Juvenile Justice:

Evaluations of Competence and Transfer/Reverse Transfer

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Overview: Updates in Juvenile Forensic Assessment

I. *UNDERSTANDING ADOLESCENTS: A JUVENILE COURT TRAINING CURRICULUM* (Rosado, 2000)

a. Joint project of three organizations
   i. American Bar Association Juvenile Justice Center in Washington, D.C.
   ii. Juvenile Law Center, in Philadelphia, Pennsylvania
   iii. Youth Law Center, which has offices in San Francisco and Washington, D.C.

b. developed to provide modular, state of the art and state of the science training to judges, attorneys, and mental health professionals involved in the juvenile justice system

c. consists of 6 modules
   i. Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court
   ii. Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims
   iii. *Mental Health Assessments in the Justice System: How To Get High Quality Evaluations and What To Do With Them in Court*
   iv. The Pathways to Juvenile Violence: How Child Maltreatment and Other Risk Factors Lead Children to Chronically Aggressive Behavio
   v. 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
   vi. Evaluating Youth Competence in the Justice System

d. Modules can be downloaded at no cost from the American Bar Association Juvenile Justice Center's website (<http://www.abanet.org/crimjust/juvjus/macarthur.html>).

e. Revision: *TOWARD DEVELOPMENTALLY APPROPRIATE PRACTICE: A JUVENILE COURT TRAINING CURRICULUM* (2009), part of the MacArthur Foundation's Models for Change: Systems Reform in Juvenile Justice initiative.

f. Joint project of National Juvenile Defender Center and Juvenile Law Center

g. Consists of 5 modules:

i. *Adolescent Development*
ii. *Screening, Assessing, and Evaluating Youth*
iii. *Special Education and Disability Rights*
iv. *Legal Questions about Youth's Capacities*
v. *Communicating with Youth: Interviews and Colloquies*

h. Curriculum may be requested from <http://www.njdc.info/macarthur2.php>

II. The MacArthur Research Network on Adolescent Development and Juvenile Justice

a. Study group funded by the MacArthur Foundation
b. Purpose of Network is to help build a foundation of solid science and legal scholarship and convey it to practitioners, policy-makers and the public at large, whose support is crucial to meaningful reform in juvenile justice. The Network works to achieve these goals through the critical analysis of juvenile justice policies and practices, the design and implementation of new research on adolescent development and juvenile justice, and the communication of the results of these activities to policy-makers, practitioners, journalists, and other social scientists and legal scholars.
c. For more information on the MacArthur Research Network on Adolescent Development and Juvenile Justice, see the Network's website at http://www.mac-adoldev-uvjustice.org

III.

IV. Adolescent Decision Making & Juvenile Justice

a. Cognitive Development
   i. How adolescents think and reason
   ii. Research suggests that adolescents have generally similar capacities to adults form age 14 on
   iii. Some argue that differences in behavior may not result from difference in ability, but rather, differences in perceived value and costs of various activities
b. Psychosocial Development (Cauffman & Steinberg)
   i. Temperance (impulse control and reflection)
   ii. Perspective (ability to consider problems or events from various positions or perspectives, and place them in broader social context)
   iii. Responsibility (self reliance, identity, independence)

c. Cauffman & Steinberg (2000) administered measures of responsibility, perspective, temperance, & antisocial decision making to 1015 adolescents (8th grade, 10th grade, 12th grade, & college students
    i. Psychosocial Maturity Inventory
    ii. Consideration of Future Consequences Scale
    iii. Weinberger Adjustment Inventory
    iv. Youth Decision Making Questionnaire
d. Cauffman & Steinberg (2000) findings
    i. Moderate relationship between antisocial decision making, and sex and age
    ii. Responsibility, perspective, and temperance were all correlated at significant levels (r's = .36 to .40)
    iii. Relationship between age and responsibility, perspective, and temperance,with 8th and 10th graders showing lower levels of maturity
    iv. Antisocial decision making was negatively correlated with measures of psychosocially maturity
    v. Age was not a significant predictor of antisocial thinking when psychosocial maturity was considered; psychosocial maturity was a more powerful predictor of antisocial decision making than age

