OBTAINING AND UTILIZING COMPREHENSIVE FORENSIC EVALUATIONS: THE APPLICABILITY OF ONE CLINIC'S MODEL

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I. INTRODUCTION

Forensic evaluations of children and/or families can provide valuable information in juvenile justice and child protection proceedings. Forensic mental health professionals are trained to recognize, address, and articulate the relationship between complex mental health issues and legal questions, and to provide written reports that assist the court in making a particular legal decision.[1] Forensic evaluations not only help lawyers to better advocate for their clients in court, but also help lawyers better understand and communicate with their clients. Therefore, forensic mental health professionals can be an important resource for lawyers. To make optimal use of this resource, it is important for lawyers to understand the specialized nature of forensic evaluations, including so-called "best practice" methods for conducting these evaluations.

This paper will provide a brief explanation of forensic evaluations, including a review of the best practice methods for conducting forensic evaluations used in juvenile justice or child protection matters. Next, the paper will describe a model that explicitly incorporates best practice methods for conducting comprehensive forensic evaluations. This model was developed for and is used by the Cook County Juvenile Court Clinic ("CCJCC" or "the Clinic"), located in a large urban juvenile court serving the city of Chicago and

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[1] The terms forensic mental health professional and clinician will be used interchangeably throughout this paper to denote a forensically trained social worker, psychologist, or psychiatrist.

surrounding suburbs.[2] The final section of this paper will describe how lawyers may utilize CCJCC's model to obtain competent forensic evaluations; thereby, becoming better consumers and users of forensic clinical information.

II. Conducting Forensic Evaluations: Best Practice

When advocating for their client, it is important for lawyers to understand the difference between forensic and therapeutic evaluations. Although both types of evaluations may be used in court proceedings, one can rarely be substituted for the other. Forensic and therapeutic evaluations differ with regard to scope/purpose, voluntariness of participation, level of confidentiality, and the methods in which the information is collected.

Forensic evaluations are narrow in scope and are aimed at assisting the court in answering a well-defined legal question. Typically, participation of the person being evaluated is involuntary and the client is the court or the retaining lawyer, rather than the person or family being evaluated. In a forensic evaluation the clinician is obligated to make certain the person being evaluated is informed of the limits of confidentiality; *i.e.*, the clinician will include the information in a report that will be tendered to the court. Forensic evaluators consider the potential underlying motives (*e.g.*, bias, secondary gain, malingering, avoiding incarceration) of the person providing the information. In contrast to a clinician conducting a therapeutic evaluation, a forensic evaluator typically is more distant and confrontational. Forensic evaluations are written for a legal audience. Consequently, forensic evaluators should avoid using mental health terminology or other terms that a non-mental health professional may not understand. Forensic evaluators also must be mindful of relevant legal considerations when conducting and writing forensic evaluations; *e.g.*, not elicit incriminating information prior to adjudication or trial, be aware that their notes are subject to discovery. Finally, forensic evaluators should be prepared for potential testimony including cross-examination and therefore should take great care to document in detail the data gathered and efforts to complete the evaluation.[3] In short, forensic evaluations should be conducted in a manner which recognizes and adheres to the nuances and complexities of the legal arena in which the evaluation will be used.

In contrast to forensic evaluations, most therapeutic evaluations are not conducted for use in a legal setting. Instead, therapeutic evaluations typically are conducted to assist in treatment and intended for use by other treatment providers. As such, the referral question is broadly defined (*e.g.*, to assess general mental health functioning and treatment needs), and the report will contain

[2] The Cook County Juvenile Court is the oldest juvenile court in the nation and hears both juvenile justice and child protection matters. Consequently, the CCJCC conducts court ordered evaluations from both sides of the court.

[3] *See generally* Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychology*, 15 Law and Hum. Behav. 655 (1991) [hereinafter *Specialty Guidelines*]; Thomas Grisso, Forensic Evaluation of Juveniles (Debra Fink ed., 1998); Lois Oberlander Condie, Parenting Evaluations for the Court (2003); Gary B. Melton et al., Psychological Evaluations for the Courts (2d ed. 1997); Karen S. Budd, *Assessing Parenting Competence in Child Protection Cases: A Clinical Practice Model*, 4 Clinical Child and Fam. Psychol. Rev. 1 (2001).

mental health terms and other terms of art familiar to mental health professionals. The client is the person being evaluated and the information provided is typically confidential, apart from the mandated exception of reporting child abuse or neglect, elder abuse, and/or harm to self or others. The clinician tends to be less confrontational, more disclosing, and is more likely to take the information obtained at face value than a forensic evaluator. When conducting therapeutic evaluations, clinicians are not typically mindful of rules of evidence or other factors germane to a legal context. Consequently, they may inadvertently provide information that could incriminate a lawyer's client or information that reflects a lack of understanding of the legal issue (*e.g.*, not limiting the condition that constitutes insanity to those defined by statute or case law, but expanding it to include any mental health or personality disorder).

The particular characteristics of forensic evaluations, as described above, are derived from best practice methods for conducting these evaluations. These best practices are well established in the literature.[4] Forensic best practice methods describe how a clinician should collect, integrate, and interpret clinically relevant information, and present clinical opinion(s) to the court. Best practice methods are consistent with and implement the "aspirational model of desirable professional practice" set forth in the *Specialty Guidelines for Forensic Psychology*.[5] The *Specialty Guidelines* incorporate and expand upon the *Ethical Principles of Psychologists and Code of Conduct* ("*Ethics Code*") to "specify the nature of desirable professional practice by forensic psychologists."[6] The *Specialty Guidelines* apply to forensic psychologists or to psychologists who know or should have known that they would be viewed as an expert "on explicitly psycholegal issues, in direct assistance to courts, parties to legal proceedings, . . . and administrative, judicial, and legislative agencies acting in an adjudicative capacity."[7]

Forensic psychologists should provide services only in areas in which they have "specialized knowledge, skill, experience, and education."[8] The specialization determines the boundaries of their competence. Psychologists must ensure they have the requisite level of understanding, training, and expertise to conduct forensic evaluations. This includes competence not only in the clinical aspects of forensic evaluation, but also a thorough understanding of the relevant legal issue including applicable statutes, legal standards, and evidentiary rules.

