that in such cases, practice guidelines function much like expert testimony and eliminate the debate over what is acceptable or customary practice for a given profession or specialty (Shuman, 1997). This underscores the potentially important link between standards of practice (as operationalized by practice guidelines) and standards of care.

These issues and the current state of FMHA practice suggest the need for practice guidelines. Such guidelines should be based on sources of authority that include relevant law as well as scientific and practice-related knowledge. Without incorporating such authority, it is unlikely that they would be acceptable as practice guidelines. They would not capture the views of the profession concerning contemporary practice. If these guidelines *were* based on an acceptable knowledge base and subjected to empirical study to determine their utility in improving the quality of FMHA, however, they might well serve as standards of practice that could influence the conceptualization of relevant standards of care.

It is informative for the field of forensic psychology to consider the relationship between practice guidelines and standards of care in forensic psychiatry. According to recent estimates, psychiatric malpractice cases are among the least frequent types of malpractice cases brought against physicians (Meyer & Simon, 2004). In the field of forensic psychiatry, as in the field of forensic psychology, identifying the applicable standard of care is often difficult, which may contribute

[1] For example, there has been a longstanding debate in forensic psychology concerning whether a forensic evaluator should answer the "ultimate legal question" that is before the court or limit his or her conclusions to describing the evaluee's relevant forensic capacities. This debate has never been resolved within the field. Because there are those who favor answering the ultimate legal question (Rogers & Ewing, 1989) and others who oppose it (Melton et al., 1997; Morse, 1978), there is clearly a "respectable minority" position supporting whatever course a forensic clinician might take in answering the ultimate legal question. Under a respectable-minority analysis, therefore, a forensic clinician should not be liable for violating a standard of care regarding ultimate legal issue conclusions—assuming that such existed and was clear about whether such ultimate legal questions should be answered.

to the relative rarity of forensic psychiatric malpractice cases. The ethical guidelines in forensic psychiatry—the *Ethical Guidelines for the Practice of Forensic Psychiatry* (American Academy of Psychiatry and the Law, 2005)—contain express disclaimers indicating that the guidelines do not establish a legally enforceable standard of care (Simon, 2005). As such, there is no single definitive standard of care in forensic psychiatry (Stone, 1999), so the standard of care differs by jurisdiction. The standard of care in forensic psychiatry is typically established in a similar manner as the standard of care in forensic psychology; specifically, courts look to relevant practice guidelines, empirical and theoretical literature, state and federal regulations and laws, and institutional policies and procedures, typically provided via expert testimony in the context of a specific dispute (Simon, 2005). However, this may be changing. The American Academy of Psychiatry and the Law has been developing practice guidelines for different evaluations conducted by forensic psychiatrists. To date, the American Academy of Psychiatry and the Law has published practice guidelines in the areas of mental state at the time of the offense (Giorgi-Guarnieri et al., 2002) and competence to stand trial (Mossman et al., 2007). It may be that such practice guidelines, developed specifically for a given type of evaluation, will be more influential in operationalizing a standard of care in litigation involving cases of this type.

Standard of Practice Versus Standard of Care in Regulating FMHA

Although the rates of malpractice actions in most areas of medical practice have increased considerably over the past decade, mental health professionals have largely escaped malpractice liability. This is particularly true with respect to mental health professionals who specialize in forensic psychology. This limited liability exposure among forensic mental health professionals may be largely attributable to the absence of an enforceable standard of care in the area of FMHA. Because a standard of care is a legal determination that establishes *minimally acceptable* standards of professional conduct in the context of a specific dispute, the absence of a widely recognized and enforceable standard of care in a particular field can make it more difficult for a court to determine whether a professional has acted negligently. As such, the absence of a standard of care in the area of FMHA has effectively served to shield forensic mental health professionals from malpractice actions alleging substandard professional conduct.

