

*MENTAL HEALTH ASSESSMENTS
IN THE JUSTICE SYSTEM:
How to Get High-Quality
Evaluations and What to Do
With Them in Court*

American Bar Association Juvenile Justice Center
Juvenile Law Center ! Youth Law Center

Lourdes M. Rosado, Editor

AMERICAN BAR ASSOCIATION JUVENILE JUSTICE CENTER

In 1999, responding to the crisis in juvenile indigent defense, the ABA, in partnership with Youth Law Center and Juvenile Law Center, created the National Juvenile Defender Center (NJDC). NJDC supports lawyers who represent children in delinquency and criminal proceedings throughout the country by improving access to counsel and the quality of representation. In order to develop the capacity of the juvenile defense bar, NJDC offers a variety of services including training, technical assistance, advocacy, networking, and resource and policy development. NJDC and its eight Regional Affiliates work together to provide quality representation for every child involved in the justice system. NJDC will ensure continuity in the development of each Regional Affiliate, coordinate efforts to provide a national voice on quality, access, and policy issues, and serve as a catalyst for change in the defense of children.

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Prepared with support from:

The John D. and Catherine T. MacArthur Foundation

Juvenile Court Training Curriculum

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This curriculum does not necessarily represent
the views of the John D. and Catherine T.
MacArthur Foundation.

This report has not been approved by the
House of Delegates or the Board of
Governors of the ABA.

© June 2000

ISBN *_*****_***_*

Acknowledgments

This multidisciplinary curriculum is the result of much thinking, effort and collaboration by a truly multidisciplinary group of people from around the country. We owe our gratitude to a number of mental health professionals, developmental specialists, social scientists, psychologist and psychiatrists, social workers, special education experts, adult education consultants, juvenile court judges, prosecutors, defenders, and probation officers, all of whom contributed their talent and vast experience to this project.

First, this curriculum would not have been possible without the vision and generous support of the John D. and Catherine T. MacArthur Foundation. We in particular want to thank our program officer Laurie Garduque for her patience and confidence as we strived to create a unique training curriculum. We also are grateful to the MacArthur Foundation for its dedication to promoting so many other projects that will better the lives of those children involved in the juvenile justice system.

We extend many thanks to the experts who conducted our pilot training programs in West Palm Beach, Florida and Oakland, California. They are: Patricia Aguiar, James Bell, Marty Beyer, David Bjorklund, Harriet Brown, Elizabeth Cauffman, Nancy Cowardin, Deborah A. Davies, Delbert S. Elliott, Sheila Foster, James Garbarino, Kirk Heilbrun, Judith Larsen, Melinda Mills, Randy K. Otto, Paul Sayrs, John Shields, Joseph Smith, S. Alex Stalcup, Lee A. Underwood, and Michael Zatopa. We are also indebted to a number of individuals who contributed their research and expertise to the curriculum, including Shelli Avenevoli, James Backstrom, Richard Barnum, Donald Bruce, Pamela Bulloch, Thomas Grisso, Steven Harper, Thomas Hecker, Paul Holland, Amy Holmes Hehn, Randy Hertz, Antoinette Kavanuagh, Richard D. Lavoie, James Loving, Jr., Lee Norton, William F. Russell, Robert E. Shepherd, Laurence Steinberg, and Joseph Tulman. These professionals brought a wealth of knowledge, scholarship and experience to the project that formed the foundation of the curriculum.

We are grateful for the support and participation of juvenile court personnel in West Palm Beach, Florida and Oakland, California, the pilot training sites for the curriculum. They provided us with logistical support and valuable feedback. In particular, we thank the following individuals in West Palm Beach, Florida: the Hon. Richard B. Burk, the Hon. Walter N. Colbath, and the Hon. Hubert R. Lindsay; Joanne Howard from the State Attorney's Office; Barbara Burch from the Legal Aid Society; Barbara White of the Office of the Public Defender; Larry Herndon and Darryl Olson with the Florida Department of Juvenile Justice; Arlene Goodman from the Palm Beach County Courthouse; and Robin Sheppet. And in Oakland, California, thanks go to: the Hon. Martin Jenkins and the Hon. Robert Kurtz; Jack Radisch from the Prosecutor's Office; Sheri Schoenberg and Mary Siegel of the Public Defender's Office; Sylvia Johnson, Chief Probation Officer; Mary Parks, Juvenile Court Administrator; Sandy Lauren and Laurel Prager, County Counsel; and Cliff Baker from the Court Appointed Attorneys Program.

We are also indebted to a number of people who assisted us with the development of a video for use in the module on interviewing young people. Our thanks go to: the staff of the Duke Ellington School for the Performing Arts; the staff of Ritchfield Productions; Kristin Henning, from the Public Defender Service of D.C., who served as our technical consultant on the video; and to Marlon Russ and Bernard Grimm, who were our actors.

No project of this magnitude could ever be completed without the administrative and technical support of staff, paralegals, and many, many interns. We are grateful to the efforts of Kelsi Brown, Angie Crouse, Amy Drake, Debbie Hollimon, Jolon McNeil, Sadie Rosenthal, and especially Joann Viola, who did our graphics design. Our army of college and law school interns

included: Lara Bazelon, Rebecca Bauer, Jack Chu, Tiffany Cox, Cheryl DeMichele, Cheryl Gestado, Hope Hicks, Jennifer Katz, Sang Woo Lee, Eliza Patten, Jennifer Pringle, Eli Segal, Adrienne Toomey, Eric Wolpin, and David Zifkin. Thank you for bringing your energy to this endeavor.

This talented and diverse group of people created a curriculum that we hope will aid juvenile court practitioners in the many difficult decisions they have to make every day, and result in better outcomes for our children and our communities at large.

THE PROJECT TEAM

June 2000

Preface

Background

In 1996, the John D. and Catherine T. MacArthur Foundation funded the Youth Law Center, the Juvenile Law Center, and the American Bar Association Juvenile Justice Center to develop and provide training for juvenile justice professionals around the country. The goal of the project was to develop a training curriculum that applied the findings of adolescent development and related research to practice issues confronted by juvenile court practitioners at the various decision-making stages of the juvenile justice process.¹ The long range objective was to improve the quality of decisions made by juvenile court practitioners.

Two jurisdictions – West Palm Beach, Florida and Oakland, California – agreed to serve as pilot training sites. Project staff worked with juvenile court professionals at both sites and a national advisory committee of practitioners and trainers to identify the training topics. The topics chosen were relevant to adolescent development and related research, unique to juvenile court practice, and typically excluded from professional training curricula.

Over the course of two years, the project sponsored a series of trainings in the pilot sites. The trainings were developed and delivered by experts from all parts of the country. Project staff recruited trainers with specialized knowledge in the relevant subject matter whose expertise was broadly relevant to juvenile court practice. The trainings were cross-disciplinary -- delivering the information to judges, prosecutors, defenders and probation staff at the same time. In both sites, the presiding juvenile court judge set aside specific dates for the trainings, and either closed the courts or lengthened the lunch recess. Most of the trainings were three hours long.

Project staff then created training modules that corresponded to the training topics. The resulting modules incorporate the materials developed by the trainers; supplemental research, literature and training materials; and feedback from the pilot sites. The completed modules were reviewed by a group of professionals with broad expertise in each subject matter.

The Training Modules

The training curriculum consists of six separate modules:

Module One: *Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court*

Module Two: *Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims*

¹The Foundation also launched the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice in 1997. The mission of the Network is to develop new knowledge regarding the assumptions on which the juvenile justice system functions, and to improve legal practice and policy-making with accurate information about adolescent development. For more information about the Network, please consult its website: <http://www.mac-adoldev-juvjustice.org>.

Module Three: *Mental Health Assessments in the Justice System: How To Get High Quality Evaluations and What To Do With Them in Court*

Module Four: *The Pathways to Juvenile Violence: How Child Maltreatment and Other Risk Factors Lead Children to Chronically Aggressive Behavior*

Module Five: *Special Ed Kids in the Justice System: How to Recognize and Treat Young People with Disabilities That Compromise Their Ability to Comprehend, Learn, and Behave*

Module Six: *Evaluating Youth Competence in the Justice System*

The modules were designed for maximum flexibility and broad application. The modules stand alone, so that jurisdictions can use any individual module or any combination of modules. Each module contains extensive information on the topic, which can form the core of the training, as well as a "tool kit" containing interactive exercises, hypothetical cases, video clips and other training tools. The information in the modules is sufficiently general to apply in any jurisdiction. However, the tools can be adapted to make the subject matter relevant to the daily practice of participants in any particular training site. The curriculum also contains an extensive literature review listing materials relevant to the training topics and related subjects. Selected articles can be assigned for reading prior to the trainings, or the literature review can be made available as a general resource.

Project staff also incorporated the advice of adult learning specialists and professional trainers who served as consultants to the project. These consultants recommended that trainers emphasize a limited number of basic concepts in each subject area and actively engage participants in the learning process. Thus, each module contains a list of the major themes to be discussed, and the subsequent information refers back to those main themes. Similarly, the modules contain several interactive exercises to involve the audience in the training process and to draw upon their experiences to illustrate significant points.

How to Use the Curriculum in Your Jurisdiction

Effective use of this curriculum in a local jurisdiction requires an individual or group of people to organize trainings that are tailored to the specific needs of practitioners. It is important to engage practitioners in the planning process from the beginning. Organizers can work with representatives from the relevant professional groups to determine what areas they are interested in covering. This feedback will help organizers decide whether to present the entire curriculum or select individual modules.

Organizers can also ask the participants to recommend potential trainers. Trainers should have expertise and experience in the relevant subject matter. Familiarity with local juvenile court practice is also helpful. However, it is even more important that the trainer be skilled in engaging the audience in the learning process, drawing from their experience and utilizing tools to make the subject matter relevant to daily juvenile court practice. Straight lecture format – even by a learned and interesting trainer -- is not usually an effective method for presenting the material. Potential sources for trainers are local colleges and universities; law schools; local chapters of national organizations, such as the American Psychological Association; and local or state professional organizations and societies. Organizers may also contact the American Bar Association Juvenile Justice Center for suggestions for experts to conduct the trainings.

Organizers can work with trainers to adapt the curriculum to make it relevant to local practice and current issues. Again, consultation with the relevant professional groups is important. For example, a fact pattern in the curriculum may require some changes to accurately reflect state law, local practice and current trends. Similarly, a video clip in the tool kit may present a scenario that is not representative of the issues important to the audience.

Organizers can also decide whether to conduct cross-disciplinary trainings, or to train professional groups separately. There are advantages and disadvantages to each approach. Cross-disciplinary trainings ensure that all of the juvenile court practitioners benefit from the same information. Issues raised and insights gained from the trainings may lead to changes in practice, which will be more successful if there is shared understanding and consensus among juvenile court professionals. Training the professions together also presents the opportunity for lively discussions among practitioners who have different roles and perceptions of the juvenile court process. On the other hand, candid discussion may be less likely with traditional adversaries in the same room. Attorneys or probation officers might also be reluctant to openly discuss local problems in the presence of juvenile court judges. There is also some advantage to tailoring the presentation of information to the specific professional groups because they are likely to use the information differently. Organizers should consult with the professional groups and determine what means of delivering the training best meets their needs and concerns.

Executive Summary

The goal of Module Three is for juvenile court personnel to become better-informed consumers of mental health evaluations. Juvenile court professionals routinely request mental health evaluations to inform critical decisions, such as whether a child is competent to stand trial, his/her mental state at the time of the offense, and what treatment and programming would best serve the child. Often, however, we receive evaluations that are difficult to decipher and raise more questions than they answer. After completing this training, participants will know what they can do to ensure that mental health professionals produce high-quality evaluations that will better aid court personnel in key decision-making.

As a first step, the trainer will “demystify” the mental health field and assessment process. Participants will learn, for example, about the DSM-IV (what does “Axis III” mean anyway?), the appropriate psychological tests for adolescents (and what the tests can and can not tell us), and those mental health disorders that are most prevalent among the juvenile justice system population.

Participants then learn step-by-step guidelines on requesting and reviewing a forensic evaluation, including:

- ! How to assess the qualifications of a mental health professional to conduct the needed forensic evaluation, including whether the evaluator understands the legal question you are trying to answer and the relevant law and psychological factors.
- ! How to write a court order that will guide the evaluator in producing a useful evaluation, including answers to developmental questions (i.e., where is the juvenile in his/her cognitive, moral and identity development and what areas of growth remain?) that are critical for determining a young person’s competence, his/her danger to the community and/or amenability to treatment.
- ! What information and history is most relevant to answering the legal issue at hand.
- ! The minimum contents of a good evaluation.
- ! Criteria for judging the quality of an evaluation, including the degree to which the examiner evaluated relevant mental states, capacities, and knowledge and their relationship to the psycholegal issue to be answered, and the appropriateness and validity of any tests or instruments administered.

Participants acquire information and skills by engaging in a number of interactive exercises, including writing court orders for evaluations, analyzing evaluations, and examining a mental health professional in court. Participants also will receive materials that they can use in their daily practice, such as an outline for assessing the qualifications of a mental health professional prior to hiring him/her and a checklist of developmentally-sensitive questions that an evaluation should answer.

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I. Introduction

A. Goal of this module

The goal of this module is to educate juvenile court personnel on what mental health professionals should be doing when they serve as consultants to the court and how they should be doing it, so that as consultants they produce mental health evaluations that aid court personnel in key decision-making. Participants should leave this training as better-informed consumers of mental health evaluations.

B. Key themes in this module

1. Court personnel have a right to demand a high quality product from the mental health consultant. It is the mental health professional's obligation to ensure that the consumers of the information understand the information and can use it.
2. There are key differences between an evaluation conducted for therapeutic purposes and one conducted for forensic purposes. In general, a therapeutic evaluation is an evaluation voluntarily initiated by the youth or parent for purposes of identifying treatment needs. A forensic evaluation is any evaluation that is done for use in court or to assist decision-makers in a court proceeding.
3. When seeking forensic evaluations, court personnel must be specific about the questions the evaluation is expected to answer and the purposes for which it will be used.
4. There are a number of factors to consider when hiring a mental health consultant. More important than the prestige of a professional's graduate training is his/her experience doing the specific type of juvenile forensic evaluation requested (i.e., is the child amenable to treatment? Is the child competent to stand trial?), familiarity with the key legal issues for which these evaluations are requested, and training in developmental issues.
5. The mere presence of a psychological disturbance does not mean that it is related to the legal issue at hand. The mental health professional has to make the connection. Most psychological tests were developed for therapeutic purposes and not specifically to be used in forensic contexts; therefore, inferences have to be made about how they apply to the question at hand. It is best if legally relevant psychological conditions can be assessed directly by administering tests that were specifically designed to answer the psycho-legal questions at issue. The more inferences an evaluator needs to draw in order to reach a conclusion about a legally relevant condition, the more that red flags should go off in the consumer's mind.
6. Lawyers and judges should generally refrain from attacking the validity or reliability of the findings of a mental health evaluation without consulting a mental health expert because of the technical knowledge involved. "Validity" can refer to "external" or "internal" validity. External validity refers to whether the findings can be generalized beyond the specific sample studies. Internal validity refers to whether the interpretation of the findings is real, or whether there are alternatives that have not been ruled out. Validity can also mean concurrent validity (e.g., in the case of an IQ test, whether it correlates with other established measures of intelligence); predictive validity (whether it predicts things it should predict, like success in school); or face validity (does test on its face measure what it purports to measure).

