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Repository Citation

Thomas Grisso, *Clinicians' Transfer Evaluations: How Well Can They Assist Judicial Discretion?*, 71 La. L. Rev. (2010)
Available at: <https://digitalcommons.law.lsu.edu/lalrev/vol71/iss1/6>

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Clinicians' Transfer Evaluations: How Well Can They Assist Judicial Discretion?

Thomas Grisso*

From its earliest years, the juvenile court exercised options for trying some cases involving youth in criminal court. The primary legal basis for transferring youth from juvenile to criminal court was by the discretion of juvenile court judges.² *Kent v. U.S.* outlined due-process requirements for discretionary (judicial) transfer as well as certain criteria to guide courts' judgments in deciding whether to transfer on a case-by-case basis.³

Beginning in the late 1980s, a majority of states created laws that increased the use of statutory exclusion of juveniles from "automatic" filings of charges in criminal court by employing certain restrictions regarding age of the juvenile and nature of the charge.⁴ Many states, however, retained the option of judicial transfer for cases that did not meet the criteria for statutory exclusion.⁵ In addition, in many states, cases involving youth that were filed in criminal court could be remanded to juvenile court by discretion of the criminal court judge, a process sometimes called "reverse transfer."⁶

Whether in juvenile court transfer proceedings or criminal court "reverse transfer" proceedings, courts' judgments about whether individual youth ought to be transferred are often informed by forensic clinical evaluations performed by mental health professionals. The legal criteria applied in a transfer case refer in part to characteristics of youth that the court must consider when determining whether the youth is a proper subject for

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1. The term for transferring youth from juvenile to criminal or criminal to juvenile jurisdiction varies from state to state. Common variations are "certification," "waiver," "bindover," and, as employed in this Article, "transfer."

2. David S. Tanenhaus, *The Evolution of Transfer Out of the Juvenile Court*, in THE CHANGING BORDERS OF JUVENILE JUSTICE 13 (Jeffrey Fagan & Franklin E. Zimring eds., 2000).

3. 383 U.S. 541 (1966).

4. Robert O. Dawson, *Judicial Waiver in Theory and Practice*, in THE CHANGING BORDERS OF JUVENILE JUSTICE, *supra* note 2, at 45.

5. *Id.* at 64.

6. Barry C. Feld, *Legislative Exclusion of Offenses from Juvenile Court Jurisdiction: A History and Critique*, in THE CHANGING BORDERS OF JUVENILE JUSTICE, *supra* note 2, at 83, 119-24.

juvenile court jurisdiction. A century of practice has presumed that these characteristics, focusing on youth's potential for future criminal behavior and the ability of rehabilitation to reduce that potential, can be assessed by mental health examiners who can offer guidance for courts' deliberations about transfer.⁷

This Article informs courts and attorneys regarding the degree to which they can depend on mental health professionals to contribute reliable expert evidence to the legal process of transfer in juvenile and criminal courts. Part I outlines the limited guidance that clinicians receive from their professions and the law for performance of transfer evaluations. Parts II, III, and IV offer background that suggests mixed outcomes for the prospect of clinicians' transfer evaluations being able to offer reliable information relevant to the legal questions in transfer. There is good evidence of the ability of transfer evaluations to provide relevant descriptions with which courts can apply the legal standards in weighing the implications of transfer. There is less research evidence, however, supporting the application of that information in ways that endeavor to answer the questions raised by transfer criteria. Part V summarizes these considerations, offering reasons to believe that protection of youth from improper assessment methods and potentially inappropriate decisions about transfer can be better accomplished when transfer evaluations (and transfer decisions) are made in juvenile court rather than in reverse-transfer hearings in criminal court.

I. STANDARDS AND GUIDELINES FOR TRANSFER EVALUATIONS

Transfer evaluations are intended to inform courts about the impact of legal decisions. Thus they are "forensic evaluations." Forensic psychology and forensic psychiatry offer standards for forensic evaluations as work products; transfer evaluations are obligated to meet these standards.⁸ In addition, professional consensus should guide courts regarding the conduct of transfer evaluations specifically. Clinicians' professions provide clear standards for forensic evaluations generally but only rudimentary guidance regarding practice standards for transfer evaluations specifically.⁹ Finally, clinicians must have a clear view of the

7. THOMAS GRISSO, FORENSIC EVALUATION OF JUVENILES 196 (1998); Thomas Grisso, *Forensic Clinical Evaluations Related to Waiver of Jurisdiction*, in THE CHANGING BORDERS OF JUVENILE JUSTICE, *supra* note 2, at 321, 322.

8. See discussion *infra* Part I.A.

9. See discussion *infra* Part I.B.

appropriate objectives of transfer hearings and evaluations, and a consensus has arisen about the nature of those objectives.¹⁰

A. Standards for Forensic Evaluations

Both forensic psychology and forensic psychiatry have developed standards and a professional consensus for the conduct of forensic evaluations in general. The American Psychological Association and the American Psychiatric Association both recognize forensic practice as a specialty. A recent text on forensic mental health evaluations listed 15 specific kinds of forensic evaluations arising in criminal, civil, and juvenile law.¹¹ Over the past 40 years, both the professions of psychology and psychiatry have reached a high degree of consensus regarding principles, methods, and skills that are required for the performance of any type of evaluation for the courts.¹²

For example, Heilbrun's 29 "principles" of forensic mental health assessment are sufficiently generic that they can be applied across various types of forensic evaluation.¹³ They refer to basic requirements when preparing for the evaluation, collecting data, interpreting the data, and communicating the results. The principles need not be reviewed here, but important examples within two of these categories—preparation for the evaluation and data collection—are illustrative and useful for later discussion of transfer evaluations.

Preparation for the forensic evaluation includes being clear about the definition of the legal question. The clinician must know how the law defines the legal decision—in this case, what criteria the law instructs courts to consider when making the transfer decision. This is necessary in order for the clinician to identify the psychological data that will be relevant for the clinician to collect, as well as the nature of the conclusions the clinician is expected to form based on those data.¹⁴

10. See discussion *infra* Part I.C.

11. KIRK HEILBRUN, THOMAS GRISSO & ALAN GOLDSTEIN, FOUNDATIONS OF FORENSIC MENTAL HEALTH ASSESSMENT 7–8 (2009).

12. PAUL APPELBAUM & THOMAS GUTHEIL, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW (2006); KIRK HEILBRUN, PRINCIPLES OF FORENSIC MENTAL HEALTH ASSESSMENT (2001); HEILBRUN, GRISSO & GOLDSTEIN, *supra* note 11; GARY MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS (3d ed. 2007).

13. HEILBRUN, *supra* note 12. The remainder of this Section draws substantially from this source.

14. See *generally* THOMAS GRISSO, EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS 42–49 (2d ed. 2003).

Data collection includes the need to employ methods that offer multiple sources of information about the relevant psychological conditions of the examinee.¹⁵ Most importantly, the methods used must meet standards for reliability as a basis for expert opinions to be entered into evidence in a legal case. These standards come from two sources. First, professional literature in forensic psychology and forensic psychiatry urges that, whenever possible, clinicians should use theories and methods with known reliability and validity regarding their meanings, based on empirical research.¹⁶ This does not exclude the use of less empirically-based methods for which there is a scientific basis for their reliability and validity.