Advantages of Using a Standard of Care to Regulate Professional Conduct

It is useful to consider the kind of professional conduct that might be regulated most appropriately through malpractice litigation. As noted earlier, a professional standard of practice is typically aspirational, promoting behavior that is desirable. A professional code of ethics, such as the APA Ethics Code, has both an aspirational component (the ethical principles described in the beginning) and an enforceable component (the ethical standards that follow the broad principles). Accordingly, the APA Ethics Code is both aspirational, promoting desirable practice, and enforceable, limiting substandard practice. However, the enforcement of the APA Ethics Code is provided through a process in which the Ethics Committee of the APA receives complaints and recommends sanctions up to and

including expulsion from the APA. In some jurisdictions (e.g., Pennsylvania), the state board that licenses psychologists has adopted the APA Ethics Code as the criterion for judging whether professional misconduct has occurred. Like APA, licensure boards have the authority to sanction individuals on a limited basis, including the termination of licensure, for professional misconduct.

Neither a professional association nor a licensure board has the authority to impose monetary damages upon practitioners, even in cases involving the most egregious conduct, in which the individual receiving services can demonstrate a breach of professional duty causally related to substantial harm that is required under tort law. This sort of action should be reserved for the most extreme forms of professional misbehavior, in our view, given that standards of practice are appropriate for promoting desirable practice, and licensure boards and ethics codes are available for less extreme professional misconduct.

But there does appear to be a role for malpractice litigation in regulating professional conduct. First, consider the practitioner who is not a member of the APA. That individual would not be subject to APA ethics reviews or sanctions. Further, suppose this practitioner was not licensed as a psychologist or in a related field; such an individual would not fall under the jurisdiction of a licensing board.[2] Finally, assume that the professional misconduct of this individual in a given case was extreme. Such misconduct might merit the consideration of malpractice litigation, even if the psychologist were licensed and a member of the APA. But it would underscore the potential for an appropriate remedy through litigation if there were no other recourse.

Consider the four potential justifications for FMHA malpractice litigation suggested by Melton and colleagues (2007): breach of confidentiality, duty to warn/protect, failure to obtain informed consent, and negligent misdiagnosis. We offer a brief discussion of how each might provide a potential basis for malpractice action against a forensic clinician.

Breach of confidentiality. The use of FMHA results is regulated through the court (in court-ordered evaluations) or through the litigant and counsel (for FMHA that is requested by criminal defendants or civil plaintiffs). Using such results for any purposes other than litigation would require the authorization of the appropriate parties. Consider the following examples in which such authorization is not obtained:

1. The forensic clinician presents the results of the FMHA at a national conference.

[2] Some might argue that an unlicensed psychologist would find it difficult or impossible to practice—that the marketplace, in effect, would prevent this scenario from occurring. This would be a reasonable argument regarding the provision of psychological services on a private basis in the community, where licensure is essential for credibility and third-party reimbursement. However, forensic services are not regulated as closely as mental health services. It is typically courts, attorneys, and litigants—not insurance companies—that pay for FMHA. A psychologist may be accepted as an expert by a court even when unlicensed. Forensic hospitals, correctional facilities, and court clinics sometimes do not require licensure or professional organizational membership for their psychology staff members. Accordingly, the prospect that an unlicensed psychologist who is not an APA member would provide FMHA services that are not subject to regulation from either source is certainly feasible.

2. The forensic clinician videotapes part of the FMHA and releases it to the media, where it is featured on *60 Minutes*.

Duty to warn/protect. It is not clear that a forensic clinician conducting FMHA is legally obligated to warn or protect third parties from threats of harm made by litigants in the same way that a mental health professional treating a patient would be, even in a jurisdiction in which the duty to warn or protect is clearly established. In defense-requested evaluations, the information gathered in the evaluation is likely protected under attorney-client privilege until introduced as evidence in litigation. However, for information clearly indicating a threat of serious violence toward an identified third party obtained in a court-ordered evaluation, the evaluator who has informed the defense attorney but been instructed to keep this information entirely privileged may have an alternative. This would involve notifying the court (see Standard 7-3.2(b), American Bar Association [1989] *Criminal Justice Mental Health Standards*).[3] Consider the following example:

> A forensic clinician in a state with an established duty to warn identifiable third parties of a patient's serious threats of violence evaluates a juvenile for possible transfer into criminal court. In the course of the evaluation, the forensic clinician learns that what appeared to be an armed robbery was actually an attempt to kill a specific individual, a member of a rival street gang, as part of the initiation process into a gang. The forensic clinician provides this information to the defense attorney, who declines to pass it on in any way and instructs the forensic clinician to likewise refrain as it is privileged under attorney-client privilege.

Informed consent. The forensic clinician is obligated to obtain the informed consent of the individual being evaluated when such evaluation is not ordered by the court. Even when conducting court-ordered FMHA, however, the evaluator may be required to obtain informed consent for conducting procedures that are outside the usual scope of forensic assessment. Consider the following example:

> The evaluator uses a sodium amytal interview without informed consent in a court-ordered evaluation. The evaluation is conducted in a university-based forensic clinic. Unbeknownst to the evaluator, the defendant suffers from PTSD stemming from a recent tour of duty in combat. The administration of the sodium amytal triggers a panic attack in which the defendant leaves the clinic and has an immediate altercation with police in which he is shot.

Negligent misdiagnosis. Diagnosis and the related assessment of clinical functioning can certainly be obtained through different approaches, which may

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[3] Duty of evaluator to disclose information concerning defendant's present mental condition that was not the subject of the evaluation. If in the course of any evaluation, the mental health or mental retardation professional concludes that defendant may be mentally incompetent to stand trial, presents an imminent risk of serious danger to another person, is imminently suicidal, or otherwise needs emergency intervention, the evaluator should notify defendant's attorney. If the evaluation was initiated by the court or prosecution, the evaluator should also notify the court (American Bar Association, 1989, p. 73).

yield differing conclusions. However, it is possible to pursue this task by obtaining so little information that mistakes are far more likely and plausible alternatives are not tested. Such a procedure could fall below the minimally acceptable standard of care in assessing clinical functioning. Consider the following example:

> An evaluator working in a court clinic conducts an evaluation of competence to stand trial. The evaluation consists of a 15-min interview and a review of the order and arrest report. No standard or specialized testing is conducted, no interviews with defense counsel, jail staff, or family are incorporated, and there is no review of offense history or medical history. The evaluator recommends that the defendant be considered competent for trial, diagnosing antisocial personality disorder and cognitive malingering. Without reviewing relevant and available records, the evaluator is not informed that the defendant has a documented history of being diagnosed as mentally retarded. Following this evaluation, the defendant is adjudicated competent to stand trial, convicted, and sentenced to a lengthy prison term.

Each of these examples might, under some circumstances, be most appropriately addressed through malpractice litigation rather than ethics board or licensure proceedings. As noted earlier in this section, if the evaluator were not licensed and not a member of the APA, the individuals who were affected by the evaluator's actions would have no recourse without malpractice litigation. Even more important, these examples describe potentially serious professional misconduct that may be causally related to very substantial resulting harm to the individual who was evaluated. The potential award of monetary damages to the plaintiff in malpractice litigation is more commensurate with the goal of compensating the individual for the harm experienced than is the action of ethics committees and licensure boards, which cannot award damages. Accordingly, the need for a standard of care is clearest in cases in which malpractice litigation is appropriate because of the seriousness of the professional misconduct and the resulting harm. The actions of ethics committees and licensure boards are more appropriate in cases without these defining features, although when the forensic clinician is not subject to the actions of these regulatory bodies, the only remaining option for recourse may be such litigation. In cases when the potential plaintiff cannot establish both misconduct and causally linked damages, there may be no recourse at all.