V. Criminal Decision Making and Youth

a. Fried & Reppucci (2001) surveyed 56 detained and non-detained 13 to 18 year olds regarding perceptions of criminal responsibility, time perspective, peer influence, and risk perception
    i. Criminal Decision Making Q
    ii. Stanford Time Perspective Inventory
    iii. Vignettes of peer Influence
    iv. Scale of Risk Perception
    v. KBIT
b. There was a curvilinear relationship between age and indicators of maturity, with the oldest and youngest adolescents scoring highest (greater time perspective, less susceptibility to peer influence)
c. Minority youth saw the offense as less serious than white youth and expected less severe sanctions

VI. Pathways of Juvenile Offending (T. Moffitt)
a. Life Course Persistent
    i. Early onset (before age 13)
    ii. Behavior disorder diagnosis (ODD, CD, ADHD)
    iii. Poor attachments
    iv. Violence history/instrumental violence

v. Lack of guilt
vi. Lack of empathy

b. Adolescence Limited
   i. Later onset (age 13 and older)
   ii. No behavior disorder diagnosis
   iii. Adequate attachments
   iv. Little violence history
   v. Lack of predatory or instrumental violence
   vi. Capable of guilt and empathy

VII. Juvenile Psychopathy

a. Psychopathy in adults is construed as a stable personality disposition that is highly predictive of violent and non-violent criminal recidivism
b. Whether psychopathy is a personality constellation that is
   i. stable
   ii. can be reliably assessed among adolescents, and
   iii. is predictive of behavior in the long-term is the subject of increasing attention
c. Psychopathy in adults is construed as a stable personality disposition that is highly predictive of violent and non-violent criminal recidivism
d. Whether psychopathy is a personality constellation that is
   i. stable
   ii. can be reliably assessed among adolescents, and
   iii. is predictive of behavior in the long-term is the subject of increasing attention
e. Although adolescents are presumed to manifest psychopathy in ways similar to adults, a number of PCL-R markers of psychopathy may be inappropriate for adolescents due to developmental differences between adolescents and adults, and differences in role expectations
f. Are adult markers of psychopathy applicable to kids? Does development make a difference?
   i. Impulsivity
   ii. Poor behavioral controls
   iii. Need for stimulation
   iv. Failure to accept responsibility for actions
   v. Promiscuous sexual behavior
g. Do role expectations make a difference
   i. Pathological lying
   ii. Parasitic lifestyle
   iii. Many short-term martial relationships
   iv. Revocation of conditional release

h. Concerns regarding juvenile psychopathy
    i. Impact of using the "label" of psychopathy with children
    ii. Is such a label that much different than the conduct disorder diagnosis?
    iii. If there is such a construct and it does have some power, do we ignore it?

i. Juvenile pychopathy & volence
    i. Moderate association between various juveniles measures of psychopathy and aggression
    ii. Unknown how stable scores on measures of juvenile psychopathy are
    iii. Unclear whether juvenile measures of psychopathy are better predictors of violence than historical factors
    iv. Moderate association between various juveniles measures of psychopathy and aggression
    v. Unknown how stable scores on measures of juvenile psychopathy are
    vi. Unclear whether juvenile measures of psychopathy are better predictors of violence than historical factors
    vii. After a review of the research literature, Edens et al. conclude that, although clinicians may use measures of juvenile psychopathy to assess short term violence risk, long term assessment should not be based on the measures given what little we know about juvenile psychopathy and its stability over time, and relationship with long term offending

VIII. Psychological Tests of Particular Relevance

a. MAYSI/MAYSI-2
    i. National Youth Screening Assistance Project (http://www.umassmed.edu/nysap/)
    ii. Nature of the MAYSI-2
        1. standardized, reliable, 52-item, true-false, paper-and-pencil method for screening every youth of ages 12-17 entering the juvenile justice system, in order to identify potential mental health problems in need of immediate attention
        2. requires less than 10 minutes to administer and using the youth's self-report
        3. feasible for use by non-clinical staff at intake probation, pretrial detention admission, and reception into a state's youth authority facilities
    iii. Registering
        1. copyrighted by Professional Resource Exchange, Inc. (2003)
        2. may be used, and the answer forms and scoring forms can be duplicated, only after purchasing the MAYSI-2 User's Manual and Technical Report from Professional Resource Press and

after receiving signed authorization from NYSAP for permission to use the instrument

