Principles of Forensic Mental Health Assessment

Implications for Neuropsychological Assessment in Forensic Contexts

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Forensic mental health assessment (FMHA) is a form of evaluation performed by a mental health professional to provide relevant clinical and scientific data to a legal decision maker or the litigants involved in civil or criminal proceedings. Such FMHA evaluations can be further specialized when the clinical and scientific data are primarily neuropsychological. This paper provides an adaptation of 29 recently derived principles of FMHA (Heilbrun, 2001) that have been described in two forms: general guidelines for application in FMHA, and guidelines for application to neuropsychological assessment in forensic contexts. Each principle is described, and the general guideline is compared with the highly specialized neuropsychological guideline. In this way, the applicability of such FMHA principles to forensic neuropsychological assessment is described.

Keywords: forensic mental health assessment; FMHA; neuropsychology

The past 2 decades have witnessed significant conceptual and empirical advances in the specialty of forensic mental health assessment (FMHA) (Grisso, 2003; Heilbrun, 2001; Melton, Petrila, Poythress, & Slobogin, 1997). These developments have occurred in both the science and the practice of FMHA and have involved the con-

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tributions of numerous specialties within psychology, including clinical, counseling, school, social, developmental, community, experimental, cognitive, and neuropsychology. FMHA refers to psychological evaluations that are performed by mental health professionals to provide relevant clinical and scientific data to a legal decision maker, such as a judge or jury, or the litigants involved in civil or criminal proceedings. Therefore, FMHA is a general term for evaluations conducted by individuals of different disciplines on a variety of questions in civil, criminal, and family law that share the broad legal context within which they were conducted (Heilbrun, Marczyk, & DeMatteo, 2002).

Forensic psychology is an American Psychological Association (APA) specialization, and FMHA is an area of specialty practice that combines forensic with other areas of clinical specialization, including neuropsychology. There are significant and important differences between FMHA and other forms of assessment that are performed primarily for therapeutic reasons, such as treatment planning and diagnosis. These important distinctions between FMHA and therapeutic/diagnostic assessment are described below.

The primary purpose of FMHA is to assist either a legal decision maker or litigant in addressing a particular legal issue as it relates to the capacities and competencies of a given individual. Generally, the evaluation is conducted to contribute empirically based information about the capacities that underlie the demands of a given civil or criminal role (e.g., competence to stand trial, sanity at the time of the offense, mental health disability, or fitness to act as a custodial parent). Conversely, a therapeutic evaluation is usually conducted to meet the mental health needs of an individual, couple, or family. The more traditional functions of this type of evaluation include diagnosing and treating mental, emotional, and behavioral disorders.

The nature of the examiner-examinee relationship provides another important distinction between forensic and therapeutic assessment. In FMHA, the evaluator assumes an objective or quasi-objective role. This typically requires using a higher standard for the accuracy and relevance of data collected and used in the assessment process; that is, the emphasis is on objectivity and not necessarily the best interests of the individual being evaluated. In a therapeutic setting, however, the evaluator assumes a different role in relationship to the patient. This usually means that the evaluator will act in a helping role, with the interests of the patient being paramount. This is not always the case in the context of a FMHA.

The nature of the examiner-examinee relationship also has a direct bearing on the notification of purpose for the assessment. FMHA evaluations begin with a formal notification that highlights the purpose of the assessment and the relationship between the examiner and examinee. This is done to clarify that the evaluator will be conducting the assessment on behalf of the court or an attorney. This is particularly important because the evaluator is not representing the individual being assessed. In addition, the results of the FMHA will not always be in the best interests of the examinee; the goal of FMHA is to provide accurate information for litigation purposes, not to improve mental health functioning.

The standards used in forensic and therapeutic assessment also differ. Standards in therapeutic assessment facilitate diagnosis and treatment and serve organizing, condensing, and orienting functions (Heilbrun, 2001). The best known example of such standards can be found in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (1994). The mental health standards that are concerned with classification and treatment are more circumscribed than the standards considered in FMHA. Forensic evaluations do, however, consider classification and treatment standards. This usually occurs when the evaluator is asked to consider the link between underlying mental, emotional, and cognitive deficits as it relates to a variety of legal issues, such as sentencing considerations, competencies, or criminal responsibility. Unlike therapeutic assessment, therefore, FMHA requires the evaluator to address both a mental health and a legal standard.

The evaluator's objective stance in FMHA highlights another important difference between forensic and therapeutic/diagnostic assessment, that is, the sources of information used in the evaluation. Forensic and therapeutic evaluations use comparable clinical data and psychosocial information. The most common sources of this information include self-report, psychological testing, and behavioral assessment (Heilbrun, 2001). However, additional information is needed in FMHA. Collateral information is typically employed to assess the accuracy and consistency of data incorporated into the evaluation.

Collateral information is particularly important in assessing the response style of the individual being evaluated. Response style refers to the nature and accuracy of the information provided by individuals being evaluated regarding their own thoughts, feelings, symptoms, and behavior (Rogers, 1984, 1997). In most types of therapeutic evaluations, there is usually limited consideration given to the possibility that the individual being evaluated will deliberately (through exaggeration or minimization) distort the nature of symptoms or experiences. This is not the case in forensic assessment, where there is consistent expectation that individuals being assessed might be motivated to present in a manner that would have the most favorable impact on their current situation. It is this consistent presence of situationally based incentives in the context of litigation

that distinguishes forensic from therapeutic evaluation with respect to response style (Heilbrun, 2001).

The process of clarifying the reasoning and the limits on knowledge also differs between forensic and therapeutic evaluation. Therapeutic evaluations tend to rely on the unquestioned assumption of the professional expertise of the evaluator and accuracy of the findings, with little expectation that the assumptions and methods used to reach a conclusion in therapeutic evaluations will be challenged. This is not the case in forensic assessment. Forensic evaluations are conducted in the context of an adversarial setting and are subject to challenge through rules of evidence or by cross-examination by opposing counsel, with the consistent expectation that relevant assumptions and methods will be challenged.