Advantages of Establishing a Standard of Care

The judicial development of a standard of care applicable to forensic mental health professionals would have several potential benefits. First, the field of forensic psychology has long recognized the need for a standard of care to ensure that forensic mental health professionals are adhering to minimally acceptable standards of professional conduct. There is a large and well-developed body of literature, spanning over 30 years, documenting discontent with the practices of mental health professionals in forensic contexts (e.g., Bazelon, 1982; Ennis & Litwack, 1974; Grisso, 1986, 2003; Haas, 1993; Melton, Petrila, Poythress, & Slobogin, 1987, 1997, 2007; Morse, 1978), with more recent literature advocating strongly for a clearer standard of care in FMHA (e.g., Goldstein, 2007b). In both

editions of his landmark text, Grisso (1986, 2003) reviewed a litany of historical problems with FMHAs, including ignorance and irrelevance in courtroom testimony, psychiatric or psychological intrusion into essentially legal matters, and insufficiency and incredibility of information provided to the courts.

In addition to the theoretical literature addressing the need for a standard of care in the practice of forensic psychology, several researchers have examined forensic practices to determine whether mental health professionals are meeting minimally accepted standards of practice. For example, several researchers have systematically identified examples of poor forensic practice in administering and interpreting certain tests in forensic contexts (e.g., DeMatteo & Edens, 2006; Edens, 2001; Skeem, Golding, Cohn, & Berge, 1998). In a recent study, researchers conducted a 50-state case-law survey and identified several cases in which forensic mental health professionals made assertions about a defendant's Psychopathy Checklist–Revised score that were inconsistent with the available scientific literature on the topic (DeMatteo & Edens, 2006). In another study, Skeem et al. (1998) found that competence to stand trial reports rarely addressed the defendants' functional abilities, which has become an important focus of such evaluations as a consequence of recent legal decisions on competence to stand trial. In yet another study of competence to stand trial reports from two states, only one quarter of the reports in which mental illness was documented contained explanations of how the defendants' symptoms influenced their abilities related to competence to stand trial (Robbins, Waters, & Herbert, 1997). Whether such deficits in practice are sufficiently serious, and causally related to resulting harm, to justify malpractice litigation is an open question. The development of a standard of care could better identify the distinction between problematic professional conduct that nevertheless does not justify litigation and more serious and harmful conduct that might.

Second, the existence of a standard of care would make it more likely that a party injured by substandard professional conduct would be able to maintain a cognizable malpractice action against a forensic mental health professional. As such, the injured party would have an established judicial mechanism for recovering damages from the offending forensic mental health professional. The judicial recognition/development of a standard of care would put forensic mental health professionals on notice that certain conduct may be considered negligent under certain circumstances. Although there are several available potential defenses against allegations of negligence in the context of a malpractice action, deviating from an established standard of care typically exposes the professional to liability that can result in compensatory and punitive monetary damages awarded as part of a successful malpractice claim.

Third, the establishment of a standard of care would protect forensic mental health professionals from baseless allegations of professional misconduct. As such, the judicial development of a standard of care would serve the dual purpose of protecting both injured parties and forensic mental health professionals. The development of a standard of care would, by definition, establish minimally acceptable standards of professional conduct, which would help to protect forensic mental health professionals from frivolous malpractice actions alleging substandard and possibly harmful professional behavior. A standard of care would establish a relatively bright line (albeit specific to fact and context) between

acceptable and unacceptable professional conduct, thereby providing the professional with a defense against allegations of professional malpractice.

Finally, it is possible that the development of a standard of care would enhance perceptions of the legitimacy of FMHA. The judicial establishment of minimally acceptable standards of conduct would likely be viewed by the lay public, as well as professionals who routinely interact with forensic mental health professionals (e.g., attorneys), as a sign of a maturing profession, requiring specific training, skills, and expertise, and holding practitioners legally responsible for substandard work.

Given the current absence of a standard of care in FMHA and the benefits that would likely flow from having such a standard, it is timely to ask how a standard of care may be promoted through the actions of a particular field of practice. We now turn our attention to this important question, discussing (a) the process by which an enforceable standard of care is typically developed, and (b) how that process can be applied in the context of FMHA. We will then address recent efforts to enhance the consistency of forensic practice and improve the overall quality of FMHA, two important considerations in establishing a standard of care.