"Reliability" refers to the accuracy of the instrument, i.e., the confidence one has in the replicability of the test results. For example, an IQ test is reliable because people's scores on it don't fluctuate day to day. One can have a reliable test that isn't valid (e.g., using a measure of head size as a test of intelligence). Each of these concepts has a different meaning and is used for different reasons.

II. Legal Contexts in Which a Mental Health Evaluation May be Indicated

A. Competence to Confess/Waive Miranda Rights

1. Legal Issue (*Miranda v. Arizona*, 1966): was the confession knowing, voluntary & intelligent?
2. Factors that might suggest referral for evaluation:
 - a. youth
 - b. limited intellectual functioning
 - c. poor verbal skills
 - d. difficulty communicating with client
 - e. history of poor academic achievement
 - f. under influence of substances at time of interrogation
 - g. history of emotional and/or behavioral problems
 - h. interrogation in absence of parents if one or more of the above factors exist

Interactive Exercise:

Elicit from participants a list of the different purposes for which they request mental health assessments. Ask participants to describe what is typically said in the order requesting the evaluation, including what information is provided to the mental health professional to guide the evaluation. Trainer will return to this list later in the class to discuss how his/her evaluation – both the methods and tests used to gather and analyze information, as well as the final product delivered to court – would differ depending on the stated purpose for which the evaluation was requested. Trainer will also work with participants on specific language for orders requesting evaluations which will better convey to the evaluator the purpose for which the evaluation is being obtained.

B. Waiver to Adult Court

1. Legal Issue: Whether the child presents a risk to the public and whether he/she shows a likelihood of reasonable rehabilitation (i.e., is the child amenable to treatment)?
2. Factors that might suggest referral for evaluation:
 - a. history of emotional/behavioral problems
 - b. history of violence
 - c. significant delinquency history
 - d. nature of the instant alleged offense
 - e. young age
 - f. history of abuse/neglect

C. Competence to Proceed

1. Legal Issues:
 - a. Is the child competent to stand trial? (Is the client able to consult with his/her lawyer with a reasonable degree of rational understanding, and does he/she have

a rational, as well as factual understanding of the proceedings?-- *Dusky v. U.S.*, United States Supreme Court, 1960)

- b. Is the child competent to enter a plea?
 - c. Is the child competent to be sentenced?
2. Factors that might suggest referral for evaluation:
- a. difficulty communicating with client about the case
 - b. age, in particular for younger adolescents
 - c. limited intellectual functioning
 - d. history of poor academic achievement
 - e. history of emotional/behavioral problems
 - f. being tried in adult court

D. Mental State at the Time of the Offense/Sanity

1. Legal Issue: At the time of the offense was the child's ability to distinguish between right and wrong, or appreciate the nature and consequences of his/her actions, impaired due to mental disease or defect? (Note to trainer: trainer should use the language for the sanity test in his/her jurisdiction.)
2. Factors that might suggest referral for evaluation:
 - a. age, in particular for younger adolescents
 - b. limited intellectual functioning
 - c. history of poor academic achievement
 - d. history of emotional/behavioral problems
 - e. third-party accounts alleging unusual/bizarre/disorganized behavior by the client at or around the time of the offense

E. Disposition/Sentencing

1. Legal Issue: What are the client's treatment and programming needs given his/her involvement in the juvenile justice process?
2. Factors that might suggest referral for evaluation:
 - a. offense committed under influence of substances or history of substance abuse suggested
 - b. history of emotional/behavioral problems
 - c. history of abuse/neglect
 - d. history of poor academic achievement
 - e. limited intellectual functioning
 - f. history of violence

III. De-mystifying Mental Health Assessments

A. Professions and Their Distinctions

1. Psychiatrists (MDs/Doctors of Osteopathy) are physicians and the focus of their training is on psychopathology and its treatment. They are authorized to prescribe medication. They have a particular expertise with respect to: distinguishing physical disorders with emotional manifestations from psychiatric disorders, psychopharmacological treatment, and neurological impairment.
2. Psychologists (PhDs/PsyDs) are doctoral level psychologists and the focus of their training is assessment and treatment of psychopathology. They have a particular expertise with respect to: psychological testing and standardized assessment of psychopathology, intellectual functioning, behavioral functioning, academic achievement, and verbal and behavioral therapies and interventions.
3. Clinical Social Workers (MSWs) have masters level social work training and the focus of their training is on assessment and treatment of psychopathology, with an emphasis on social and family systems as they affect the individual. They have a particular expertise with respect to: social and family systems as they affect the individual, and social services and programs available for persons with emotional/behavioral problems.

B. The Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)

1. **Overview:** DSM-IV is a manual published by the American Psychiatric Association. It lists the diagnostic criteria for, and prevalence rates of, mental disorders, which reflect a consensus of those in the field. This is a classification system that aids in the collection of statistical information about mental disorders and in the diagnosis and treatment of those disorders. It is used by psychiatrists and psychologists, and it is routinely accepted by courts.
2. **DSM-IV** is organized to allow for assessment and description of disorders. When psychiatrists or psychologists conduct evaluations and rely on DSM-IV, they classify the disorders that people have, allocating the disorder to five different domains. Each domain is called an "axis." For purposes of juvenile court practitioners, the first two axes are usually the most important.
 - a. **Axis I looks at Clinical Disorders**, which includes Depression, Anxiety Disorders, Schizophrenia, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder. It also includes other conditions that may be a focus of clinical attention, including physical abuse of child, sexual abuse of child, parent-child problems, borderline intellectual functioning.
 - b. **Axis II looks at Personality Disorders**, which are more ingrained, long-standing aspects of a person's personality that are typically not expected to change over time. Children typically should NOT receive personality disorder diagnoses because their personalities are still developing. Examples include antisocial

personality disorder and borderline personality disorder. Also included in Axis II is mental retardation, which may be relevant in many cases.

- c. **Axis III: General Medical Conditions Relevant to Emotional/Behavior Functioning.** Examples include seizure disorder, head injury.
 - d. **Axis IV: Psychosocial and Environmental Problems.** Examples include educational problems, occupational problems, housing problems, and problems related to interactions with the legal system.
 - e. **Axis V: Global Assessment of Functioning (GAF).** The examiner's judgment of the examinee's overall level of functioning ranging from 0 to 100. This information is useful in planning treatment and measuring its impact.
- C. **Disorders by Category.** It is important to note that DSM-IV does not classify people. Rather, it classifies disorders that people have. It is also important to note that one does not give a diagnosis by category, but rather by specific disorder. Note: trainer does not have to go through all of these if time does not permit. Most important to flag those disorders prevalent among children in the juvenile justice system. (See Note following #15, next page.)
1. Disorders usually first diagnosed in infancy, childhood, or adolescence. Examples include: Mental Retardation, Learning Disabilities, Attention-Deficit and Disruptive Behavior Disorders, Pervasive Developmental Disorders.
 2. Delerium, Dementia, and Amnestic and other Cognitive Disorders.
 3. Substance-related Disorders. Examples include: Alcohol Dependence or Abuse, Cocaine Dependence or Abuse, Polysubstance Dependence.
 4. Schizophrenia and other Psychotic Disorders. Examples include: Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder.
 5. Mood Disorders. Examples include: Major Depressive Disorder, Bipolar Disorder-Manic, Dysthymic Disorder.
 6. Anxiety Disorders. Examples include: Panic Disorder, Posttraumatic Stress Disorder, Obsessive-Compulsive Disorder.
 7. Somatoform disorders. Examples include: Pain Disorder, Hypochondriasis, Somatization Disorder, Conversion Disorder.
 8. Factitious Disorders.
 9. Dissociate Disorders. Examples include: Dissociative Identify Disorder, Dissociative Amnesia.
 10. Sexual and Gender Identify Disorders. Examples include: Gender Identity Disorder of Childhood or Adolescence, Exhibitionism, Voyeurism, Pedophilia.

11. Eating Disorders. Examples include: Anorexia Nervosa, Bulimia Nervosa.
12. Sleep Disorders. Examples include: Sleep Terror Disorder, Nightmare Disorder, Primary Insomnia.
13. Impulse Control Disorders. Examples include: Pyromania, Tricotillomania, Kleptomania.
14. Adjustment Disorders. Examples include: Adjustment Disorder with Depressed Mood, Adjustment Disorder with Anxiety.
15. Personality Disorders (TYPICALLY NOT DIAGNOSED UNTIL AGE 18 OR ABOVE). Examples include: Antisocial Personality Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder.

(Note to trainer: In reviewing the above disorders, pay particular heed to those that are most prevalent in delinquency populations: **Conduct Disorder, Attention-Deficit/Hyperactivity Disorder, Substance Abuse and Dependence, Affective disorders, and Posttraumatic Stress Disorder.**)

D. **The Conduct Disorder Diagnosis in Juvenile Delinquency Cases.** Thomas Grisso, in *Forensic Evaluations of Juveniles* (1998), pays particular attention to diagnosis of Conduct Disorder. Because the prevalence of Conduct Disorder as a diagnosis in delinquency cases is so high, trainers should alert the class to the following three pitfalls, cited verbatim, that are identified by Grisso:

1. Some clinicians have a tendency to stop the diagnostic process when they find that the youth meets the formal criteria for Conduct Disorder [thus missing other problems a youth might have.] . . . This ignores the fact that Conduct Disorder is often comorbid with one or more other psychiatric disorders. The job is not to find “a diagnosis” but to discover and describe the youth’s psychological condition. Rarely is this job completed by establishing a diagnosis of Conduct Disorder.
2. Clinicians should recognize that not all youth who meet the formal criteria for Conduct Disorder– even perfectly– should be given a diagnosis of Conduct Disorder. . . . DSM-IV commentary points out . . . that “the Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an underlying dysfunction within the individual and not simply a reaction to the immediate social context” . . . This requires that the clinician explore the causal relationship between the criterion behaviors and (a) the youth’s personality as well as (b) the social and cultural conditions in which the youth’s past criterion behaviors occurred. In at least some instances, youth who meet all of the formal criteria for Conduct Disorder should not be given the diagnosis.
3. Clinicians who are unaccustomed to diagnostic work with adolescents should very carefully identify the relation of Conduct Disorder to Antisocial Personality Disorder. [Grisso cites examples of false claims by testifying mental health professionals, such as: children with Conduct Disorder become adults with Antisocial Personality Disorder; or Conduct Disorder is the adolescent version of Antisocial Personality Disorder; or Antisocial Personality Disorder is what youths with Conduct Disorder become– “after

all, according to DSM-IV criteria, an adult can be APD only if he was CD in adolescence." . . . The majority of youths who can be diagnosed Conduct Disorder "remit by adulthood." [citing DSM-IV]

IV. Psychological Assessment and Testing

A. Basic Information

1. Although psychological tests vary in their types and purposes, generally speaking they all can be described as standardized ways of assessing various aspects or abilities of a person (e.g., mood, intelligence, quality of thought process, adaptive behaviors, memory, knowledge, visual motor coordination) which allow for comparing that person to others.
2. Tests assess skills, abilities, or traits that are measurable. Those attributes that are measurable are called "constructs," which may or may not be relevant, or may be indirectly related to, the question(s) at issue in court. For example, an instrument that measures competence to stand trial will measure constructs of "appreciation," "understanding" and "ability to communicate," which together inform the judge who has to decide whether the youth's capacities for appreciation, understanding and ability to communicate meet the legal standard for competence.
3. Many of the tests that are widely administered to children (and that are reviewed below) do not directly answer the relevant legal questions.
4. A few psychological tests have been designed for forensic purposes and specifically assess psycholegal constructs (e.g., Grisso's Miranda Waiver measures, Competence Screening Test, MacArthur Competency Assessment Tool-Criminal Adjudication, Competency Assessment for Standing Trial-Mental Retardation.)
5. No matter what test is being used, practitioners should know basic information about the test's validity. [Trainer should review matters highlighted in the Introduction, B.6.] Basic questions include:
 - a. What does the test purport to assess? (E.g., intelligence is not the same thing as competency to proceed).
 - b. For what purposes has the test been demonstrated to be valid?
 - c. Is it appropriate to use with children? Have norms been developed for children? Was the test developed specifically for children? For children involved in the juvenile and/or criminal justice systems?
 - d. Is there any reason to believe that the test is biased with respect to race or gender?
 - e. Has the most recent version been employed? Why or why not?

- B. **Focus of testing.** Consumers should ensure that the mental health professionals conducting the evaluations are familiar with the instruments most relevant to the legal questions at issue.

1. **Competence to Waive Miranda Rights.** In 1966, in *Miranda v. Arizona*, the U.S. Supreme Court required procedural safeguards to protect the rights of an accused person to be free from compelled self-incrimination when they are being questioned while in custody. An accused can “waive” (give up) Miranda rights and give a statement to police, but such waivers must be knowledgeable and voluntary. Psychologist Thomas Grisso has developed a standardized assessment of a youth’s competence to waive Miranda rights. (The instruments used to conduct the assessment, *Instruments for Assessing Understanding and Appreciation of Miranda Rights*, are discussed thoroughly in Module Six: *Evaluating Youth Competence in the Justice System*.)
2. **Competence to Stand Trial.** In 1960, the U.S. Supreme Court, in *Dusky v. United States*, adopted the legal standard of competence that is followed in the states. The Dusky standard asks “whether he [the defendant] has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against him.” Tests for competency include the MacArthur Competence Assessment Tool -- Criminal Adjudication (MCAT-CA) and the Interdisciplinary Fitness Interview. It should be noted, however, that these tests have only been validated with adults; they have not been validated for juveniles. (Competency to stand trial is discussed thoroughly in Module Six.)