The differences between forensic and therapeutic assessment are also apparent in the documentation and communication of the results of the assessment. Such documentation and communication is usually accomplished through report writing and testimony. Given the range of theoretical approaches, choices of instruments, and levels of expertise, there are no clear expectations about the structure, format, and content of the written report needed to document a therapeutic evaluation. By contrast, the expectations for the documentation and communication of forensic evaluations are more extensive. FMHA reports tend to be lengthy and detailed, primarily because the legal issue being considered requires extensive documentation that clearly describes the procedures, findings, and reasoning used in the assessment (Heilbrun, 2001). There is a similar difference between the two types of evaluation in the communication of results through expert testimony. Only rarely will a therapeutic evaluation be entered into evidence in a legal proceeding, so the likelihood of having to provide testimony is unlikely. The forensic evaluator, in contrast, should always anticipate that testimony could be associated with the assessment.

In sum, the process of forensic assessment differs substantially and in important ways from therapeutic assessment. Any set of general principles that guide therapeutic assessment will be insufficient at best when applied to FMHA (Heilbrun, 2001). Like many forms of assessment, neuropsychological assessment can take place in both therapeutic and forensic contexts. As noted earlier, numerous commentators have made the distinction between evaluations that are conducted for diagnostic and therapeutic purposes and those performed in a forensic context. This suggests that some procedures that would be appropriate for one form of assessment would not be readily transferable to the other form. We should not assume, therefore, that expertise in conducting neuropsychological evaluations for therapeutic and diagnostic purposes would translate directly into expertise performing forensic assessment of individuals with, for example, brain dysfunction. It seems reasonable to draw a distinction between diagnostic/therapeutic and forensic neuropsychological assessment.

One can conceptualize neuropsychological assessment as a method of examining the brain by studying its behavioral product. Because the subject matter of neuropsychological assessment is behavior, it relies on many of the same techniques and assumptions as does traditional psychological assessment for therapeutic and diagnostic purposes. As with other psychological assessments, neuropsychological evaluations involve the systematic study of behavior by means of standardized tests that provide relatively sensitive indices of brain-behavior relationships. Neuropsychological tests have been used on an empirical basis in various medical and psychiatric settings, are sensitive to the organic integrity of the cerebral hemispheres, and can often pinpoint specific neurological or psychological deficits (Zillmer, 2003). In effect, the neuropsychological exam offers an understanding of the relationship between the structure and the function of the nervous system. Thus, the goal of the clinical neuropsychological exam is to be able to evaluate the full range of basic abilities represented in the brain.

The objective and quantitative nature of the neuropsychological assessment have become valuable assets in the courtroom to offer information to the jury or judge regarding the determination, effects, and prognosis of brain dysfunction. Because neuropsychology assessment batteries typically evaluate a wide range of behaviors, this multidimensional approach to measuring higher cortical functioning has proven to be very helpful in quantifying disabilities resulting from head trauma or other neuropathological conditions. Neuropsychological evaluations are critical for the comprehensive understanding of the cognitive, behavioral, and emotional sequelae of a variety of neurological conditions for purposes of legal documentation. Therefore, neuropsychologists are often in a position to deal with varied aspects of brain dysfunction and are increasingly asked to conduct forensic assessments in cases related to personal injury, disability determination, and workman's compensation. In a recent survey of the membership of the National Academy of Neuropsychology, 7% of all neuropsychological evaluations were reported to be forensic in nature (Zillmer & Spiers, 2001). Thus, forensic neuropsychology is a rapidly emerging subspecialty of neuropsychology that directly applies the principles and practices of neuropsychology in cases where questions of brain injury are relevant to civil or criminal litigation.

Thus, it is helpful to consider how the broad principles of FMHA and associated guidelines might apply specifi-

cally to forensic neuropsychological assessment. We will now turn to the question of how a set of recently derived principles of FMHA applies to neuropsychological assessment in forensic contexts.

DERIVATION OF PRINCIPLES OF FMHA

Until recently, a set of principles sufficiently broad to be applied to the shared features of different types of FMHA was conspicuously absent. Although several clinical-legal scholars have addressed this issue in recent years, the applicability of their proposed principles was fairly circumscribed and largely limited to the specific types of FMHA being described in their respective works (e.g., Greenberg & Brodsky, June 2000); Melton et al., 1997). For example, Greenberg and Brodsky described the key components of a model of civil forensic psychological assessment, and Melton et al. (1997) recommended procedures that are specifically relevant to psychological testing in FMHA. Despite the usefulness of their detailed descriptions and recommendations, a set of general principles with applicability across all types of FMHA was still needed.

Heilbrun (2001) recently provided a detailed description of a set of broad principles that are applicable across all types of FMHA. The 29 principles described by Heilbrun (2001), which incorporated the guidelines offered by Greenberg and Brodsky (June 2000) and Melton et al. (1997), can be applied to all types of civil and criminal FMHA. Subsequently, Heilbrun et al. (2002) demonstrated the applicability of these 29 principles to a wide range of case reports in civil, criminal, and juvenile/family forensic contexts. There is some support in the literature for the applicability of these principles (e.g., Heilbrun, 2003; Heilbrun, DeMatteo, & Marczyk, in press; Heilbrun et al., 2002), although they have not been discussed specifically with respect to forensic neuropsychological assessment.

The 29 principles of FMHA identified and described by Heilbrun (2001) were organized sequentially around the four broad steps within FMHA: preparation, data collection, data interpretation, and communication (see Table 1). Heilbrun (2001) discussed each of the principles in terms of the support that it received (relevant to the fields of psychology and psychiatry) from sources of authority in ethics, law, science, and practice. The major sources of ethical authority were the ethical standards for psychology ("Ethical Principles of Psychologists and Code of Conduct," see American Psychological Association, 1992), the ethical guidelines for forensic psychology ("Specialty Guidelines for Forensic Psychologists," see Committee on Ethical Guidelines for Forensic Psychologists, 1991), the ethical standards for psychiatry (*Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, see American Psychiatric Association, 1998), and the ethical standards in forensic psychiatry (*Ethical Guidelines for the Practice of Forensic Psychiatry*, see American Academy of Psychiatry and the Law, 1995). Support from legal sources of authority was analyzed by examining federal case law (federal appellate and U.S. Supreme Court cases), federal statutes and administrative regulations, and "model" mental health law (e.g., *Criminal Justice Mental*

TABLE 1
Principles of Forensic Mental Health Assessment

Preparation
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 role of therapist and forensic evaluator.
8. Determine the particular role to be played within the forensic assessment if the referral is accepted.
9. Select the most appropriate model to guide data gathering, interpretation, and communication.