Promoting a Standard of Care

The primary purpose of a standard of care is to ensure that professionals render their services in a minimally acceptable fashion, using the skills and technical proficiencies normally exercised by other professionals in the same field. The determination of whether a professional has breached an applicable standard of care is a complicated, contextual, mixed question of fact and law. The most important factual issues are whether the resulting injury in a given case was or should have been foreseeable to the professional and whether the injury can be reasonably attributed to a breach of the standard of care (i.e., whether there is proximate causation; see the previous sections of this article for a discussion of the elements of a negligence cause of action). By contrast, the most important legal issue is what the standard of care should be in a particular case.

When a court undertakes the task of establishing a standard of care, the defining benchmark is typically nationally accepted or customary standards in a professional's particular field. As discussed earlier, courts typically consider common law, state and federal statutes, agency statements, applicable codes of ethics, relevant scientific research, public policy considerations, and standards of practice specific to the field, all of which contribute to defining nationally accepted or customary standards. Depending on the jurisdiction, the standard of care will be defined either in terms of a local standard or a national standard. Courts will frequently permit experts to offer opinions regarding whether a particular professional has deviated from accepted practice and may consider documents such as practice guidelines when establishing a standard of care. As previously noted, some courts are moving away from using the majority approach when defining a standard of care and instead use a reasonableness standard. With this standard, the key question is whether the practice is reasonable, not whether it is used by the majority of practitioners.

Promoting a Standard of Care in FMHA

In recent years, there have been several efforts to establish guidelines for increasing the consistency of forensic practice and improving the quality of FMHA, which are two important considerations in establishing a standard of care. The Specialty Guidelines (currently undergoing extensive revision) was developed to improve the quality of forensic psychological services and to provide guidance on what constitutes competent substantive forensic practice. The Specialty Guidelines presumably represents some consensus regarding behavior that is aspirational and behavior that is unacceptable in the context of forensic psychology. The relationship between the Specialty Guidelines and the establishment of a standard of care deserves some additional comment. In particular, it is important to note that the Specialty Guidelines can assist courts in establishing a standard of care. Courts often look to standards of practice established by a discipline when determining minimally acceptable standards of professional conduct in a particular situation.

A recent effort to describe the foundational features of FMHA is also relevant to standards of practice. It involved the development of a broad set of principles applicable to all types of FMHA (Heilbrun, 2001). Heilbrun (2001) identified and described 29 broad principles of FMHA that were organized around the four broad steps within forensic assessment—preparation, data collection, data interpretation, and communication.[4] Each principle was described according to its relevant support from the areas of law, ethics, science, and practice. When evidence was reasonably strong and consistent across most or all of these areas, the principle was classified as "established." When evidence was less consistent across sources or more mixed, the principle was described as "emerging." Heilbrun et al. (2002) subsequently demonstrated how these principles could be applied to various types of FMHA across a range of legal questions in criminal, civil, and family law contexts. Because these principles are generic, they can be applied to different types of FMHA (e.g., Heilbrun, 2003; Heilbrun et al., 2002,