3. to register the MAYSI-2 please fax (508-856-6805) or mail the registration form (located in the back of MAYSI-2 manual) to NYSAP Project Manager, Department of Psychiatry WSH 8B-3, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655

iv. Research

1. *Wasserman et al. (2004)* – examined associations between the Massachusetts Youth Screening Instrument--Version 2 (MAYSI-2) and Diagnostic Interview Schedule for Children-Present State Voice Version (DISC-IV) and the extent to which they overlap in identifying youths with mental health concerns. In 325 New Jersey and South Carolina correctional youths, associations were examined using receiver operating characteristic analyses and logistic regression (binomial and multinomial). Alcohol/Drug Use and Suicide Ideation, respectively, identified youths reporting substance disorder and recent attempt; other scales did not identify parallel DISC-IV disorders as well. MAYSI-2 identifies some DISC-IV disorders better than others. Lack of overlap may result from MAYSI-2's combining diagnostic constructs into single scales. Substantial percentages of disordered youths were not identified by corresponding scales. In systems with multiple avenues of referral, the MAYSI-2 is a useful intake screen, but its utility as the sole means for identifying diagnoses for treatment purposes is limited. The authors differentiate between screening for emergent risk and service needs, recommending best practices for a comprehensive approach to mental health assessment among justice youth.
2. *Lexcen, Vincent, & Grisso (2004*) - examines the structural, concurrent, and divergent validity of the Psychopathy Content Scale, a 20-item self-report instrument derived from the Millon Adolescent Clinical Inventory (MACI). Data for 481 youths who had taken the MACI, the Child Behavior Checklist Youth Self-Report (YSR), and the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2), were analyzed. Results showed that the PCS is best described by a two-factor model and that analyses of the two factors offer limited support for convergent and divergent validity. High scores on both factors were associated with high YSR and MAYSI-2 scales, suggesting that the measure identified youth who were distressed on several measures of emotional, psychological, and behavioral disorder.

3. *Cauffman (2004)* - between May 2000 and October 2002, 18,607 admissions were administered the computerized version of the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) 24 to 48 hours after their arrival at detention centers throughout Pennsylvania. Approximately 70% of the males and 81% of the females scored above the clinical cutoff on at least one of the following five MAYSI-2 scales: Alcohol/Drug Use, Angry-Irritable, Depressed-Anxious, Somatic Complaints, and/or Suicide Ideation. Girls were more likely than boys to exhibit internalizing as well as externalizing problems. Mental health problems were most prevalent among white youths and least prevalent among African American youths. When youths repeated the screen upon subsequent visits to detention, their scores generally remained stable. The findings suggest that the MAYSI-2 is a promising triage tool for emergent risk.
4. *Warren et al. (2003*) – examines the competence-related abilities of 120 psychiatrically hospitalized male juveniles age 10 to 17 years, using the MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA), the Brief Psychiatric Rating Scale-Anchored (BPRS-A), the Massachusetts Youth Screening Instrument (MAYSI), the Kaufman Brief Intelligence Test (K-BIT), and discharge diagnoses derived from file review. The findings indicate significant age-related differences across adolescence with a relatively strong performance for most of the youths on the competence measure. While intellectual and psychiatric factors were found to contribute substantially to deficits in legal decisional ability, they were modulated by age and the developmental factors associated with it. These findings, replete with caveats concerning both the dimensional structure of competence as measured by the MacCAT-CA and the interplay with the mental status and developmental factors affecting it, underscore the multifarious nature of legal decisional capacity in youths of varying ages. The relevance of these findings to the structuring of restoration services and the application of legal theory to the competence standard in juvenile court are discussed.
5. *Espelage et al. (2003*) – cluster-analysis used to identify psychological profiles and related mental health symptoms among male and female juvenile offenders. Participants were juvenile offenders (N = 141) incarcerated in the California Youth Authority completed the Minnesota Multiphasic Personality Inventory (MMPI) and the Massachusetts Youth Screening Instrument--Version 2 (MAYSI-2). MMPI cluster analysis revealed four

