Psychological Evaluations for the Courts:

Applying Forensic Evaluation Methods to Transfer Cases

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Introduction: The following sections summarize the basic steps and principles[1] involved in conducting *any* forensic mental health evaluation. The application of these principles to the specific case of Juvenile Transfer is described, and psychological research relevant to juveniles retained in the juvenile system versus those transferred to the adult system is reviewed. Finally, a list of recommended reading and other sources of information are included.

I. Defining the Referral Questions

The mental health clinician is informed of the relevant statutes, case law, and other criteria considered by the legal decision makers.

In North Carolina, the criteria for consideration of transferring a case to superior court is summarized in N.C.G.S. § 7B-2203(b), which states, "In the transfer hearing, the court shall determine whether the protection of the public and the needs of the juvenile will be served by transfer of the case to superior court and shall consider the following factors:

(1) The age of the juvenile;
(2) The maturity of the juvenile;
(3) The intellectual functioning of the juvenile;
(4) The prior record of the juvenile;
(5) Prior attempts to rehabilitate the juvenile;
(6) Facilities or programs available to the court prior to the expiration of the court's jurisdiction under this Subchapter and the likelihood that the juvenile would benefit from treatment or rehabilitative efforts;
(7) Whether the alleged offense was committed in an aggressive, violent, premeditated, or willful manner; and
(8) The seriousness of the offense and whether the protection of the public requires that the juvenile be prosecuted as an adult."

[1] For additional principles, see K. Heilbrun's Principles of Mental Health Assessment (2002) and Heilbrun, Marczk, & DeMatteo (2002)

Kent v. U.S. (1966): The determinative factors which will be considered by the Judge in deciding whether the Juvenile Court's jurisdiction over such offenses will be waived are the following:

1. The seriousness of the alleged offense to the community and whether the protection of the community requires waiver.

2. Whether the alleged offense was committed in an aggressive, violent, premeditated or willful manner.

3. Whether the alleged offense was against persons or against property, greater weight being given to offenses against persons especially if personal injury resulted.

4. The prosecutive merit of the complaint, *i.e.,* whether there is evidence upon which a Grand Jury may be expected to return an indictment (to be determined by consultation with the United States Attorney).

5. The desirability of trial and disposition of the entire offense in one court when the juvenile's associates in the alleged offense are adults who will be charged with a crime in the U.S. District Court for the District of Columbia.

6. The sophistication and maturity of the juvenile as determined by consideration of his home, environmental situation, emotional attitude and pattern of living.

7. The record and previous history of the juvenile, including previous contacts with the Youth Aid Division, other law enforcement agencies, juvenile courts and other jurisdictions, prior periods of probation to this Court, or prior commitments to juvenile institutions.

8. The prospects for adequate protection of the public and the likelihood of reasonable rehabilitation of the juvenile (if he is found to have committed the alleged offense) by the use of procedures, services and facilities currently available to the Juvenile Court.

Clinical Research: In addition to statutes and case law, consideration should be given to what social science research indicates is considered in transfer cases.

1. Based on a national survey of U.S. Statutes on juvenile transfer, Heilbrun, Leheny, Thomas, &Huneycutt (1997) identified four factors that are specified as relevant to the functioning of juveniles and the consideration of transfer:

    - Treatment needs and amenability (39 states, DC, & federal)
    - Risk assessment of future criminality (30 states & DC)
    - Offense characteristics (22 states)
    - Presence of mental retardation or mental illness (10 states & DC)

2. Judges and psychologists have also been asked to rate specific constructs important to decision making about transfer (theoretically; not in an actual or hypothetical case, Salekin, et. al., 2001 & 2002). In general, both groups rated the following as important:

    - Dangerousness (rated highest for judges and child psychologists)
    - Amenability to treatment (rated highest for forensic diplomats)
    - Sophistication-maturity

3. Researchers have also examined the actual *weight* judges place on three specific criteria (dangerousness, sophistication-maturity, and amenability to treatment) *in a hypothetical case* (Brannen, et. al., 2006):

    - Juveniles high in dangerousness and sophistication-maturity but low in amenability to treatment were most likely to be transferred.

    - Juveniles low in dangerousness, sophistication-maturity, and high in amenability to treatment were least likely to be transferred.