[4] These principles are as follows: (a) identify relevant forensic issues; (b) accept referrals only within area of expertise; (c) decline referral when evaluator impartiality is unlikely; (d) clarify role with attorney; (e) clarify financial arrangements; (f) obtain appropriate authorization; (g) avoid dual-role relationships of therapist and forensic evaluator; (h) select and employ a model to guide data gathering, interpretation, and communication; (i) use multiple sources of information for each area being assessed; (j) use relevance and reliability (validity) as guides for seeking information and selecting data sources; (k) obtain relevant historical information; (l) assess relevant clinical characteristics in reliable and valid ways; (m) assess legally relevant behavior; (n) ensure that conditions for evaluation are quiet, private, and distraction-free; (o) provide appropriate notification of purpose and/or obtain appropriate authorization before beginning; (p) determine whether the individual understands the purpose of the evaluation and associated limits on confidentiality; (q) use third-party information in assessing response style; (r) use testing when indicated in assessing response style; (s) use case-specific (idiographic) evidence in assessing causal connection between clinical condition and functional abilities; (t) use nomothetic evidence in assessing causal connection between clinical condition and functional abilities; (u) use scientific reasoning in assessing causal connection between clinical condition and functional abilities; (v) do not answer the ultimate legal question directly; (w) describe findings and limits so that they need change little under cross examination; (x) attribute information to sources; (y) use plain language; avoid technical jargon; (z) write report in sections, according to model and procedures; (aa) base testimony on results of properly performed FMHA; and (bb) testify in an effective manner.

2003; Heilbrun, Marczyk, DeMatteo, & Mack-Allen, 2007).[5] Of relevance, Heilbrun (2001) described each principle in terms of its support from sources of authority in ethics, law, science, and standards of practice, which are some of the factors considered by courts when establishing a standard of care. The potential usefulness of these principles in informing a standard of care in FMHA is discussed in the next section of this article.

Scientific and Professional Contributions Toward Informing a Standard of Care in FMHA

Although standard of practice and standard of care are not equivalent concepts, they are related. In this section, we describe their relationship and discuss how behavioral and medical science and practice can contribute to defining each standard. In the course of this discussion, we address the potential contributions of a broad set of principles of FMHA in helping to define the standard of practice (and inform the standard of care) in this area.

The legal decision maker must identify a standard of care in the course of personal injury litigation. There are three important reasons why courts do not (and should not) simply use existing professional standards of practice in defining this standard of care. First, a standard of practice is typically composed of sources that describe aspirational, or desirable, practice, but a standard of care outlines a level of practice that is legally considered to be minimally adequate. The relationship between desirable and minimally adequate is certainly not straightforward and often not even clear. Second, a standard of practice is necessarily presented in broad, general terms. By contrast, a standard of care must integrate a broad standard into the context of a specific case. Third, a decision involving a standard of care must draw an explicit boundary between professional conduct that is minimally adequate and conduct that is not. Consequently, there are moral and political values reflecting the jurisdiction of the litigation that are embedded in this decision to a much greater extent than in the one involving a broad, aspirational standard of practice.[6]

There is a useful analogy to be drawn from the role of law in conducting forensic assessment. For many years, a number of psycholegal scholars (e.g., Melton et al., 1997; Morse, 1978; Slobogin, 1989; Tillbrook, Mumley, & Grisso, 2003) have pointed to important problems that arise when a forensic clinician attempts to answer an "ultimate legal question" directly, as that clinician is

[5] It should be noted that each of these previous articles involved the application of these principles to a specific legal question and resulting FMHA. None of the articles, however, addressed the broader questions of standards of practice and care or the potential contributions of these principles to the development of such standards.

[6] The important question embedded in a decision regarding standard of care—"How much is enough for the care to be minimally adequate?"—is particularly susceptible to the influence of values. Published scientific research that contributes to defining a standard of practice typically addresses the question of what is good (i.e., effective, efficacious, or predictive) but not what is minimally adequate. In the absence of scientific evidence, the influence of values on the decision is relatively greater. Moreover, the process of legal decision making incorporates the expectation that local values will play a role through having members of the community serve on juries and having judges either elected in the jurisdiction or appointed by elected officials. By contrast, the role of values in defining standard of practice is more limited.

"expert" in clinical and scientific data but not in the values embedded in the legal standard (see Footnote 1). Using the example of a defendant's competence to stand trial, the court's decision regarding such competence should certainly incorporate data properly provided by the forensic clinician, including the defendant's clinical condition, functional legal capacities, and the causal connection between symptoms and functional legal deficits. There are also value-laden aspects to the court's decision, however, that cannot be addressed through the clinical and scientific data. How impaired must the defendant be for the court to determine that he/she is incompetent for trial? Is a greater degree of impairment acceptable in cases in which the sentence upon conviction is less severe?