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[4] *See, e.g.*, KIRK HEILBRUN, PRINCIPLES OF FORENSIC MENTAL HEALTH ASSESSMENT (2001) [hereinafter HEILBRUN, PRINCIPLES OF FORENSIC MENTAL HEALTH]; GRISSO, *supra* note 3; KIRK HEILBRUN ET AL., FORENSIC MENTAL HEALTH ASSESSMENT: A CASEBOOK (2002) [hereinafter HEILBRUN, FORENSIC MENTAL HEALTH CASEBOOK]; MELTON ET AL., *supra* note 3; Annette Christy et al., *Juveniles Evaluated Incompetent to Proceed: Characteristics and Quality of Mental Health Professionals' Evaluations*, 35 PROF. PSYCHOL.: RES. & PRAC. 380 (2004); Budd, *supra* note 3; *Specialty Guidelines*, *supra* note 3; Am. Psychological Ass'n, *Ethical Principles of Psychologists and Code of Conduct*, 57 AM. PSYCHOL. 1060, 1060-73 (2002) [hereinafter *Ethics Code*].

[5] *Specialty Guidelines*, *supra* note 3, at 656.

[6] *Id.*

[7] *Id.* at 657.

[8] *Id.* at 658.

Best practice methods encourage clinicians to collect data from multiple sources, including records and clinical and collateral interviews.[9] According to the *Specialty Guidelines* a "forensic psychologist maintains professional integrity by examining the issue at hand from all reasonable perspectives, actively seeking information that will differentially test plausible rival hypotheses."[10] Furthermore, "forensic psychologists attempt to corroborate critical data that form the basis for their professional product."[11] Gathering data from multiple sources allows the clinician to corroborate information and obtain a more accurate understanding of the relevant psychological and functional factors. For example, during a clinical interview as part of a fitness evaluation, a sixteen-year-old youth presents as if he cannot understand or learn the role of his attorney or the judge. The clinician also knows that the youth does not receive special education services or mental health treatment. Best practice dictates that, before rendering a clinical opinion, the clinician attempt to corroborate the interview data, rather than simply accept it at face value. The clinician might conduct a collateral interview with the youth's teacher and inquire about the youth's ability to learn and retain new information. Further, the clinician could interview the youth's social studies teacher who would report that just one month prior, the student learned information pertaining to the legal system, and earned grades of A on a paper and a test, demonstrating an understanding of the role of the legal participants. Based on data from these collateral sources, the clinician would have reason to doubt the accuracy of the youth's performance during the clinical interview.

Data collection also requires use of appropriate and relevant methods. For example, in conducting evaluations of parenting capacity, clinicians should observe parent-child interactions.[12] According to one expert, observing parent child-interaction "provides an index of behavior when the parent presumably is attempting to use his/her best caregiving skills, and it offers the opportunity to observe a range of parent and child behavior under different conditions."[13]

Another important data gathering method is test administration. Psychological tests that may be used as part of a forensic evaluation include tests of cognitive, personality, emotional, and adaptive functioning, as well as measures specifically designed for a forensic arena. Best practice dictates appropriate use of testing. The *Ethics Code* asserts that when interpreting assessment results, clinicians account for "test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations."[14] According to the *Ethics Code* when choosing measures, it is important for clinicians to have knowledge of the validity[15] of each measure with the population being evaluated and the reliability[16] of the mea-

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[9] *See generally* GRISSO, *supra* note 3; MELTON ET. AL., *supra* note 3.

[10] *Specialty Guidelines*, *supra* note 3, at 661.

[11] *Id.* at 662.

[12] *See generally* Budd, *supra* note 3; CONDIE, *supra* note 3.

[13] Budd, *supra* note 3, at 11.

[14] *Ethics Code, supra* note 4, at § 9.06.

[15] The extent to which a test measures what it purports to measure.

[16] An indication of how accurately the measure performs its function.

sure for the context in which it is being used so as not to draw inaccurate conclusions. Further, best practice methods prohibit clinicians from using out dated tests and tests that have not been designed for that specific population. Finally, forensic evaluators must choose tests that are admissible in court, *e.g.*, measures that meet the *Frye* or *Daubert* standards for admissibility.[17]

Best practice dictates that forensic clinicians support their clinical interpretations, recommendations, and opinions with the data gathered and presented in the report. The *Specialty Guidelines* provide that "[f]orensic psychologists do not, by either commission or omission, participate in a misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny, or subvert the presentation of evidence contrary to their own position."[18] Conflicting or discrepant data is a frequent by-product of collecting data from multiple sources. Rather than ignoring conflicting data, clinicians should articulate what weight to give the discrepant pieces of data. Best practice also prescribes that clinicians limit the scope of their reports and testimony. Specifically, according to *Specialty Guidelines* "forensic psychologists avoid offering information from their investigations or evaluations that does not bear directly upon the legal purpose of their professional services and that is not critical as support for their product, evidence or testimony, except where such disclosure is required by law."[19]

Finally, when writing reports and presenting information, forensic psychologists should always be mindful that they are presenting mental health information to a non-mental health audience. All the "best practice methods" described above become literally meaningless if the reader cannot understand the report. Therefore, forensic clinicians should take care to limit the amount of jargon or terms that a non-mental health professional may not understand in their communication.[20] Consistent with this the *Specialty Guidelines* advise that "forensic psychologists make reasonable efforts to ensure that the products of their services, as well as their own public statements and professional testimony, are communicated in ways that will promote understanding and avoid deception, given the particular characteristics, roles, and abilities of various recipients of the communications."[21]

Despite the existence of best practice methods, many psychologists fail to use these methods. For example, a review of 1357 competency or fitness reports completed in Florida demonstrated that clinicians frequently administered tests that were not designed to be administered to children or adolescents and were not designed to assist evaluating competence to stand trial.[22] The

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[17] Forensic psychologists should be aware of evidentiary considerations such as whether their expert testimony would be admitted under the "general acceptance," standard articulated in *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923) or their methodologies considered reliable using the factors in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 592-95 (1993).

[18] *Specialty Guidelines*, *supra* note 3, at 664.

[19] *Id.* at 662.

[20] *See* HEILBRUN, FORENSIC MENTAL HEALTH CASEBOOK, *supra* note 4, at 46-48; HEILBRUN, PRINCIPLES OF FORENSIC MENTAL HEALTH, *supra* note 4, at 246-49; MELTON ET AL., *supra* note 3.

[21] *Specialty Guidelines*, *supra* note 3, at 663.