    - Of all three constructs, dangerousness had the greatest impact.

    - Judges like assessing transfer on a case-by-cases basis, as well as the use of psychological evaluations in making the determinations; however, there were complaints that some reports seem to "only parrot back the social history" or to use excessive "statistical or psychological jargon…"

II. Determining the Scope of the Evaluation

The mental health clinician determines the legal criteria that are relevant for consideration in a forensic mental health assessment.

Before determining *how* a construct can be assessed, the clinician must determine the appropriateness of the construct. In other words, certain legal criteria are *issues of fact* (e.g., age of the juvenile, prior record of the juvenile) and others are "*questions beyond the scope of clinical forensic expertise"* (e.g., the impact of the offense on the community). Neither of these areas can be formally "assessed," per se; however, they are not ignored as they are "important for the assessment of legally relevant capacities and behavior that are addressed by the evaluation" (Heilbrun, Marczk, & DeMatteo, 2002).

Based on a review of the NCGS § 7B-2203(b), the following criteria are viewed as directly relevant and appropriate for psychological assessment in transfer cases:[2]

1. Intellectual functioning
2. Maturity (and, according to *Kent*, sophistication)
3. Prior attempts to rehabilitate the juvenile
4. The likelihood that the juvenile would benefit from treatment/ rehabilitative efforts

Further consideration as to the implications of two additional criteria suggest some relevance in terms of assessing risk of dangerousness and treatment amenability:

5. Age
6. Prior delinquency history

Although *issues of fact*, these criteria provide mental health clinicians with useful information. Age, for example, is a static predictor of recidivism among juveniles who have prior records, with those who are younger at the age of first offense at increased risk of offending (Cottle, Lee, & Heilbrun, 2001).

[2] *Kent* is not used as a model for mental health evaluations because it is not specific to NC and because some of the criteria are even less relevant to mental health expertise (e.g., prosecutive merit of the case).

Likewise, there is a different level of risk associated with juveniles with no prior delinquency history versus those with many prior offenses or with specific types of prior offenses.

The final two criteria are much more complicated in that they are based on a determination of public decency, morality, and a balancing of the juvenile's needs versus those of the public. In addition, these criteria require some degree of finding of adjudication/guilt:

7. The seriousness of the offense and whether the protection of the public requires that the juvenile be prosecuted as an adult.

8. Whether the alleged offense was committed in an aggressive, violent, premeditated, or willful manner.

Above all, these determinations are matters for the courts and not within the scope of mental health expertise. Simply put, it is not within the realm of clinical opinion for a mental health professional to comment on ultimate legal issues.

These concerns highlight one complicating factor in the evaluation process: "The Dilemma of the Alleged Offense," which has been described and addressed by Thomas Grisso in his book, *Forensic Evaluations of Juveniles* (1998). The following sections summarize information described by Grisso (1998):

- Can evaluators always have access to information about the alleged events?

  In transfer evaluations, information about the juvenile's role (or lack thereof) in the alleged offense may not be available to evaluator, either because the defendant actually did not engage in the act(s); the defendant was involved but for a variety of reasons denies any involvement in the events; or the examiner is not allowed to discuss the events by the court and/or defense attorney.

- Is information about the alleged events really relevant?

  Information pertaining to the alleged offense may be relevant to mental health professionals' determination of dangerousness and treatment needs/ amenability. For example, one important factor in predicting or making estimates of future violence/delinquent behavior is the circumstances of the offense. The prediction of future behavior depends, in part, on an

assessment of how, with whom, and for what reasons the past behavior occurred.

If the juvenile actually committed the act and discloses that information to the evaluator, then the seriousness of the offense is indirectly related to the evaluation in that certain components of the act can influence a clinician's opinion about "criminal sophistication," risk of dangerousness, and amenability to treatment. For example, a different set of risk factors emerge from a defendant who takes a leadership role, who spends a lot of time planning and preparing for the case than one who has a limited role in the act or who is forced or otherwise coerced into becoming involved.

- How can clinicians weigh the significance of an offense for the prospect of future delinquency/violence when they cannot learn from the defendant whether the offense occurred or, if it did, how it occurred, in what social circumstances, and with what thoughts and motivations?