Answering the ultimate legal question in such cases involves using behavioral science information to address both the components of the question that involve behavioral science and those in the realm of community and moral values. Contemporary researchers developing specialized tools have recognized this and do not develop measures that will "determine" whether a defendant is incompetent to stand trial. Rather, such researchers aim to measure relevant clinical and functional legal capacities and compare the level of a defendant's functioning in such areas to other known groups (such as defendants from a jail population for whom the issue of trial competence has never been raised or defendants who have been adjudicated incompetent for trial and hospitalized). This was the strategy used by the investigators who developed the MacArthur Competence Assessment Tool–Criminal Adjudication (MacCAT-CA; Poythress et al., 1999). Using this approach, the investigators developed a measure that can gauge how the defendant functions in relevant areas compared with other known groups; the clinician can incorporate this with other relevant information and convey it to the court. However, the MacCAT-CA's authors explicitly avoid any attempt to address value-laden questions. As a consequence, the MacCAT-CA does not target the final decision regarding competence to stand trial as an outcome to be "measured."

Just as the provision of relevant data for the legal decision regarding competence to stand trial should be limited to data and information that are clinical and scientific, comparable professional data and standards constituting a standard of practice should inform, but not answer, the question concerning the applicable standard of care. The case-specific circumstances and included values will typically mean that the decision regarding standard of care will be more variable than that concerning standard of practice. The factors contributing to the definition of standard of care include the questions of law (affected by relevant statutes, case law, and evidentiary law), determinations of fact (appropriate to the case circumstances), interpretations of questions of law and fact (with embedded values), and evidence from the applicable standards of practice. Considering this, there is a reasonable precedent for encouraging and expecting professions to develop appropriate standards of practice that inform but do not determine a standard of care.

There appear to be at least seven kinds of professional authority that might influence the development of a standard of practice in FMHA. These are described in the order in which they appear to exert such influence. The first, and most influential, is the ethics code that applies to the entire discipline. Such a body of ethical standards is developed by and applicable to professionals who practice in such a discipline; as such, it probably best articulates the views of the entire field

concerning both desirable and less than adequate professional conduct. However, one disadvantage of broad ethical standards is this very breadth. Broadly applicable ethical standards may be insufficiently specific to exert much influence on defining a standard of practice in FMHA.

The second source of influence involves specialized guidelines, which are more specific to the area but not enforceable. Despite this, such specialized guidelines (e.g., Specialty Guidelines, Committee on Ethical Guidelines for Forensic Psychologists, 1991; *Ethical Guidelines for the Practice of Forensic Psychiatry*, American Academy of Psychiatry and the Law, 2005) have the advantage of reflecting the views of a specialized discipline as they are typically developed in a process that seeks input from professionals in the discipline throughout.

The third type of influence involves the kind of broad principles of FMHA that have been developed using multiple sources of authority. Examples of such principles may be seen in the works of Heilbrun (2001) and Melton et al. (2007). Such principles are particularly relevant to the broad questions associated with a standard of practice. These principles may capture much of what has been written in the area of FMHA; nevertheless, they reflect the work of a single author or a small group of scholars. As such, any consideration of representativeness must be weighed in the absence of the broad input from others in the field.

A fourth source of influence involves an overall description of research and practice as offered in the literature, through a national survey conducted concerning views or practice or a meta-analysis of empirical research. Although this kind of summary is less likely to integrate multiple sources of authority (e.g., law, ethics, science, and practice), it nonetheless does offer a certain level of breadth within FMHA. In addition, quantitative summaries such as meta-analyses and surveys offer the additional advantage of numerical precision in capturing practice trends, views, or findings. Such surveys are a potentially valuable source of information about the normative beliefs of forensic evaluators. Of course, the beliefs endorsed in such surveys do not necessarily reflect actual practice. As a result, it is important to obtain empirical data about both evaluator beliefs and FMHA work products, particularly reports and testimony.