Second, standards for data collection are based in part on legal criteria for the admissibility of expert testimony.¹⁷ In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, for example, the Court offered several factors to weigh when deciding whether an expert's opinion has sufficient foundation: whether the method can be empirically tested, whether it has been subjected to peer review, whether its rate of error is known, whether there is a standardized way of employing the method, and the degree to which the method has been generally accepted in the relevant part of the professional community.¹⁸ Methods employed in transfer evaluations, therefore, could be subjected to scrutiny regarding these factors when questions of admissibility are raised.

These requirements apply similarly to transfer evaluations as to any other forensic evaluation. However, each different type of forensic evaluation requires additional guidelines related to its specific forensic purpose.

B. Guidelines Specific to Transfer Evaluations

A review of professional literature on juvenile transfer evaluations indicates that clinicians have little guidance for this specialized forensic evaluation. There are no national statistics on the frequency of transfer evaluation requests by juvenile courts. There have been no studies on the nature and quality of transfer evaluations as they are performed in everyday practice. No book has ever been published solely on juvenile transfer evaluations.

15. HEILBRUN, *supra* note 12, at 99–107.

16. See generally GRISSO, *supra* note 14; HEILBRUN, *supra* note 12; MELTON ET AL., *supra* note 12.

17. FED. R. EVID. 702; *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993); *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

18. *Daubert*, 509 U.S. at 592.

A number of book chapters and journal articles have offered commentary on transfer evaluations, most of them appearing in the professional literature only within the past 15 years.¹⁹ This small body of literature does not offer a professional consensus regarding how a juvenile transfer evaluation should be conducted. Major textbooks on forensic evaluation typically offer a paragraph or two, or nothing at all, regarding transfer evaluations. For example, the latest edition of the leading text on forensic psychological assessments does not discuss transfer evaluations specifically but merely has a brief section on evaluating amenability to rehabilitation as well as a sample transfer evaluation report.²⁰ Recently a project reported progress in the development of a standardized assessment tool for identifying critical characteristics of youth that are relevant for transfer decisions.²¹ But it stands alone as a specialized tool for clinicians' transfer evaluations. All of this is in stark contrast to other areas of juvenile forensic evaluation, for which extensive guidelines and considerable professional consensus are available: e.g., evaluations of child custody, of juveniles' competence to stand trial, of juveniles' risk of violence, and of child abuse and neglect.²²

19. See, e.g., Richard Barnum, *Clinical Evaluation of Juvenile Delinquents Facing Transfer to Adult Court*, 26 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 922 (1987); Charles P. Ewing, *Juveniles or Adults? Forensic Assessment of Juveniles Considered for Trial in Criminal Court*, 3 FORENSIC REP. 3 (1990); Thomas Grisso, *Evaluations for Waiver to Criminal Court, in FORENSIC EVALUATION OF JUVENILES* 195 (1998); Grisso, *supra* note 7, at 322; Ivan Kruh & Stan Brodsky, *Clinical Evaluations for Transfer of Juveniles to Criminal Court: Current Practices and Further Research*, 15 BEHAV. SCI. & L. 151 (1997); James L. Loving & Nicholas S. Patapis, *Evaluating Juvenile Amenability to Treatment: Integrating Statutes and Case Law into Clinical Practice*, 7 J. FORENSIC PSYCHOL. PRAC. 67 (2010); Stephanie P. Penney & Marlene S. Moretti, *The Transfer of Juveniles to Adult Court in Canada and the United States: Confused Agendas and Compromised Assessment Procedures*, 4 INT'L J. FORENSIC MENTAL HEALTH 19 (2005); Randall T. Salekin, *Clinical Evaluation of Youth Considered for Transfer to Adult Criminal Court*, 2 J. FORENSIC PSYCHOL. PRAC. 55 (2002); Philip H. Witt & Frank J. Dyer, *Juvenile Transfer Cases: Risk Assessment and Risk Management*, 25 J. PSYCHIATRY & L. 581 (1997).

20. MELTON ET AL., *supra* note 12, at 477–79, 661–68.

21. RANDALL SALEKIN, RISK-SOPHISTICATION-TREATMENT INVENTORY: PROFESSIONAL MANUAL (2004); Randall Salekin et al., *Risk-Sophistication-Treatment Inventory*, in MENTAL HEALTH SCREENING AND ASSESSMENT IN JUVENILE JUSTICE 341 (Thomas Grisso, Gina Vincent & Daniel Seagrave eds., 2005).

22. For recent reviews of forensic assessment methods in these areas, see KAREN BUDD, JENNIFER CLARK & MARY CONNELL, EVALUATIONS FOR CHILD PROTECTION (forthcoming 2011); GERI FUHRMANN & ROBERT ZIBBELL, EVALUATIONS FOR CHILD CUSTODY (forthcoming 2011); ROBERT D. HOGE &

Nor do most juvenile forensic examiners have extensive formal training in performing transfer evaluations. There are a significant number of psychiatry fellow and psychology post-doctoral training programs nationwide for specialization in forensic evaluation practice. Only a few of these programs offer specialization in juvenile forensic practice, however, and even those typically provide experience in performing only a limited number of transfer evaluations during the typical one-year specialized training program.

This description of the relatively uncertain state of the art for transfer evaluations is striking considering that clinicians have been performing transfer evaluations for juvenile courts since the early part of the twentieth century, anecdotally with considerable frequency. The literature, research, and standards of practice specific to transfer evaluations offer clinicians less professional guidance than can be found for most of the 15 types of forensic evaluations that constitute the domain of clinicians' forensic contributions to criminal, civil, and juvenile courts.²³

As noted earlier, this does not mean that clinicians are without guidance for conducting transfer evaluations. They are guided by an extensive literature on the *general* principles of forensic assessment and, as will be reviewed in Parts II, III, and IV, on guidelines that at least focus their assessment process on the specific questions in transfer cases. But the lack of specific guidelines for transfer evaluations has implications for their use in juvenile court proceedings. Without a consensus in the literature regarding the conduct of transfer evaluations, it is likely that the evaluations will manifest considerable variability in how they are conducted and reported from one clinician to another.²⁴ This increases the likelihood that two or more clinicians in a transfer case will use different methods and arrive at different opinions, there being no "standard" way to perform such evaluations.

C. The Objectives of Transfer Evaluations

As previously mentioned, clinicians who perform forensic evaluations must begin with an understanding of what the law wants to know by way of expert opinion, so that their evaluations

D.A. ANDREWS, EVALUATION FOR RISK OF VIOLENCE IN JUVENILES (2010); IVAN KRUIH & THOMAS GRISSO, EVALUATION OF JUVENILES' COMPETENCE TO STAND TRIAL (2009).

23. HEILBRUN, GRISSO & GOLDSTEIN, *supra* note 11.

24. We can only speculate about this, however, in the absence of any systematic research studies of transfer evaluations.

are conducted in a manner that is relevant to the law's concerns. It is expected that forensic clinicians will read the relevant statutes and appellate cases in the state in which they practice, in search of criteria that will guide their evaluations. In addition, they are likely to read digested reviews of the law of transfer as published in journals and books in the field of forensic psychology or forensic psychiatry. It is instructive, therefore, to review what that literature tells them with regard to the legal standards and criteria for transfer cases. Standards for transfer to criminal court vary somewhat across jurisdictions, and their meanings are open to considerable differences in interpretation. But they do offer structure at the broadest level, and a transfer evaluation that does not begin with these general standards as its guide is open to challenge.