  Sometimes the alleged offense is one that the defendant has engaged in repeatedly in the past. Therefore, one strategy is to use information about past behaviors to make inferences about how the present offense may have occurred. However, clinicians should clearly state the limits on their confidence!

  In some cases information from relatives and friends might be able to describe characteristics of the youth on the day in question, including emotional states, intoxication, or behavior suggesting mental illness. Then, the evaluator could make inferences about the circumstances under which certain behavior are more (or less) likely to occur.

  HAVING SAID ALL OF THAT: using inferences of this sort is very dangerous and any "conclusions" based on these inferences is not great. Therefore, mental health professionals may wish to describe interpretations as *possibilities* and highlight the following facts:

  - Different conclusions could be reached with the same data (it is even better to list a range of possibilities that could be reached with the data so that they no one sticks out as being more probable)
  - If additional information were provided, the examiner may reach a different opinion
  - Estimates of future risk should rely more heavily on factors with known validity (e.g., past behaviors, personality) rather than on inferences about the alleged offense.

- Cottle: estimates of risk should be based on multiple types and sources of information, not solely one event (e.g., the alleged offense) or source (e.g., defendant).

III. Translating Legal Standards to Evaluation Objectives

The mental health clinician translates legal criteria to psychological constructs and develops a plan of action for assessing those constructs.

Once a determination is made as to *what* legal criteria can and should be assessed, the clinician then determines how to define and assess those constructs. For Juvenile Transfer cases, legal constructs are defined and assessed as follows:

1. Age: Current age and age at the time of the alleged offense

2. The intellectual functioning of the juvenile

    - Refers to "the ability to adjust or adapt to the environment, the ability to learn, or the ability to perform abstract thinking" (Sattler, 1992).

    - From a broader perspective, intelligence encompasses the juvenile's ability to interact with the world effectively, which involves not only an assessment of "intelligence" but also the ability to apply capacities to real-life situations, such as at home and school. Therefore, an assessment of related domains, such as adaptive functioning and academic achievement, is also important.

    - Intellectual (and related) functioning can be assessed through:

        a. Individually administered test of intelligence (Wechsler Intelligence Scale for Children);
        b. Tests of academic achievement (e.g., Wide Range Achievement Test);
        c. Measures of adaptive functioning
        d. Academic records;
        e. Interviews with others (e.g., teachers, parents)

- The evaluator should investigate records regarding the juvenile's prior functioning. If there has been a substantial change in functioning (i.e., significant drop in IQ), then that may raise hypotheses as to the juvenile's history (e.g., head injury), as well as about his/her behavior, treatment needs/amenability, and risk for delinquency.

3. The maturity of the juvenile

   - Refers to cognitive maturity (intelligence, as described above); emotional maturity (e.g., ability to understand and regulate emotions), as well as the ability to consider consequences (short and long-term), decision-making skills, and practical knowledge for survival (e.g., "street smarts").

   - Can be assessed through

     a. Intellectual testing

     b. Personality testing, which may provide hypotheses regarding the juvenile's capacity for emotional regulation, understanding of self in relation to others, and ability to organize thoughts coherently.

     c. Interviews with the juvenile and adults in order to determine the juvenile's level of maturity, both in comparison to other adolescents and with respect to juveniles already within the juvenile justice system. The evaluator may investigate such factors as:
        i. level of autonomy,
        ii. sense of identity,
        iii. capacity for and level of moral reasoning
        iv. understanding of behavioral norms, and
        v. decision making capacities[3]

     d. Completion of the Risk-Sophistication-Treatment Inventory (RSTI, described below), which assesses "maturity-sophistication" and provides a distinction between "prosocial" and "antisocial" sophistication (i.e., *how* a

[3] Not an exhaustive list

juvenile's level of maturity and sophistication is *applied* in the real-world).

4. Prior record of the juvenile

    - Refers to past involvement in delinquent acts, as well as the role the juvenile had in those acts (e.g., leader, follower, coerced)

    - Indirectly refers to risk for future delinquency/violence and treatment amenability.