C. General Measures

1. Overview

- a. These measures were developed to diagnose patients in order to provide appropriate treatment or therapy.
- b. Because these general measures were not developed specifically to be used in forensic contexts, inferences have to be made about how they apply to the question at hand. However, when something can be assessed directly, it must be done that way. For example, if the judge wants to know whether a child has the cognitive abilities to understand Miranda warnings, it would be useful to have the results of one or more of the intelligence tests listed in the next paragraph. Red flags should go off in the consumer’s mind when a huge leap must be made in order to answer the legal question, for example, taking the results of an achievement test and inferring that a child a) had the capacities to waive rights, and b) that those capacities were not interfered with by personality or emotional problems.

2. Types.

a. Intelligence (cognitive) testing.

- (1) A cognitive evaluation can be conducted by either a clinical, counseling or certified school psychologist.
- (2) The two most commonly administered intelligence tests are:

- (a) **WAIS-III** (Wechsler Adult Intelligence Scale-III). The WAIS-III assesses capacity for intelligent behavior of adolescents and adults ages 17-74 (Harrington, 1986). It consists of two major scales: Verbal and Performance, each of which contains six subtests. IQ scores are derived for each of these scales as well as a composite Full Scale IQ score. The WAIS-III is available in Spanish.
 - (b) **WISC-III** (Wechsler Intelligence Scale for Children- Third Edition). The WISC-III assesses mental ability in children ages 6-16. It is used to measure a child's capacity to understand and cope with the world (Harrington, 1986). It consists of two major scales: Verbal and Performance, each of which contain six subtests. IQ scores are derived for each of these scales as well as a composite Full Scale IQ score. The WISC-III is available in Spanish.
- (3) For these intelligence tests, a score of 100 is the average, with a standard deviation of 10 points. Accordingly, the following IQ ranges apply:

Very Superior	130 and above
Superior	120-129
High Average	110-119
Average	90-109
Low Average	80-89
Borderline	70-79
Mentally Retarded	69 and below

Ranges of Mental Retardation

Mild	56-69
Moderate	41-55
Severe	26-40
Profound	0-25

- (4) There are other less widely used intelligence tests that may be employed as part of the evaluation. The IQ ranges for the following tests and the normative samples upon which they are based are different than the Wechsler scales. Thus, an IQ number derived from these tests may have slightly different meaning than one from the WAIS-III or WISC-III. It is preferable to have a client evaluated using either the WAIS-III or WISC-III, depending upon the client's age. These less widely used intelligence tests include:
- (a) The Slosson Intelligence Test (SIT)
 - (b) Kaufman Brief Intelligence Test (KBIT)
 - (c) Stanford-Binet Intelligence Scale: Fourth Edition (SB:FE).

b. Academic achievement tests.

- (1) Academic achievement tests are often administered in conjunction with intelligence tests. This allows the examiner to determine whether an individual suffers from a learning disability.
- (2) Such tests include the Wide Range Achievement Test-Third Edition (WRAT-III), the Wechsler Individual Achievement Tests (WIAT) and the Woodcock Johnson Psycho-educational Battery-Revised (WJEB-R).
- (3) The results of these tests will include a grade-equivalent score and a standard score. The standard score can be compared to the IQ scores (Verbal, Performance, Full Scale) to determine if there are significant differences in level of functioning.

c. **Emotional/personality functioning tests.**

- (1) Court evaluations will also usually include some measures designed to provide an index of a client's emotional/personality functioning. These can include both highly structured self-report measures and loosely structured "projective" techniques.
- (2) Clinical psychologists typically have more training in the administration and interpretation of these types of tests than either counseling or school psychologists.
- (3) Commonly employed measures of emotional/personality functioning include:
 - (a) **Beck Depression Inventory (BDI).** The BDI is a 21-item inventory that measures the degree of depressive symptoms found in adolescents and adults. Scales for this inventory include: sadness, pessimism, sense of failure, suicidal ideas, social withdrawal and work difficulty, etc. (Harrington, 1986).
 - (b) **MMPI-A** (Minnesota Multiphasic Personality Inventory- Adolescent Edition). The MMPI-A (used with children and adolescents up to age 18) is a standardized questionnaire that elicits a wide range of self-descriptions scored to give a quantitative measurement of an individual's level of emotional adjustment and attitude toward test-taking (Groth-Marnat, 1984). The MMPI-A has a total of 13 scales, 3 of which relate to validity, and 10 which relate to clinical or personality indices. An individual's score is based on these 13 different categories of responses and is represented in graph form on a profile sheet. This score can be compared with the scores obtained from different normative samples (Groth-Marnat, 1984).
 - (c) **Rorschach Psychodiagnostic Test.** The Rorschach evaluates an individual's personality (usually ages 10 to adult), as one is asked to interpret what one sees in ten inkblot cards. This technique is based on the assumption that an individual's responses are rooted in aspects of personality unique to him or her. Extensive scoring systems have been

developed, and an individual's responses can be compared to normative samples (Harrington, 1986), although this method is considered controversial by some.

V. Ensuring Developmentally-Sensitive Mental Health Assessments

A. To determine the young person's competence, risk for reoffending or amenability to treatment, it is often helpful for the court to know qualitative answers to developmental questions -- where the juvenile is in his/her cognitive, moral, and identity development and what areas of growth remain. (These are the areas of adolescent development that we discussed at length in Module One.) Specifically, qualitative answers to developmental questions:

1. **Assist us in determining the young person's level of culpability for the offense in question, and his/her intent at the time of the offense.**
2. **Help us to determine the young person's amenability to treatment and clarify the young person's needs so that an appropriate disposition/sentence can be designed that rehabilitates the young person while also protecting the community.**

a. **Determining amenability to treatment.** Knowledge of where a young person is developmentally can assist the court in making a more informed determination regarding amenability to treatment; such knowledge allows the court to examine whether services provided in the past were appropriate for the young person's needs. For example, in the context of a transfer hearing, a determination that the services provided did not address the young person's unique developmental needs suggests that the young person may still be amenable to treatment -- the young person was not resistant to treatment but instead was not provided with right to type of treatment -- and should remain in juvenile court. By contrast, a finding that a young person has received developmentally-appropriate services in the past suggests that he/she is may not be receptive to treatment and therefore should be transferred to adult court.

b. **Fashioning developmentally-sensitive dispositions and sentences.** Disposition plans and sentences must specifically address the developmental needs of the individual. It is not enough to state in a disposition order, for example, that a young person should receive counseling while on probation. Instead, a disposition plan must specify what particular services a young person will receive to help him/her learn, for example, to walk away from provocative situations, or to succeed in some area and not rely on negative peers for approval.

B. **Examples of questions that a developmentally-sensitive mental health assessment should answer.** *See Appendix E for a full list of questions.*

1. Maturity of Thought

- a. At the time of the offense, to what extent was this young person anticipating outcomes? Reacting to threat? Minimizing consequences? Seeing only one choice?
- b. Could this young person foresee the consequences of his/her actions?

- c. Was this young person able to plan like an adult, and under stress, did he/she react similar to or different from an adult if things did not occur as planned?
2. **Moral Values**
 - a. What is this young person's understanding of fairness, rights, and responsibility?
 - b. Does this young person consider loyalty a higher moral principle than conventional views of right and wrong?
 3. **Empathy**
 - a. Is this young person capable of empathy? Are this young person's adolescent bravado and/or his/her view of the offense as accidental being interpreted as a lack of remorse?
 4. **Prior Trauma**
 - a. Is there evidence of prior trauma? Of serious child abuse or neglect? What connections, if any, exists between his/her trauma and the offense?
 - b. How does this young person's past trauma impact his/her cognitive processes, if at all? His/her perception of threat?
 5. **Learning Issues**
 - a. Does this young person have a history of school problems or learning disabilities? If yes, what connections, if any, exist between this young person's history of school problems or learning disability, and the offense?
 - b. What connections, if any exist between this young person's learning problems and his/her cognitive processes? His/her perception of threat?
 6. **Purposes Served by Delinquency**
 - a. To what extent is this young person's delinquency driven by a need for approval?
 7. **Amenability to Treatment**
 - a. Does the young person want to change? Does the young person have a desire for approval that could lead to change?

VI. How to Think About, Request, and Review a Forensic Evaluation

A. Distinguish Between Therapeutic Evaluation and Forensic Evaluation.

1. Therapeutic Evaluation

- a. Initiated by the client (or guardian in the case of a minor).
- b. Voluntary.
- c. For purposes of identifying treatment that will improve the client's overall behavioral adjustment, psychological functioning and welfare.
- d. Confidential and privileged (via psychotherapist-client relationship).

2. Forensic Evaluation

- a. Initiated by a third party (an attorney or the court).
- b. Can be compelled over the objection of the examinee.
- c. Purpose is to assist the court in answering a legal question or questions (e.g., competence, treatment/placement to be initiated as part of disposition, mental state at the time of the delinquent act/sanity). Sometimes the court's specific purpose is to help the child's well being (e.g. disposition evaluations), while in other cases the child's well-being is largely irrelevant to the question the evaluation seeks to answer (e.g., waiver evaluations).
- d. Not confidential because not obtained in the context of a therapeutic relationship, but evaluations requested by the examinee's attorney may be privileged (via the attorney-client privilege).
- e. The format and process of forensic evaluation is controlled by more specific, focused professional standards than are general mental health evaluations. *(Note to trainer: Full citations for these standards are attached at Appendix G.)*
 - (1) Specialty Guidelines for Forensic Psychologists (1991), adopted and promulgated by the American Academy of Forensic Psychology and the American Psychology/Law Society.
 - (2) Ethical Guidelines for the Practice of Forensic Psychiatry (1989), adopted and promulgated by the American Academy of Psychiatry and Law.

B. Pre-Evaluation Preparation

1. Identify the law and the relevant psychological factors that are relevant to the legal issue and discuss with the evaluator. Examples:
 - a. Competence to proceed.

- (1) Child's capacity to understand and appreciate the charges and penalties that he or she is facing.
 - (2) Child's ability to understand the legal process.
 - (3) Child's ability to work with his or her attorney by way of providing relevant information, discussing case options, etc.
 - (4) Child's understanding of how the hearing process works and ability to participate in the process.
- b. Waiver to adult court.
- (1) Violence risk the child presents as affected or suggested by a number of factors including violence history, mental health history, substance abuse history.
 - (2) Available treatments that might bring about significant change in this child's delinquent behavior, given emotional, behavioral, and other problems the child is experiencing. The child's treatment history and success or failure.
 - (3) the child's emotional and intellectual maturity.
2. List mental states, capacities, abilities, behaviors, knowledge, skills that are relevant to the legal questions or issues. Examples:
- a. Competence to proceed.
- (1) Communication abilities (both receptive and expressive).
 - (2) Basic intellectual abilities along with clear and deliberate thinking.
 - (3) Emotional appreciation of the significance of the proceedings.
- b. Waiver to adult court.
- (1) Social/emotional/behavioral problems as they impact the child's history of delinquent behavior.
 - (2) The child's history of treatment for these difficulties.
 - (3) The child's (and significant others') motivation to treatment/rehabilitation.
 - (4) The child's support systems.
 - (5) Available treatment for the child in juvenile versus adult criminal court systems.

3. Gather any relevant information about the child that might bear on the particular psycholegal issues at question and provide to the examiner (e.g., school records, psychiatric record, arrest reports, depositions, witness/victim reports, family accounts or reports).
- C. **Assessing the Evaluator.** *(Note to trainer: trainer should hand out and review the "Outline for Assessing an Expert Witness" attached at Appendix C.)*
1. Ensure that an examiner is appointed who understands the relevant law and psycholegal factors that are at issue (you should not have to do this for an experienced examiner).
 - a. *(Note to trainer: trainer should show overhead attached as Appendix D.)* Mental health professional needs to know the question the court is trying to answer (box A). Otherwise, he/she won't know what to assess. He/she also needs to know both clinical (box B') and forensic assessment (box C') instruments, because failure to use the latter could lead to significant errors.
 - b. Do not assume that simply because a person has conducted a number of evaluations he or she knows the law, or he/she is good at what he/she does. **Few psychologists and psychiatrists receive formal forensic training.** Therefore, don't assume that simply because a professional went to a good school that he/she knows forensics.
 2. Absent extenuating circumstances (e.g., you are practicing in a remote area in which only one qualified mental health professional is available), ensure that the examiner HAS NOT previously been involved with the child in any kind of treatment or therapeutic capacity.
 - a. As noted above, forensic evaluation is a different enterprise than treatment.
 - b. Involvement with an individual in both a forensic and therapeutic context arguably constitutes a dual relationship, which is discouraged by the two leading professional organizations in this area – The American Academy of Forensic Psychology/American Psychology-Law Society and the American Academy of Psychiatry and Law.
 3. Ensure that the examiner has relevant clinical knowledge. The examiner's experience with and knowledge of children in the courts is more important than the examiner's degree. Many mental health professionals do not get a great deal of exposure to children in their training. An examiner should be familiar with the following substantive areas:
 - a. Child and developmental psychology.
 - b. Child psychopathology.
 - c. Mental retardation.

- d. Treatment options within the juvenile justice and mental health systems in the jurisdiction.
- D. **Post-Evaluation Review of the Evaluation.** *Note to trainer: trainer should hand out and review the checklist of "Minimum Criteria for a Good Forensic Evaluation" attached at Appendix I.*

1. **Minimum Contents of a Good Forensic Evaluation.**

- a. Inclusion of relevant identifying information (e.g., who referred for evaluation, whether completed via court appointment or confidential/ex parte, examinee's involvement with the legal system).
- b. Statement of legal question(s) to be addressed.
- c. Identification of all sources of information relied upon (e.g., review of medical or school records, interview with examinee, testing, parent interview, review of police reports). Note: in some jurisdictions, this is required by statute or court rules.
- d. Description of relevant mental states, capacities, abilities, knowledge, and/or skills that are relevant to the legal question at hand.
- e. Description of the relationship between the mental states, capacities, abilities, knowledge, and/or skills assessed and their causal connection to the youth's abilities or issues about which the court is interested.
- f. Information that contextualizes the conclusions.
- g. Information qualifying the conclusions drawn. What external limitations (i.e., in the testing conditions, the tests themselves, the amount of time evaluator was given to interview the relevant parties, in the amount of background information that the evaluator was able to collect and review, etc.) should be taken into account when relying on the evaluator's conclusions?
- h. Specific recommendations for intervention (when appropriate) with a reasonable attempt to identify interventions that are available in the community.

2. **Steps in Reviewing an Evaluation**

- a. Ensure that the examiner correctly understood the relevant law and psychological factors that were at issue and addressed them accordingly.
- b. Determine if examiner failed to consider or obtain any relevant information.
 - (1) Did the examiner obtain a thorough personal and social history?
 - (2) Did the examiner tell you how the child's particular history interacts with other clinical measures and techniques used?