The description of a specialized tool, particularly when it has been developed with careful attention to reliability and validity, is a fifth kind of influence on an FMHA standard of practice. Such a description does not allow the reader to gauge whether and to what extent the use of such a tool is a part of good practice in FMHA. However, the manual from a specialized tool can help the reader assess the quality of this kind of specialized tool and to place the tool in the broader context of FMHA practice.

A sixth source for consideration in the development of a standard of practice involves the systematic review of what recognized scholars and practitioners in the field have written and taught regarding the elements that comprise a competent, thorough FMHA. Scholarly texts (such as those cited earlier in this article) describe the multiple sources of information that must be considered by forensic mental health experts in forming psycholegal opinions. Training and postdoctoral workshops offered through specialized providers frequently include consideration of FMHA methodology on a wide range of psycholegal issues. If there is consistency between these sources of information, such teaching and commentary

may inform the profession and the courts regarding standard of practice in the field of FMHA.

Finally, a single study describing a survey of practice or offering an empirical description of some aspect of FMHA practice can contribute to a description of the standard of practice in a particular area of forensic assessment. This should be the least influential contribution to such a standard of practice, but it may nonetheless provide some valuable information that can contribute to a broader summary described earlier among these influences.

Conclusion

As the specialty of FMHA matures, the need for a standard of care in FMHA becomes clearer. Standards of practice and care are not synonymous, but a standard of practice clearly articulated by a profession can help to inform a standard of care in that area. We have noted that having standard of practice inform but not define standard of care is analogous to observing that forensic assessment should inform, but not encroach upon, legal decision making.

We are calling for a clearer, more explicit standard of practice in FMHA. Such a standard, if developed and endorsed by the field, could inform the development and application of a legal standard of care. It is beyond the scope of a behavioral scientific field, such as psychology, to either directly advocate for or be overly involved in the development of a standard of care; such a standard is developed through case law and legislation. But the development of a clearer, stronger standard of practice endorsed by the field would clearly have influence on courts and policy makers with respect to an FMHA standard of care. It is also likely that a clearer, better operationalized standard of practice in FMHA would have other benefits, making professional regulatory bodies such as licensure boards and professional association ethics committees more consistent in their decision making regarding complaints about professional conduct that are pursued through these venues.

Having a clear standard of care in FMHA would be important if tort law is to be applied to the regulation of professional conduct in a meaningful way. Such litigation would probably be appropriate in a small number of cases, characterized by allegations of egregious professional conduct that is causally linked to significant harm to the recipient of FMHA services. But this would be a useful addition to current regulatory practices involving state licensure boards and professional organizations' ethics committees, particularly when licensure boards and ethics committees do not have jurisdiction.

Because a standard of practice in this area would need to reflect some consensus within the field, we do not advocate the use of any single work (e.g., Grisso, 2003; Heilbrun, 2001; Melton et al., 1997) as a proxy for a standard of practice. Such works, particularly when they strive for breadth and comprehensiveness, might usefully inform the development of a clearer, stronger FMHA standard of practice. But such publications from a single author or group do not allow for public comment on their recommendations. As such, they cannot meaningfully represent a consensus within the field. It is ultimately a process, like that involved in developing the Specialty Guidelines (Committee on Ethical Guidelines for Forensic Psychologists, 1991) and their revision, with multiple

drafts integrating ethics, science, and practice and the opportunity for commentary from the field, that is closer to what we envision. In a more focused way, it might also involve the collaboration of national organizations in the development of practice guidelines in various criminal, civil, and juvenile/family domains, comparable to the practice guidelines developed by the American Academy of Psychiatry and Law in the areas of insanity and competence to stand trial. Such processes, yielding standards of practice in FMHA that could in turn affect litigation and policy, would both consolidate scientific advances in the field and meaningfully integrate them into forensic practice—ultimately to the benefit of all who use the products of forensic assessment.

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