    - Can be assessed through

        a. Review of delinquency record, including current detention records

        b. Interviews with juvenile and others to learn
            i. the circumstances under which any past behavior began or persisted;
            ii. if there were environmental or other factors (e.g., onset of mental illness) precipitating involvement in delinquent behaviors
            iii. any time periods during which there was little or no involvement in delinquent behaviors and why

        c. Interviews to determine the juvenile's
            - past behavior;
            - history of substance use;
            - peer relationships and nature of community;
            - family functioning,
            - social stressors/support;
            - personality traits;
            - mental illness, if present;
            - opportunity for future delinquency; and
            - future residence (Grisso, 1998)

d. Formal risk assessment instruments (e.g., Youth Level of Service/Case Management Inventory; see Psychological Tests, below)

Note that statements regarding risk are explained in terms of *estimates*, not predictions.

5. Prior attempts to rehabilitate the juvenile

- Relevant to treatment needs/amenability

- Refers to any prior counseling, mental health treatment, substance abuse rehabilitation, vocational training, and academic and prevention programming (e.g., mentoring) in which the juvenile has participated.

- Can also refer to involvement in extra-curricular activities, community programming (e.g., YMCA, girl scouts) and current school and detention records.

- Can be assessed through

  a. Self report of the juvenile to determine
     - The juvenile's reported motivation for treatment in the past and currently
     - If the juvenile has developed an attachment with another caregiver or treatment provider in the past

  b. Interviews with caregivers to determine
     - Different perspective as to the juvenile's response to treatment and possible motivation
     - The caregiver's capacity to assist in treatment

  c. Records (treatment, school, camp, etc…) and interviews with teachers and treatment/intervention personnel to describe what has or has not been attempted or effective in the past, as well as to identify potential sources of treatment and interventions in the community.

6. Facilities or programs available to the court prior to the expiration of the court's jurisdiction under this Subchapter and the likelihood that the juvenile would benefit from treatment or rehabilitative efforts;

    - Refers to the treatment needs and amenability

    - Can be assessed through

        a. A determination of any mental health diagnoses, including mental retardation, learning disabilities, and substance abuse or dependency
            - Clinical interviews
            - Record review and interviews with others
            - Personality/Psychopathology Testing

        b. A determination of familial and other social-environmental factors that may influence the juvenile's level of risk and treatment amenability (e.g., family discord, criminality among parents versus supportive, involved caregivers)
            - Clinical interview
            - Interview/observation of family
            - Interview of school personnel, therapists, mentors, and other adults

        c. Knowledge of the research pertaining to treating juveniles in the juvenile justice system (see Research, below);

        d. Knowledge of the North Carolina Juvenile Justice System, or the ability to determine the programs available in the community and within the Department of Juvenile Justice

versus those available within the Department of Correction[*s*].

e. Knowledge of the time available to the juvenile system to accomplish the rehabilitative goals (Grisso, 1998).

7. Whether the alleged offense was committed in an aggressive, violent, premeditated, or willful manner;

8. The seriousness of the offense and whether the protection of the public requires that the juvenile be prosecuted as an adult

    - Indirectly refers indirectly to risk of dangerousness.

    - The mental health clinician should discuss with the attorney whether or not s/he can talk with the juvenile about his/her version of events *before* the evaluation begins.

    - Risk of dangerousness (in terms of *estimates*, not predictions) can be assessed through

        a. Knowledge of research regarding delinquency, more generally, as well as for first-time offenders and recidivism among repeat offenders (see Research, below);

        b. An understanding of the *time frame* in discussing the risk level;

        c. An understanding that different offenses have different risk factors (e.g., sex offenders, female offenders)

        d. Interviews to determine the juvenile's past behavior; history of substance use; peer relationships and nature of community; family functioning, social stressors/support; personality traits; mental illness, if present; opportunity for future delinquency; and future residence (Grisso, 1998)

e. Formal assessment/testing of risk level (e.g., Youth Level of Service/Case Management Inventory, see section on Psychological Tests, below)

IV. Issues that May Arise During the Evaluation Process

The mental health clinician maintains communication with the referral source and makes changes to the evaluation objectives and process as necessary.

A. Additional evaluation questions: Over the course of the evaluation, a mental health clinician may become aware of or suspect that a juvenile lacks certain legal capacities (e.g., to stand trial, to waive *Miranda* rights). With ongoing communication with the attorney, the clinician can recommend or question the attorney about the relevance of these issues in the preparation of the case.