- c. Consider the degree to which the examiner evaluated and described relevant mental states, capacities, abilities, behaviors, knowledge, or skills and **their relationship and their connection with or relationship to the psycholegal issues of interest**. Statements such as “The child is depressed” or “The child has limited intelligence” are not particularly helpful because they only provide half the information needed. They don’t link the child’s adjustment or capacity with the behavior that brought the child to the attention of the court. Follow up such “half answers” with questions, i.e., “How does the child’s depression play out in terms of the child’s deliberate behavior, and what implications does that have for interventions?” or “How does the child’s limited intelligence affect the child’s interactions with his attorney?”

- (1) Consider how “direct” the examiner was in his/her examination.

- (2) Your wariness about the utility of the report in helping you resolve the legal question should increase as the level of inference employed by the examiner increases. (See discussion of inferences on next page.)

- d. Assess whether you need to consult an expert on the particular condition or mental illness diagnosed by the expert evaluator.

- e. Assess appropriateness and validity of any techniques, tests, or instruments used.

- (1) General Test Validity²

- Review questions raised in Part IV above, entitled “Psychological Assessment and Testing.”

- (2) Appropriateness.

- (a) What is the relationship between the capacities assessed by this test and the psycholegal question at issue? The examiner has to explain the relationship, and should be discouraged from using statements like, “The child has borderline IQ and therefore the child is incompetent to proceed.”

²Attorneys wishing to obtain an independent review of the test(s) used can consult some references. First, the various volumes of the *Mental Measurements Yearbook* (published by University of Nebraska Press and available in any good library) publishes reviews of hundreds of tests. Second, forensic evaluation books (the best being *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Attorneys* published by Guilford Press) address the reliability and validity of specific forensic measures and the appropriateness of using more general tests in the context of forensic evaluation. Keep in mind that the former two publications are written by and for psychologists, and they may be dense reading.

- (b) What kinds of inferences did you have to make to go from your assessment of the psychological construct to the legal question? For example, compare:
- i) Considerable level of inference moving from psychological construct assessed to psycholegal issue
 - a) The examiner believes that the adolescent was incompetent to proceed because she obtained an IQ of 78 (borderline intellectual functioning).
 - b) The examiner believes that the child was sane at the time of the offense because her MMPI-A profile is flat and suggests no significant psychopathology.
 - ii) Lesser degree of inference
 - a) The examiner believes that the adolescent is incompetent to proceed based on her responses to the Competence Screening Test and the Florida Juvenile Competency Assessment Procedure.
 - b) The examiner believes that the child was sane at the time of the offense because interview and third party data indicate that the child's behavior was purposeful and not affected by any symptoms of mental disorder. (In certain situations, a battery of tests may not be useful to the legal question, and therefore basing an assessment on such third-party data may be more appropriate.)
- (c) Are there any measures available which assess these relevant psycholegal constructs more directly?

Interactive Exercise: John Doe**Part A
Analysis of Psychological Evaluation**

The purpose of Part A of this exercise is to help participants develop a system for analyzing a psychological report under severe time pressures.

- Step 1: Break the participants into small groups. (If at all possible, make sure that there is representation from each of the professions – judges, prosecutors, defense attorneys and probation officers – in each group.) Randomly assign each group the role of judge, prosecutor or defense attorney. Ask each group to select one individual to act as a recorder and reporter for the group. Hand out the packet attached as Appendix A to this module, which includes: (1) a one-page description of Doe’s current legal status; (2) a copy of the court order requesting the evaluation; (3) a summary of Doe’s court-ordered psychological evaluation; (4) a worksheet for this exercise; and (5) DSM-IV criteria for Adjustment Disorder with Conduct Disorder.
- Step 2: Give the participants 20 minutes to read the court order, the one-page description and the evaluation, and complete Part A only of the worksheet as a group.
- Step 3: Reconvene as a large group to discuss the evaluation and specifically the groups’ responses to the questions in Part A of the worksheet. Trainers should be prepared to comment on the following:
- ! The stated goals of the evaluations: Are they idealistic? Realistic? Not helpful for the purposes of this hearing?
 - ! The areas of the evaluation that groups selected to concentrate on in their examinations to support their goals. What are potential traps or pitfalls of going into these areas? Where might the questioner get bogged down during the examination? How can these traps be avoided without giving up the quest for information?
 - ! The groups’ strategies to deal with the areas of the evaluation that are less helpful. What are the potential traps or pitfalls of going into these areas?

- ! The pros and cons of making a record versus making a point: should you aim to be inclusive and attack all weaknesses in the evaluation, or should you concentrate on those few elements that support your goal?

Part B

Examination of Mental Health Professional

The purpose of Part B of this exercise is to help participants develop the skill to formulate questions that will: (1) illuminate the nexus between the diagnosis in an evaluation and the supporting components of the evaluation; and (2) reveal whether the evaluator's route to diagnosis was based on adequate information and skilled interpretation.

- Step 1: Break the participants into pairs. (Again, ask participants to team up with a person from a profession not their own so that each pair is multi-disciplinary.) Randomly assign pairs the role of judge, prosecutor or defense attorney.
- Step 2: Ask participants to review the DSM-IV criteria in their information packet and then complete Part B of the worksheet.
- Step 3: Reconvene as a group. Trainer should prep a participant in advance of the role play, or select an experienced member of the class, to act the part of the professional who prepared the evaluation. Participants shall question the professional on the stand at the disposition hearing. Trainer will critique the questions during the course of the exercise and make suggestions on how to fine tune them. Trainer will also be prepared to comment on the following after completion of the psychologist's testimony:
- ! Whether weaknesses in the evaluation arose from: (1) the psychologist's failure to correctly interpret background information; and/or (2) the psychologist's failure to cast a wide enough net to capture relevant information; and/or (3) lack of court guidance about what specific issues s/he should concentrate on.
 - ! Whether more information and/or skilled interpretation would have led to a different diagnosis, i.e., a more precise diagnosis.

- ! Whether a diagnosis that considered substance abuse was adequately considered (trainer can introduce concepts of “dual diagnoses” or “co-morbidity”).”
- ! Whether the psychologist chose tests that covered the range of issues needed to be addressed at the disposition hearing. What does each test measure? Do the chosen measurements leave any gaps?
- ! If inadequate measures were chosen, was this due to the psychologist’s failure to chose appropriate measures, or lack of guidance from the court?

Part C

Writing Court Orders for Mental Health Evaluations

The purpose of Part C of this exercise is to practice how to draft a court order that will give the best possible guidance to the psychologist about the issues s/he should address in the evaluation and the report to the court.

- Step 1: Break the participants into the same small groups as they did for Part A of the John Doe exercise.
- Step 2: Ask participants to go back in time and assume that they are in court on the day that John Doe entered his guilty plea. The judge asks the parties to draft an order for a psychological evaluation for John’s disposition. Participants should write out a sample order and submit it to the trainer.
- Step 3: Trainer critiques orders that the groups submitted.
- Step 4: Trainer should then return to the list generated at the beginning of the class of the different purposes for which mental health evaluations are requested in juvenile court. Trainer will discuss how his/her evaluation – both the methods and tests used to gather and analyze information, as well as the final product delivered to the court – would differ depending on the stated purpose of the evaluation. Trainer will discuss specific language and information that should be included in the court order for the different types of evaluations requested.

Interactive Exercise: Analyzing Evaluations

Part A

Trainer should give out and review with the group the more thorough psychological evaluation of John Doe, attached at Appendix B. Trainer should discuss/ elicit from participants the following:

- ! In what ways is this a stronger evaluation as compared to the summary that was used in the earlier exercise?
- ! What relevant information is still missing from this evaluation?
- ! What statements and/or omissions should you question the evaluator about?

Part B

Prior to the training session, trainer should arrange for participants to submit mental health assessments from their own cases in juvenile court. (Names of all relevant parties should be deleted for confidentiality reasons.) Or the trainer may use the sample evaluations attached at Appendix B. At the session, the trainer will go through selected evaluations to (1) help participants understand the information that is typically in an evaluation; (2) suggest questions that the participant could have posed to the mental health professional in order to clarify any ambiguity and/or seek additional information; and (3) elicit from participants the strengths and the weaknesses of each evaluation.

Bibliography

(Note to trainer: trainer should consult the literature review included under separate cover for additional reference materials and suggestions for assigned readings for training participants.)

American Academy of Psychiatry and the Law, *ETHICAL GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY*. Bloomfield, CT: American Academy of Psychiatry and the Law (October 1989).

American Psychiatric Association, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS-IV (DSM-IV)*. Washington, D. C.: American Psychiatric Association (4th ed. 1994).

Beyer, M., T. Grisso, & M. Young, *Experts for Juveniles at Risk of Adult Sentences* in P. Puritz, A. Capozello, & W. Shang eds., *MORE THAN MEETS THE EYE: RETHINKING ASSESSMENT, COMPETENCY AND SENTENCING FOR A HARSHER ERA OF JUVENILE JUSTICE*. Washington, D. C.: American Bar Association Juvenile Justice Center (August 1997).

Shay Bilchik, *Office of Juvenile Justice and Delinquency Prevention Fact Sheet #82: Mental Health Disorders and Substance Abuse Problems Among Juveniles* (July 1998).

Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 *LAW AND HUMAN BEHAVIOR* 655 (1991).

Thomas Grisso, *FORENSIC EVALUATIONS OF JUVENILES*. Sarasota, FL: Professional Resource Press (1998).

Thomas Grisso, *EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS*. New York: Plenum (1986).

Thomas Grisso, *JUVENILES' WAIVER OF RIGHTS: LEGAL AND PSYCHOLOGICAL COMPETENCE*. New York: Plenum (1981).

Thomas Hecker, *Psychological Assessment in the Juvenile Justice System*. Unpublished paper (1997). On file at the American Bar Association Juvenile Justice Center, Washington, D. C.

Thomas Hecker, *Mental Disorders Among Adolescents in the Juvenile Justice System*. Unpublished paper (1997). On file at the American Bar Association Juvenile Justice Center, Washington, D. C.

Kirk Heilbrun, *The Role of Psychological Testing in Forensic Assessment*, 16 *LAW AND HUMAN BEHAVIOR* 257 (1992).

Impara, J., L. Plake, & B. Plake, *THE THIRTEENTH MENTAL MEASUREMENTS YEARBOOK AND SUPPLEMENT*. Lincoln, NE: University of Nebraska Press (1999).

Judith Larsen, Presentation to West Palm Beach County, Florida Juvenile Court, February 19, 1998.

Judith Larsen, *How to Seek Accuracy in Mental Health Assessments*, 16 CHILD LAW PRACTICE 1 (November 1997).

Pamela K. McPherson, *Providing Mental Health Services in Juvenile Detention*, 8 JOURNAL FOR JUVENILE JUSTICE AND DETENTION SERVICES (Spring 1998).

G. Melton, J. Petrila, N. Poythress, & C. Slobogin, *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND ATTORNEYS*. New York: Guilford (1997).

Randy Otto, Presentation to West Palm Beach County, Florida Juvenile Court, February 19, 1998.

Randy Otto, Presentation to Alameda County, California Juvenile Court, August 5, 1998.

J. Petrila, & Randy K. Otto, *LAW & MENTAL HEALTH PROFESSIONALS: FLORIDA*. Washington, D. C.: American Psychological Association (1996).

J. Ziskin, *COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY: PRACTICAL GUIDELINES, CROSS-EXAMINATIONS, AND CASE ILLUSTRATIONS*. Los Angeles, CA: Law and Psychology Press (1995 and 1997 Supplement).

APPENDIX A

Materials for John Doe Exercise

Includes:

1. One-page description of John Doe's current legal status
2. Court order requesting evaluation
3. Summary of John Doe's court-ordered psychological evaluation
4. Worksheet
5. DSM-IV criteria for Adjustment Disorder with Disturbance of Conduct

JOHN DOE'S CURRENT LEGAL STATUS

Today is John Doe's dispositional hearing in juvenile court. Several weeks ago, John entered a plea to the charges of unauthorized use of a vehicle and possession of marijuana. John is fourteen years old. The facts of the case are as follows: He was apprehended by the police while driving recklessly. John drove his vehicle right at the police car and came to a screeching halt, just short of a head-on impact. The officer grabbed John from the vehicle. He then lunged at the officer and attempted to escape, but the attempt was thwarted. John was charged with unauthorized use of a vehicle, possession of marijuana (which was found in the car), and resisting arrest (which was later dropped).

This is not John's first contact with the juvenile court. He was previously charged with possession of an illegal substance and was placed into a diversion program for a period of six months. He attended three counseling sessions, but then stopped going; however, the charge was not reinstated by the government. At the time that John was apprehended on the current charges, he had run away from home and was staying at the home of a different friend or acquaintance each night.

The presiding judge ordered a psychological evaluation and for the psychologist to be present in order for counsel to interview him/her. The judge (and the training participants) have not yet seen the evaluation, as it just came into court. Counsel asks for a continuance in order to evaluate the report. The judge asks the psychologist if he could be present for a hearing in one month. The psychologist informs the judge that he will be out of the country for the next six months on a teaching fellowship and will be unavailable. The judge orders the disposition to go ahead. Counsel will have a brief recess to go over the assessment in order to determine what questions to ask.

Please read the attached court order and summary of the psychological evaluation. Then turn to the worksheet and discuss and complete Part A only of the worksheet as a group.

COURT OF COMMON PLEAS OF LINCOLN COUNTY
FAMILY COURT DIVISION – JUVENILE BRANCH

IN THE MATTER OF : J -4287-9X
 : :
 : :
 John Doe, : Judge Schiff
 : :
 : :
 a Minor : Disposition: February X, XXXX

ORDER

IT IS HEREBY ORDERED this XX day of December, XXXX, that Court Social Services shall arrange for the Respondent, John Doe, to undergo a mental health evaluation in preparation for Respondent’s disposition. A copy of said evaluation shall be provided to the Court and to counsel no later than one (1) week prior to Respondent’s disposition.

IT IS SO ORDERED.

Schiff, J.

SUMMARY OF PSYCHOLOGICAL EVALUATION OF JOHN DOE Mary Smith, Ph.D.

Sources of Information Utilized: Clinical Interview, Telephone interview with Louise Doe, Mental Status Examination, Wechsler Intelligence Scale for Children-R, Wide Range Achievement Test-R, Draw-A-Person, Incomplete Sentence Blank (High School Version).