Data Collection
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.

Data Interpretation
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 causal connection between 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 directly.
24. Describe findings and limits so that they need little change under cross-examination.

Communication
25. Attribute information to sources.
26. Use plain language; avoid technical jargon.
27. Write the report in sections, according to model and procedures.
28. Base testimony on the results of the properly performed FMHA.
29. Testify effectively.

SOURCE: Heilbrun (2001).
NOTE: FMHA = forensic mental health assessment.

Health Standards, see American Bar Association, 1989). Scientific support was assessed by reviewing relevant behavioral science and medical literature, with a particular focus on well-designed empirical studies whenever possible. Finally, the standards-of-practice criterion considered the extent to which each principle is recognized by various authorities as being important or useful for the practice of FMHA.

Based on an analysis of the four evaluative criteria—ethics, law, science, and standards of practice—Heilbrun (2001) classified each principle as either established or emerging. Established principles are largely supported by research, accepted in practice, and consistent with ethical and legal standards; emerging principles are supported in some areas but with mixed or absent evidence from others, or they are supported by some evidence but with continuing disagreement among professionals regarding their application (Heilbrun, 2001). We will now summarize each of the 29 principles and comment on the application of each to neuropsychological evaluations in forensic contexts.

APPLICATION OF PRINCIPLES OF FMHA TO NEUROPSYCHOLOGICAL ASSESSMENT IN FORENSIC CONTEXTS

Each broad principle has been described as associated with a general guideline (Heilbrun, 2003), as may be seen in Table 2. A more specific context—neuropsychological assessment in forensic areas—can also be described using a guideline that is a specific adaptation of the FMHA principle. It is also useful to consider how closely the general FMHA guidelines parallel the neuropsychological guidelines, to determine how well these 29 principles apply to neuropsychological assessment in forensic contexts.

1. *Identify relevant forensic issues*. This principle puts into perspective the relevant capacities and behaviors that are evaluated in FMHA. It distinguishes between the broader legal question, which is decided by the court in the course of the litigation, and the more specific forensic issues, which are the capacities and abilities included within the legal question.

The general guideline, which is broadly applicable to FMHA, calls for citation of both the legal question and the included forensic issues in the first section of the report. This guideline would change only slightly when the forensic assessment was neuropsychological—the included forensic issues would be more specifically neuropsychological, emphasizing executive, attention/concentration, or other cognitive capacities or other cognitive strengths and weaknesses. In addition, neuropsychological consultations often address residual cognitive deficits after some neurological trauma, an estimate of the person's overall adaptive and neuropsychological functioning, and an estimation of premorbid functioning and posttrauma recovery.

2. *Accept referrals only within area of expertise*. This principle underscores the importance of expertise in FMHA as having two parts: (a) clinical and didactic training and experience with populations similar to the individual(s) being evaluated and (b) previous application of this expertise in a forensic context. Indicators such as training, licensure, and board certification status may provide some basis for judging forensic expertise, but it is often important to document experience in the form of the Curriculum Vitae and a description of comparable forensic cases in which assessment has been conducted. *Expertise* takes on an even more specific meaning when the evaluation involves neuropsychological assessment in a forensic context because neuropsychological expertise requires specialty training in the procedures of neuropsychological assessment. Thus, the evaluator should be able to document particular expertise in neuropsychology, which is a more specialized area than clinical psychology, as well as experience applying this expertise in FMHA.

3. *Decline the referral when evaluator impartiality is unlikely*. This principle stresses the important role of impartiality in FMHA. In this context, impartiality involves the absence of personal beliefs or circumstances that could significantly interfere with the evaluator's effort to be fair and evenhanded in collecting data and drawing conclusions. When there are substantial barriers to such impartiality, whether personal, professional, or monetary, this principle and its associated general guideline suggest that the forensic clinician should decline involvement in that particular case.

The specific adaptation of this guideline for neuropsychological assessment in forensic contexts is fairly similar to the general guideline. There are particular kinds of cases in which neuropsychological assessment is more likely to be indicated. Although any individual who experiences deficits functioning as a result of brain injury and is involved in litigation could require neuropsychological assessment, the kinds of cases in which the demand for forensic neuropsychological assessment is highest are probably personal injury cases (with associated brain trauma) and capital sentencing cases, in which the scope of the mitigating cognitive factors to be evaluated is typically very broad.

4. *Clarify the evaluator's role with the attorney*. The most common roles played by the evaluator in forensic assessment are those of court-ordered evaluator; defense-, prosecution-, or plaintiff-requested evaluator; and consultant (Heilbrun, 2001). Assuming more than one such role

TABLE 2
Guidelines for Application of FMHA Principles to Neuropsychological Assessment in Forensic Contexts