B. Unhelpful Information is uncovered: Sometimes juveniles will provide conflicting or outright "harmful" information about the case. It is also possible that as the evaluation progresses the evaluator begins to form an opinion that would not be helpful in the case. Therefore, it is crucial that mental health professionals inform the attorneys of all information that is gathered, as well as how that information influences the forensic opinion.

C. Conflicts of Interest: When a mental health clinician becomes aware that there is an actual or potential conflict of interest – or when the clinician's objectivity is otherwise compromised – then the clinician must inform the attorney of those conflicts.

V. Overview of Psychological Tests That May be Used in Transfer Cases

The mental health clinician utilizes valid, reliable, and generally accepted methods of accessing constructs. Whenever possible, the mental health clinician uses multiple methods for assessing and describing constructs.

Although it may be tempting for mental health clinicians (and judges and attorneys) to rely solely on the results of the types of assessment tools described

in the following sections, care must be taken to remember that a more comprehensive evaluation requires consideration of a multitude of factors measured or assesses through multiple measures and methods.

A. Measures of Intelligence, Adaptive Functioning, and Academic Achievement

Intellectual Functioning: The most widely used intelligence test is the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV). The WISC-IV provides information about a juvenile's functioning in four areas: verbal ability; nonverbal reasoning and spatial abilities; processing speed; and working memory. Adaptive Functioning: Adaptive behavior can be measured with a number of tools (e.g., Vineland Adaptive Behavior Scales), which are used to determine if a person meets criteria for Mental Retardation. Information about a juvenile's adaptive functioning is also relevant to a determination of treatment needs.

Academic Functioning: There are a number of different ways to measure academic achievement, ranging from very brief screening tools to rather extensive assessments (e.g., Woodcock Johnson). The Wide Range Achievement Tests provide a relatively brief but thorough assessment of a juvenile's achievement in Spelling, Reading, and Mathematics. Practically, a measure of reading ability ensures that the juvenile has the requisite skills to complete other tests (e.g., PAI, which has a 4th grade reading level). In terms of the evaluation, a measure of academic achievement allows for the diagnosis or ruling-out of learning disabilities, which will guide decisions about treatment needs.

B. Personality Testing and Measures of Psychopathology, Behavioral Disturbance, and Substance Abuse: There are hundreds of different personality tests. The most widely used *comprehensive assessment instruments*[4] include the Minnesota Multiphasic Personality Inventory, Adolescent Version (MMPI-A); the Personality Assessment Instrument, Adolescent Version (PAI-A); the Diagnostic Interview Schedule for Children; and the Millon Adolescent Clinical Inventory. These instruments assess a number of psychological constructs and personality traits. Some have scales describing the juvenile's response style, which can be helpful in establishing the juvenile's attitude and motivation during the evaluation.

Other instruments are also available to assess specific areas, such as a particular disorder or problem area (e.g., substance abuse, anger, aggression). These

[4] See T, Grisso, G. Vincent, & D. Seagrave's *Mental Health Screening and Assessment in Juvenile Justice* (2005) for a more complete review of instruments used in the juvenile justice system.

instruments are good *supplements* to the more comprehensive instruments described above but may not always include an index of the juvenile's response style. In addition, these scales will vary in their utility and psychometric properties, and mental health clinicians should be able to demonstrate that the scales meet the standards for admissibility in court.

C. Measures of Effort or Malingering: Adolescents do not seem to make as many attempts to malinger or feign mental illness as adults. And, when they do, they are usually not as effective as adults in appearing more impaired (T. Grisso, personal communication, December 2005). It is perhaps for this reason that there are not many scales designed specifically to measure effort or malingering among adolescents.

Some general personality measures (e.g., MMPI-A, Millon Clinical Multiaxial Inventory, PAI) have scales of embedded in them to assess response style and profile validity. In addition, there are some basic interview techniques and means of assessing test-taking effort available to clinicians assessing adolescents.[5]

Mental health clinicians should be aware of the possibility that juveniles involved in the legal system may exaggerate or fabricate symptoms. As a matter of routine, some measure or other assessment of effort should be conducted in *every* case. This will (hopefully) increase the validity of the findings and opinions, as well as preempt challenges during cross-examination.