Background Information: John is currently enrolled in the 9th grade at Lincoln Middle School. He lives with his mother and younger brother Jeremy. John's parents have been separated for the past year and his father currently lives outside of Atlanta with his girlfriend. Ms. Doe reported an unremarkable medical and psychological history for the first 12 years of her son's life. She indicated that, over the past year, John has shown a pattern of troubled behavior including lying, skipping school, talking back to her, staying out late, and sleeping late, sometimes missing school. She reported that John had no academic or significant behavioral problems through 8th grade (he was a B/C student). In 9th grade his grades began to suffer, and he received all Ds and Fs on his most recent report card. He has been suspended twice, once for fighting with another student and once for threatening a teacher. Ms. Doe believes that her son has experienced other difficulties that she is unaware of and she attributed this lack of knowledge to her busy work schedule (she has worked 4PM to midnight at a convenience store since her husband left the home).

Clinical Interview: John was cooperative with the evaluation process. He admitted to stealing the car ("it was a joyride") and claimed that he found the drugs in his possession in the car's glove box. He admitted to trying marijuana and alcohol in the past but stated that he did not use any drugs on a regular basis because it interfered with sports. John admitted to skipping school and stated that he wanted to drop out and get a job. He cited his prior record of acceptable grades as evidence that he was able to do school work if he wanted to. He acknowledged difficulties with his mother but attributed them to her being over-worked and him trying to "be a teenager." John reported a prior arrest for loitering and indicated that he was placed on community control. Records of this arrest were not available.

Test Results and Interpretation: John's WISC-R Full Scale score of 98 places him in the average range of intellectual functioning. Analysis of his verbal and performance scores suggests that his verbal and non-verbal abilities are equally developed, and he shows no particular strengths or weaknesses with respect to these abilities. John's performance on the WRAT-R suggests academic achievement lower than that expected given his intellectual abilities. John's performance on the Spelling, Arithmetic, and Reading subtests places him in 80th, 72nd, and 40th percentiles, respectively, when compared to same age peers. John's responses to the Draw-A-Person Test and Incomplete Sentence Blank suggest underlying feelings of anxiety and insecurity for which he is trying to compensate at this time, perhaps related to his parents' separation and divorce.

Provisional Diagnosis: Axis I: Adjustment Disorder with Disturbance of Conduct, Rule out Reading Disorder, Axis II: No Diagnosis, Axis III: No Diagnosis, Axis IV: Educational Problems, Problems with Primary Support Group, Axis V: 80-Current (Transient symptoms resulting from psychosocial stressors)

Recommendations: John Doe is a 14 year old boy who shows a recent history of some delinquent behavior that coincides with his parents' separation and related family stressors.

While John maintains that he is not particularly affected by these family events, results of psychological testing suggest a young man who is emotionally challenged by his parents' separation and is responding by acting out, perhaps as a way of challenging these feelings or gaining attention. His use of defense mechanisms such as repression and denial, however, minimize his ability to draw these connections. Individual or group therapy is recommended so that John can focus on his parents' divorce, and how that has affected him and his behavior. Psychotherapy at this juncture is considered to have a positive prognosis, given apparent development of superego functions, and positive object relations predating the parents' separation and divorce.

SMALL GROUP EXERCISE WORKSHEET

John Doe Exercise

Part A

Complete the following questions as a group:

What will be the goal of your examination of the mental health professional who prepared the evaluation? Reach a consensus in your group about the goal of your examination. (If you can't reach consensus, then report on the separate goals, but work hard to reach consensus.)

Which areas of the evaluation support your goal?

Which areas of the evaluation are less helpful to your goal? What are your strategies for dealing with this less helpful information?

What are the weak areas in the evaluation? Why do you consider them weak?

What additional sources of information, tests, etc., do you think the psychologist should have considered before making her diagnosis?

What relevant questions are left unanswered by this evaluation?

SMALL GROUP EXERCISE WORKSHEET

John Doe Exercise

Part B

Review the DSM-IV criteria in your packet and complete the following with your partner:

Formulate 1-3 questions intended to elicit from the psychologist how the **tests** that were administered to John Doe bear on the adjustment disorder diagnosis.

Formulate 1-3 questions for the psychologist about how the **background information** on John relates to the diagnosis.

Formulate 1-3 questions for the psychologist about how the **clinical interview** with John relates to the diagnosis.

DSM-IV DIAGNOSTIC CRITERIA FOR ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT (DSM-IV 309.3)

Diagnostic Criteria for Adjustment Disorders (309.X)

1. The development of emotional or behavioral symptoms in response to identifiable stressor(s) occurring within three months of the onset of the stressor(s).
2. These symptoms or behaviors are clinically significant as evidenced by either of the following:
 - a. marked distress that is in excess of what would be expected from exposure to the stressor.
 - b. significant impairment in social or occupational (academic) functioning.
3. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
4. The symptoms do not represent Bereavement.
5. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

- a. Acute: if the disturbance lasts less than six months.
- b. Chronic: if the disturbance lasts for 6 months or longer.

Adjustment orders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(c) can be specified on Axis IV.

With Disturbance of Conduct (309.3)

This subtype should be used where the predominant manifestation is a disturbance in conduct in which there is a violation of the rights of others or of major age-appropriate social norms and rules (e.g., truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities).

APPENDIX B

Sample Mental Health Assessments for Use With Exercise on Analyzing Assessments

Includes:

1. Second John Doe evaluation
2. Josh Adams evaluation
3. Paul Prentiss evaluation

PSYCHOLOGICAL EVALUATION OF JOHN DOE

NAME: John Doe
CASE NO: J-4287-9X
DATE OF BIRTH: 1/3/84
AGE: 14
EDUCATION: 9th grade

DATE OF EVALUATION: 1/8/98
DATE OF REPORT: 1/14/98

IDENTIFYING INFORMATION/REASON FOR REFERRAL/NOTIFICATION

John Doe is a 14 year-old white adolescent who was referred for evaluation by the Honorable Susan Schiff. John had been arrested for possession of marijuana and auto theft and Judge Schiff ordered a psychological evaluation to determine any treatment or placement needs that John might have at this time.

Accordingly, John was interviewed and tested on January 8, 1998. Prior to initiating the evaluation its nature and purpose were explained to John and his mother, who accompanied him to the evaluation. John and his mother were informed that the evaluation was for purposes of making treatment and placement recommendations with respect to the current case, that the evaluation was not confidential, and that any information they revealed might be included in a report, which would be provided to his public defender, the state attorney, and the judge. John and his mother understood this notification and agreed to participate in the evaluation process.

SOURCES OF INFORMATION

The following sources of information were relied upon in completing this evaluation:

Clinical Interview with John Doe (1/8/98, 1.0 hours)

Administration of Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A, 1/8/98)

Interview with Louise Doe, John's mother (1/8/98, .50 hours)

Review of arrest/incident reports (1/6/98)

Review of John's DJJ record (1/8/98)

Telephone interview with Lloyd Samuels, John's school counselor (1/9/98, .25 hours)

Review of John's school records at Riverdale High School

RELEVANT HISTORY

John is the oldest of two boys born to and raised by his parents. Jeremy, his younger brother, is 10 years old. John currently lives with his mother and younger brother. Mr. Doe moved to Atlanta one year ago after announcing his intention to divorce.

Ms. Doe indicated that, over the past year, John has shown a pattern of troubled behavior including lying, skipping school, talking back to her, staying out late, and sleeping late,

sometimes missing school. She reported that John had no academic or significant behavioral problems through 8th grade (he was a B/C student). In 9th grade his grades began to suffer, and he received all Ds and Fs on his most recent report card. He has been suspended twice, once for fighting with another student and once for threatening a teacher.

Ms. Doe first reported that she was not aware of her son having any problems with alcohol or drugs. More detailed questioning, however, indicated that Ms. Doe had found John drinking beer in the home on a few occasions but she clearly minimized the significance of this, stating it was inevitable that children will experiment with alcohol. Ms. Doe reported not being aware of any drug use on her son's part, however, and she denied any history of emotional or behavioral problems prior to the past two years. Ms. Doe reported being unaware that John had been ordered to participate in substance abuse treatment but rather, believed that he was ordered to receive counseling, which, she believed, was being provided by Mr. Samuels. Ms. Doe acknowledged that John may have experienced other difficulties that she is unaware of and she attributed this lack of knowledge to her busy work schedule (she has worked 4PM to midnight at a convenience store since her husband left the home).

A report by John's school counselor, Mr. Samuels, was generally consistent with comments offered by Ms. Doe. Mr. Doe corroborated Ms. Doe's report of her son's academic achievement, and he indicated that testing with the school psychologist did not identify any intellectual limitations or learning difficulties. Mr. Samuels, however, perceived a pattern of escalating intimidating behavior with peers at school, and noted that the incidents for which John was suspended were quite serious. Mr. Samuels also reported that other students had reported John to be using drugs at school, but John denied this on interview. Mr. Samuels also voiced concerns about Ms. Doe's involvement with her son as she had not responded to two requests for a meeting to discuss his repeated absences, poor academic performance, and acting-out behavior.

Records provided by the Department of Juvenile Justice indicate that John had previously been arrested for possession of a controlled substance and ordered to undergo substance abuse counseling. Arrest records obtained by this writer indicate that John initially fled from police when observed driving a stolen car. After being stopped, John allegedly lunged at officers and tried to escape before being apprehended. Officers at the scene reported that John appeared to be under the influence of drugs or alcohol at the time of his arrest.

BEHAVIORAL OBSERVATION & CLINICAL INTERVIEW

John and his mother were interviewed in this writer's office. They arrived promptly for their appointment. John is a tall, lean young man who came to the evaluation casually but neatly dressed, wearing jeans, tennis shoes, and a white t-shirt. When interviewed with his mother, John appeared angry, and frequently contradicted his mother, even about minor and irrelevant issues. He was more cooperative and less disagreeable when interviewed alone. Overall, John was cooperative with the evaluation process.

When interviewed, John was oriented to time, place, and person (i.e., he knew when it was, where he was, and who he was). He spoke at a normal rate and tone. His speech was logical and goal directed and his responses to questions were typically informative although at times, his responses appeared guarded. The above indicates that the structure and form of his thought process was not in any way impaired. Similarly, the content of John's thought process

was not considered to be impaired insofar as he did not voice any unusual ideas or beliefs (i.e., delusions). John also denied experiencing other symptoms indicative of major mental disorder (i.e., hallucinations).

John's attention and concentration appeared unimpaired as indicated by his ability to remain involved in the interview process. He was considered to be a good historian overall, but, as is described in more detail below, he appeared to be somewhat guarded and defensive, and there were some indications that he intentionally withheld information from this examiner that he thought might be detrimental to his case.

In order to further assess John's current adjustment and functioning, he was administered the MMPI-A, a structured, self-report measure of behavior and psychopathology. Validity indices of the MMPI-A indicate that John responded to the inventory items in a reliable and consistent, although somewhat defensive manner, perhaps in an attempt to present himself in a positive light. Thus, while valid, the MMPI-A profile produced by John may underestimate his current difficulties to some degree.

Teenagers who obtain MMPI-A profiles similar to that produced by John show a disregard for social standards and are likely to display impulsive and acting out behaviors. They may experience school-related, legal, and family problems as a result of the above. As compared to their peers, they are more focused on their own needs and interests, to the exclusion of others. Although they may make a good first impression on others, their self focus is likely to prevent establishment of enduring relationships. Significant family difficulties, frustration with parents, a desire to leave home, and feelings of being misunderstood are also suggested by John's MMPI-A profile.

Testing with the MMPI-A also portrayed John as experiencing a moderate level of distress, which may be characterized by feelings of depression and anxiety. There remains the possibility that these reported symptoms are, in part, related to his current circumstances and involvement with the legal system. Indeed, the MMPI-A profile suggests the possibility that John may engage in a pattern of behavior whereby he acts out impulsively followed by expression of remorse and regret. The MMPI-A profile also suggested the possibility of drug and/or alcohol abuse.

As noted above, John was judged to be somewhat guarded during the interview, and he selectively revealed information to this writer. For example, John admitted to stealing the car, describing it as a joyride, and claimed that he found the drugs in his possession in the car's glove box. While John maintained that he did not use drugs he was unable to explain why he took them from the glove box. John claimed that the arresting officers were guilty of police brutality and he admitted to attempting to strike one officer, but only in self defense. He denied being under the influence of any substances when arrested. John admitted to trying marijuana and alcohol in the past but stated that he did not use any drugs on a regular basis because it interfered with sports. Contrary to his mother's report, John denied ever using alcohol in the home with friends.

John was also less than forthcoming about his contact with the juvenile justice system. Apparently unaware that this writer had access to his juvenile justice record, John reported a prior arrest for loitering and indicated that he was placed on community control. As noted below, however, John was previously arrested for possession of a controlled substance. When

confronted with this inconsistency, John at first claimed that it was a mistake and he became angry, asking this examiner if he was calling him a liar. John then acknowledged the incident but claimed that he had forgotten about it, and he maintained that he had been wrongfully accused.

John admitted to skipping school and stated that he wanted to drop out and get a job. He cited his prior record of acceptable grades as evidence that he was able to do school work if he wanted to. He acknowledged difficulties with his mother but attributed them to her being over-worked and him being a teenager.

John was willing to talk about his parents' separation. He reported being angry with his father and described him as taking advantage of his mother. John sees himself, his brother, and mother as suffering financially as a result of his father's departure.

Overall, John did not see himself as having any significant difficulties. He portrayed his recent academic difficulties as fleeting and he downplayed the significance of the behavior leading to his suspensions. He claimed that he only fought after another student instigated the fight, and he denied threatening his teacher but claimed that she harbored negative feelings towards him because he had challenged her in class before. John denied any emotional or psychological difficulties at this time or in the past. He portrayed difficulties with his mother as minor and largely the result of her over-concern. He denied recent or current use of alcohol or drugs and described his involvement with the juvenile justice system as resulting from nothing more than mistakes or poor judgment, which would not occur again.

DIAGNOSTIC IMPRESSION

The diagnostic picture at this time is somewhat unclear, largely as a function of inconsistencies between John's self-report and accounts offered by third parties. Overall, however, information provided to this writer suggests that John has a substance abuse or dependence problem at the current time. Specific substances that John may be abusing are unclear but may include alcohol and marijuana, and there remains the possibility that other substances may be involved. Additionally, John appears to have developed a constellation of behaviors characterized by rule and norm breaking, with little concern for the impact of his behavior on others. Accordingly, the following provisional diagnoses are offered:

Axis I: Conduct Disorder, Adolescent Onset, Moderate Polysubstance Abuse, Rule out Polysubstance Dependency

Axis II: No Diagnosis

Axis III: No Diagnosis

Axis IV: Educational Problems, Problems with Primary Support Group, Problems Related to the Legal System

Axis V: 55-Current

SUMMARY AND RECOMMENDATIONS

John Doe is a young man with a two year history of increasingly problematic behavior that is characterized by intimidating and aggressive behavior towards peers and adults, theft, academic underachievement, and substance abuse.