[22] Christy, *supra* note 4.

majority of the reports addressed some aspect of competency consistent with Florida law. However, in approximately half of the reports, the clinician failed to include data (*e.g.*, referencing examples from tests or interviews) to support their assessment of the minor's functioning related to competency to stand trial.[23] Similarly, although the jurisdiction requires that the clinician explicitly state the bases for the determination of incompetence, clinicians only provided this information in sixty-two percent of the reports.[24] In another jurisdiction, a quality review of 172 predisposition reports tendered in a Philadelphia area juvenile court revealed that at least seventy-five percent of the reports included insufficient data regarding the child's delinquency and mental health or drug/alcohol history.[25] Equally troubling, thirty-six percent of the reports failed to present sufficient data on the minor's family and forty-two percent failed to explain sufficiently the recommendations offered to the Court.[26] As described below, the CCJCC has established a model for clinical evaluation that insures compliance with established best practice. However, prior to its establishment, evaluations tendered in child protection proceedings routinely failed to cite the legal decision or permanency option being considered. A quality review of 207 child protection evaluations further revealed that, ignoring psychological standards related to assessing children, the evaluators failed to use multi-source and multi-session techniques.[27]

Clearly, a gap exists between best and actual practice in forensic evaluations. The CCJCC model for conducting forensic evaluations was designed specifically to present the court with forensic information that has been gathered using best practice methods. As such, this model can be used in other jurisdictions to present courts with relevant clinical information to use in legal decision-making. Moreover, evaluations conducted using the CCJCC model result in information that lawyers can use to better advocate for and communicate with their client.

III. CCJCC Model for Forensic Clinical Evaluations

CCJCC's model is grounded in the fundamental principles of forensic best practice. CCJCC is the result of a research project that determined a multi-faceted approach was required to produce accurate, timely, and relevant mental health information to the court.[28] The Clinic provides an array of services including consulting with lawyers and judges about requests for mental health information, responding to court-ordered requests for forensic evaluations, gathering and providing information to the court about community based mental health services, conducting training and education on issues related to mental health information and court proceedings, and conducting program eval-

[23] *Id.* at 385.
[24] *Id.* at 386.
[25] Thomas Hecker & Laurence Steinberg, *Psychological Evaluation at Juvenile Court Disposition*, 33 Prof. Psychol.: Res. & Prac. 300, 300-04 (2002).
[26] *Id.*
[27] Karen S. Budd et al., *Clinical Assessment of Children in Child Protection Cases: An Empirical Analysis*, 33 Prof. Psychol.: Res. & Prac. 3 (2002).
[28] Joseph T. Scally et al., *Problems in Acquisition and Use of Clinical Information in Juvenile Court: One Jurisdiction's Response*, 21 Child. Legal Rts. J. 15 (2001).

uation activities to monitor the clinic's operation and provide data for research and development. In addition, the Clinic serves as a national multidisciplinary training site for students in the fields of law, social work, and psychology. To carry out its multiple functions, the Clinic's staff includes master's level social workers, doctoral level forensic psychologists, and lawyers.

The Clinic conducts forensic evaluations to answer specific questions raised by lawyers or judges in Juvenile Court. Evaluations for use in juvenile justice cases typically involve competency to stand trial (fitness); ability to provide a knowing, intelligent, and voluntary waiver of Miranda rights; and sentencing/dispositional issues. Evaluations for use in child protection cases include parenting capacity related to permanency goals, visitation, and termination of parental rights.[29]

A. *Accepting a Referral and Shaping the Referral Question*

The Clinic's mission is to provide the Juvenile Court with accurate, timely and relevant clinical information. The Clinic's operation is designed to carry out this mission, and a central feature is the Clinical Coordinators who serve as the link between the Juvenile Court's legal and mental health communities. Clinical Coordinators, individuals with master's degrees in social work or related fields, are contacted whenever court personnel believe they need mental health information pertaining to the children and families before the court.

A primary step in conducting evaluations is shaping the referral question to assure that the court receives useful information. When paged to court, Clinical Coordinators engage in detailed discussion with relevant parties in order to ascertain the nature of the request and the particular legal question, if any. Clinical Coordinators also gather information from parties concerning the current contextual factors unique to the child and family which prompt the need for clinical information. The final step for the Clinical Coordinator is to utilize the gathered information to shape individualized referral questions for the clinician to answer. The clinician therefore receives referral questions that reflect the specific legal issue at hand and the unique context of the child and/or family.[30]

The following vignette illustrates the steps taken by Clinical Coordinators in carrying out the tasks of accepting requests for clinical information and shaping referral questions:

> *Vignette #1*: The Assistant Public Defender pages the Clinical Coordinator to court and states that a clinical evaluation is needed to understand better the child's treatment needs. After discussion, the Clinical Coordinator learns the child has been found delinquent for theft and at the next court date the Judge will be making a dispositional/sentencing decision and is considering placement in the Department of Corrections or community based services. The Clinical Coordinator asks about clinical issues giving rise to the request and learns that the child is using drugs and

[29] In our jurisdiction, evaluations of minors involved in child protection matters are generally conducted by the Illinois Department of Child and Family Services.

[30] Only those requests that pertain to a specific legal issue are referred to the Clinic for a forensic evaluation. Typically, when there is no pending legal decision, the Clinical Coordinator documents the referral questions and directs the case to a source outside of CCJCC to provide a response to the request.

was frequently running away from home. In addition, there is considerable conflict between the child and his stepfather. Taking these factors into consideration, the Clinical Coordinator writes the following referral question: "Given the conflict at home and the child's drug use and running away behaviors, what are the child's mental health treatment needs and what sentencing option (Department of Corrections or community based services) is recommended and why?" The clinician thereby receives important contextual information; had the question only asked the clinician "to address treatment needs" without the additional details and stated concerns, the clinician could have reasonably recommended that the child would benefit from individual therapy to address emotional issues. Although this recommendation might have been reasonable, it would not have assisted the court in considering the significance of the specific characteristics of the child in this case, *i.e.*, runaway behavior, conflict with his step-father, and drug-use, when making a dispositional or sentencing decision.

B. Forensic Evaluations: Data Gathering

One of the foundations of the CCJCC model is the importance of collecting data from multiple sources including records, clinical interviews with the child and family, collateral interviews, parent-child observation as appropriate, and administration of psychological tests as needed. As described below, clinicians gain a richer and more comprehensive understanding of a child and family by taking into consideration data from diverse and varied sources. Clinicians also consistently take into account the unique family and environmental contexts that apply to a child and family as relevant to the legal issue at hand.