D. Measures of Risk of Delinquency and Violence: There are a variety of tools available designed to help clinicians develop opinions and make estimates about a juvenile's risk for future delinquent acts, as well as for other specific types behaviors (e.g. , violence, sexual offending). Some of these instruments are unstructured assessment tools that rely more on "clinical judgment" while others are "actuarial assessments," which contain empirically derived items that are scored according to some algorithm to produce a judgment about the likelihood of some event (e.g., violence; Grisso, et al., 2005). Both types of tools have strengths and weaknesses (e.g., clinical judgment tools lack explicit criteria in and actuarial assessments rely almost solely on certain "static" variables, such as age). As described by Grisso, et al. (2005), a new approach is emerging that involves

[5] See J. McCann's *Malingering and Deception in Adolescents: Assessing Credibility in Clinical and Forensic Settings* (1998).

the use of "structured professional judgments," which allows for the use of both methods in forming opinions about risk level.

The Washington State Juvenile Court Assessment (Barnoski & Markussen, 2004) is a tool designed to determine a juvenile's risk of reoffending by identifying specific risk and protective factors, as well as a case management approach to reduce risk level. The tool assesses components falling in thirteen domains: criminal history, demographics, school, use of free time, employment, relationships, family, alcohol/drugs, mental health, attitudes/behavior, aggression, skills, and sex offender status. Several states have formally adopted the tool.

The Youth Level of Service/Case Management Inventory (YLS/CMI, Hoge & Andrews, 2002) is a standardized inventory that assesses factors associated with risk of recidivism, as well as need factors that assist in case management. The instrument can be completed by court counselors, probation officers, or other trained individuals with an interview and file review.

Other instruments have been developed for very specific populations, such as individuals under the age of 12 years (Early Assessment Risk List for Boys and Girls, Augimeri, Koegl, Webster, & Levene, 2001) or for specific types of outcome variables, such as violence (Structured Assessment of Violence Risk in Youth, SAVRY; Bartel, Borum, & Forth, 2003). These instruments may be relevant, depending on the details of the case.

E. Specific Forensic Instruments:

The Risk/Sophistication/Treatment Amenability Instrument (RSTI; Salekin, 2004) is a semistructured interview and rating scale used to assess functioning of adolescents in the juvenile justice system (aged 9-18 years) in three areas: risk for dangerousness, sophistication-maturity, and treatment amenability.

Risk for dangerousness refers to the likelihood of committing future acts of violence or recidivism and measures such factors as "violent and aggressive tendencies, planned and extensive criminality, and psychopathic features."

Sophistication-maturity refers to emotional and cognitive maturity and measures such factors as autonomy (locus of control/dependency on others, self concept); ability to delay gratification, emotional regulation, moral development, interpersonal skills, and a number of cognitive capacities (decision making capacities, awareness of wrongfulness). A "valence" can be assigned to sophistication such that a juvenile can be viewed as mature and sophisticated but

still apply that maturity and sophistication in an antisocial manner (i.e., the criminally sophisticated). Alternatively, a juvenile can be mature and sophisticated in a more prosocial manner, which could be seen as a positive predictor of success in treatment.

Treatment amenability refers to the likelihood of the juvenile responding positively to treatment and measures the degree and type of psychopathology; responsibility and motivation to change; and consideration and tolerance of others.

VI. Applying Psychological Research

The mental health clinician has an up-to-date knowledge of research relevant to the forensic issues of the case and is able to apply that research appropriately.

A. Treatment Amenability

- Change is associated with discomfort, which can be exhibited in a variety of ways (e.g., depression, anxiety, physical symptoms, anger).

- "Remorse" is difficult to translate in terms of predicting rehabilitation. For example, some individuals can appear rather remorseful but actually do not experience any feelings that would motivate change while others – who do not appear particularly remorseful – may have strong feelings of guilt/shame that are repressed and may be uncovered (Grisso, 1998).

- The juvenile's capacity to form an attachment with an adult is important to the therapeutic process. Included in "attachment" are such factors as a desire for acceptance; concern about an adult's approval/disapproval and developing trust with another adult.

- Long term behavior problems are more difficult to treat.[6]

- Strong family support and encouragement improves the likelihood that rehabilitation efforts will be successful

[6] See distinction between "adolescent-limited" and "life course persistent" distinctions as described by T. Moffitt in Adolescent-limited and life-course-persistent antisocial behavior: A developmental taxonomy. Psychological Review, 100, 674-701, 1993.