Principle	*General Guidelines for Application in FMHA*	*Guidelines for Application to Neuropsychological Assessment in Forensic Contexts*
1. Identify relevant forensic issues.	Cite legal question and included forensic issues in first section of report.	Same as general guideline. Describe neuropsychological aspects of forensic issues.
2. Accept referrals only within area of expertise.	Give degree and licensure, board certification status. Provide CV and/or summary of qualifications if requested.	Same as general guideline. Ensure that CV includes information about neuropsychological assessment in clinical and forensic contexts. Provide information documenting training and experience with particular populations, forensic issues, and legal questions similar to those in present case.
3. Decline the referral when evaluator impartiality is unlikely.	Avoid involvement in cases in which there is substantial incentive for the forensic clinician (personal, professional, or monetary) to have case decided in a particular direction.	Same as general guideline. Monitor own personal and professional reactions to questions concerning criminal responsibility and compensation for personal injury in those who have neuropsychological deficits, specifically to particular questions to be assessed in this case.
4. Clarify the evaluator's role with the attorney.	Ensure that both the forensic clinician and the referral source are clear whether the clinician will serve as court-appointed evaluator, attorney-requested evaluator, or consultant.	Same as general guideline.
5. Clarify financial arrangements.	Ensure that terms of payment for evaluation are understood by both the forensic clinician and the party responsible for payment.	Same as general guideline.
6. Obtain appropriate authorization.	Cite basis for evaluation request (e.g., court-ordered, attorney-requested). Describe whether informed consent was obtained if evaluation was not court-ordered.	Same as general guideline. Underscore the difference between the forensic evaluation and treatment/rehabilitation, particularly if the individual being assessed has a history of such rehabilitation.
7. Avoid playing the dual roles of therapist and forensic evaluator.	Minimize the frequency of this combination. If such roles are combined, it should be with explicit justification, advance planning, and clear notification to the individual involved.	Same as general guideline. Be particularly cautious in specialized rehabilitation facilities that any combination of treatment and FMHA is planned and notification is clear to those involved.
8. Determine the particular role to be played within forensic assessment if the referral is accepted.	If report will be submitted into evidence, evaluator should be impartial—the tone of the report should reflect this.	Same as general guideline. Remain within designated role and do not address treatment/rehabilitation needs unless contained within forensic issues that constitute referral question(s).
9. Select the most appropriate model to guide data gathering, interpretation, and communication.	Use the Morse model (mental disorder, functional abilities, and causal connection) or the Grisso model (functional, contextual, causal, interactive, judgmental, and dispositional characteristics).	Same as general guideline. Interpret mental disorder very broadly, to include components of neuropsychological functioning that contribute to defining the forensic issues and help to inform the court on the legal question(s).
10. Use multiple sources of information for each area being assessed.	Obtain self-report, psychological testing data, third-party interviews, and collateral records data.	Obtain self-report, neuropsychological testing data, third-party interviews, and collateral records data
11. Use relevance and reliability (validity) as guides for seeking information and selecting data sources.	Use data sources with demonstrated reliability and validity (when this has been researched) and that will provide information relevant to the area being assessed.	Same as general guideline. Provide theoretical and empirical justification for use of particular neuropsychological measures for assessing specific functions.
12. Obtain relevant historical information.	In a separate section, document the individual's history and previous functioning in areas relevant to current clinical condition and functional legal capacities.	Same as general guideline. Add historical information regarding nature and date(s) of brain injury and functioning in relevant areas prior to and following injury.
13. Assess clinical characteristics in relevant, reliable, and valid ways.	Describe clinical characteristics using measures that are reliable, valid for the purpose used, and/or weighed against information from collateral sources.	Same as general guideline. Define clinical characteristics broadly to include aspects of functioning that are potentially relevant to functional demands in specific case.

(continued)

TABLE 2 (continued)

Principle	*General Guidelines for Application in FMHA*	*Guidelines for Application to Neuropsychological Assessment in Forensic Contexts*
14. Assess legally relevant behavior.	Document information collected from multiple sources regarding the individual's functional legal capacities.	Same as general guideline. Focus primarily on functional demands, using neuropsychological functioning data to inform assessment of such demands.
15. Ensure that conditions for evaluation are quiet, private, and distraction-free.	Note any deviation from reasonably quiet, private, and distraction-free conditions. Describe impact on data collected.	Same as general guideline. May be particularly important to ensure such conditions when testing is timed and assesses cognitive capacities and attention/concentration.
16. Provide appropriate notification of purpose and/or obtain appropriate authorization before beginning.	Describe elements of notification of purpose or informed consent given to individual being evaluated and to third parties who are interviewed.	Same as general guideline.
17. Determine whether the individual understands the purpose of the evaluation and the associated limits on confidentiality.	Document how the individual's understanding was assessed and to what extent he/she understood the relevant information.	Same as general guideline. When neuropsychological deficits of various kinds are assessed, more detailed documentation of lack of understanding and possible reasons for such may be indicated.
18. Use third-party information in assessing response style.	Describe the consistency of third-party information with self-reported information, and be particularly cautious about self-report when it is significantly different from third-party accounts.	Same as general guideline. Anticipate problem of potential malingering or exaggeration of neuropsychological deficits in forensic contexts, and be prepared to use third-party information as independent source of information on functioning.
19. Use testing when indicated in assessing response style.	Administer test(s) sensitive to response style, particularly when there is concern about the accuracy of self-report.	Same as general guideline. Assess measures of cognitive malingering, malingering of memory, and the like when indicated.
20. Use case-specific (idiographic) evidence in assessing clinical condition, functional abilities, and causal connection.	Describe the individual's clinical condition and functional legal abilities in the context of his/her history of symptoms and demonstrated capacities.	Same as general guideline. Compare individual's functioning to his/her previous levels (prior to brain injury, for example).
21. Use nomothetic evidence in assessing clinical condition, functional abilities, and causal connection.	Describe the results of psychological tests, structured instruments, and specialized tools validated for assessing (a) clinical condition or (b) functional legal capacities.	Same as general guideline. Compare individual's levels of neuropsychological functioning to normative levels as gauged from validated measures.
22. Use scientific reasoning in assessing causal connection between clinical condition and functional abilities.	Describe explanations for clinical condition and functional abilities that have the most supporting evidence and least disconfirming evidence. When evidence is mixed, or competing explanations seem comparably well supported, say so.	Describe explanations for neuropsychological capacities and functional abilities that have the most supporting evidence and the least disconfirming evidence. When evidence is mixed or competing explanations seem comparably well supported, say so.
23. Do not answer the ultimate legal question directly.	Present conclusions about forensic capacities but not the larger legal question(s).	Same as general guideline.
24. Describe findings and limits so that they need little change under cross-examination.	Be careful, impartial, and thorough in presenting data and reasoning. Consider alternative explanations.	Same as general guideline.
25. Attribute information to sources.	Describe data so that the source(s) of any specific finding is clear.	Same as general guideline.
26. Use plain language; avoid technical jargon.	Make minimal use of technical language, and define technical terms when they must be used.	Same as general guideline. It is particularly important to translate, define, and give examples, considering the high density of technical language used in neuropsychological assessment.

(continued)

TABLE 2 (continued)

Principle	*General Guidelines for Application in FMHA*	*Guidelines for Application to Neuropsychological Assessment in Forensic Contexts*
27. Write the report in sections according to the model and procedures.	Include sections on referral information, sources of information, relevant history, clinical functioning, relevant functional legal capacities, and conclusions. Describe causal relationship between clinical symptoms and functional legal capacities.	Include sections on referral information, sources of information, relevant history, neuropsychological functioning, relevant functional legal capacities, and conclusions. Describe causal relationship between neuropsychological deficits and functional legal capacities. May be pre-post comparisons in some evaluations.
28. Base testimony on the results of the properly performed FMHA.	Master the contents of the report, which contains thorough documentation of evaluation, and use report contents to guide testimony.	Same as general guideline.
29. Testify effectively.	Use effective style in presenting substantive FMHA findings in testimony. Same as general guideline.	