1. Record Gathering and Review

Review of records allows the clinician to obtain multiple perspectives, formed in and outside of the legal setting, about the child and family. This allows the clinician to examine relevant family systems and environmental factors across contexts. Review of records also provides an historical view of a case so that the clinician can examine patterns of behavior over time. The type of records collected depends upon the particulars of the case. Child protection evaluations typically involve the parent; however, information about the functioning of the child involved in the case is also relevant to understanding the parent's capacity to meet that child's needs. As such, records are sought for both the parent and child.[31] In contrast, evaluations performed on the juvenile justice side of the court typically focus on the child; consequently, records requested typically pertain only to the child.[32]

Gathering records begins with identification of all sources through consultation with lawyers involved in the case, intake with the child and family, and identification of further sources through clinical interviews and review of obtained records. Standard protocol is to collect and review all records that may contain applicable information on the case. Frequently the records include information that is beyond the scope of the court's request. Consequently, not all of the records will be referenced in the report tendered to court.

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[31] See *infra* App. A for records typically sought in child protection cases.

[32] See *infra* App. B for records typically sought in juvenile justice cases.

The following vignette illustrates a clinician's use of records to educate the court about the extent of a child's condition and develop a clinical opinion regarding if the child could be restored to fitness within one year.

Vignette #2: At the time the court referred the case to the Clinic, the court was aware that the child had comprehension difficulties and was in special education services. A clinical review of the child's medical records revealed the child had been in a car accident in the past and suffered traumatic brain injury. In reviewing the school records, the clinician determined that the child was developing and functioning appropriately in school prior to the accident and demonstrated little academic growth in the years following the accident. Despite repeated interview efforts, the child was unable to demonstrate knowledge of courtroom proceedings and an ability to assist in his defense. Using data from records produced in different contexts (*i.e.,* medical and school) in combination with information obtained from interviews with the mother and child, the clinician concluded that, just as the child had demonstrated little academic growth, it was very unlikely that he would obtain the necessary improvements to become fit within one year. Without this thorough review of medical and school records, the clinician may have provided the court with a limited understanding of the child's abilities and potential for restoration given the relevant contextual factors.

2. *Clinical and Collateral Interviews*

Another vital component of the CCJCC model is having multiple clinical interviews with the child and family members. Conducting multiple interviews acknowledges that the child and family members may present differently over time. Given that the evaluations are court-ordered, the child and family members may either attempt to present themselves favorably or may initially be resistant to the process. As such, having multiple contacts allows the clinician to build rapport and accurately assess and address the child and family member's presentation. Moreover, conducting multiple interviews provides the clinician an opportunity to address discrepancies in the data gathered over the course of the interviews, in the records, and through interviews with collateral sources. Thus, this methodology increases the validity of the clinician's conclusions.

As illustrated in the following vignette, conducting multiple interviews with a parent allows the clinician to develop a rapport, and thereby make an accurate clinical assessment.

Vignette #3: In the first interview, the parent was resistant, irritable and oppositional during the interview, often ignoring the clinician when questions were posed. The clinician could have interpreted this presentation as being consistent with previous descriptions of the mother contained in reviewed clinical records—that she suffered from a personality disorder that fueled rigidity and passive aggression. Instead, after three interviews, it became clear to the clinician that the parent was depressed and her presentation was an attempt to manage her depressive symptoms. Moreover, the parent was able to discuss the impact of her depression on her ability to parent. If the clinician had rushed to draw the same conclusions as previous service professionals, and therefore not moved beyond the information obtained from records, critical insight into a reason for parenting deficits would have been missed.

Interviews with collateral sources are an additional and import data source. Collateral contacts provide an opportunity to obtain differing perspec-

tives about the child and family. These perspectives can be invaluable because they may stem from relationships that exist independent of the current legal situation (*e.g.*, relationships with teachers, pastors, paramours, neighbors, or extended family members). Collateral contacts with other mental health professionals can provide the forensic evaluators with another clinical perspective. Furthermore, through conversation with a clinical collateral source, the clinician can attempt to verify the accuracy of information obtained in interviews.

Through interviewing the child and family across contexts and gathering numerous perspectives on the child and family from outside sources, the clinician gains an individualized perspective of the factors within the family system and environment relevant to the child and family's functioning. For example, at the start of an evaluation process, an evaluator may know that a mother is diagnosed with schizophrenia and has three children. The clinical and collateral interviews afford the clinician an opportunity to gain a richer understanding of the interaction between the particular nuances of the mother's mental health condition and the particular developmental needs of her children. For example, the clinician may learn through interviews with the mother's caseworker, minister, and aunt that the mother is able to maintain stability and does not display characteristics of schizophrenia such as delusional thinking when she receives support (*e.g.*, assistance with child care), but when under stress (*e.g.*, when the children are sick), the mother can be at high risk for instability and may experience distorted perceptions of interactions with others (*e.g.*, believing the caseworker is "out to get" her).

3. Parent-Child Observation

In the context of child protection evaluations, observation of parent-child interaction is necessary to supplement other forms of data collection. Conducting observations can be an essential tool for obtaining a comprehensive understanding of a parent's strengths and weaknesses in the parenting role, of the parent's specific abilities related to the needs of the child involved in the evaluation (*i.e.*, physical, cognitive and emotional), and of the quality of the relationship and connectedness between the parent and child. Clinicians, when able, conduct observations in a "natural" setting, thereby allowing for the most accurate assessment of the parent's hands-on abilities. This also allows the clinician to obtain a better understanding of the environment within which the parent and child function. Clinicians also make every effort to conduct multiple observations over time.

The following vignette illustrates the importance of parent-child observations for eliciting data demonstrating how parents respond in "real life situations."

> *Vignette #4*: During interviews, the father was able to provide appropriate answers related to questions about parenting. However, during the parent-child observation he consistently demonstrated an inability to respond appropriately to his eighteen-month-old daughter. For example, when she moved away from him, he would grab her and squeeze her so tightly that she cried. The clinician noted that in these instances he failed to read the child's cues, and only ceased squeezing his daughter when the clinician intervened. The father also placed headphones on his daughter's ears without lowering the volume of the music to an appropriate level (the music was

so loud that the observer could hear it despite being across the room). Only through taking into consideration data from both interviews and the parent-child observation was the clinician able to gain a thorough and accurate understanding of the father's abilities to meet his child's needs, and thus, to provide useful information to the court when making decisions about this child's future. By stopping at the interview, the clinician may have concluded that the father was able to meet the needs of the child.

Parent-child observations, while extremely important, may not always occur. In certain circumstances, a clinician may seek out other means of gathering the needed information. For example, if a parent has not had regular contact with the child for an extended period, it is unlikely that the parent-child observation will yield relevant data. In addition, the clinician may forgo an observation if it is determined that conducting an observation could be detrimental to the physical or psychological well being of the child.