Across the years, clinicians have been consistently informed that reviews of the states' transfer laws have identified three concepts that constitute the focus for transfer hearings.²⁵ They are (1) *risk of danger to others* (or "public safety"), (2) *amenability to rehabilitation* in the juvenile justice system, and (3) level of *sophistication-maturity*.²⁶ Clinicians, then, are urged to use these concepts as the focus of their transfer evaluations when identifying the nature of the data that they should obtain and the interpretive objectives of the evaluation.

These three concepts have evolved through analyses of courts' applications of legal criteria in transfer cases as well as empirical research that synthesized the criteria that judges and attorneys claim to apply.²⁷ These concepts are consistent with the factors that were outlined in *Kent*, but they do not simply repeat *Kent*'s eight factors.²⁸ This is because several of the factors in *Kent* are not clinical matters (e.g., whether the case has prosecutorial merit and the desirability of trial in criminal court because the case involves adult associates).²⁹ Other factors such as "previous history of the youth" are so general that they provide no guidance for examiners.³⁰

The identification of these three concepts is of utmost importance for guiding transfer evaluations. Yet they are ambiguous in ways that will allow for variability among clinicians'

25. See *supra* note 19.

26. See *supra* note 19.

27. Dia N. Brannen et al., *Transfer to Adult Court: A National Study of How Juvenile Court Judges Weigh Pertinent Kent Criteria*, 12 PSYCHOL. PUB. POL'Y & L. 332 (2006); Thomas Grisso, Alan Tomkins & Pamela Casey, *Psychosocial Concepts in Juvenile Law*, 12 LAW & HUM. BEHAV. 403 (1988).

28. 383 U.S. 541 (1966).

29. *Id.*

30. *Id.*

interpretations of what the factors mean. These ambiguities will be discussed in Parts II, III, and IV. In addition, the three concepts clearly are not distinct and separate from each other. A judgment about future danger to others will be influenced by one's perceptions of whether the youth is sufficiently amenable to rehabilitation to respond to efforts to modify his behavior. Moreover, amenability to rehabilitation in the juvenile justice system may be seen as more or less likely depending on a youth's level of cognitive and emotional maturity. This creates difficulties in identifying psychological factors as related to any particular concept.

How, then, can forensic clinicians address these concepts in their transfer evaluations? What methods are at their disposal to assess youth's amenability to rehabilitation, their risk of future danger to others, and their sophistication and maturity? Parts II, III, and IV address the clinical application of these three concepts, with special attention given to evidence of the reliability and validity of methods that are available to clinicians in fulfilling these objectives.

The following three Parts do not necessarily describe how *most* clinicians perform transfer evaluations. This analysis takes a different perspective. It considers the assessment task, based on the legal demands, and presents what may be considered the best that a clinician can do in light of current scientific knowledge and clinical methods. It is possible that the methods described here exceed the "average practice" of clinicians in their current performance of transfer evaluations.

II. ASSESSING RISK OF DANGER TO OTHERS

The volume of scientific literature on assessing risk of future aggression has become large and complex during the past 30 years, and methods for using this knowledge in clinical assessment have grown apace.³¹ Through this literature, supported by a vast array of research studies, a number of observations about the practice of risk assessment have gained general acceptance in the field.³² Similarly, a significant body of knowledge has developed

31. See HANDBOOK OF VIOLENCE RISK ASSESSMENT (Randy K. Otto & Kevin Douglas eds., 2010).

32. See RANDY BORUM & DAVID VERHAAGEN, ASSESSING AND MANAGING VIOLENCE RISK IN YOUTH (2006); MELTON ET AL., *supra* note 12; VERNON QUINSEY ET AL., VIOLENT OFFENDERS: APPRAISING AND MANAGING RISK (1998). All assertions in Part II.A, *infra*, regarding "general acceptance" are supported by these three sources.

regarding the nature of aggression in youth³³ and methods for the assessment of youth's potential for aggression, violence, and repeated offenses.³⁴ The application of this information in transfer evaluations, however, is subject to several important limitations.³⁵

A. Overview of Principles for Risk of Harm Assessments

First, the field long ago discarded the notion that clinicians should try to predict that individuals “will” or “will not” engage in aggression against others in the future because they have learned that dichotomous (“yes” or “no”) predictions of aggression in individual cases are doomed to be wrong more often than right.³⁶ What clinicians now aim for is a reasonable estimation of the likelihood or probability of future aggression. Thus examinees' scores on a risk assessment tool can be used to classify them in groups of persons who scored similarly and have demonstrated a low or high base rate of subsequent aggression against others. For many tools of this kind, a high base rate represents a 40 to 60% likelihood of future aggression.³⁷ Moreover, only a minority of persons in offender populations score in the high-risk range on such instruments.³⁸

Second, there is general acceptance that clinicians seeking estimates of the likelihood of future aggression should employ risk factors (e.g., age at first offense, frequency of prior offenses, and certain traits) that have been shown to have empirical relations to future aggression. As described later, many structured tools for use in risk assessments employ such risk factors.³⁹ They also provide for scores or ratings of the factors, which are often combined mathematically to arrive at summary scores that assign examinees to risk categories, based on research samples that have been shown to have low, moderate, or high rates of future aggression. Although many tools use this “actuarial” approach, others provide for “structured clinical judgment.” The latter methods allow clinicians to use risk factors more flexibly, as long as the factors that they use are empirically validated and the clinician rates the examinee on those factors to provide anchors for their decisions.⁴⁰

33. See *infra* Part II.B.

34. See *infra* Part II.C.

35. See *infra* Part II.D–E.

36. John Monahan, *Violence Prediction: The Last 20 Years and the Next 20 Years*, 23 CRIM. JUST. & BEHAV. 107 (1996).

37. JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT (2001).

38. *Id.*

39. See *infra* Part II.C.

40. See BORUM & VERHAAGEN, *supra* note 32.

Third, when employing these methods, clinicians are urged to be careful to choose those that have been validated for the actual outcomes that are relevant for their assessment task. For example, some risk assessment tools have been validated for identifying recidivism in the form of any crime, although others have been validated for purposes of identifying recidivism for violent offenses or specific types of offenses (e.g., sex offenses). Some of the latter assess for any future aggressive behavior, although others assess specifically for future *arrests* for offenses involving harm to others.

Finally, practice standards urge clinicians to make “conditional” risk estimates. The estimated risk of future aggression against others is often dependent upon the context, not merely the characteristics of the individual. Two contexts are particularly important for the present analysis. One is the environment in which an individual is likely to reside in the future. Some environments are more structured and secure than others, thus creating different conditions that may increase or decrease the likelihood of violence. Another context is the temporal definition of “future.” Any estimate of aggression in the near future (e.g., the next year) is likely to be more accurate than for the long-range future (e.g., many years after the assessment).

This matter of context and “conditional” risk is of special significance for courts’ transfer decisions.⁴¹ In such a case, the court must attend to whether the youth is likely to harm other youth if placed in juvenile justice facilities, as well as whether the youth is likely to create a generally increased public safety risk if the youth escapes from such facilities. From a temporal perspective, both of those risk estimates have to do with relatively immediate risk (i.e., within the next year or two). But courts contemplating transfer are also interested in whether the youth is of a type that will continue to present a substantial risk of violence continuing into adulthood. Thus clinicians are often faced with making not one risk estimate, but several. Can the youth manage impulses if placed in a secure juvenile facility? Would he present a significant risk if he were not in that facility but rather in unsupervised situations in the general community? Is this a youth who is going to continue to be a long-range risk into adulthood, thus suggesting that the use of juvenile justice resources is questionable? The clinician must face the possibility that the answers to these three questions are not all the same.