B. Risk of Future Delinquency/Harm to Others (Grisso, 1998; Grisso, 2000)

Past Behavior:

- Younger age of onset of aggression is associated with increased risk
- More recent and frequent incidents of aggression increases risk
- Youths who are "under-controlled" (impulsive) in their acts of violence or aggression are troublesome; however, the "under-controlled" youths are less predictable and more difficult in terms of estimating risk.
- There appears to be little association between seriousness of a violent act and subsequent risk for future harm.

Substance Use

- Substance use can increase the likelihood of increasing violence; however, it is important to consider the relation substance use has (if any) on any given act of delinquency/violence (it is possible that a juvenile *never* engages in violence while high)

Peers and the Community

- Youths associating with delinquent peers, including gangs, are at increased risk of violence.

Family Conflict and Aggression

- Current family conflicts could increase stress levels and anger, which could result in more aggression/acting out.
- Those who have been victims of abuse are at greater risk of engaging in violent behaviors.

Social Stressors/Supports

- Acute stressors (pending divorce, deaths) could add to the stress and increase the risk of aggression.
- Risk level may be mitigated for youths who have significant social supports.

Personality Traits

- Anger, impulsivity, and lacking in empathy are associated with an increased risk for violence.

Mental Illness

- We do not know if youths with mental disorders are more likely than other youths to engage in violent behaviors.
- Youths with depressive disorders (and perhaps PTSD) frequently display anger, irritability, and demandingness – those youths who have histories of aggression – are at increased risk of violence.
- Youths with ADHD are at increased risk for violence, perhaps due to deficits in self-constraint or over-responsivity to the environment.

C. Factors Associated with Recidivism among Adolescents

Among juveniles *with prior involvement* in the juvenile system, the following variables have been found to be predictive of general recidivism (Cottle, C., Lee, R., & Heilbrun, 2001)[7]:

- Demographic Information
  - Male gender
  - Low socioeconomic background
  - After controlling for SES, race was no longer significant

- Offense History*
  - Younger age at first contact with the law and at commitment (strongest)
  - Number of prior arrests
  - Number of commitments
  - Those with longer incarcerations
  - Seriousness of prior offenses

- Family and Social Factors*
  - History of physical or sexual abuse
  - Raised in a single family home
  - Have more out-of-home placements
  - Presence of significant family problems
  - Ineffective use of leisure time
  - Association with delinquent peers
  - Note: parental pathology was not a significant predictor

[7] See Heilbrun, Lee, & Cottle (2005) for a review of predictors of sexual recidivism and violent recidivism.

- Educational Factors
  - History of special education
  - School attendance and reports of academic achievement were not predictive

- Intellectual and Achievement Scores
  - Lower standardized reading scores
  - Lower Full Scale & Verbal Scale IQ (not Performance IQ)

- Substance Use History
  - Substance abuse (but not use)

- Clinical Factors
  - History of conduct problems
  - History nonsevere pathology
  - A history of severe pathology or a history of psychiatric treatment was not predictive
  - Formal risk assessment scores

D. Effects of Interventions on General Recidivism

Treatment of juveniles involved in the juvenile justice system has repeatedly been shown to be effective. The following treatment characteristics have been found to be associated with a lowered risk of recidivism (Heilbrun, et al., 2005):

- Juveniles receiving treatment were less likely to recidivate
- Behavioral treatments are typically superior to other types of treatments (e.g., psychodynamic)
- Contingency management, family therapy (particularly multisystemic and functional family therapy), and cognitive behavioral therapy were among the most successful in reducing recidivism
- More structured and focused treatments and multimodal treatments were more effective than less structured and focused approaches.
- Deterrence interventions (scared straight) produced negative treatment effects

E. Effects of Transfer on Juveniles[8]

Based on research conducted through the MacArthur Foundation (see website):

- Adolescents incarcerated in adult facilities are more likely to be re-arrested and to be re-arrested earlier, more frequently, and for more serious crimes
- These findings are greatest for those with no prior arrest record who were prosecuted and sentenced as adults
- Only for drug offenses are youths in adult court less likely to be arrested.