4. Psychological Testing

CCJCC clinicians use testing judiciously; *i.e.*, when the relevant data cannot be sufficiently gathered from the aforementioned data collection methods.[33] In choosing which measure to administer, the clinician must consider what the test was designed to measure as well as factors related to the individual being examined (*e.g.*, gender, age, culture, ethnicity, socio-economic status) that may influence the appropriateness of the measure. Once the test has been administered, it is critical for the clinician to interpret the test data in a manner that reflects an understanding of cultural and demographic factors.

When sufficient information is already available, a clinician may not need to conduct testing. For example, if the court has a concern about a child's cognitive functioning and the child recently underwent cognitive testing as part of the Individual Education Program (IEP),[34] the clinician may determine that those results are valid and no new testing is needed. Testing in this case would subject the child to an unnecessary procedure. Furthermore, if no concerns about or evidence of cognitive impairment exist, a clinician does not need to do cognitive testing.

The following vignette illustrates appropriate use and interpretation of a measure in a parenting capacity evaluation:

Vignette #5: A clinician is asked to assess the risk and protective factors related to returning a child home to his mother, who has a history of physically abusing this child. The clinician utilizes the Child Abuse Potential Inventory ("CAP")[35] to assist in the assessment. In choosing this measure, the clinician takes into consideration that the CAP is used with parents to detect the presence of characteristics similar to known physical abusers and has acceptable validity and reliability rates with this population.[36] The measure contains a validity scale that assesses for "faking good," a stance that is not uncommon in court ordered parenting evaluations. In this case,

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[33] See *infra* App. C for a list of different psychological measures that may be used in forensic evaluations.

[34] An IEP documents: 1) how it was determined that a student has a disability that requires special education services, 2) the nature of the disability, and 3) the nature of the special education services that will address the disability.

[35] See *infra* App. C for a more complete description of this instrument.

[36] *See generally* JOEL S. MILNER, THE CHILD ABUSE POTENTIAL INVENTORY: MANUAL (2d ed. 1986).

the results were valid and revealed that the mother displays characteristics similar to known physical child abusers and a rigid parenting style (*e.g.*, has rigid expectations regarding a child's behavior) that is known to be associated with increased risk for child abuse. Based on this information, along with that gathered from interviews, records, and the parent-child observation, the clinician concludes that one risk factor associated with returning the child home is the mother's current risk for engaging in physically abusive behavior. Use of the CAP provided the clinician with insight into the mother's individual functioning as a parent (*e.g.*, rigidity) and, through interpretation within the broader family system, information about the risk of abuse to her child.

C. *Forensic Evaluations: Presentation of Data*

Once all relevant data has been collected, the clinician must integrate and present the data in a manner that insures all conclusions are clearly supported. When discrepancies or limitations exist within the data, the clinician acknowledges, not ignores, these factors. For example, if the clinician collects one piece of data about a family that is inconsistent with the rest, the clinician considers the potential motivation of the source. In a child protection matter, a caseworker and a parent may have a conflicted relationship. The caseworker therefore may tend to view the parent in a negative light and unintentionally fail to acknowledge a parent's strengths. By placing the caseworker's view in a broader context, the clinician is able to weigh appropriately this perspective. When drawing conclusions, the clinician always places the behavior of the child and family in the broader context, including the family system and environmental context. For example, a reluctance to seek professional help may be culturally driven, yet could be misinterpreted by a clinician as a form of resistance or negligence. In conducting accurate forensic evaluations, it is the clinician's duty to be aware of and acknowledge potentially relevant cultural factors and interpret the behavior within the appropriate cultural frame.

Forensic clinicians must keep in mind they are not preparing reports for other mental health professionals. Clinicians therefore avoid using psychological terminology or "jargon" that those outside the field of psychology might not understand. For example, when describing a child's awareness of himself and his surroundings, rather than stating the child was "oriented to all spheres," the clinician would state the child could accurately identify his name, the location, and the time and reason for the visit. Additionally, clinicians use footnotes to describe psychological measures, diagnostic categories, and psychiatric medications. For example, if reference is made to the Wechsler Intelligence Scale for Children-III,[37] a footnote would be provided indicating that this is a test used to measure intellectual functioning in children and adolescents.

In presenting information gathered in clinical interviews, clinicians use direct quotes from children and family members when appropriate to provide the court with an accurate sense of the person's opinions and thoughts and to illustrate salient points while giving a voice to the individual. For example, indicating that a child stated: "My mom calls me ugly and stupid every day"

[37] See *infra* App. C for more information on the Wechsler Intelligence Scale for Children-III.

conveys something quite different than stating the child indicated his mother makes hurtful comments to him.

Forensic clinicians must support clinical opinions and conclusions with specific data referenced from information in the body of the report. The court should not have to speculate why a clinician has a particular opinion or made a certain conclusion; rather, opinions and conclusions should all be clearly supported and explained. For example, a forensic clinician would not simply state that a child "displays depressive symptoms." Rather, the clinician would specifically describe the symptoms (*e.g.*, sad mood, suicidal thoughts, loss of interest in activities) and cite the data supporting the clinician's conclusion (*e.g.*, during a clinical interview the child reports that he "wants to die" and cries every day, his mother reports that he is "sad all day" and no longer goes out to be with friends, and his teacher reports that he shows little interest in activities he used to enjoy and appears "down" more often than usual). Clear and explicit explanations provide the court with useful information. Moreover, reports that contain clearly explained and well-supported conclusions limit the potential for misinterpretation of unsupported statements such as "displays depressive symptoms." Finally, a well-written and clearly supported report can serve to correct misinformation such as a previous diagnosis that is irrelevant or incorrect.

The CCJCC model is designed to provide the court with forensic reports that are thorough, relevant, and accurate. Consequently, clinicians do not routinely testify because the evaluations "speak for themselves." However, when testimony is needed, the party who subpoenaed the clinician is required to meet with the clinician for testimony preparation. Preparation ensures that the lawyer understands the clinician's perspective and the manner in which the clinician views the family and child relative to the legal issue at hand. Forensic clinicians are trained to avoid offering opinions beyond the scope of the evaluation and their area of expertise.