As noted earlier, the scientific and clinical literature that is available to guide clinicians in making risk estimates of future

41. See GRISSO, *supra* note 7, at 128–30.

aggression is vast. However, that literature is not so large regarding estimates of future aggression among youth. Moreover, very little attention has been given to applying that research in transfer evaluations. What can courts reasonably expect of clinicians who employ their best risk-of-aggression methods to address whether a youth presents a significant “danger to others,” as that concept relates to the question of transfer?

B. Youth Violence in a Developmental Context

When assessing youth for risk of future aggression, clinicians are aware of a number of difficulties they face compared to similar assessments of adults. Youth are assessed in the context of adolescence, a period of development that has significant implications for making estimates of future behavior based on present behavior.

Aggression is nearly normal for adolescent boys.⁴² Most of this aggression is minor, but adolescence is a developmental stage marked by impulsiveness, sensation-seeking, and risk-taking.⁴³ Not surprisingly, per-capita arrest rates for felonies begin to climb around age 14 and continue to rise until they peak in the late teens, after which they subside.⁴⁴

If a youth engages in violent behavior that is serious enough to result in arrest, there is often some increase in the likelihood of future harm to others compared to a youth who has not been arrested for a violent offense—at least in the short run. In the long run, the nature of a youth’s offense has far less value for assessing the likelihood of continued harm in adulthood. Most adolescents, even those who commit very serious offenses as juveniles, do not continue to engage in such behaviors in adulthood.⁴⁵ Thus, when making longer-range estimates, clinicians performing risk-of-

42. Delbert Elliott, *Serious, Violent Offenders: Onset, Developmental Course, and Termination*, 32 *CRIMINOLOGY* 1 (1994).

43. See, e.g., Laurence Steinberg et al., *Age Differences in Future Orientation and Delay Discounting*, 80 *CHILD DEV.* 28 (2009); Laurence Steinberg et al., *Age Differences in Sensation Seeking and Impulsivity as Indexed by Behavior and Self-Report*, 44 *DEVELOPMENTAL PSYCHOL.* 1764 (2008).

44. *Statistical Briefing Book: Age-Specific Arrest Rate Trends*, OFF. JUV. JUST. & DELINQ. PREVENTION, <http://www.ojjdp.gov/ojstatbb/crime/qa05301.asp?qaDate=20040801> (last updated Aug. 1, 2004).

45. Terrie Moffitt, *Adolescent-Limited and Life-Course-Persistent Antisocial Behavior: A Developmental Taxonomy*, 100 *PSYCHOL. REV.* 674 (1993); Terrie Moffitt & Avshalom Caspi, *Childhood Predictors Differentiate Life-Course Persistent and Adolescence-Limited Antisocial Pathways Among Males and Females*, 13 *DEV. & PSYCHOPATHOLOGY* 355 (2001).

future-harm evaluations with youth who have engaged in violent offenses face an interesting circumstance. They must begin their evaluations with a presumption that these youth are *not* likely to be high-risk as they age into adulthood. Then the clinicians seek data that will confirm or disconfirm that presumption.

The fact that youth continue to change in their cognitive, personality, and social characteristics throughout adolescence creates other significant challenges for estimating likelihood of future aggression. Long-range estimates about future adult behavior are even more difficult when assessing a young teenager (e.g., younger than age 15), simply because there is more time for biological, psychological, and social development to alter the youth prior to adulthood. In addition, adolescents are more prone to variability in their behavior from week to week or month to month, thus increasing errors in estimates about a youth's "typical" behavior based on evaluating the youth at a particular point in time.⁴⁶

C. The State of Juvenile Risk Assessment

Despite these difficulties inherent in risk estimates during adolescence, research on the relation of present and future aggression among youth has made exceptional strides in the past 15 years.⁴⁷ Two important things have happened to greatly improve the prospect for assessing risk of future aggression among youth. One is the evolution of a "best practices" standard in forensic clinical assessment that insists on the use of evidence-based practices in performing forensic assessments.⁴⁸ This means that if there is reasonable research evidence that one or more assessment methods for a particular purpose have known reliability and validity, failure to use one or more of those methods is inferior clinical forensic practice.

The other advance, as noted in current reviews, is the recent development of several assessment tools for assisting in estimation of risk of future violence or aggression in adolescents, many having risen to the level of evidence-based practices within the past ten years.⁴⁹ For example, the *Youth Level of Service/Case*

46. LAURENCE STEINBERG, *ADOLESCENCE* (5th ed. 1999).

47. KIRK HEILBRUN, NAOMI GOLDSTEIN & RICHARD REDDING, *JUVENILE DELINQUENCY: PREVENTION, ASSESSMENT, AND INTERVENTION* (2005); ROLF LOEBER & DAVID FARRINGTON, *SERIOUS AND VIOLENT JUVENILE OFFENDERS: RISK FACTORS AND SUCCESSFUL INTERVENTIONS* (1998).

48. HEILBRUN, GRISSO & GOLDSTEIN, *supra* note 11, at 55–63.

49. *HANDBOOK OF VIOLENCE RISK ASSESSMENT*, *supra* note 31; HOGE & ANDREWS, *supra* note 22; Gina Vincent, Anna Terry & Shannon Maney,

Management Inventory (YLS/CMI) uses a number of empirically derived risk factors that are scored and summed to provide a quantitative estimate of risk of both general and violent repeated offenses in youth.⁵⁰ The instrument also assesses youth's needs—i.e., characteristics or external circumstances that are contributing to their delinquency and that become targets for “case management” and intervention to reduce the likelihood of repeated offenses. The *Structured Assessment of Violence Risk in Youth* (SAVRY) allows a clinician to rate youth on empirically derived factors in four clusters: (1) historical variables regarding past behavior and environmental influences, (2) social variables that are known to increase risk due to the youth's associations, (3) clinical variables involving the youth's traits or disorders, and (4) protective factors that can mitigate repeated offenses.⁵¹ Highly objective criteria allow clinicians to rate the youth on these factors, but no summary score is used. This method allows for “structured clinical judgment” in reaching a final conclusion about level of risk.

Substantial research evidence has accumulated regarding the ability of instruments such as these to classify youth according to levels of risk that are borne out by actual outcomes during periods of one to three years after assessment.⁵² When used with youth who have already offended at least once, they offer a decided improvement in the ability to describe youth according to degrees of risk of future harm, compared to the use of clinical intuition that marked typical practice in earlier years.

Nevertheless, the reviews of juvenile risk assessment instruments identify various limits in their application. Currently little is known about potential differences among clinicians in the way they rate the instruments' risk factors in actual practice.⁵³ In addition, there is some question about whether the instruments work equally well for younger adolescents and older adolescents.⁵⁴

Risk/Needs Tools for Antisocial Behavior and Violence Among Youthful Populations, in HANDBOOK OF VIOLENCE RISK ASSESSMENT AND TREATMENT 377 (Joel Andrade ed., 2009).

50. ROBERT HOGE, DON ANDREWS & ALAN LESCHIED, YOUTH LEVEL OF SERVICE/CASE MANAGEMENT INVENTORY: USER'S MANUAL (2002).

51. RANDY BORUM, PATRICK BARTELL & ADELLE FORTH, MANUAL FOR THE STRUCTURED ASSESSMENT OF VIOLENCE RISK IN YOUTH (SAVRY) (2003).