In a related study, researchers compared the correctional experiences of adolescents placed in juvenile versus adult correctional facilities from 2000-2001. The results suggest clear differences in the therapeutic and service contexts of each of these settings:

- Youths placed in adult correctional settings reported significantly weaker correctional climates along four critical dimensions: fairness, counseling and therapeutic services, educational and job training services, and program structure, compared with matched groups of youths placed in juvenile facilities.

- At the same time, the juvenile facilities were more chaotic. Adolescents in the juvenile programs reported higher rates of witnessing violence and violent victimization. They also reported higher rates of involvement in several types of crimes while incarcerated as well as more drug use.

- Despite these unruly settings, they reported greater feelings of safety compared with youths placed in adult settings. This paradox may reflect the social networks that were dominant in the two different types of placements: older criminal offenders in more organized prison gangs were the dominant social group in the adult facilities, compared to the loosely organized groups of peers that populated the juvenile facilities.

- This greater sense of danger, then, perhaps explains the higher rates of mental health problems reported by youths in the adult facilities

[8] See also McGowan, et. al. (2007). Effects on Violence of Laws and Policies Facilitating the Transfer of Juveniles from the Juvenile Justice System to the Adult Justice System: A Systematic Review. Am. J. Prev. Med 32 (4S).

- Mental health symptoms of youths in adult corrections were significantly worse on two dimensions of mental health functioning compared with rates reported by youths in juvenile facilities.
- The same youths also reported higher rates of post-traumatic stress disorder.

The Campaign for Youth Justice (November, 2007) also provides a summary of research related to adolescents in adult facilities:

- Adolescents in adult facilities do not get the programming they need.
- There are increased rates of mental illness, suicide, isolation, and sexual assault.

VII. Practical Issues

A. Ex Parte Motion

B. Records: Oftentimes a review of records prior to meeting the juvenile can help set the parameters and purposes of the initial encounters with the juvenile. A review of all pertinent records help the clinician remain objective and prevents embarrassing surprises during testimony. Records most likely to be requested by the clinician include:

1. Juvenile Petition(s)
2. Delinquency History (if applicable), including past successes/failures in juvenile system.
3. Academic Records, including grades, description of conduct, formal testing, record of suspensions/expulsions.
4. Mental Health Evaluations and Treatment Records.
5. Medical Records, particularly if there is a history of abuse/neglect, head trauma, or other neurological impairment(s).
6. Department of Social Services records, if they can be obtained.

7. Other types of interventions: substance abuse, mentoring programs, community service involvement

C. Detention/Jail Letters

D. Maintain Communication: It is often helpful to have ongoing phone consultations, e-mails, and/or written summaries prepared by the clinician after each encounter with the juvenile; interview of a collateral source; or records review. These communications serve as a means of identifying any problems that may arise and of becoming aware– as early as possible in the process – of the possibility that the results may not be particularly helpful in the case. Therefore, the attorney can "terminate" the relationship when it becomes apparent that the information would not be useful and might even be harmful.

VIII. Communicating the Results

A. Letters, Reports, and Testimony

The mental health clinician effectively communicates results with legal professionals and decision makers.

Methods of Communicating Results:

1. No Written or Verbal Communication: Following the evaluation and prior to the hearing and preparation of any report, the mental health clinician and attorney should discuss the benefits and risks of using the expert; preparing a letter/report; and/or testifying in court.

2. Letters/Reports: Letters are usually brief, approximately 2-4 pages in length; highlight important aspects of the juvenile's history; and it concludes with information relevant to the legal criteria described in N.C.G.S. § 7B-2203(b). Reports are lengthier and provide a more detailed account of the juvenile's history; evaluation process; and description of diagnoses (if any), opinions and recommendations.

3. Testimony: If testimony is required, it may be helpful for the mental health clinician and/or attorney to develop a list of possible questions, including potential cross-examination questions.

Regardless of format, make sure that all the components of the statutes are covered – as well as any other pertinent factors in the case – before submitting the report or calling the expert to testify.

In addition:

- The report/testimony should respond directly to the referral question and legal criteria (see samples);
- Communications should avoid jargon;
- The evaluator should not respond directly to the ultimate legal question directly;
- The evaluator should provide a full description of findings so that they need change little under cross-examination (Heilbrun, Marczk, & DeMatteo, 2002)