IV. UTILIZING CCJCC'S MODEL

It is important that lawyers recognize the value of forensic evaluations that are performed according to best practice methods. Courts may receive forensic evaluations from many different sources. Research conducted by Grisso on the National Survey of Court Clinical Services found that forensic services fall within at least three categories: court clinic, community mental health agency, and private practitioner.[38] Not all forensic service providers conduct evaluations according to the CCJCC model that incorporates best practices for forensic evaluation. However, as described below, by applying aspects of the model, lawyers can become more informed consumers of the forensic evaluations they receive.

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[38] Thomas Grisso, A National Survey of Juvenile Court Clinical Services (Aug. 2005) (unpublished manuscript, presented at the American Psychological Association Conference).

A. *Obtaining a Competent Forensic Evaluation*

An essential starting point in the process of obtaining a competent evaluation is determining if a forensic evaluation is required. Choosing a type of evaluation may depend on various factors, such as the stage of the legal proceedings (*e.g.*, pretrial or post adjudication) and the questions or concerns regarding the client.[39] For example, if a lawyer is concerned about a child's mental health functioning and the child has been involved in therapy for one year, it is likely that the therapist could provide the necessary information. However, if a lawyer is concerned about a child's mental health functioning pretrial as it relates to fitness, a referral for a forensic evaluation would be appropriate. Making an uninformed decision with regard to the specific type of evaluation may have negative implications for a client such as unduly delaying court proceedings if the report was not needed or does not provide the expected response. Table 1 provides questions for lawyers to consider when determining which evaluation would be most appropriate.

TABLE 1
MAKING A DECISION BETWEEN A FORENSIC OR THERAPEUTIC EVALUATION

Is the evaluation aimed at assisting the court in making a legal decision?
Is the evaluation court ordered?
Is there potential that the evaluation will be tendered to court?

* Consider the need for a forensic evaluation if the response to any of these questions is yes.

Once it has been determined that a forensic evaluation is needed, it is important that lawyers identify and articulate clinical issues (*e.g.*, mental health and cognitive functioning, psychiatric hospitalizations and therapeutic progress) and family issues (*e.g.*, who is living in the child's home, any domestic violence, abuse and/or substance use in the home, the child's relationships with family members) that are significant components of the referral questions. Communicating the referral questions and purpose of the forensic evaluation clearly to the clinician will increase the likelihood that the evaluation addresses the reason for referral.

Thinking strategically about moving forward with obtaining a forensic evaluation is important. If a forensic evaluation is court ordered, all parties should have a shared understanding of the reason for the evaluation and agree upon referral questions. However, if a lawyer independently retains a clinician to conduct a forensic evaluation, the lawyer then solely determines the referral questions and whether the report will be tendered to court. The two different pathways to obtaining a competent evaluation can influence a client and court proceedings. If court ordered, the lawyer for the client runs the risk that information provided in the report will thwart the legal strategy. However, if the clinician is retained, the lawyer has more control over the utility of the report.

A clinician conducting forensic evaluations in the juvenile court should be proficient in the area of child protection and/or juvenile justice matters and in

[39] As described above, there are two distinct types of evaluations: therapeutic or forensic.

the principles of forensic best practice. Discussion points, as provided below in Table 2, can assist the lawyer in gauging whether or not this person is appropriate for the case. A competent clinician should be willing to discuss these and any related issues in a coherent manner.

TABLE 2
DISCUSSION POINTS RELATED TO FINDING A COMPETENT CLINICIAN

Describe your clinical training and area of expertise.
Describe your training working with children and families in a forensic context.
Describe your training in case law and the forensic guidelines of your profession?
Describe any other relevant components of your Curriculum Vita and provide a copy.
Describe any relevant scholarly publications, presentations and/or lectures that you have authored or given.
In what state(s) are you licensed to practice?
Explain the difference between a therapeutic and forensic evaluation.
Have you conducted forensic evaluations on children and/or families before? If so, how many and describe your evaluation methods.
Have you conducted forensic evaluations related to the relevant legal issue? If so, how many and describe your evaluation methods.

As stated previously, best practice methods recommend that clinicians use multiple sources in conducting a forensic evaluation. Record collecting is very time consuming; therefore, a lawyer should make every effort to provide records or assist in obtaining records for the clinician to review. Lists of records commonly used in child protection and juvenile justice evaluations are provided in Appendix A and B.

B. Utilizing the Report

A forensic evaluation should be accurate, timely and include relevant information for the purpose of answering the referral questions. To ascertain whether a forensic evaluation fulfills these goals, a lawyer can utilize the checklist provided in Table 4. If the lawyer determines that the forensic evaluation does not fulfill these goals, the lawyer should contact the clinician to ask specific questions and to determine if an addendum report or testimony is necessary.

TABLE 3
BEST PRACTICE METHODS CHECKLIST

Evaluation is within the boundaries of the clinician's competence	
Evaluation includes information relevant to the court's questions	
Limited use of psychological terminology, and, if used, explanation provided	
Inclusion of data from multiple sources	
Multiple clinical interviews were conducted	
Parent-child observation for parenting capacity evaluations	
Collateral interviews were completed, and if not, explanation provided	
Valid and reliable test/measures used	
Direct quotes used to provide an accurate description of the person's opinions and thoughts	
Identifies discrepant data	
Notes limitations of data when it exists	
Report tailored to child and family's particular needs	
Clinical interpretations, recommendations and opinions are based on the data gathered	
Writing is clear	

A forensic evaluation conducted according to best practice methods yields multiple benefits to the court, attorneys, and clients. One benefit is that it provides useful data and information that assists the court in making the pending legal decision. Also beneficial is that, as a result of the lawyer receiving an evaluation conducted according to best practice methods, the lawyer can better understand and communicate with the client. For example, in Vignette # 2, the child exhibited comprehension difficulties as a result of a traumatic brain injury. Knowledge about the child's medical history may assist a lawyer in understanding the child's limitations and the importance of changing the way in which he/she communicates. This may, in turn, lead to a lawyer and client exchanging a greater depth of information and having a more complete understanding of information. In this particular vignette, a more complete understanding of the child's special needs may result in the court finding the child unfit, or it could enable the lawyer to communicate meaningfully with the client and create an environment such that he/she is better able to communicate with the lawyer and assist in his/her defense.

The details in the report related to the family and child may also improve advocacy. For example, in Vignette # 1, information regarding the parent-child conflict suggests the possibility of abuse as a reason for runaway behavior and/or drug use. This specific information can assist an Assistant Public Defender in starting an open dialogue with their client about factors that contribute to delinquency, thereby improving their ability to advocate effectively for the client in court. Similarly, this information can assist the Assistant State's Attorney in understanding the risk for recidivism and advocating for a sentence that addresses the needs of the youth and the community. This example illustrates

the importance of having comprehensive information about the broader context and how this can directly impact the representation of a child.