52. See HEILBRUN, GRISSO & GOLDSTEIN, *supra* note 11.

53. Vincent, Terry & Maney, *supra* note 49.

54. *Id.*; see also Jodi Viljoen et al., *Assessing Risk for Violence in Adolescents Who Have Sexually Offended: A Comparison of the J-SOAP-II, J-SORRAT-II, and SAVRY*, 35 CRIM. JUST. & BEHAV. 5 (2008).

Clinicians and courts must also be cautious about interpreting the meaning of “high risk” results. What is considered “high” or “low” is always relative. Youth in high-risk categories certainly present a greater risk than those in low-risk categories, but this does not necessarily mean that high-risk youth will commit future harmful offenses. As noted earlier, for many risk-of-aggression tools, “high risk” groups of youth often have a 40 to 60% likelihood of future aggression, which is not a probability that would be considered “highly likely” in an absolute sense.⁵⁵

D. Application of Risk Tools in Transfer Hearings

Other limits are associated with the use of the new risk assessment tools specifically in transfer hearings. These limits pertain to the pretrial circumstances of transfer hearings as well as the nature of existing validation studies in relation to critical risk questions that transfer cases pose.

First, most of the validation studies for these instruments have used samples of delinquent youth who were being evaluated at some point after their adjudications.⁵⁶ In contrast, risk assessments in transfer evaluations occur prior to youth’s adjudications. Some youth will have had no prior offenses, which is a factor in some risk tools, and it cannot be presumed that the youth’s current charges constitute “offenses” for purposes of scoring the instrument’s risk factors. Moreover, youth’s pre-adjudication emotional reactions to their offenses, or their manner of talking about them, may be different from their post-adjudication reactions. This could influence the rating of factors that pertain to attitudes toward authority or degree of empathy or remorse.

Second, recall that transfer evaluations ask clinicians to address short-term risk of future harm to others if youth are retained in (or reverse transferred to) juvenile custody. This requires estimates of risk in at least two short-range contexts: if placed in secure juvenile custody and if functioning in the general community outside youth facilities. For the two leading instruments mentioned above,⁵⁷ the majority of studies validating them have used recidivism in the general community (i.e., after release to the community) as their outcomes measure. Fewer studies have

55. MONAHAN ET AL., *supra* note 37.

56. See HANDBOOK OF VIOLENCE RISK ASSESSMENT, *supra* note 31.

57. See *supra* Part II.C.

examined the tools' capacities to identify degree of risk in institutional settings.⁵⁸

Finally, transfer hearings often involve a consideration of the likelihood that a youth will continue to present a risk of violence beyond adolescence and into his adult years. The most definitive of studies validating the ability of juvenile risk tools to estimate likelihood of future violence have assessed large samples of youth and have then followed them across some number of years in order to collect re-arrest data.⁵⁹ For the two leading instruments previously described, the majority of these studies followed youth for periods ranging from six months to three years.⁶⁰ As a consequence, solid information on the validity of the instruments for assessing likelihood of repeat offenses during adulthood (e.g., in their 20s or 30s) is still unavailable. This suggests that the tools do not yet offer adequate support for clinical judgments about long-range risk, an issue often raised in transfer cases. Most of the research efforts to discover long-range predictors have focused on the concept discussed in the next section.

E. The Relevance of "Psychopathic Traits"

As noted earlier, the majority of delinquent youth do not continue to engage in serious criminal behavior in adulthood.⁶¹ But can we identify in adolescence those delinquent youth who *will* continue to present a significant risk well beyond their adolescence? A great deal of recent research focuses on that question, much of it looking specifically for the precursors of adult psychopathy.⁶²

The concept of psychopathy centers on a set of personality traits that are relatively enduring and consistent for an individual across time, relatively difficult to modify, and empirically related to repeat offenses when measured among adult offenders.⁶³ The features of personality included in the concept fall into two

58. Randy Borum et al., *Structured Assessment of Violence Risk in Youth (SAVRY)*, in HANDBOOK OF VIOLENCE RISK ASSESSMENT, *supra* note 31, at 63; Robert D. Hoge, *Youth Level of Service/Case Management Inventory*, in HANDBOOK OF VIOLENCE RISK ASSESSMENT, *supra* note 31, at 81.

59. See HANDBOOK OF VIOLENCE RISK ASSESSMENT, *supra* note 31.

60. See *supra* note 54 (studies of the SAVRY and YLS/CMI).

61. See *supra* Part II.B.

62. See, e.g., Donald Lynam, *Pursuing the Psychopath: Capturing the Fledgling Psychopath in a Nomological Net*, 106 J. ABNORMAL PSYCHOL. 425 (1997).

63. See generally PSYCHOPATHY: THEORY, RESEARCH AND IMPLICATIONS FOR SOCIETY (David Cooke, Adelle Forth & Robert Hare eds., 1998).

categories. The first category, often called “Callous-Unemotional Traits,” includes various emotional and interpersonal deficits: e.g., grandiose sense of self-worth, manipulative tendency, lack of remorse, and lack of empathy. The second, often called “Antisocial Traits,” includes characteristics that are likely to give rise to irresponsible behavior: e.g., poor behavioral controls, impulsivity, lack of long-term goals, and need for stimulation. Note that features of the second factor are characteristic of a fair majority of adult offenders. Theoretically, these features in combination with the “callous-unemotional” factor identify a subgroup of offenders (with psychopathic personality) who are especially likely to engage in persistent, repetitive, and dangerous behavior. The adult research supporting the relation of psychopathy to chronic and repeated offenses among serious offenders is substantial and convincing.⁶⁴

There is little doubt that psychopathic traits do not merely spring up with adulthood. Like most personality traits, they are very likely the product of childhood and adolescent history and development. Thus considerable research of the past 15 years focuses on identifying psychopathic traits among adolescents and examining their relation to future aggression.⁶⁵ These studies define psychopathic traits by a variety of special assessment tools developed for use with adolescents: e.g., the Psychopathy Checklist: Youth Version (PCL:YV),⁶⁶ the Youth Psychopathic Traits Inventory (YPI),⁶⁷ and the Antisocial Process Screening Device (APSD).⁶⁸ Moreover, many of these studies tracked youth for sufficient periods of time to identify whether their psychopathy scores during adolescence provide reasonable estimates of their low or high risks for offending as adults.⁶⁹

The results of these studies have been mixed. First, there are some questions about the instruments themselves in terms of their psychometric properties. One major study found a significant correlation between scores on psychopathy trait instruments when

64. David DeMatteo, John F. Edens & Allison Hart, *The Use of Measures of Psychopathy in Violence Risk Assessment*, in HANDBOOK OF VIOLENCE RISK ASSESSMENT, *supra* note 31, at 19.

65. *Id.*

66. ADELLE FORTH, DAVID KOSSON & ROBERT HARE, PSYCHOPATHY CHECKLIST: YOUTH VERSION (2003).

67. Henrik Andershed, Sheilagh Hodgins & Anders Tengstrom, *Convergent Validity of the Youth Psychopathic Traits Inventory: Association with the Psychopathy Checklist: Youth Version*, 14 ASSESSMENT 144 (2007).