Given the above, John is in need of intensive treatment at this time. First, although John maintains that he is not abusing substances at this time, information provided to this writer suggests that placement in an intensive substance abuse treatment program is indicated. Following completion of either a residential or intensive outpatient program, John will need intensive follow-up and monitoring that includes random drug testing.

Additionally, John will also benefit from structured supervision by and contact with DJJ. John may also benefit from involvement in individual therapy. There may be some concern about John's peer group at this time and some restrictions with respect to this may be indicated. Involvement in prosocial activities (e.g., organized sports or clubs) will be helpful and should be considered as part of his intervention plan. If John does leave school, stable employment or participation in an alternative training or educational program is indicated.

The relationship between John's recent behavioral difficulties and his parents' marital difficulties is unclear, but John may benefit from having the opportunity to discuss these and related issues. Reports by John's mother suggest that she might benefit from parent training or individual therapy.

Positive prognostic indicators include John's relatively good adjustment until the past two years, his history of academic achievement, and his mother's support and involvement. Factors that prove to be of some concern regarding positive changes on John's part include his unwillingness to acknowledge what appear to be clear problems (e.g., his substance use), his tendency to minimize the severity of some of his behavior, and the pattern of increasingly criminal behaviors. Certainly, without significant intervention, John is at risk for continued and more serious delinquent/criminal activities.

Thank you for this opportunity to serve the court. As always, if you have any questions about my evaluation, please do not hesitate to contact me.

Respectfully submitted,

Mary Smith, Ph.D
Licensed Psychologist

REPORT OF PSYCHOLOGICAL EVALUATION OF JOSH ADAMS

Name: Josh Adams
Date of Evaluation: 4/18/2002
Age: 13 years
Date of Birth: 9/15/1988
Referral Source: Linda Attorney
Evaluator: Lawrence Henderson, Psy.D

REASONS FOR REFERRAL:

Josh Adams was referred for a psychological evaluation by his attorney to assist in understanding and treating a variety of serious behavioral concerns. Results of this evaluation were to be used to inform specific treatment and placement plans for Josh.

RECORDS REVIEWED:

Psychological Evaluation by Gordon Humphrey, Ph.D. (2/21/2002)
Pediatric Neurology Outpatient Notes, Jack Marshall, M.D., Lang Medical Center (1/31/02)
Pediatric Cardiology Outpatient Notes, Joseph Bellows, M.D., Lang Medical Center (1/18/02)
Records from Mountain View Academy Intermediate Secure Treatment Facility, *including*:
 Psychiatric Assessment by Miles Wilson, M.D. (3/12/02)
 Individual Service Plan Six Month Review (3/4/02)
 Individual Service Plan Three Month Review (1/4/02)
 Individual Service Plan (9/30/01)
Psychiatric Evaluation by Steven Butler, M.D. (9/14/01)
Psychological Evaluation by Charles Lundy, M.A. (9/17/01)
Records from Juvenile Court of Milwaukee, Wisc., *including*:
 Transcript of Detention Hearing (9/7/01)
 Juvenile Petition (9/6/01)
 Written Statement of Josh Adams and Signed Waiver (9/5/01)
Records from Child & Adolescent Clinic, *including*:
 Psychological Evaluation by Charles Lundy, M.A. (9/29/00)
 Psychological Re-Evaluations by Charles Lundy, M.A. (11/24/99, 3/20/00)
 Psychiatric Evaluation by Gary Ginsburg, M.D. (8/30/99)
 Psychological Evaluations by Diane Snyder, M.A., and Roger Santiago, Ph.D. (6/4/98, 9/19/98)
 Psychiatric Evaluation by Trude Bianco, M.D. (5/28/98)
 Psychological Evaluations by Katherine Hollimon, M.A., and Paulette Miller, Ph.D. (10/29/95, 1/25/97)
 Psychiatric Evaluations by Sarah Hurwitz, M.D. (9/20/95, 10/4/96)
 Psychiatric Evaluation by Steven Fitzmartin, M.D. (11/11/95)
Records from Elmhurst Hospital, *including*:
 Discharge Summaries by John Richman, M.D. (11/26/93, 9/25/94, 8/13/95, 10/11/97)
 Psychiatric Assessment by Michael Dalton, M.D. (9/14/97)
Records from First Milwaukee Hospital, *including*:
 Discharge Summary by Michael Dalton, M.D. (5/10/97)

Social Service Discharge Summary by David Morgan, M.A. (5/10/97)
History and Physical Report by Angie Simmons, M.D. (4/30/97)
Records from Presbyterian Hospital, *including*:
Discharge Summary by Mina Patel, M.D. (7/26/96)
Social Assessment by Don Meadows, M.S. (7/8/96)
History and Physical Record by Jonathan Ebert, M.D. (7/4/96)
Records from Children's Hospital of Milwaukee, *including*:
Discharge Summary by Robert Silver, M.D. (12/20/95)
Diagnostic Summary by Donna Crouse, M.S.W. (12/16/95)
Psychiatric Update by Robert Silver, M.D. (12/15/95)
Biopsychosocial Summary by Donna Crouse, M.S.W. (11/30/95)
Psychiatric Evaluation by Robert Silver, M.D. (11/11/95)
Records from Various Schools, *including*:
Notices of Recommended Assignment (5/3/95, 11/21/96, 7/23/01)
Individualized Education Programs (9/8/95, 12/1/00, 6/8/01)
Comprehensive Evaluation Reports (10/6/99, 6/3/01)

EVALUATION METHODS:

Collateral Interview via Telephone with Josh's Mother, Evelyn Drake
Collateral Interviews via Telephone with Mountain View Academy Counselor, Joe Merna;
Unit Supervisor, Matthew Simmons; and Group Therapy Facilitator, Sue Stotland
Achenbach Child Behavior Checklists, Completed Separately by Mr. Merna and Mr. Simmons
Clinical Interview with Josh
Bender Visual-Motor Gestalt Test
Projective Figure Drawings
Thematic Apperception Test (TAT)
Rorschach Inkblot Method (Attempted)
Minnesota Multiphasic Personality Inventory – Adolescent Version (MMPI-A)

BACKGROUND INFORMATION:

Identifying Data and Family History

Josh Adams is a thirteen year-old Caucasian male who is currently being held in residential placement at the Mountain View Academy in Woodside, WI. Josh entered this placement on 9/28/01, after being arrested for Indecent Assault earlier that month. Prior to his arrest, he was living with his mother, step-father, and sister Samantha (age four). Josh's arrest stemmed from charges that he had been engaging Samantha in sexually inappropriate behavior on multiple occasions over a roughly two-month period of time.

Josh was born in Ohio but has lived in north-central Wisconsin since he was approximately eighteen months old. His parents divorced when he was very young, and he has had little or no contact with his biological father. In available records (e.g., see evaluation by Dr. Ginsburg, 8/30/99), his father has been described as a "very hyperactive individual ... known to be quite aggressive [and] ... in and out of jails." According to Josh's mother, his father had a history of alcohol abuse, as did Josh's paternal grandfather and four of the father's siblings.

According to records, Josh's mother also has a remote history of poly-substance abuse but has been substance free for roughly twelve years. Records indicate that this contributed to an early history of physical neglect for Josh, but this has reportedly not been a concern since he was a young child. According to records, the family history also includes alcohol abuse in Josh's maternal grandfather and other maternal relatives. Mrs. Drake denies any additional family history of substance abuse or other mental health concerns.

History of Presenting Problems

On 9/6/01, Josh was charged with Indecent Assault. According to police records, Josh admitted to "[touching Samantha's] genital area with his penis many times during the months of May 2001 and June 2001." In conjunction with the current assessment, Mrs. Drake offered the evaluator the following account of events leading to her son's arrest: Approximately one year ago, Mrs. Drake observed Samantha "grinding against people" in a sexualized manner, and when she asked her daughter what she was doing, Samantha replied, "playing the 'oh baby game.'" Samantha then told her mother that, on more than one occasion in the home, Josh had laid on top of her and "rubbed against her." According to Mrs. Drake, Samantha added that this generally took place with both of their clothes on, but that once he had taken her underwear off. Mrs. Drake subsequently reported Samantha's comments to authorities in an effort to seek services for both children. A medical exam of Samantha revealed a "broken hymen but no proof of penetration." She was referred for outpatient psychotherapy, which Mrs. Drake states is currently continuing. During a psychological evaluation of Josh conducted shortly after his arrest, (see report by Psychological Evaluation by Charles Lundy, M.A. (9/17/01)), Josh reportedly provided a very similar account of the sexual incidents but added that "he had his pants down" during at least one of these incidents. In the report of a subsequent psychiatric evaluation by Dr. Butler, M.D. (9/14/01), there is additional mention of "oral genital contact," but this is not discussed in any other records, and Mrs. Drake and Josh both assert that this is an error, denying any knowledge of such contact.

Since being placed at Mountain View Academy, Josh had exhibited extremely poor adjustment. Staff members describe him as "really struggling," as he has demonstrated "constant" defiance and oppositional behavior to varying degrees throughout his placement. One staff member suggested that Josh "needs more" structure and support than this placement can provide because he refuses to comply with staff to improve his behavior. He reportedly requires verbal redirection on a frequent basis throughout the day, as well as numerous "assists" from staff to physically redirect or control his behavior. At times, he appears unable to focus and has difficulty staying on task to complete assignments. Additionally, staff members and records describe Josh as manipulative and provocative, apparently deriving pleasure from "setting off staff to see what they'll do." He reportedly tells "blatant small lies to instigate" conflict among peers and staff. However, staff members each reported there have been no significant incidents of aggressive or violent behavior during his placement, and there have been no known incidents of sexually inappropriate behavior (in terms of physical contact, verbalizations, or gestures). Staff further report that one area where Josh has made progress is in groups, including sex offenders group, where he has acknowledged and discussed the sexual offending behavior that prompted placement. Although he initially was reluctant to disclose, he has since reportedly maintained consistent acknowledgment of his sexual behavior and has worked on relevant treatment goals. According to his group facilitator, Grace Stotland, Josh has expressed concerns that he may repeat that behavior upon discharge to his home.

Josh has an extensive history of behavioral and emotional concerns and corresponding mental health interventions, which began shortly before his fourth birthday. This includes approximately eleven psychiatric hospitalizations, beginning at age five, each in response to out-of-control, violent, or otherwise destructive behaviors. Voluminous records are available for specific details of these hospitalizations, but presenting problems at the time of various admissions have included the following: labile mood and tantrums; threatening his mother with a knife; threatening to hurt his mother and her unborn child (Samantha) during her pregnancy; attempting to stab his step-father with a barbecue fork; trying to set fire to a cot at home; being cruel and malicious to a cat; fighting with peers and school staff; urinating on peers and on property when angered; stealing. Records also indicate an early childhood history of anxious behaviors, including chewing his hands, and enuresis and encopresis as late as age six. There is a documented history of early psychotic symptoms, but these are not clearly delineated in available records. Josh has been followed for mental health services through the Child & Adolescent Clinic since he was nearly four, and numerous interventions have been offered in the community. He has participated in individual therapy, intensive home-based family counseling, wrap-around services in the home and school, and partial hospitalization. Most recently, he was placed into residential care through Bethany Christian Services in 1997 for approximately nine months (exact dates unavailable), then discharged to his home with wrap-around services and related interventions. Josh has been assigned numerous diagnoses, most often including Attention-Deficit/ Hyperactivity Disorder, Conduct Disorder, and Bipolar Disorder. He has been prescribed an extensive array of medications to address these conditions, including various psychostimulants, antidepressants, mood stabilizers, and antipsychotics. None of these medications have proven effective over time, with the exception of Tegretol and Dexedrine. The former was discontinued because of a negative allergic reaction. The latter has been discontinued in the past, because it suppressed Josh's appetite and weight. However, at the time of this assessment, he was taking Dexedrine spansules (10 mg twice daily) plus Remeron (30 mg, ½ tab at bed time) to counteract those negative effects. He had been taking this combination of medications since 10/27/01, after multiple prior medication adjustments at Mountain View Academy.

Developmental and Medical History

Josh's perinatal history was marked by multiple complications. According to records, during the pregnancy his mother used alcohol, cocaine, heroin, and Thorazine. He was born full-term (at seven pounds, six ounces) but was delivered via unplanned Caesarian section due to fetal distress. At the time of delivery, Josh suffered from meconium asphyxiation (i.e., swallowing his own feces). He was separated from his mother following the delivery, due to medical complications both were experiencing, and he had limited contact with her throughout the hospitalization. Josh was able to leave the hospital after two weeks, but his mother remained there for over a month. Following these initial insults, Josh reportedly showed no significant medical difficulties as a young child. All developmental milestones were reached within age-expectable limits.

In September 1994 (age six), Josh was evaluated for Fetal Alcohol Syndrome (FAS) at Children's Hospital of Milwaukee, in light of his prenatal history and ongoing problems with hyperactivity and poor behavior control. At that time, FAS was ruled out. In November 1994, a neurological evaluation revealed an abnormal EEG, suggesting that some form of neurological dysfunction might be contributing to Josh's behavior control problems. However, recently he was referred for an updated neurological evaluation and cardiology exam. These procedures,

which were both performed at the Lang Medical Center in January, 2002, revealed no abnormal findings.

Josh states that he is currently in good physical health, with no significant medical limitations. He describes a variety of minor injuries he sustained from various childhood accidents, but he denies any serious head trauma, loss of consciousness, or seizures. Records indicate a history of surgical procedures in 7/93 and 6/94 to realign both eyes due to strabismus. There is no other significant medical history.

Academic History

Prior to his current placement, Josh last attended public school as a seventh grader at Dorset Middle School. Records indicate that at that time, he was enrolled on a part-time basis in an Emotional Support classroom. He has a long history of special education services to address his behavior problems in the classroom, but records describe a history of earning high marks. Josh has reportedly never repeated a grade.

Achievement testing conducted through the school district for his most recent Comprehensive Evaluation Report (6/3/01) revealed fifth grade math and reading levels, as well as middle school level performance in other subject areas. These scores reflect slight delays in academic areas relative to Josh's intelligence, which has recently been found to be at least average. Specifically, during a recent psychological evaluation by Dr. Humphrey (1/21/02), Josh earned a WISC-III Verbal IQ in the Average range and Performance IQ in the High Average range. Earlier testing of cognitive abilities (in 9/92 and 10/95) produced discrepant results, reportedly due to poor attention and/or cooperation during those test sessions. On the basis of early test results, Josh has been diagnosed in the past with Borderline Intellectual Functioning, but this appears to be a gross underestimate of his true abilities, in light of more recent results.