distinct profiles: two for male and two for female juvenile offenders. Among males, there was one *Normative* cluster with no clinically elevated scores. A second male cluster, labeled *Disorganized*, exhibited clinical elevations on scales 8 (Schizophrenia), 6 (Paranoia), 4 (Psychopathic Deviate), and 7 (Psychasthenia). Among females, two clinically elevated profiles emerged. One *Impulsive-Antisocial* cluster consisted of clinical elevations on scale 4 (Psychopathic Deviate), which has been consistently associated with delinquent and antisocial behavior. The second cluster, labeled *Irritable-Isolated*, produced elevations on MMPI scales 4 (Psychopathic Deviate), 8 (Schizophrenia), 6 (Paranoia), and 7 (Psychasthenia). There were no significant sex, ethnicity, or offense differences across clusters, but the clusters exhibit distinct psychiatric profiles (MMPI) and mental health symptoms (MAYSI-2). The findings suggest that male and female offenders show qualitatively distinct psychiatric profiles. Results reinforce the need for assessment of mental health symptoms for male and female juvenile offenders as well as sex-appropriate treatments.

6. *Goldstein et al. (2003*) – examined patterns of comorbidity in 232 girls in juvenile justice facilities. It was hypothesized that the more depression or anxiety a girl reported, the more substance use, family discord, and suicidal ideation she would also report. Simple findings revealed that both depression and anxiety related to the three dependent variables. However, upon controlling for the relationships among depression, anxiety, and externalizing behaviors, more specific relationships were revealed: depression independently predicted substance use and suicidal ideation; anxiety did not predict any of the three dependent variables; and externalizing behaviors predicted substance use and family discord. No significant interactions were found. The current research helps clarify relationships among the targeted problems and provides initial information for developing multifaceted treatment programs for girls in the juvenile justice system.
7. *Stewart & Trupin (2003*) – examined the utility of the MAYSI-2 to identify youths with mental health problems and co-occurring substance use problems. This study also examined the relationship of these symptoms to treatment utilization both before and after intake to the juvenile justice system. Ethnic and gender differences in the screening results were studied. The MAYSI-2 was administered to 1,840 youths consecutively admitted to state custody. Cluster analysis was used to group the

youths by mental health symptom status, and the relationship between symptoms and treatment utilization was tested in the groups identified in the cluster analysis. Youths who reported a high level of mental health symptoms, with or without co-occurring substance abuse problems, were more likely to have received previous mental health treatment than youths with a low level of mental health symptoms. Youths with a high level of mental health symptoms were more likely to receive extraordinary sentences and were thus less likely to be eligible for community transition programs than youths with a low level of mental health symptoms. Significant gender and ethnic differences in mental health symptom reporting on the screening inventory were found. Female offenders were significantly more likely than male offenders to report a high level of symptoms, and Hispanic youths were significantly less likely than youths in other ethnic groups to report a high level of symptoms. The MAYSI-2 has utility in identifying youths in the juvenile justice system who have mental health problems, and MAYSI-2 results are related to use of treatment services both before and after intake to the juvenile justice system. Ethnic and gender differences in MAYSI-2 reporting must be considered in interpreting mental health screening data.

8. *Nordess et al. (2002*) – examined the number of youths who present symptoms of a mental health disorder at intake into a juvenile detention center in the Midwest. Two hundred and four youths were assessed with the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2; Grisso & Barnum, 2000), a mental health screening instrument. At least 68% of the youths identified symptoms of a mental health disorder at intake. Given the significant number of youths who identified symptoms of a mental health disorder at intake into detention, the need to provide mental health services for juvenile detainees should not be ignored.