68. PAUL FRICK & ROBERT HARE, THE ANTISOCIAL PROCESS SCREENING DEVICE (2001).

69. See FORTH, KOSSON & HARE, *supra* note 66; FRICK & HARE, *supra* note 68; Andershed, Hodgins & Tengstrom, *supra* note 67.

obtained in adolescence and scores obtained after retesting with the instrument in adulthood.⁷⁰ On the other hand, in another major study employing three measures of psychopathic traits with older adolescents, there was only modest overlap among the three measures, so that some youth who scored high on any one measure did not necessarily score high on the others.⁷¹ Researchers are currently questioning whether these instruments are measuring the same or different concepts and whether any of those concepts are the same as the concept of psychopathy when it is applied to adults.⁷²

Second, as recently reviewed, a number of studies tracking youth from adolescence well into adulthood do show a significant relationship between high scores on psychopathic traits in adolescence and continued offenses in adulthood,⁷³ but some studies do not. For example, in a recent study of youth given the PCL:YV at ages 15 to 16 and followed for ten years, researchers found no significant relation between scores on the measure in adolescence and likelihood of reconviction during adulthood for general or violent offenses.⁷⁴ Another study found no relation between psychopathic trait scores and self-reported aggressive offenses even when the measure of offenses was examined only three years later.⁷⁵

Third, when studies find a significant relation between psychopathic trait measures in adolescence and then again in adulthood, these relations are not likely to translate into an ability to identify psychopathic individuals at an early age. This was recently demonstrated in a study comparing the measurement of psychopathic traits among individuals at age 13 to their measurement when the same youth reached age 24.⁷⁶ The correlation between the measures was .31, which researchers consider to be substantial. Yet in the same study, the authors noted that among the boys who scored in the highest group on the psychopathy traits scale at age 13, only 16% scored in the

70. Donald Lynam et al., *Longitudinal Evidence That Psychopathy Scores in Early Adolescence Predict Adult Psychopathy*, 116 J. ABNORMAL PSYCHOL. 155 (2007).

71. Elizabeth Cauffman et al., *A Multimethod Assessment of Juvenile Psychopathy: Comparing the Predictive Utility of the PCL:YV, YPI and NEO PRI*, 21 PSYCHOL. ASSESSMENT 528 (2009).

72. *Id.*; Penney & Moretti, *supra* note 19.

73. DeMatteo, Edens & Hart, *supra* note 64.

74. John Edens & Melissa Cahill, *Psychopathy in Adolescence and Criminal Recidivism in Youth Adulthood*, 14 ASSESSMENT 57 (2007).

75. Cauffman et al., *supra* note 71.

76. Lynam et al., *supra* note 70.

“psychopathic range” on the adult psychopathy scale at age 24.⁷⁷ In other words, this suggests that if clinicians in juvenile court transfer cases were to use high scores on a psychopathy traits measure to testify that youth will “be psychopathic” when they reach adulthood, they would be wrong 84% of the time.

Finally, studies examining the relation of measures of psychopathic traits in adolescence and adult recidivism have found that the results sometimes differ by gender and race. A review of 21 studies of juvenile offenders found poorer relations between psychopathy measures and subsequent offenses in studies with high proportions of non-Caucasian youth, as well as generally weak or non-significant relations for female juvenile offenders.⁷⁸ Transfer of young women is relatively unusual in most juvenile courts. But in some jurisdictions, African American youth will constitute the majority for whom the transfer question is raised. Thus, the study suggests that the use of measures of psychopathic traits to estimate those traits or offenses in adulthood could run a greater risk of misidentifying racial/ethnic minority youth.⁷⁹

III. ASSESSING AMENABILITY TO REHABILITATION

In virtually all jurisdictions that employ discretionary (judicial) transfer, a major question in transfer hearings is whether the youth is “amenable to rehabilitation.” Clinicians who attend to the analyses offered in literature about transfer evaluations will understand that the forensic meaning of this issue is somewhat different from the meaning that might be presumed in general clinical settings. “Amenability” in the context of transfer is a shorthand term referring to one of *Kent*’s criteria: “The likelihood of reasonable rehabilitation of the juvenile . . . by the use of procedures, services, and facilities currently available to the Juvenile Court.”⁸⁰ This standard highlights the fact that the court must consider not only whether the youth is “changeable,” but also whether the juvenile justice system is a proper place to try to change the youth, given society’s concerns for public safety and rehabilitation.

In this light, the amenability issue requires that clinicians have three types of baseline information in order to form expert opinions

77. *Id.*

78. John Edens et al., *Youth Psychopathy and Criminal Recidivism: A Meta-Analysis of the Psychopathy Checklist Measures*, 31 LAW & HUM. BEHAV. 53 (2007).

79. *Id.*

80. *Kent v. United States*, 383 U.S. 541, 567 (1966).

that are relevant.⁸¹ First, of course, clinicians and the clinical and scientific fields that support their expertise must have methods for identifying youth's clinical and criminogenic features that would need to change in order to accomplish rehabilitation. What characteristics of the youth contribute to a youth's delinquency? What is known about the modifiability of those characteristics—for youth in general who have those characteristics and as they are manifested in this specific youth? What is known about a youth's receptiveness to intervention or a youth's history of failing to respond to various types of interventions in the past?

Second, clinicians must have a thorough knowledge of the intervention methods that are available within or through the juvenile justice system for effecting rehabilitation, the evidence for effectiveness of the methods that they use, and the qualities of programs that implement those methods. What rehabilitation programs, therapeutic methods, and placements exist in the juvenile justice system in question? Can the system access services outside the juvenile justice system itself (e.g., in the state's mental health system)? Once those resources are known, what is known empirically about the rates of success of those methods, and about types of youth with whom those methods have had success? How does a youth in question match up with those types of youth?

Third, clinicians and their scientific and clinical fields must be able to identify the amount of time that is likely to be required to create change in a youth, given that successful rehabilitation is possible. Many transfer cases involve youth who are near the upper age of the juvenile court's jurisdiction, beyond which the juvenile court will no longer have custody. In these cases, the question is not merely whether rehabilitation is possible in general, but whether it is probable before the time that the court must relinquish jurisdiction.⁸² Clinicians, therefore, must have a baseline regarding the amount of time that is typically required for rehabilitation of particular types of youth with the particular types of rehabilitation services that the system can provide.

A. Youth's Needs and Potential for Change

Clinicians are probably best prepared to assess the first set of questions described above—i.e., factors that are contributing to a youth's delinquency as well as a youth's characteristics that may work for or against change. The methods at a clinician's disposal

81. For an expanded discussion of the following, see GRISSO, *supra* note 7.

82. See *supra* note 80 and accompanying text.

to address those questions are far too wide-ranging to review here, but they include:

- A large domain of well-validated methods for diagnosing and assessing mental disorders, developmental disabilities, substance abuse, and poor adaptive functioning;
- A significant array of validated methods for assessing personality traits, emotional dysregulation (e.g., impulsiveness), criminogenic characteristics, and factors in youth's historical environments and relationships with relevance for treatment planning;
- Methods for classifying youth according to types, patterns, or causes of delinquent behavior;
- Measures developed to assess psychosocial needs in a variety of domains (e.g., family functioning, peer relations, and school functioning and behavior); and
- Clinical methods to identify intellectual abilities, cognitive functioning, learning disorders, and brain damage and dysfunction.

Methods for assessing likelihood of harm to others⁸³ would also be included here, because risk of harm is a relevant characteristic of a youth for questions of rehabilitation. Whether a youth presents a low or high short-term risk of harm to others will expand or limit the range of intervention programs that can be used, because different types of interventions are available or possible in secure and non-secure settings.