Juvenile History

Josh has no charges prior to his current arrest.

Substance Abuse History

Josh denies any use of alcohol, marijuana, or any other drugs throughout his life. There is no indication in available records to suggest he has used any of these substances.

Psycho-Sexual History

The sexually inappropriate behavior that prompted Josh's current placement is described above. Records indicate no known sexually assaultive or inappropriate behavior committed by Josh prior to the above-mentioned contact with his sister, with the exception of an earlier history of being removed from his school bus "on occasion" for making "sexually lewd comments to female drivers." No further information is available about those incidents.

Josh's history is significant for at least one incident of sexual victimization. Specifically, when he was approximately eight years old, he was reportedly touched on the genitals on multiple occasions by an older male peer while placed out of the home. In earlier records (see

psychiatric assessment by Dr. Dalton, 9/14/97), there is mention of a separate incident of "inappropriate sexual stimulation by a [male] van aide" when Josh was age five. This incident was never confirmed. There are no other known incidents of sexual abuse. Josh denies having any direct exposure to sexual behavior, including witnessing sexual activity or nudity in person. At the same time, according to records, (see psychiatric assessment by Dr. Miles Wilson, M.D., 3/12/02), Josh has had some limited exposure to soft pornography with friends. This was characterized by Dr. Wilson as "within the realm of normal adolescent curiosity." During the current assessment, Josh acknowledged such exposure to pornographic videos and magazines, but he categorically denied any other instances of participating in sexual activity of any kind. He denied having any girlfriends, minimized having any sexual interest in females, and denied having engaged in any intimate or sexual contact with peers.

Behavioral Observations and Clinical Interview

Josh was seen jointly by two evaluators at Mountain View Academy on one day for a morning and afternoon session totaling approximately six hours to complete clinical interviewing and psychological testing. At that time, he presented as an attractive, dark-haired latino male whose small stature made him appear slightly younger than his stated age. At the time of the assessment, he was dressed in casual, clean, appropriate attire and had adequate hygiene. Josh had reportedly taken his morning dosage of medication approximately one hour prior to the start of the assessment, which clearly impacted his behavior as noted below. At all times, Josh was alert and fully oriented. He generally presented little evidence of excessive restlessness or distractibility throughout both lengthy sessions. However, nearing lunch time, he did become increasingly distracted and less focused, so that he was unable to complete certain test exercises. Subsequently, he was administered his midday dosage of medication, and this had a dramatically positive effect on his ability to focus throughout the afternoon. Josh's gross motor abilities were judged to be intact, with no problems with gait, balance, or posture. Fine motor skills were also intact. Speech, receptive language, and expressive language were all age-appropriate, with no major impediments preventing communication with the evaluators. During much of the assessment, Josh's speech was rapid and voluminous, though not pressured. His mood was bright, with a normal range of affect. Josh acknowledged feeling depressed but had difficulty articulating his exact experiences. He denied any present suicidal or homicidal ideation. He denied a variety of psychotic symptoms upon direct questioning. His thought content and thought processes were normal.

Josh met the evaluators with no reluctance and quickly became engaged in active conversation. He arrived carrying several paperback books and related that he often reads up to ten books at a time. He described various personal interests with a fair amount of knowledge and depth. Shortly into the session, he openly bragged about his intelligence, his memory, and other assets, including his ability to "outsmart" doctors. He also boasted happily about numerous assaults he had carried out at Mountain View Academy (staff later refuted the fact that Josh had been involved in five major assaults, as he had claimed). In response to questions in most areas, Josh appeared open, honest, and matter-of-fact. In contrast, however, he appeared more reluctant and cautious in answering questions about the sexual behavior that prompted his admission. With encouragement and prompting, he eventually related an in-depth account of one incident of sexual contact with his sister. He provided a careful and extremely detailed description of events leading up to his actual sexual behavior, but then claimed to have difficulty remembering information about the actual sexual contact. With continued prompting and support, he finally provided an account that was highly similar to events described above

and in available records, with two exceptions: by his current report, Josh rubbed on top of Samantha on only one occasion; and, during that occasion, there was no removal of clothes. Later, when he was confronted with records that were inconsistent with his account, and Josh adhered to his story and could provide no explanation for such discrepancies. At other times during the clinical interview, Josh provided contradictory statements about other topics, and when questioned for clarification, he appeared unconcerned about these inconsistencies.

When he was presented with formal testing exercises, Josh generally took a highly invested approach, working slowly and deliberately, reworking his products, and offering comments that suggested he was very concerned with the quality of his responses. Over time during the morning session, he became increasingly frustrated and less able to focus, which seriously reduced his level of effort. This appeared to be related to a combination of the ambiguous nature of certain testing exercises (which prevented Josh from controlling the quality and content of information he was providing) and the wearing off of his morning medication. During the remainder of the assessment, Josh was highly verbal and productive, providing rich information that suggested relatively high levels of intelligence and imagination. Notable during the evaluation was some extreme slowness, which at times appeared intentional and controlling (e.g., to prolong the evaluation and to avoid other tasks). Overall, data collected during this evaluation appear to be valid indicators of Josh's levels of functioning.

Evaluation Results

This assessment finds Josh to be currently functioning better than in the past but still experiencing significant behavioral, interpersonal, and emotional concerns that are causing discomfort for himself and the people around him. Behavior checklist results provided by two Mountain View Academy staff members provide a snapshot of Josh's current functioning. Showing average to above-average agreement, these staff members endorsed significant problems across several of the broad areas assessed, with an emphasis on externalizing or acting-out problems. Based on the verbal reports of staff, Josh's current behavior is characterized by "constant" disobedience, as well as a variety of provocative, instigating, and attention-seeking behaviors directed toward peers and staff, which collectively make him extremely difficult to manage over time.

Despite these widespread difficulties, it is notable that staff report relatively little overt physical aggression, except for incidents that took place earlier during his placement. Although he is currently demonstrating difficulties managing his behavior in many areas, this actually represents an improvement relative to his long history of repeated, serious, out-of-control behaviors. Available information indicates the presence of a serious Attention-Deficit/Hyperactivity Disorder (ADHD), composed of both hyperactive-impulsive symptoms and difficulties focusing attention and concentration. These symptoms are in addition to longstanding entrenched conduct-disordered behaviors that have made Josh difficult to manage in any setting. It is possible that an underlying mood disorder (e.g., bipolar disorder) accounts for some of Josh's volatility and other symptoms, but at present his negative behaviors seem best explained by the presence of both severe ADHD and conduct disorder stemming in part from his exposure to difficult environmental factors, discussed in more detail below. In contrast to the pattern of behavior documented throughout his childhood, it is notable that he is currently described as usually being in control of himself, acting in defiant and oppositional ways only to a degree that he needs to gain attention or intervention. One component that appears to be working effectively at present is Josh's current medication regimen. Based on behavioral

observations during this assessment, as well as other available information, it is obvious that his medication is allowing Josh to maintain a comparatively high level of focused concentration and behavioral control, which is in contrast to his functioning in the absence of medication.

Also notable about Josh's current presentation is the complete absence of sexual aggression or sexually inappropriate behavior, according to reports provided by all staff members and by Josh. All available information portrays his sexual contact with his sister as a relatively isolated series of behaviors, rather than being indicative of an emerging pattern of deviant sexuality. Although his acts could be seen by observers as such, at present it would be inaccurate and detrimental to Josh to label him as a child with deviant sexual interests or behaviors. Instead, his sexual acting-out appears to be symptomatic of pervasive impulse control problems and other concerns described in this report. Josh has demonstrated a life-long pattern of maladaptive, impulsive behaviors, and as he has approached puberty and adolescence, it is not surprising that some of these behaviors have been expressed through sexual acting out. Josh remains at risk of acting out sexually as he did prior to placement, as long as he remains at risk of more generalized acting out. Treatment is most likely to be effective in reducing his risk of sexually inappropriate behavior by viewing this area of functioning as one component of much larger behavior control problems that need to be alleviated.

Josh's longstanding conduct problems appear largely attributable to two main sources. First is the presence of an ADHD condition rooted in low-grade, diffuse neurological impairment, which hinders his ability to focus and control his behavior effectively unless medication and other intensive interventions are in place. Second is the presence of attachment deficits associated with Josh's experience of multiple important separations and losses throughout his childhood (e.g., separation at birth from his mother during a critical bonding period; inconsistent attachment, as well as reported neglect during his earliest months of life; absence of his biological father; and repeated separations from family due to the need to place him outside the home on numerous occasions).

Josh's attachment difficulties continue to impact his ongoing behavior in a number of ways. First, he exhibits strong needs for connection, including tactile closeness, but has not developed age-appropriate strategies for getting those important needs met. It is notable that some of his acting-out behaviors appear geared toward eliciting attention and physical contact from others. In fact, one staff member commented that Josh has been observed acting "out of control" just long enough and seriously enough to warrant an "assist" from staff, then stopping himself as if he has "gotten what he wanted." Josh's provocative behavior elicits emotionally charged attention from others, but usually this attention is highly negative. Although he may be capable of positive, mutually enjoyable exchanges, he has not learned to connect with people in these ways on a consistent basis. Instead, he often seeks closeness or attention in indirect, maladaptive ways. Josh has been repeatedly described as manipulative, but it should be noted that at least some of his "manipulative" behaviors appear aimed at gaining important interpersonal connections, rather than simply representing efforts to control or con others.

Another consequence of Josh's chronic, repetitive separations and losses is the presence of strong negative emotions that he has difficulty identifying and expressing appropriately. One of these powerful emotions is anger, which certainly has contributed to violent behavior in the past. Much of Josh's earlier aggression was directed toward close family members, who were

the target of poorly controlled rage. More recently, with a high level of structure and support, Josh has not shown such serious aggression. Instead, he continues to act out his anger through oppositional and passive-aggressive behaviors directed toward authorities. Other negative emotional experiences for Josh involve feelings of sadness, loss, and emptiness. These are difficult for him to identify and articulate effectively, so he is often prone to act them out through irritable, frustrated behavior directed toward the people around him. Josh's comments during the clinical interview, as well as his responses to a lengthy self-report inventory, reveal the presence of various low-grade anxious and depressive experiences. He appears to be internalizing negative experiences because he has not developed effective strategies for coping with them. It is important to note this tendency to internalize, as it clearly causes Josh discomfort and distress that could go unnoticed by the people around him, as they are often forced to focus on his overt acting-out behaviors.

Josh is a bright child with notable strengths, including a creative imagination, varied interests, and solid verbal skills. (Intellectual abilities were not formally tested during this assessment, but recent testing and current behavioral observations suggest average to high average potential.) While these are obviously strengths, Josh's ability to function at a high level in some areas may actually be problematic for him at times. That is, despite his high intelligence and other strengths, he experiences longstanding serious problems in other important areas (i.e., behaviorally, interpersonally, and emotionally). He is acutely aware of these problem areas and the fact that they are preventing him from living up to his ample potential. This appears to be highly distressing to him. Josh's responses to a thorough self-report inventory portray him as an individual who, along with mild depressive and anxious features, often feels alienated and alone, misunderstood by others and uncomfortable around them. He may avoid direct social contact with people at times because he is suspicious of them or is afraid of being rejected. He is intensely sensitive to perceived slights or maltreatment from other people, and he may retaliate behaviorally when he feels he has been put down. He often sees himself as a victim, which presents problems in interpersonal situations and causes him to avoid blame for his part in interpersonal conflicts.

Summary

Josh Adams is a thirteen-year-old male referred for a psychological evaluation to assist in placement and treatment planning, in light of recent (nearly one year ago) sexually inappropriate behavior directed toward his sister for a period of approximately two months. In addition to this behavior, which prompted legal charges and residential placement, he has a life-long history of extensive behavior management problems, which have required varied and intensive treatment interventions throughout his childhood. The current evaluation finds that, despite his highly structured, supportive, and controlled setting, Josh continues to demonstrate serious behavior management problems in the form of constant oppositional and defiant behaviors. Notably, he currently displays a complete absence of sexually inappropriate activity and a relative absence of the kinds of explosive, physically aggression behavior documented in the past. Information from all sources indicates the presence of underlying ADHD, barely controlled throughout his childhood but now attenuated to some degree by his current medication regimen. In addition, Josh exhibits longstanding behavioral symptoms associated with a conduct disorder, partly rooted in early and repeated separations and losses. These experiences continue to impact his functioning and are played out in his daily interactions. For example, he demonstrates socially delayed interpersonal skills, including a tendency to use inappropriate strategies for seeking out emotional and physical contact from others.

Additionally, he experiences powerful negative emotions that he cannot fully identify or articulate, and this contributes to his likelihood of acting out in an effort to externalize these experiences. Josh is acutely aware of his serious behavioral and emotional difficulties, because they are in stark contrast to his notable strengths in other areas, and this awareness is causing him a great deal of discomfort. Self-report measures reveal the presence of mild anxious and depressive features, as well as a prominent sense of interpersonal isolation and alienation. Josh appears to genuinely want to change his behavior for the better, but he simply lacks an understanding of how to do so. With regard to Josh's history of sexually inappropriate behavior, it is important to view this behavior as one symptom within a pervasive pattern of impulsive control problems, combined with a tendency to act in inappropriate ways to meet his needs for physical and emotional closeness. While there is no evidence to suggest Josh will display an ongoing pattern of sexually deviant arousal and behavior, he does remain at risk of acting out sexually as long as he continues to exhibit his larger pattern of difficult-to-manage behavior.

Diagnostic Impression

Axis I: Attention-Deficit/ Hyperactivity Disorder, Combined Type
 Conduct Disorder, Childhood-Onset Type, Severe
 Rule/Out Bipolar II Disorder

Axis II: Deferred

Axis III: No Diagnosis

Axis IV: Current Stressors = Severe: Legal involvement; Separation from family;
 History of multiple removals from home; Social conflicts with peers and
 adults; Absence of biological father

Axis V: Current Global Assessment of Functioning (GAF): 40

Recommendations

Josh has shown a life-long course of severe acting out behavior, which has repeatedly placed himself or others at risk of serious harm. While there have been periods of relative calm, even those times have not been problem-free. For example, Mrs. Drake reports that during roughly the year prior to Josh's current placement, he was "doing well" with "few aggressive outbursts;" however, it was during this period that he began sexually acting out with his sister for an extended period of time before finally being discovered. All available information suggests that if Josh is returned to the community at the present time, even with all the intensive resources available in his area, he would present a risk of acting out and risking harm to himself (e.g., causing re-arrest) or to others (e.g., making sexual contact with his sister again, which he has expressed worries about during his placement).