V. SUMMARY

The growing field of forensic psychology has developed best practice methods for clinicians to use when conducting evaluations of children and families. However, research has shown that clinicians do not regularly use these practices. This paper presents the CCJCC model for conducting forensic evaluations. The CCJCC model utilizes best practice methods when offering the court clinical information that can be used in making a specific legal decision. Although the CCJCC model for conducting forensic evaluations is part of a larger, multifaceted court clinic model, this paper also provides tangible tools that lawyers can use to find clinicians who produce work that is consistent with best practice methods as used in the CCJCC's model. Additionally, utilizing these tools will increase the likelihood that lawyers can find clinicians who will produce evaluations that not only provide the court with information to assist in legal decision-making, but that lawyers can use to effectively communicate with and advocate for their client.

APPENDIX A
FORENSIC EVALUATION RECORDS LIST: CHILD PROTECTION*

Child Protection Records

- ☐ **Child abuse/neglect Investigation Notes**
- ☐ **All case/service plans and social histories**
- ☐ **Visitation logs/records**
- ☐ **Unusual incident reports**

Court Records

- ☐ **Copies of orders related to court proceedings (e.g., temporary custody, adjudication, disposition, permanency, and protective)**
- ☐ **Copies of motions related to court proceedings (e.g., motion for change in visitation, motion for change in permanency goal/planning, motion for case closure)**
- ☐ **Reports from Court Appointed Special Advocates (CASA)**

Criminal Records

- ☐ **Incarceration records (including treatment records or unusual incident reports)**
- ☐ **Certified copy of conviction**
- ☐ **Criminal history report**
- ☐ **Police (arrest) report**
- ☐ **Incident report**

Service Records

- ☐ **Parenting service records**
- ☐ **Domestic violence service records**
- ☐ **Substance abuse service records**
- ☐ **Educational group records**
- ☐ **Certificates for service or training program completion**

Mental Health Records

- ☐ **Previous assessments (including therapeutic/clinical assessments and forensic assessments)**
- ☐ **Inpatient and outpatient treatment records (including psychiatric evaluations, intake assessments, psychological or social assessments, progress notes, transfer summaries, and discharge summaries)**

Records Regarding Children

- ☐ **Academic records (e.g., Individualized Education Program(s) [IEP], Special Education Report)**
- ☐ **Medical records (including any medical records related allegations for findings of abuse/neglect)**
- ☐ **Mental Health treatment records (including assessments, inpatient and outpatient records, progress reports, transfer summaries and discharge summaries)**

*This list is not exhaustive and should be tailored to reflect particular psycho-legal issues at hand.

APPENDIX B
FORENSIC EVALUATION RECORDS LIST: JUVENILE JUSTICE*

Police records related to the current arrest

- ☐ **General progress notes from the officers involved**
- ☐ **Arrest report(s)**
- ☐ **Self-incriminating statement(s) (written and/or videotaped)**
- ☐ **Any relevant transcripts**
- ☐ **Any relevant police records**
- ☐ **Records documenting interviews with the minor that were related to the offense but did not result in an arrest**
- ☐ **Petition**

Police records related to previous arrests or station adjustments

- ☐ **Juvenile police records**
- ☐ **Probation records**
- ☐ **Any official documents describing prior contact with the police**

Academic or Vocational records

- ☐ **Prior and current Individualized Education Program(s) (IEP) and Multidisciplinary Conference Records**
- ☐ **Discipline records**
- ☐ **Report cards**
- ☐ **Standardized test scores**
- ☐ **Any other academic records**
- ☐ **Any other educational or vocational training records**
- ☐ **Any other educational or vocational evaluations**

Mental health, substance abuse, medical, and disability records

- ☐ **Psychiatric, psychological, or social work treatment records**
- ☐ **Prior psychiatric hospitalization records**
- ☐ **Restoration services records including progress notes from court ordered treatment**
- ☐ **Disability records including the evaluations used to determine eligibility**
- ☐ **Any other previous mental health assessments including court ordered assessments**
- ☐ **Substance abuse treatment records**
- ☐ **Residential treatment records**

*This list is not exhaustive and should be tailored to reflect particular psy cho-legal issues at hand.

APPENDIX C
PSYCHOLOGICAL MEASURES FOR FORENSIC EVALUATIONS*

A. *Measures to assess behaviors and/or mental health symptoms*

1. *Beck Depression Inventory-II (BDI-II)*[40]

The BDI-II is a self-report measure used for measuring the severity of depression in adults and adolescents 13 years of age and older.

2. *Behavior Assessment System for Children Second Edition (BASC-2)*[41]

The BASC-2 is a measure completed by a parent, teacher and/or child. This measure provides information about problem behaviors and emotional functioning in children and adolescents.

3. *Child Behavior Checklist (CBCL)*[42]

The CBCL is a measure completed by a parent, teacher and/or child. This measure provides information about behavioral and emotional functioning in children six to eighteen years of age.

4. *Child Depression Inventory (CDI)*[43]

The CDI is a self-report measure designed to assess depressive symptoms in children and adolescents seven to seventeen years of age.

5. *Conner's Parent (CPRS)/Teacher Rating Scale (CTRS)*[44]

The CPRS and CTRS are used to identify behavioral problems (including a measure of symptoms related to Attention Deficit/Hyperactivity Disorder) in children three to seventeen years of age.

6. *Symptom Checklist-90-R (SCL-90-R)*[45]

The SCL-90-R is a self-report measure designed to assess current psychological problems and symptoms of psychopathology in adults.

7. *Trauma Symptoms Checklist for Children (TSCC)*[46]

The TSCC is a self-report measure designed to assess current psychological symptoms (i.e., anxiety, depression, anger, posttraumatic stress, dissociation, sexual concerns) in children eight to sixteen years of age.

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[40] AARON T. BECK, ROBERT A. STEER & GREGORY K. BROWN, BDI-II, BECK DEPRESSION INVENTORY: MANUAL (2d ed. 1996).
[41] CECIL R. REYNOLDS & RANDY W. KAMPHAUS, BASC-2, BEHAVIOR ASSESSMENT SYSTEM FOR CHILDREN (2d ed. 2004).
[42] THOMAS M. ACHENBACH, CHILD BEHAVIOR CHECKLIST (1981).
[43] MARIA KOVACS, CHILDREN'S DEPRESSION INVENTORY (1992).
[44] C. KEITH CONNERS ET AL., CONNERS' RATING SCALES (1989).
[45] LEONARD R. DEROGATIS, SCL-90-R: SYMPTOM CHECKLIST-90-R (3d ed. 1994).
[46] JOHN BRIERE & PAR, TRAUMA SYMPTOM CHECKLIST FOR CHILDREN (TSCC) (1996).