Some of the most recent advances in structured assessment of youth in juvenile justice settings have produced tools that are particularly well-suited for transfer evaluations, even though that has not been their developers' primary objective. They are sometimes called "RNR tools," referring to their assessment of "Risk," "Needs," and "Responsivity."⁸⁴ The YLS/CMI, for example, offers in one-tool measures of risk of future recidivism, several criminogenic and psychosocial needs of a youth, and indicators that suggest the degree to which the youth is likely to respond to interventions.⁸⁵ The latter refers to indicators of a youth's motivation for change, as well as characteristics of a youth that are known empirically to be related to better intervention outcomes. In general, the risk and needs factors in evidence-based

83. See *supra* Part II.

84. Kirk Heilbrun et al., *Violence Risk Assessment Tools: Overview and Critical Analysis*, in HANDBOOK OF VIOLENCE RISK ASSESSMENT, *supra* note 31, at 1, 2; Don Andrews et al., *Classification for Effective Rehabilitation: Rediscovering Psychology*, 17 CRIM. JUST. & BEHAV. 19 (2006).

85. HOGE, ANDREWS & LESCHIED, *supra* note 50.

RNR tools have received more attention in validation studies, although the responsivity factors are currently considered “promising” while awaiting further study.⁸⁶

Clinicians and courts often use a youth’s degree of responsiveness to *past* interventions as one indicator of likelihood of future prospects for rehabilitation. This is fraught with difficulties, however. Often an intervention is unsuccessful not because the youth is unreceptive, but it fails because the intervention itself is inappropriate, inadequately designed, or poorly implemented. Youth should not be considered “unamenable,” or to have failed in past interventions, if the intervention itself had little prospect for success with youth in general.

B. Interventions and Their Value for Rehabilitation

As noted earlier, “amenability” is not merely a characteristic of the youth.⁸⁷ It is also necessary to take stock of the system’s interventions, its prospects for rehabilitating youth, and the potential to “match” youth with intervention methods.

The research literature on the impact and value of various therapeutic and rehabilitation methods for delinquent youth has grown substantially in recent years. It includes research on child psychopharmacology, various forms of individual psychotherapy, individual and group methods for cognitive restructuring and problem-solving, discipline-oriented programs (e.g., boot camps), behavioral modification programs, and family-based interventions.⁸⁸ In recent years, significant emphasis in juvenile justice has been placed on using methods for which there is solid research evidence of their value and discarding methods that have no research-based benefit. During the 1970s and 1980s there was little evidence that any interventions for delinquency actually worked.⁸⁹ Today, however, many rehabilitation and treatment methods for delinquent youth have adequate scientific evidence for their value.⁹⁰

86. Vincent, Terry & Maney, *supra* note 49.

87. *See supra* note 80 and accompanying text.

88. For a brief summary of outcomes with these interventions, see THOMAS GRISSO, *DOUBLE JEOPARDY: ADOLESCENT OFFENDERS WITH MENTAL DISORDERS* 81–100 (2004). For a more detailed review of research on the full range of interventions, see PETER GREENWOOD, *CHANGING LIVES: DELINQUENCY PREVENTION AS CRIME-CONTROL POLICY* (2006).

89. Robert Martinson, *What Works? Questions and Answers About Prison Reform*, 35 *PUB. INT.* 22 (1974).

90. GREENWOOD, *supra* note 88; Mark Lipsey, *The Primary Factors That Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic*

Moreover, many states are increasing their commitments to these evidence-based methods.⁹¹

The availability of evidence-based interventions greatly improves the clinician's ability to begin the amenability analysis with a set of interventions that use methods for which there is a known value. Clinicians encounter several challenges, however, when they take the next steps in the analysis.

First, the fact that a method has proved effective in research does not mean that services in a juvenile justice system that use that method will be effective—they may be implemented poorly. Indeed, in a recent analytic review comparing various rehabilitation methods, some were better than others, but facilities that employed the good methods poorly had no more success than less successful methods.⁹² As a consequence, clinicians must keep track of the quality of interventions as they are actually practiced in facilities and programs in their jurisdictions. Because such matters are rarely stable across time in most juvenile justice systems, this creates a potential source of error in clinicians' efforts to estimate prospects for rehabilitation.

Second, clinicians have few guides for matching types of youth with types of intervention programs. It would seem logical, and has long been presumed, that certain programs work better with certain youth. The field has searched for many years for the best ways to "match" youth with programs to maximize rehabilitation, but with little success. Some new methods show promise, but they have not yet been validated in ways that offer clinicians sound guidance.⁹³ For clinicians in transfer evaluations, this means that there is little to assist them in identifying specific types of youth for which the resources of the juvenile justice system (the available intervention methods) are appropriate.

Third, clinicians in many jurisdictions encounter difficulties identifying appropriate placements and interventions for youth with serious mental disorders. A small but important proportion of delinquent youth require both intensive mental health services

Overview, 4 VICTIMS & VIOLENCE 124 (2009); *Blueprints for Violence Prevention: Overview*, CENTER FOR STUDY & PREVENTION OF VIOLENCE, <http://www.colorado.edu/cspv/blueprints/> (last visited Aug. 25, 2010).

91. STEPHEN PHILLIPPI, JR. ET AL., EVIDENCE BASED PRACTICES FOR JUVENILE JUSTICE REFORM IN LOUISIANA (2010), available at http://public.health.lsuhsu.edu/LAMC/pdf%20files/EBP%20Whitepaper%20FINAL%20FEB%202010%20_3_.pdf.

92. Lipsey, *supra* note 90.

93. For a few instruments with this potential that are in development, see Vincent, Terry & Maney, *supra* note 49.

because of chronic mental disorders and secure care because of their impulsiveness and danger to others. Few states can provide this type of care within the juvenile justice system, yet psychiatric hospital beds for children often are not sufficiently secure (or available) to meet this need. Moreover, these are youth whose symptoms may be reduced—and whose potential for repeat offenses may be diminished—with adequate care, but many of them will continue into adulthood to be clients of the state’s mental health system. For a transfer case, this creates a risk of finding a youth “unamenable” due partly to the youth’s qualities and partly to the state’s lack of an appropriate secure mental health facility. In such a situation, a clinician must be careful to explain that the youth’s condition is treatable (if it is) and that the failure of “amenability” lies with the system’s inadequacies.

C. The Temporal Component in Amenability

A majority of youth who are the subjects of transfer or reverse transfer evaluations are older adolescents (e.g., ages 15 to 17). In most states, the upper jurisdictional age for juvenile justice is the 17th or 18th birthday. This greatly influences the nature of the concept of amenability to rehabilitation. In many transfer hearings, this means there is a limited period of time for rehabilitation to occur. Thus a youth who might be considered to have good responsiveness and to be a good match for available programs could conceivably be retained in the juvenile justice system if the youth is 15, yet transferred as “non-amenable” if the hearing is occurring at 17 in a jurisdiction in which the court will lose custody at the 18th birthday.

Clinicians have little to guide them, other than their clinical experience and common sense, in making estimates of the length of time that will be required for rehabilitation. Were there research on the proportion of youth who show adequate change in rehabilitation programs, it might be possible to identify the proportions that manifest various degrees of change at various time intervals after entering the programs. But no body of research has done so with regard to youth of various ages, type and seriousness of delinquency histories, and mental or intellectual disabilities.

D. Difficulties Inherent in Pretrial Evaluations

Other sources of error for clinicians’ assessments of amenability (and estimates of risk of future harm, as well) are created by their pretrial context. Necessarily, much of the clinician’s information is obtained from a youth by way of

interviews and responses to structured assessment tools. As in many forensic contexts, people being evaluated may be motivated to convey information in a way that they believe will produce an outcome that is in their favor. Most forensic clinicians are attuned to this possibility of dissimulation and deception or malingering of mental disorders and poor cognitive abilities. There are few methods that have been developed specifically to detect such “response styles” in evaluations of youth, but certain strategies are available.⁹⁴ Nevertheless, these methods are a source of potential error inherent in the pretrial context of transfer evaluations.