SOURCE: Heilbrun (2003).
NOTE: FMHA = forensic mental health assessment; CV = Curriculum Vitae.

in a single case is potentially problematic; this principle underscores the importance of identifying a single role from the outset. This appears no different for neuropsychological forensic assessment than it does with less-specialized clinical forensic assessment.

5. *Clarify financial arrangements*. Sometimes payment for FMHA is established in law or policy, and there is no flexibility for negotiating other than a set fee. When there is discretion regarding the source and amount of payment, however, the understanding regarding who will be responsible for payment, when, at what rate or total amount, and other such considerations should be clarified in advance. Like the previous principle, this would seem to apply to forensic neuropsychological assessment as well as it does to more general clinical FMHA, and most neuropsychologists have forensic rate information available for purposes of being retained by legal counsel.

6. *Obtain appropriate authorization*. The forensic clinician may need to obtain authorization from the court or from the retaining attorney and client, depending on the role being played and on who requested the evaluation. In court-ordered FMHA, the forensic clinician needs a signed order from the court. The forensic clinician needs authorization from both the referring attorney and the individual being evaluated when serving as an expert for the defense/prosecution/plaintiff.

This principle and its associated general guideline apply reasonably well to forensic neuropsychological assessment. The nature of "treatment" may differ substantially between the rehabilitation provided to brain-injured individuals and the therapy and medications that form the basis for the treatment of serious mental illness and related disorders. When the forensic clinician is obtaining authorization for the assessment from the individual being evaluated, the distinction between forensic and therapeutic evaluation may differ as well, consistent with the individual's history of receiving services of one particular kind.

7. *Avoid playing the dual roles of therapist and forensic evaluator.* This principle emphasizes that simultaneous or even sequential assumption of the roles of both therapist and forensic evaluator with the same individual has the potential to create substantial problems and should, accordingly, be avoided. In cases in which it cannot be avoided, the associated general guideline stresses the importance of explicit justification, advance planning, and clear notification to the individual(s) affected.

Such role combination, if it were to occur in forensic neuropsychology, is perhaps most likely to be seen in a hospital neurology unit or a rehabilitation facility. Although the nature of such treatment may differ significantly from clinical treatment, the same elements of justification, planning, and notification would apply.

8. *Determine the particular role to be played within forensic assessment if the referral is accepted*. Identifying a single role in FMHA and maintaining that role throughout the case are stressed in this principle. The forensic clinician should strive to maintain impartiality in any role that involves submitting a report and possibly testifying, whether that role is court appointed or as an expert for a referring attorney. Part of maintaining an impartial stance is addressing only the questions that are requested, thereby avoiding gratuitous opinions. Such opinions may come in the form of unrequested or irrelevant treatment recommendations in the more general clinical FMHA. Likewise, the specific adaptation of this principle and guideline for

neuropsychological assessment involves having the evaluator avoid addressing treatment/rehabilitation needs for identified brain-behavior deficits unless such needs are both a requested and relevant part of the broader forensic assessment.

9. *Select the most appropriate model to guide data gathering, interpretation, and communication*. Two models—described by Morse (1978) and Grisso (1986)—are appropriate for guiding the conceptualization, procedure selection, interpretation of results, and reasoning in FMHA. Both models have a section in which "clinical condition" or "symptoms" are featured prominently. This clearly needs to be applied flexibly to account for the potential deficits and symptoms that are assessed through neuropsychological measures. If "clinical" and "symptoms" are considered broadly and flexibly, however, then the general guideline for this principle can be adapted reasonably well to apply in forensic neuropsychological contexts. One area that is perhaps more prominent to neuropsychological evaluations in the legal arena is the notion of "cause." That is, are the neurobehavioral sequelae related to the present neuropsychological functioning? Thus, the variable and continuum of "time" is important and challenging to forensic neuropsychologists as they attempt to understand how the examinee has functioned in the past or will adapt in the future.

10. *Use multiple sources of information for each area being assessed*. Litigation creates a particular motivation to distort the accuracy of self-reported information. In addition, the tests and measures used in FMHA were often developed for somewhat different contexts. The use of a multimethod, multisource approach to assessing the important symptoms and capacities in forensic assessment is particularly important for these reasons. Therefore, the use of three particular sources—self-report, formal tests and measures and third-party information (both records and collateral interviews)—is indicated.

The applicable guidelines in Table 2 are consistent between clinical and neuropsychological assessment in forensic contexts. The specific tests and measures will differ and may cover achievement, aptitude, behavioral/adaptive, intelligence, neuropsychological, personality, and vocational testing procedures. However, the importance of obtaining detailed self-report, reviewing available records, and conducting interviews with collaterals in targeted areas is comparable.

11. *Use relevance and reliability (validity) as guides for seeking information and selecting data sources*. Relevance to the question(s) before the court and reliability (in a legal context, meaning both psychometric reliability and validity) are important elements of evidentiary law that are directly applicable to the admissibility and weight of expert testimony. Accordingly, this principle stresses the importance of both relevance and reliability in considering sources of information in FMHA. The broad guideline emphasizes that data sources with demonstrated satisfactory levels of reliability and validity, particularly psychological tests (for which such information is often available) are preferable.

This guideline translates fairly readily into a more specific version applicable to neuropsychological assessment. Within the neuropsychological domain, there may be a number of different cognitive areas assessed, including orientation (arousal), sensation and perception, attention/concentration, motor skills, verbal functions/language, visual-spatial organization, memory, and judgment/problem solving. Some neuropsychological assessment procedures have become extremely specialized (e.g., executive functions as measured by the Tower of London test; Culbertson & Zillmer, 1998). What are the psychometric properties of each particular test and measure that the neuropsychologist would like to use in a given case? There is often little convergence between traditional tests of clinical psychological assessment (e.g., MMPI-2) and those of neuropsychology (Zillmer & Perry, 1996). Awareness of this information, critical analysis of the properties of some measures leading to their exclusion, and the use of other sources of information to supplement and strengthen the data obtained through testing are all valuable by-products of applying this principle and specific guideline.