Assessing Risk and Needs (Public Safety and Treatment Amenability)

I. Structured Assessment of Violence Risk in Youth (Borum et al., 2005)
   a. Structured Professional Judgment tool
   b. 25 items
   c. Items are scored -/+
   d. Historical
      i. Violence history
      ii. Non-violent offense history

iii. Violence in the home
iv. Early onset of delinquent behavior
v. Parental criminality
vi. Poor school achievement

e. Social/Contextual
i. Peer delinquency
ii. Peer rejection
iii. Poor parental involvement and management
iv. Lack of personal and social support

f. Individual/Clinical
i. Impulsivity
ii. Substance abuse
iii. Anger management problems
iv. Psychopathic traits

g. Protective Items
i. Prosocial peers
ii. Strong social support
iii. Strong school commitment
iv. Open to intervention
v. Strong attachment to adult role model

II. Youth Level of Service/Case Management Inventory
a. Adolescent adaptation of Level of Service inventories
b. Actuarial tool that includes both static and dynamic risk factors
c. Eight domains
i. Prior and current offenses/dispositions
ii. Family circumstances/parenting
iii. Education/employment
iv. Peer relations
v. Substance abuse
vi. Leisure/recreation
vii. Personality/behavior
viii. Attitudes/orientation

III. Risk-Sophistication-Treatment Inventory
a. Describes factors widely used in transfer proceedings
i. Risk/dangerousness
ii. Sophistication-maturity
iii. Treatment amenability
b. Appropriate psychometric properties
i. Internal consistency/reliability
ii. Validity

iii. Factor structure

IV. Amenability to Treatment
- a. Is there a reasonable prospect that rehabilitative efforts in the juvenile justice system will reduce the likelihood of future behavior that will endanger public safety?
- b. Person/context concept
- c. Amenability contingent upon
  - i. Juvenile justice program resources
  - ii. Adolescent's characteristics, including
    1. Age
    2. Emotional and behavioral functioning
    3. Mental disorder
    4. Substance abuse
    5. Learning disabilities
    6. Violence risk
  - iii. Environmental and contextual factors including
    1. Family functioning and resources
    2. Peers
    3. School resources
    4. Vocational/training resources
    5. Other programming resources

Miranda Waiver Capacities

I. Instruments for Assessing Understanding and Appreciation of *Miranda* Rights (Grisso, 1998b)

- a. Purpose
  - i. Assist court in determining whether defendants were able to meet legal standard for valid waiver of rights to silence and legal counsel
    1. knowing
    2. intelligent
    3. voluntary (not focus in these tools)
  - ii. "Totality of circumstances" context
  - iii. No "competence to waive Miranda" as such
- b. Instruments
  - i. Comprehension of Miranda Rights (CMR)
  - ii. Comprehension of Miranda Rights—Recognition (CMR-R)
  - iii. Comprehension of Miranda Rights-Vocabulary (CMV)
  - iv. Function of Rights in Interrogation
- c. Interpretation

i. Nomothetic
ii. Supplemented by idiographic (questioning regarding specific standard in jurisdiction, including word comprehension and reasoning)

Competence to Proceed

I. The MacArthur Juvenile Adjudicative Competence Study (Grisso et al., 2003)

a. Study Rationale - in recent years, an increase in the number of adolescents tried as adults and the number of younger children tried in juvenile court has raised questions about children's and adolescents' capacities to participate in their trials—not necessarily due to mental illness or mental retardation, but because of intellectual and emotional immaturity. In order to address these questions, the Network on Adolescent Development and Juvenile Justice conducted the first-ever large-scale study of age differences in competence to stand trial.
b. Methodology - over 1,400 males and females between the ages of 11 and 24 participated in the study, which was conducted in four sites—Philadelphia, Los Angeles, Northern and Eastern Virginia, and Northern Florida—in order to obtain a sample with cultural, ethnic, and socioeconomic diversity. Half of the study participants were in jail or detained in juvenile detention centers at the time of the study, and half were individuals of similar age, gender, ethnicity, and social class but residing in the community.
    i. these individuals were administered a standardized battery of tests designed to assess their knowledge and abilities relevant for competence to stand trial, their legal decision-making in several hypothetical situations (such as whether to confess a crime to the police, share information with one's attorney, or accept a proffered plea agreement), and measures of a number of other characteristics that could potentially influence these capacities, such as intelligence, symptoms of mental health problems, and prior experience in the justice system.
    ii. The primary measure of abilities relevant to competence to stand trial was an evaluation tool that has been used extensively in prior studies of competence among adults with mental illnesses (the MacCAT-CA). The evaluation does not label individuals as "competent" or "incompetent," but it does identify individuals whose knowledge, understanding, and reasoning are sufficiently impaired that they are at grave risk of being incompetent to stand trial in a adults with mental illness who have been found incompetent to stand trial were used to establish a threshold in the present study that served as the basis for identifying individuals' levels of ability as "impaired" or "seriously impaired."
    iii. Individuals who were identified as "seriously impaired" performed at a level comparable to adult defendants with mental illness who would likely