Because he presents this high level of risk, it is strongly recommended that Josh continue to be placed in a residential treatment facility that is designed to meet his needs, for a minimum of twelve months. This recommendation has not been made lightly, in light of Josh's and his mother's strong wishes for him to return home. There are serious concerns about the possible difficulties related to further separation from his family, especially given how prior separations have impacted his functioning. However, these important concerns are outweighed by the high level of risk Josh currently presents to his sister, himself, and others if placed into a setting any less restrictive than his current residential placement.

The goal of Josh's continued placement is the stabilization of his behavior through medication management and other critical mental health interventions. These include his participation in a controlled, structured milieu with specific interventions provided to help him develop the internal controls necessary to function appropriately in society over time.

An important component will include teaching Josh cognitive-behavioral strategies for building age-appropriate interpersonal problem-solving skills. In formal settings such as group therapy, as well as informally through the structured, therapeutic milieu, Josh's ability to delay behavior, think about possible consequences, and decide on the most appropriate alternative must be developed and constantly reinforced.

Josh also needs interventions designed to bolster his social skills and ability to relate to others in age-appropriate ways. In group therapy and in the overall milieu, positive interactions must be reinforced. At the same time, whenever possible it will be helpful to discourage and ignore Josh's efforts to engage people negatively (e.g., instigating peers; provoking staff to the point of receiving physical restraint). As Josh starts to escalate, the most effective intervention may be to remove him from any reinforcement, through time-out or seclusion, so his negative behavior cannot earn the contact and attention he is seeking at those times.

Josh would benefit from participation in regularly scheduled individual psychotherapy to address the emotional and interpersonal issues that continue to impact his behavior. His therapist can help him to identify negative emotions (e.g., anger, sadness) and to cope more effectively with them, instead of lashing out when he experiences these feelings. Josh's therapist must be a skilled professional with experience working with children with his types of background experiences and provocative behaviors. Josh is likely to provoke and frustrate his therapist, so this person must remain vigilant to his or her own reactions of anger, irritation, or even helplessness, so that these reactions do not hinder Josh's treatment.

Josh's current medication regimen appears to be having some positive impact on his ability to remain focused and control his behavior in his current setting. This is especially notable given his long history of multiple medication failures. Even if Josh experiences a change in treating physician or placement, it is strongly recommended that he remain on his current medications unless there are compelling reasons to make a change.

Placement in a facility geared toward sex offenders does not appear indicated at this time. Once Josh has met treatment goals in his current sex offender group, it would be in his best interest to treat his history of sexual acting-out as another manifestation of his acting-out and impulse control problems in all areas. Alleviating Josh's generalized conduct problems is expected to reduce his specific risk of sexually inappropriate behavior.

Staff's approach to Josh is critical to his behavioral adjustment. Some of his current defiant behaviors appear to represent a reaction to extremely behavioral expectations. Staff may find it helpful to "pick their battles wisely" with Josh and allow some flexibility over minor issues, insofar as this is possible in a residential setting. Allowing some flexibility without accepting manipulation of the rules is expected to have a positive impact on Josh's oppositional behaviors.

Another critical component of Josh's treatment is the involvement of his family prior to his release home. There must be regular contact between Josh and his family, including ongoing visits at the facility. Staff and the family must be unified in their approach to Josh's treatment in order to promote success. Throughout his placement, Josh should be allowed to step down

gradually to the community, by participating in regular home visits that eventually increase in frequency and duration. This step-down process may also require an intermediate placement prior to full return to the home from residential placement. These decisions can be made by the treatment team over time, depending on Josh's level of risk and his progress in placement.

The Abraham Lincoln Mental Health Residential Treatment Facility appears to be uniquely qualified to meet Josh's varied behavioral and emotional needs. Because this facility services both dependent and delinquent youths of a wide age range, there is a reduced risk of Josh's being placed solely among more serious, persistent delinquent offenders. Also, the facility provides an extensive step-down program that will be critical for Josh's long-term adjustment.

Prior to his return to the home, there must be intensive interventions already in place there, so there is no gap in services during that critical transition period. At that time, he will probably need intensive wrap-around services in the home and school to provide the high level of monitoring and behavioral support he requires. In the home these services will be especially crucial, as they will provide close monitoring of his behavior, and support to his parents in their efforts to monitor and discipline Josh. Continued enrollment in individual psychotherapy will also be beneficial on an outpatient basis, to continue progress that had been made in placement and to deal with new stressors that emerge in home and school. The treatment team working with Josh at that time will be able to make more specific recommendations as needed.

Lawrence Henderson, Psy.D.
Licensed Psychologist

Thomas Earle, Ph.D.
Licensed Psychologist

APPENDIX C

Outline for Assessing Expert Witness

For use as a handout.

*The attached worksheet was prepared by Antoinette Kavanaugh, Ph.D.,
Clinical Co-Director, Clinical Evaluation and Services Initiative, Chicago, IL
Tel: 312. 433.6850 Email: a-kavanaugh@nwu.edu*

Date: _____
witness _____

Name of witness/potential

AN OUTLINE FOR ASSESSING AN EXPERT WITNESS OR POTENTIAL WITNESS

Developed by Antoinette Kavanaugh, Ph.D.

For more information, call 312-433-6850

I. The Case

The redefined referral question (should be clear, concise and reference the legal issue at hand)

II. The Evaluation

A) What would your evaluation consist of?

B) What does my office need to provide at this point?

III. The Expert Witness

A) Training and supervised experience

a) Did you complete a post-doctoral program in forensic psychology or a forensic psychiatry fellowship? _____
i) If so, describe the program.

b) Have you had training in case law and forensic ethical guidelines? _____
i) If so, describe the training.

B) Independent work experience

a) Describe the clinical experiences you have with children/adolescents (ask about your client's age group).

b) Describe your experience conducting forensic evaluations, conducting forensic evaluations involving the legal issue at hand, and conducting forensic evaluations with children/adolescents.

Date: _____
witness _____

Name of witness/potential

C) Certification

- a) Are you licensed? _____ Since when and in what state? _____
- b) Psychiatrist - Are you board certified? _____
 - i) If so, in what area(s)? _____
- c) Psychologist - Are you a diplomat of the American Board of Professional Psychology? _____
 - i) If so, in what area(s)? _____

D) Relevant scholarly activities

a) Publications

b) Presentations

c) Workshops/conferences/lectures

d) Describe your university affiliations (e.g., when, which university, position, role/duties/responsibilities).

e) Describe the professional organizations that you are currently an active member of.

E) Knowledge of relevant psycho-legal issues

a) Can you explain the differences between a therapeutic and forensic evaluation?

b) Can you explain the difference between a treating witness and an expert witness?

c) How do you conceptualize the legal standard/issue at hand?

d) What is your opinion regarding providing an ultimate or penultimate opinion?

e) What does the literature say regarding this specific legal issue for people who are similar to my client (in terms of age, intelligence, and prior court history)?

IV. Logistics

YES NO

- A) Interested in this expert witness? _____
- B) Requested a copy of CV/resume? _____
- C) Discussed judicial opinion about ultimate issue? _____
- D) Need to send expert witness relevant legal standard, statute, or case law? _____
- E) Fees _____
- F) Asked to send letter of agreement? _____

APPENDIX D

Conceptual and operational definitions for forensic assessment

For use as overhead.

APPENDIX E

Questions that a Developmentally-Sensitive Assessment Should Answer

This questionnaire is excerpted from "Expert Evaluations of Juveniles at Risk of Adult Sentences," by Marty Beyer in ABA CHILD LAW PRACTICE, Vol. 18, No. 2 (April 1999).

Strengths

1. What are this young person's strengths?

Maturity of Thought

1. How mature are this young person's thought processes?
2. At the time of the offense, to what extent was this young person anticipating outcomes? Reacting to threat? Minimizing? Seeing only one choice? Could this young person foresee the consequences of his/her actions?
3. Was this young person able to plan like an adult, and under stress, how did he/she react if things did not occur as planned?
4. If the young person was carrying a weapon, to what extent had he/she envisioned using the weapon to cause injury?
5. What else is informative about this young person's intent at the time of the offense?

Moral Values

1. What moral values was this young person brought up with in his/her family?
2. What is this young person's understanding of fairness, rights, and responsibility?
3. Does this young person consider loyalty a higher moral principle than conventional views of right and wrong?
4. How does this young person view the wrongness of the offense, and how does he/she explain if the offense was a violation of his/her moral values?

Relationships

1. Who is this young person most attached to?
2. Does the young person feel a sense of belonging?

Empathy

1. Who does this young person show the most empathy for?
2. What are the young person's feelings for his/her victim?
3. Are this young person's adolescent bravado and/or his/her view of the offense as accidental being interpreted as a lack of remorse?

Prior Trauma

1. What connections, if any, exists between his/her childhood trauma and the offense? How does this young person's past trauma impact his/her cognitive processes? his/her perception of threat?
2. Does this young person need help recognizing that he/she is not to blame for childhood neglect, physical or sexual abuse, or domestic violence? Does the young person need help getting out of a victim role?
3. How much loss has the young person experienced?
4. To what extent has the young person grieved these losses?
5. Is this young person unusually controlling because of early victimization?

Learning Style

1. What connections, if any, exist between this young person's history of school problems and the offense?
2. What connections, if any exist between this young person's learning problems and his/her cognitive processes? His/her perception of threat?
3. Is this young person primarily an auditory learner, a visual learner, or someone who learns best by doing?
4. Does the young person need to develop compensatory skills for difficulties in processing visual or spoken information?
5. What is this young person's current reading and math skill level?
6. What is this young person's school history, including most recent IEP objectives?
7. Does the young person require special teaching techniques or help to follow instructions or to organize material?
8. What specifically are the triggers of school behavior problems for this young person – does he/she have difficulty concentrating? does he/she feel picked on by teachers or students?
9. Is school nonattendance caused by boredom or being embarrassed by lack of skills?
10. Does this young person have sports/music/art or other special interests that should be built on?

Anger and Fears

1. Does this young person have an anger cycle or a fear cycle?
2. Does this young person overreact to perceived hostility from others?
3. Does this young person need to improve the ability to regulate specific behaviors?
4. Does this young person need to improve the ability to express him/herself in effective, non-aggressive ways?
5. In what ways, if any, was this young person's anger cycle or fear cycle operating during the offense?

Purposes Served by Delinquency

1. To what extent is this young person's delinquency driven by a need for approval?
2. What is this young person good at?
3. Does this young person have a positive view of him/herself in the future?
4. What type of vocational instruction and/or employment assistance would fit this young person's need for success?

Substance Abuse

1. What connections, if any, exist between this young person's substance abuse and the offense?
2. What is the extent of this young person's use of alcohol and drugs?
3. Does this young person use substances to relieve depression or numb feelings?

Services to Build Strengths/Meet Needs

1. Having identified the young person's strengths and clarified what additional areas of need remain for this young person, what are the specific services that would meet his or her emotional, educational, and other developmental needs and build on those strengths?
2. What setting is likely to have the identified services to meet these needs and build on those strengths?
3. What setting would not meet this young person's needs or would be harmful to this young person?
4. To what extent have services designed specifically to meet the young person's needs been provided in the past, through child protective services, mental health services, school, and/or the juvenile justice system?

Amenability to Treatment

1. Does the young person want to change? Does the young person have a desire for approval that could lead to change?
2. What is the prognosis for this young person if these services are provided (i.e., will there be a reduction in the likelihood of recidivism)?

APPENDIX F

Psychological Testing References

Butcher, J.M. & Williams, C.L., *ESSENTIALS OF MMPI-2 AND MMPI-A INTERPRETATION*. Minneapolis, MN: University of Minnesota Press (1992).

DeMers, S.T., *Legal and Ethical Issues in Child and Adolescent Personality Assessment* in H.M. Knoff ed., *THE ASSESSMENT OF CHILD AND ADOLESCENT PERSONALITY* 35. New York: Guilford (1986).

Groth-Marnat, G., *HANDBOOK OF PSYCHOLOGICAL ASSESSMENT*. New York: John Wiley and Sons (2nd ed. 1990).

Harrington, R.G., *TESTING ADOLESCENTS: A REFERENCE GUIDE FOR COMPREHENSIVE ASSESSMENTS*. Kansas City, MO: Test Corporation of America (1986).

Kestenbaum, C.J. & Williams, D.T., eds., *HANDBOOK OF CLINICAL ASSESSMENT OF CHILDREN AND ADOLESCENTS, VOLS. 1 & 2*. New York: New York University Press (1988).

Sattler, J.M., *ASSESSMENT OF CHILDREN*. San Diego, CA: Jerome Sattler (3rd ed. 1992).

Williams, C.L., Butcher, J.N., Ben-Porath, Y.S., & Graham, J.R., *MMPI-A CONTENT SCALES*. Minneapolis, MN: University of Minnesota Press (1992).

APPENDIX G

American Academy of Psychiatry and the Law, ETHICAL GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY. Bloomfield, CT: American Academy of Psychiatry and the Law (October 1989).

Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW AND HUMAN BEHAVIOR 655 (1991).

APPENDIX H

Checklist of Minimum Criteria for a Good Forensic Evaluation

For use as a handout.

CHECKLIST OF *MINIMUM* CRITERIA FOR A GOOD FORENSIC EVALUATION

Inclusion of relevant identifying information

- ___ Who referred for evaluation
- ___ Completed via court appointment or confidential/ex parte?
- ___ Examinee's age
- ___ Examinee's grade in school
- ___ Examinee's involvement with the legal system
- ___ Past record
- ___ Current charges
- ___ Examinee's current status
- ___ Identification/attribution of all sources of information relied upon
- ___ Dates/duration of all interviews and tests
- ___ List of procedures used/ tests administered to conduct evaluation
- ___ Reason for evaluation (i.e., competence evaluation, evaluation for treatment options, etc.)
- ___ Notification to child of reason for evaluation, lack of confidentiality
- ___ Statement of legal question(s) to be addressed

___ **Review of all relevant information/records**

- ___ Is there relevant information that evaluator failed to consider?

___ **Description of mental states, capacities, abilities, knowledge, and/or skills that are relevant to the legal question at hand.**

___ **Description of the relationship between the mental states, capacities, abilities, knowledge, and/or skills assessed and their causal connection to the youth's abilities or issues about which the court is interested.**

___ **Information qualifying the conclusions drawn.** An explanation of the external limitations (i.e., testing conditions, the tests themselves, amount of time evaluator was given to interview the relevant parties, amount of background information that the evaluator was able to collect and review, etc.) that should be taken into account when relying on the evaluator's conclusions.

___ **Specific recommendations for intervention** (when appropriate) including specific interventions that are available in the community.