12. *Obtain relevant historical information*. Relevant historical information about the individual being evaluated is almost always essential in FMHA and typically in greater detail than that needed in therapeutic evaluation. This varies according to the type of FMHA, however, with some evaluations (e.g., competence to consent to treatment) needing only a reasonably focused history and others (e.g., capital sentencing) requiring greater detail. The general guideline suggests that such history, particularly information addressing previous mental health and functional legal data, be documented in a separate section of the report.

In many forensic neuropsychological evaluations, the historical information will need to be quite detailed in describing the nature and possible causes of the brain dysfunction being assessed. In some particular evaluations, this may include a careful "pre-post" analysis of symptoms, behaviors, and particular performance (e.g., school, job) when there is a specific injury at a given time that is the focus of the litigation.

13. *Assess clinical characteristics in relevant, reliable, and valid ways*. The decision about which clinical characteristics to assess and how to assess them is facilitated

through the use of relevance and reliability as guides, according to this principle. More specifically, the general guideline calls for the use of appropriate measures, the results of which are weighed against findings from collateral sources.

The important difference between the general guideline and the more specific neuropsychological guideline simply concerns the domain of symptoms that are being assessed. If clinical characteristics were defined broadly and flexibly, to include the cognitive, executive, attentional, and linguistic characteristics that are often the primary focus in neuropsychological assessment, there would be no need for a more specific guideline.

14. *Assess legally relevant behavior.* This principle addresses the capacities and behavior related to the specific legal question(s) being addressed by the court and being used to guide FMHA. Relevance and reliability are again useful in considering how to assess those functional legal capacities and behavior. For some forensic assessments, there are now validated tools that can be used to help the evaluator determine how the individual being evaluated compares with other such individuals on certain relevant legal capacities (e.g., the MacArthur Competence Assessment Tool-Criminal Adjudication [MacCAT-CA] for competence to stand trial, Poythress et al., 1999; the MacCAT-T for competence to consent to treatment, Grisso & Appelbaum, 1998; *Instruments for Assessing Understanding and Appreciation of MIRANDA Rights*, Grisso, 1998).

For the majority of forensic issues that are assessed by evaluators, however, there is not yet a validated tool available to assist in this manner. In these cases, the evaluator must carefully identify the relevant functional demands associated with the legal question and obtain cognitive, affective, and behavioral data on the individual's capacities to meet such demands at the time specified by the parameters of the evaluation. Such functional criteria vary according to the legal question, not population evaluated, and so this particular principle does not need a neuropsychological guideline that is much more specific. It should also be noted, however, that an individual's capacity to perform relevant functional demands is affected by symptoms of neuropsychological deficit or mental illness; it is the evaluator's responsibility to identify such deficits and link them to functional capacities, a description that will clearly vary according to the nature of such deficits.

15. *Ensure that conditions for evaluation are quiet, private, and distraction-free*. This principle describes the important balance between reasonable evaluation conditions—those in which noise and other distractions are limited and the communication between evaluator and evaluee cannot be overheard—and other influences, such as security and limited available time. FMHA is sometimes conducted in correctional or secure psychiatric settings in which evaluation conditions are problematic, and the evaluator must determine when they become sufficiently problematic to require a change or a postponement of the entire process. This balance may be different in neuropsychological assessment, particularly when attention/concentration and other cognitive functions are being directly assessed. It might be even more important to ensure a very minimal level of distraction in such neuropsychological assessment to accurately attribute measured performance to existing deficits rather than problematic conditions. Meaningful interpretation of an individual's neurological integrity cannot be accomplished without a thorough understanding of subject variables that might influence that performance. Those can include age, premorbid functioning, gender, and motivational variables, in addition to test variables of arousal and medication. Whereas some of the variables presented in this section are important to consider when conducting any type of psychological assessment, these variables are presented in reference to their specific impact on neuropsychological functioning. Recently, there has been more frequently expressed arguments by opposing legal counsel to audiotape, videotape, or have a third party present during forensic neuropsychological evaluations. Some jurisdictions (e.g., New Jersey) have allowed such additional scrutiny, which is consistent with some ethical guidelines (e.g., "Specialty Guidelines for Forensic Psychologists,' see Committee on Ethical Guidelines for Forensic Psychologists, 1991), although strongly opposed by others on ethical and psychometric grounds (National Academy of Neuropsychology, 2000). This aside, however, we would add that this principle applies well to both general and more specifically neuropsychological FMHA.

16. *Provide appropriate notification of purpose and/or obtain appropriate authorization before beginning*. The forensic clinician provides a notification of purpose or obtains informed consent before beginning the FMHA. This principle underscores that one of these must be provided; which one depends on the role being played and the nature of the associated authorization obtained. When an attorney retains a forensic clinician to evaluate the attorney's client, the evaluation is legally voluntary—the client has no legal obligation to participate—and informed consent should, therefore, be obtained before proceeding. In contrast, when conducting a court-ordered evaluation, the forensic clinician should notify the individual being evaluated about the nature and purpose of the evaluation, its authorization by the court, and the associated limits on confidentiality, including how it might be used. In a court-ordered context, however, the individual's participation in

the evaluation is not voluntary, and the clinician is providing a notification of purpose but not seeking informed consent.

There would seem to be no difference between the more general FMHA and one more specifically neuropsychological in this regard. For both, the important elements of the notification should be identified. When notification of purpose is the goal, these elements are simply communicated to the individual being evaluated. When informed consent is sought, they are also communicated, but the individual is asked to indicate his or her consent as well before the evaluation begins.

17. *Determine whether the individual understands the purpose of the evaluation and associated limits on confidentiality.* The information communicated in the course of providing notification of purpose or obtaining informed consent must be understood. To the extent that it is not, the notification or informed consent process becomes less meaningful. This principle stresses the importance of gauging how well such information has been understood and how the evaluator might proceed if the information was not well understood.

When seeking consent for a neuropsychological assessment, the examiner should inform the examinee that the evaluation may be self-disclosing and require disclosure of personal history and that the assessment and subsequent report may be favorable, unfavorable, or nondeterminant regarding his or her legal issues. When potential deficits in neuropsychological functioning are involved, it is possible that individuals being evaluated will have more difficulty understanding such a notification or providing consent. This makes it particularly important for the evaluator to describe and document how such information was apparently understood at the beginning of neuropsychological FMHA. There may also be a clearer link between the deficits identified in the evaluation and the barriers to understanding the initial information regarding the evaluation.