be considered incompetent to stand trial by clinicians who perform evaluations for courts.

c. Results - juveniles aged 11 to 13 were more than three times as likely as young adults (individuals aged 18 to 24) to be "seriously impaired" on the evaluation of competence-relevant abilities, and juveniles aged 14 to 15 were twice as likely as young adults to be "seriously impaired". Individuals aged 15 and younger also differed from young adults in their legal decision-making. Also:
    i. juveniles of below-average intelligence (i.e., with an IQ less than 85) were more likely to be "significantly impaired" in abilities relevant for competence to stand trial than juveniles of average intelligence (IQ scores of 85 and higher)
    ii. Age and intelligence were the only significant predictors of performance on the evaluation of abilities relevant to competence to stand trial. Performance on the evaluation did not vary as a function of individuals' gender, ethnicity, socioeconomic background, prior experience in the legal system, or symptoms of mental health problems.
    iii. Because mental illness and its impact on competence to stand trial was not the focus of this study, very few individuals with serious mental disorders were included in the sample, and the study's results do not answer questions about the competence of juveniles with serious mental illnesses.
    iv. The study did not find differences between juveniles aged 16 and 17 and young adults in abilities relevant to their competence to stand trial.
d. Implications
    i. Compared to adults, a significantlygreater proportion of juveniles in the community who are 15 and younger, and an even larger proportion of juvenile offenders this age, are probably not competent to stand trial in a criminal proceeding.
    ii. Juveniles of below-average intelligence are especially at risk of being incompetent to stand trial.
    iii. States that transfer large numbers of juveniles who are 15 and under to the criminal justice system may be subjecting significant numbers of individuals to trial proceedings for which they lack the basic capacities recognized as essential for competent participation as a defendant.
    iv. States that permit juveniles 13 and under to be tried as adults may wish to re-examine this policy in light of the substantial proportion of individuals of this age who are at great risk for incompetence to stand trial.

II. *Evaluating Juveniles' Adjudicative Competence: A Guide for Clinical Practice*[1] (Grisso, 2005)

[1] Evaluating Juveniles Adjudicative Competence is available from Professional Resource Press (http://www.prpress.com).

a. Incorporates MacArthur research and recent literature, but very readable and practical
b. Summarizes relevant domains of evaluating juveniles' adjudicative competence
    i. Legal concept of adjudicative competence
    ii. Developmental perspective for evaluations of juveniles' adjudicative competence
    iii. Preparing for the evaluation
        1. determining the purpose
        2. making contact with the defense attorney
        3. deciding the scope and methods
        4. caretakers—making contact and invitations
        5. obtaining records
    iv. Data collection
        1. overview
        2. preparing youth and caretakers
        3. obtaining developmental and clinical history
        4. evaluating developmental and clinical status
        5. assessing competency abilities
        6. exploring caretakers' perceptions of youth's adjudication
    v. Interpretation
        1. overview
        2. formulating opinions related to competency
        3. formulating remediation
        4. writing the report
c. Includes CD with reproducible practice forms

III. Kruh & Grisso (2009)

a. Structured CST Models
    i. Competency-domains model
        1. Rational ability to consult with counsel
        2. Rational and factual understanding of the proceedings
    ii. Cognitive complexity model
        1. Factual understanding
        2. Rational abilities (including both rational consultation abilities and rational understanding)
    iii. Discrete abilities model
        1. Rational ability to consult with counsel
        2. Factual understanding of the proceedings
        3. Rational understanding of the proceedings
    iv. Bonnie's model