B. *Intelligence and academic measures for children, adolescents and adults*

1. *Kaufmann Brief Intelligence Test (K-BIT)*[47]

The K-BIT measures an individual's knowledge of words and their meaning and the ability to solve problems. The measure can be administered to individuals four years of age and older.

2. *Wechsler Adult Intelligence-Scale Third Edition (WAIS-III)*[48]

The WAIS-III is designed to assess the cognitive abilities of individuals 16 years of age or older. Several Intelligence Quotient (IQ) scores are computed (*e.g.*, Verbal Comprehension Index, Performance Reasoning Index, Perceptual Organization Index, Working Memory Index, Processing Speed Index and Full Scale IQ).

3. *Wechsler Intelligence Scale for Children (WISC-IV)*[49]

The WISC-IV is designed to assess the cognitive abilities of individuals six to sixteen years of age. Several IQ scores are computed (e.g., Verbal Comprehension Index, Performance Reasoning Index, Working Memory Index, Processing Speed Index and Full Scale IQ) based on the child's age.

4. *Wechsler Abbreviated Scale of Intelligence (WASI)*[50]

The WASI is an abbreviated intelligence test that assesses cognitive abilities in individuals six years of age and older.

5. *Wechsler Individual Achievement Test (WIAT-II)*[51]

The WIAT-II is a measure designed to assess abilities related to academic achievement (e.g., listening comprehension) of individuals four years of age and older.

6. *Wide Range Achievement Test-III (WRAT-III)*[52]

The WRAT-III is a measure used to assess basic reading, mathematical and spelling abilities in individuals five to seventy-five years of age.

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[47] ALAN S. KAUFMAN ET AL., KBIT2 KAUFMAN BRIEF INTELLIGENCE TEST (2d ed. 2004).

[48] PSYCHOLOGICAL CORP., WAIS-III, WESCHLER ADULT INTELLIGENCE SCALE (3d ed. 1997).

[49] DAVID WECHSLER & PSYCHOLOGICAL CORP., WISC-IV: ADMINISTRATION AND SCORING MANUAL (4th ed. 2003).

[50] DAVID WECHSLER, WASI: WECHSLER ABBREVIATED SCALE OF INTELLIGENCE (1999).

[51] PSYCHOLOGICAL CORP., WIAT-II: WECHSLER INDIVIDUAL ACHIEVEMENT TEST EXAMINER'S MANUAL (2d ed. 2002).

[52] GARY S. WILKINSON, WRAT-3: WIDE RANGE ACHIEVEMENT TEST ADMINISTRATION MANUAL (1993).

7. The Woodcock-Johnson Psycho-Educational Battery-III[53]

The Woodcock-Johnson III is a comprised of a set of tests that assesses general intellectual ability, specific cognitive abilities, scholastic aptitude, oral language, and academic achievement in persons two years of age and older.

C. Personality Measures

1. The Millon Clinical Multiaxial Inventory-III (MCMI-III)[54]

The MCMI-III is a measure that provides information about adults' personality styles and clinical functioning.

2. Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)[55]

The MMPI-A is a measure that provides information about adolescents' personality characteristics. It is designed for use with individuals fourteen to eighteen years of age.

3. Minnesota Multiphasic Personality Inventory-2 (MMPI-2)[56]

The MMPI-2 is a measure that provides information about adults' personality characteristics.

4. Personality Assessment Inventory (PAI)[57]

The PAI is a measure of adult personality. The PAI is designed to provide information relevant to clinical diagnosis, treatment planning, and screening for psychopathology.

5. Personality Inventory for Youth (PIY)[58]

The PIY is used in the evaluation of children and adolescents nine to eighteen years of age. The measure assesses emotional and behavior adjustment, family interaction, and school and academic functioning.

D. Parenting Assessment Measures

1. Child Abuse Potential Inventory (CAP)[59]

The CAP is a screening measure utilized with parents and designed to identify characteristics that are often found in/shared with known physical abusers.

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[53] RICHARD W. WOODCOCK, KEVIN S. MCGREW & NANCY MATHER, WOODCOCK-JOHNSON III TESTS OF ACHIEVEMENT (2001).

[54] THEODORE MILLION, MACI: MILLION ADOLESCENT CLINICAL INVENTORY (1993).

[55] JAMES NEAL BUTCHER, ET AL., MMPI-A: MINNESOTA MULTIPHASIC PERSONALITY INVENTORY-ADOLESCENT: MANUAL FOR ADMINISTRATION, SCORING, AND INTERPRETATION (1992).

[56] STARKE R. HATHAWAY, J. C. MCKINLEY & JAMES NEAL BUTCHER, MMPI-2: MINNESOTA MULTIPHASIC PERSONALITY INVENTORY-2 (1989).

[57] LESLIE CHARLES MOREY, PERSONALITY ASSESSMENT INVENTORY (1991).

[58] DAVID LACHAR ET AL., PERSONALITY INVENTORY FOR YOUTH (PIY) (1995).

[59] MILNER, *supra* note 37.

2. *Parenting Stress Index (PSI)*[60]

The PSI is designed to identify parent-child dyads that are experiencing stress or may be at risk to develop dysfunctional parenting and child behavioral problems. The PSI is designed for use with parents of children ranging in age from one month to twelve years of age.

E. Juvenile Justice Forensic Assessment Measures

1. Instruments for Assessing Understanding and Appreciation of Miranda Rights[61]

Using four subtests, this test assesses the current understanding and appreciation of a standard Miranda warning for individuals ten years of age and older.

2. *Juvenile Adjudicative Competence Interview (JACI)*[62]

The JACI is an interview guide that assists clinicians in conducting competency (fitness) evaluations.

*This is not an exhaustive list of psychological measures for forensic evaluations

[60] RICHARD R. ABIDIN, PARENTING STRESS INDEX: PROFESSIONAL MANUAL (3d ed. 1995).
[61] THOMAS GRISSO, INSTRUMENTS FOR ASSESSING UNDERSTANDING & APPRECIATION OF MIRANDA RIGHTS (1998).
[62] THOMAS GRISSO, EVALUATING JUVENILES' ADJUDICATIVE COMPETENCE: A GUIDE FOR CLINICAL PRACTICE (2005).