18. *Use third-party information in assessing response style*. Response style—whether an individual being evaluated is deliberately overreporting or exaggerating deficits, underreporting or minimizing such deficits, or trying to report them as accurately as possible—is clearly of particular importance in FMHA. This principle addresses the value of collateral interviews and records to help provide a description of history, clinical functioning, and functional legal capacities from multiple sources of information. When information from other sources is not consistent with self-report, then response style must be scrutinized with particular care.

The nature of the symptoms that are exaggerated (or minimized) might certainly vary according to whether the FMHA is specifically neuropsychological. When there is particular emphasis on the measurement of deficits through testing, as in neuropsychology, there is also the question of whether such measures have built-in validity indicators associated with overreporting and underreporting. Individuals suffering from neuropsychological dysfunction as a result of trauma frequently complain of problems in attention and memory. The combination of potential motivation for inaccurate self-report and the use of a number of measures that do not have validity indicators would mean that third-party information would be even more important as a means of assessing the consistency of self-report and measured functioning with other information regarding such functioning.

19. *Use testing when indicated in assessing response style*. There are tests and measures, however, that do address response style. They may have been developed specifically to measure malingering (e.g., the Validity Indicator Profile [VIP], see Frederick, 1997; the Structured Interview of Reported Symptoms [SIRS], see Rogers, 1992; the Test of Memory Malingering [TOMM], Tombaugh, 1997), or they may have validity indicators built into their structure (e.g., the MMPI-2, see Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; the MCMI-III, see Millon, 1994). This principle urges the use of tests and specialized measures whenever they are available and appropriate for the kind of potential distortion in response style that is being considered.

The particular tests used in a general FMHA versus a more specifically neuropsychological assessment would vary in this way. Assuming that an individual being evaluated for the impact of a brain trauma would be more likely to malinger the symptoms of executive, attentional, verbal or memory deficits, or more general cognitive problems, it would be appropriate to use a measure such as the VIP or the TOMM rather than the SIRS, which measures malingering of symptoms of severe mental illness. There are still relatively few well-validated psychological tests or specialized measures available for either cognitive malingering or malingering of severe mental illness, however, making the previous principle (concerning third-party information) particularly salient at present.

20. *Use case-specific (idiographic) evidence in assessing clinical condition, functional abilities, and causal connection*. Heilbrun (2001) asserted that science can be applied to FMHA in three ways: using idiographic analysis, considering nomothetic data, and using scientific reasoning. This principle describes the first—obtaining information specific to the case and present functioning of the individual and comparing it to that individual's capacities and functioning at other times. This approach is consistent with the law's goal of individualized justice, so

developing and presenting FMHA findings in this manner may have particular appeal to judges and attorneys.

A particular variation on this approach is indicated when an individual is involved in litigation that alleges personal injury, perhaps resulting from an accident in which a brain trauma was sustained. In conducting an FMHA in a case like this, one important task for the evaluator involves a pre-post analysis of the nature of neuropsychological deficits and related functional abilities prior to and following the trauma.

21. *Use nomothetic evidence in assessing clinical condition, functional abilities, and causal connection*. Science can also be applied to FMHA by considering empirical data applicable to populations similar to that of the individual being evaluated and by using tests and instruments developed and validated on similar populations. Assessing forensic capacities with norm-referenced tools allows the evaluator and the legal decision maker to compare such measured capacities to those of individuals in "known groups."

The example used to illustrate the previous principle can be used again to suggest how nomothetic data might be used in forensic neuropsychological assessment. An individual, who has experienced a brain trauma with potential loss in function in various areas, can also be compared with other individuals to determine how current functioning might be described in a normative sense. Indeed, this is perhaps more often the primary focus in psychological assessment, including neuropsychological assessment, with the comparison to group norms providing the empirically supported basis for describing the individual's degree of impairment.

22. *Use scientific reasoning in assessing causal connection between clinical condition and functional abilities*. In some ways, FMHA procedures are comparable to those used in a scientific study. The results obtained from one source of information (e.g., interview) can be treated as "hypotheses to be verified" through further information obtained from additional sources of information. Accepting or rejecting hypotheses depending on whether they account for the most information with the simplest explanation applies the principle of parsimony. This principle suggests that scientific reasoning is a third important way in which science can contribute to the FMHA process.

This yields a general guideline, specifying that hypothesis testing and reasoning in FMHA proceed by clarifying which information seems supportive and which seems nonsupportive of various possible explanations that might account for the pattern of observed results. To do this, the evaluator must scrutinize results critically and describe the level of consistency across data sources and for particular explanations. Serial assessments in neuropsychology, specifically, can make the attribution of causality between trauma and recovery particularly complex. This process would seem very similar for more general FMHA and that which is more specifically neuropsychological.

23. *Do not answer the ultimate legal question directly.* This principle concerns the unsettled and often debated question of whether forensic evaluators should answer the "ultimate legal question" (the legal question to be decided by the judge or jury, such as a defendant's liability for a plaintiff's injury and the associated damages). Some (e.g., Rogers & Ewing, 1989) have argued that many judges and attorneys expect the forensic clinician to offer an ultimate opinion (which, with few exceptions, is permitted by the evidentiary laws in most jurisdictions) and that there is little harm in doing so. Others (e.g., Melton et al., 1997) emphasize the importance of the relevant included forensic capacities, but observe that the ultimate legal question, which includes moral, political, and community values, should not be the focus of the evaluation's conclusion.

This disagreement is not settled within the field. However, the arguments on both sides of the question do not seem to apply differently to FMHA that is broad versus that which is more specifically neuropsychological.

24. *Describe findings and limits so that they need little change under cross-examination*. According to this principle, FMHA findings should be described carefully and thoroughly, be supported by multiple sources of information, and be accompanied by acknowledgment of the limits on data accuracy and consistency. When this kind of critical scrutiny is applied to the results and reasoning that are communicated in the report and, subsequently, in testimony, the forensic clinician can expect that the description of findings and conclusions will not change significantly during cross-examination. This applies equally well to broader and more specific FMHA.

25. *Attribute information to sources*. This principle emphasizes the importance of attributing all information in the FMHA report by specific source(s). This allows the evaluator to describe consistency (or inconsistency) across sources; it also permits the judge and opposing counsel to gauge the credibility of any given information when it is linked to its source. This principle and associated guideline also applies equally well to broader versus more specifically neuropsychological FMHA.