1. Capacity to understand the legal process
2. Capacity to appreciate the significance of legal circumstances for one's own situation
3. Capacity to communicate information
4. Capacity to use reasoning and judgment in making decisions

b. Empirical correlates of Incompetence
   i. Age
   ii. Intelligence
   iii. Learning and academic functioning
   iv. Mental health problems

c. Typical practices in CST evaluations (Christy et al., 2004; Ryba et al., 2003a, 2003b)
   i. Because of problems with sampling (Christy used only Florida reports; Ryba surveyed 82 practitioners nationally), these results do not necessarily generalize nationally
   ii. Important domains identified
      1. Cognitive abilities
      2. Social skills
      3. Judgment and decision-making
   iii. Psychological tests used
      1. IQ (most common)
      2. Measures of behavior, adaptive functioning, personality

Transfer and Reverse Transfer

II. Overview
   a. Based on legal system's presumption that some children are not suitable for rehabilitation
   b. Allows for disposition via the criminal justice system of those minors who are considered to be inappropriate for continued rehabilitation attempts via the juvenile justice system

III. Transfer/Waiver Process as of 2008
   a. All states have mechanisms that enable them, in some circumstances, to try youth in adult criminal court
   b. As of 2008, 29 states allowed for automatic waiver in some cases (e.g., where specific age and offense criteria are met)
   c. As of 2008, 15 states allowed prosecutors discretion to "direct file" cases which meet certain criteria)

d. All but 5 states allow the juvenile court judge to waive the juvenile court's jurisdiction in a certain subset of cases
e. 25 states have protective transfer mechanism allowing transferred youth to petition criminal court for return to juvenile court
f. Criteria are typically risk, treatment amenability, and sophistication/maturity

IV. The Impact of Transfer/Waiver
a. No research indicating that children waived to the adult system do better than their counterparts who remain in the juvenile system. In fact, it appears they do worse (Bishop & Frazier, 2000)
b. Some have raised concerns about whether this process is applied consistently
    i. Across jurisdictions (Dawson, 2000)
    ii. In racially discriminatory ways (Bortner et al., 2000)

V. Study of Florida Waivers/Transfer
a. Bishop (1996) compared 2738 adolescents who were transferred to adult court in Florida with a sample of adolescents who remained in the juvenile system and were matched for age, sex, offense history, race, and index offense
b. By every measure employed, reoffending was greater among transfers than matched controls
c. Other researchers report similar findings (Fagan, 1996)

VI. Transfer/Waiver Criteria
a. Non-Psychological Factors
    i. Offense history
    ii. Age of accomplices and court jurisdiction
    iii. Person or property offense
b. Psychological Factors
    i. Emotional and intellectual functioning/maturity
    ii. Risk for reoffending (violent and otherwise)
    iii. Amenability to treatment

VII. Amenability to Treatment
a. Whether there is a reasonable prospect that rehabilitative efforts in the juvenile justice system will be able to reduce the likelihood of future endangering behaviors of the child
b. Person/context concept
c. Amenability is contingent upon
    i. Juvenile justice program resources
    ii. Child characteristics, including
        1. age

2. emotional and behavioral functioning
3. mental disorder
4. substance abuse
5. learning disabilities
6. violence risk

iii. Environmental and contextual factors including
1. Family functioning and resources
2. peer group
3. school resource
4. vocational/training resources
5. other programming resources

VIII. Amenability to Treatment Assessment Objectives
a. Report and describe the child's history, personality, & development
b. Present an explanation of the alleged offense
c. Identify preferred interventions
d. Describe available interventions
e. Describe factors that may affect rehabilitation potential
f. Discomfort
g. Attachment potential
h. Cognitive and behavioral resources
i. Social support & stressors (family and community factors)
j. Be careful about remorse, either expressed or not expressed

IX. Report Format (Grisso, 1996)
a. Referral Question/Notification
b. Sources of Information
c. Current Clinical Functioning
d. Risk for Future Endangering Behavior
e. Amenability to Treatment
f. Conclusions/Recommendations

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