26. *Use plain language; avoid technical jargon*. It is unusual for consumers of FMHA—judges, attorneys, and jurors—to have specific training in the behavioral sciences or applied psychology. For this reason alone, it is clear that the communication of results without technical jargon is

preferable; technical language may have a specific meaning that is quite different from how it might appear. This problem is exacerbated in neuropsychology, where the use of technical language abounds. It may be difficult to communicate neuropsychological findings without some use of technical language. At least, however, the definition of technical terms in a way that laypersons can understand is indicated.

27. *Write the report in sections, according to the model and procedures*. The organization of the report into specific sections can facilitate the demonstration of many of these principles. The following sections have been suggested (Heilbrun, 2001):

- referral (with identifying information concerning the individual, his or her characteristics, the nature of the evaluation, and by whom it was requested or ordered),
- procedures (times and dates of the evaluation, tests or procedures used, different records reviewed, and third-party interviews conducted as well as documentation of the notification of purpose or informed consent and the degree to which the information was apparently understood),
- relevant history (containing information from multiple sources describing areas important to the evaluation),
- current clinical condition (broadly considered to include appearance, mood, behavior, sensorium, intellectual functioning, thought, and personality),
- forensic capacities (varying according to the nature of the legal questions), and
- conclusions and recommendations (addressed toward the relevant capacities rather than the ultimate legal questions).

There are two ways in which a forensic neuropsychological evaluation may need more specific application of this principle. First, as in many of the previous guidelines, the substitution of "neuropsychological symptoms" for the broader "clinical symptoms" will describe the context of forensic FMHA better. Second, there may be an additional section in the report that would facilitate a pre-post comparison that is necessary when the evaluator is assessing the impact of a previous event involving brain trauma on the individual's current and future functioning. Many neuropsychologists use a loosely hierarchical model of cognitive functioning when interpreting test results from attention to executive functioning.

28. *Base testimony on the results of the properly performed FMHA*. The FMHA report should document the substantive basis for an expert's testimony. This allows the referring attorney to present the expert's findings more effectively, the opposing attorney to challenge them, the judge to understand them, and the expert to communicate them. This does not apply differently to broader versus more specifically neuropsychological FMHA.

29. *Testify effectively.* This principle describes both the substantive (covered by the previous principles) and stylistic aspects of expert testimony. Stylistic aspects concern how the expert speaks, dresses, responds to challenges, and otherwise behaves to make testimony clear and credible. When both substance and style of expert testimony are strong, then testimony is maximally effective. This principle also seems to apply equally well to broader and more specifically neuropsychological FMHA.

DISCUSSION

We have considered the applicability of a broad set of FMHA principles (Heilbrun, 2001) to neuropsychological assessment conducted in forensic contexts. These principles and their associated guidelines appear to fit well with more specialized neuropsychological assessment. This can be illustrated in two ways. First, each principle seemed to apply without extensive modification to forensic neuropsychology, and the associated general guideline almost always applied as well. Often it was necessary to elaborate on the general guideline to make the principle fit better, but this elaboration rarely required changes beyond specification of the somewhat different assessment focus. We would conclude, therefore, that these broad FMHA principles apply well to neuropsychological evaluations conducted for judges and attorneys.

This conclusion provides some additional support for the broad applicability of these principles, although clearly detailed analyses of a number of specific populations assessed in FMHA remain to be done. Nonetheless, it now seems clear that these principles

- are not inconsistent with more focused sets of principles in FMHA (e.g., Greenberg & Brodsky, June 2000; Melton et al., 1997);
- can be applied to a broad range of legal questions and forensic issues as illustrated by case reports (Heilbrun et al., 2002);
- can be applied to the population of sexual offenders, a population with a more distinctive pattern of offending, thinking, feeling, and behavior (Heilbrun, 2003);
- can be applied to neuropsychological forensic assessment, which differs in some important ways from both FMHA generally and FMHA with sexual offenders more specifically; and
- can be applied to a single case report to gauge overall quality and identify particular strengths and weaknesses (Heilbrun et al., in press).

American psychology has become increasingly characterized by the development of applied specialty areas in the past decade. In addition to the traditional specialty areas designated by the APA (clinical, counseling, school, and industrial-organizational), APA has formally granted specialty status to behavioral psychology, clinical child psychology, clinical health psychology, clinical neuropsychology, family psychology, forensic psychology, and psychoanalysis within the past decade. There is certainly strength in having diverse areas of specialty within a discipline, yet one of the challenges in this process is to avoid the scientific and applied fragmentation that can occur when common areas are considered by distinctive specialties as if they were not common. Psychological and neuropsychological assessment in legal contexts is a good illustration of this challenge. When an area such as neuropsychology, made distinctive by a particular focus on brain-behavior relationships and measures to capture them, overlaps with forensic psychology, an area that is distinctive in the process of delivering assessment services in legal contexts, there should be important common ground. Using broad principles and specifically adapted guidelines, we have tried to illustrate such common ground in this article.

There are important implications for forensic neuropsychology that can be highlighted by this perspective. First, research on measures that are particularly relevant to forensic neuropsychological assessment (such as cognitive malingering or malingered memory) should continue, expanding beyond such promising tools as the VIP (Frederick, 1997) and the TOMM (Tombaugh, 1997). There is a wide range of functional legal capacities (e.g., competencies) and relevant constructs (e.g., violence risk) that have not been well researched from a neuropsychological perspective. Additional empirical investigation of such areas would strengthen the contributions of the behavioral sciences to the legal system. Second, the training and continuing education of neuropsychological specialists who deliver forensic assessment services would be enhanced by attention to the process of such assessment in legal contexts that is described by these principles. Expertise in neuropsychology is insufficient; expertise in forensic neuropsychology is also needed. Third, it seems possible to make a reasonably informed judgment about the quality of any given forensic neuropsychological assessment by applying these broad principles. This could have a dual impact, promoting assessment with careful attention to the forensic process as well as neuropsychological substance and informing primary consumers, such as judges and attorneys, about the differences between stronger and weaker evaluations. If any of these three consequences of applying broad principles to forensic neuropsychological assessment had the ultimate effect of making better informed legal decisions, the disciplines of law and of psychology would each be strengthened, and our society would benefit directly.

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