The pretrial evaluation must also co-exist with protections against self-incrimination. Concerns have been raised about the practice of interviewing youth who face transfer hearings in a manner that elicits a description of events or feelings related to the charged offense.⁹⁵ The risk is too great, some believe, that the information will taint later adjudicative hearings, even if laws protect against the information being entered directly as evidence against the youth at trial. Yet information about the circumstances of a youth’s offense, and the youth’s thoughts and feelings associated with it, may be important data for forming opinions about both amenability to rehabilitation and likelihood of future repeat offenses. When this information is not available, clinicians must recognize—and acknowledge when questioned—that their opinions might have been different if they had that information. The ultimate consequence, however, is not the clinician’s frustration, but the court’s lack of access to what might be highly relevant information for considering the legal standards to reach a transfer decision.

IV. ASSESSING SOPHISTICATION-MATURITY

Current guides for clinicians performing transfer evaluations instruct them that transfer involves a third concept called “sophistication and maturity.” The term appeared as one of the eight factors in *Kent*.⁹⁶ The concept seems to direct courts to attend to the “adult-like” qualities of a youth. Yet the purpose, meaning, and intent of the law’s interest in youth’s maturity in transfer cases has been difficult to discern. Might it be intended to reduce the risk of harm to other youth in juvenile facilities when a more “mature,

94. JOSEPH MCCANN, *MALINGERING AND DECEPTION IN ADOLESCENTS: ASSESSING CREDIBILITY IN CLINICAL AND FORENSIC SETTINGS* (1998).

95. Richard Barnum, *Self-Incrimination and Denial in the Juvenile Transfer Evaluation*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 413 (1990).

96. 383 U.S. 541, 566–67 (1966).

adult-like” person is retained in the juvenile system? Or is it related more closely to “amenability” concerns, referring to youth who are more “hardened” and “set” in their criminal patterns and thus less likely to be proper subjects for rehabilitation in a system designed for “malleable” adolescents?

A. Interpretation of “Sophistication-Maturity”

Recent analyses of “sophistication-maturity” by researchers and commentators suggest that this component carries at least some meaning that is distinct from the risk of harm and amenability standards for transfer decisions.⁹⁷ For example, based on a national survey of juvenile court judges and clinicians, one study suggested that “the legal term and construct of sophistication-maturity may consist of several interrelated factors: culpability (the ability of youth to formulate criminal intent); criminal sophistication (progressively more involvement in advanced criminality); understanding of behavior norms; and ability to identify alternative actions.”⁹⁸ It appeared that courts wanted to know about youth’s decision-making abilities compared to those of adults and whether youth seemed to have the capacity to commit crimes in a manner that was premeditated, planned, or otherwise “adult-like.”

These findings have been interpreted to suggest that courts faced with transfer decisions are asking not only, “Is this youth a proper subject for juvenile court?” but also, “Is this youth an *improper* subject for *criminal* court procedures and penalties?” Woven through the factors and variables in the above description of the concerns is an interest in whether youth have been committing crimes “like adults” or whether youth’s crimes have occurred in the context of immature impulsiveness and without adult capacities to weigh the consequences before they acted. The implication is that youth who are less mature, and therefore less capable of understanding the implications of their actions and regulating their behavior, are less appropriate subjects for criminal adjudication.

97. Brannen et al., *supra* note 27; Penney & Moretti, *supra* note 19; Randall Salekin et al., *Juvenile Transfer to Adult Courts: A Look at the Prototypes for Dangerousness, Sophistication-Maturity, and Amenability to Treatment Through a Legal Lens*, 8 PSYCHOL. PUB. POL’Y & L. 373 (2002); Randall Salekin, Richard Rogers & Karen Ustad, *Juvenile Waiver to Adult Criminal Courts: Prototypes for Dangerousness, Sophistication-Maturity, and Amenability to Treatment*, 7 PSYCHOL. PUB. POL’Y & L. 381 (2001).

98. Salekin, *supra* note 19, at 62.

Commentators have proposed that courts may see very immature youth as less appropriate subjects for criminal court for two reasons.⁹⁹ They may be perceived as *less blameworthy* because of their immaturity, so that the more severe sentences associated with criminal prosecution are less appropriate. Less mature youth might also be perceived as *less competent* to participate in criminal proceedings. That is, their immature cognitive and emotional characteristics raise doubt about their capacities to participate in their trials in a manner that satisfies due process regarding the competence of defendants to stand trial.

B. Prospects for Assessing Psychological Maturity

Research in recent years has produced a great deal of evidence regarding the ways in which adolescents and adults differ in their cognitive, intellectual, emotional, and social characteristics.¹⁰⁰ The process of maturation during adolescence proceeds from less to greater capacity to regulate impulses, less to greater likelihood of recognizing risks and weighing them meaningfully, less to greater capacity to consider options and their consequences before acting, and less to greater resistance to the influence of peers on making choices. The evidence for these changes comes from research on youth's behavior and on their brain development. Much of this research has been analyzed regarding its relevance for legal questions of blameworthiness or culpability and youth's competence to stand trial.¹⁰¹ Clinicians, therefore, have a considerable body of recent psychological information to inform their conceptualization of the assessment of sophistication-maturity in transfer evaluations.

Clinicians are aware of a wide variety of ways to describe developmental maturity and immaturity. Developmental psychologists have been measuring children's and adolescents' intellectual abilities, cognitive development, emotional control capacities, and social skills for about a century. A large number of

99. Penney & Moretti, *supra* note 19; Salekin, *supra* note 19.

100. For a readable review of what recent scientific research has discovered about adolescents' capacities relevant for legal policy, see ELIZABETH SCOTT & LAURENCE STEINBERG, *RETHINKING JUVENILE JUSTICE* 28–60 (2008).

101. See, e.g., Dickon Reppucci, Jaime Michel & Jessica Kostelnik, *Challenging Juvenile Transfer: Faulty Assumptions and Misguided Policies*, in *CHILDREN AS VICTIMS, WITNESSES, AND OFFENDERS* 295 (Bette Bottoms, Cynthia Najdowski & Gail Goodman eds., 2009); Elizabeth Scott & Thomas Grisso, *Developmental Incompetence, Due Process, and Juvenile Justice Policy*, 83 N.C. L. REV. 793 (2005); Laurence Steinberg & Elizabeth Scott, *Less Guilty by Reason of Adolescence*, 58 AM. PSYCHOLOGIST 1009 (2003).

psychology's intelligence and achievement tests, neuropsychological measures, and social maturity tests are widely recognized for their validity. Especially promising are some new tools and norms arising from studies of youth's decisional capacities in relation to adults with specific relevance to blameworthiness¹⁰² and competence to stand trial.¹⁰³

One tool has been developed recently for clinicians' use, specifically in transfer hearings—the Risk-Sophistication-Treatment Inventory (RST-I), which provides a structured way to assess all three of the transfer concepts.¹⁰⁴ It is mentioned at this point, however, because it may be especially helpful in structuring the assessment of maturity as it relates to transfer decisions. Sophistication-maturity in the RST-I guides the clinician to collect data on three maturity dimensions: greater autonomy (self-directedness), better cognitive capacities (such as foresight), and better emotional maturity (such as ability to control impulses). Although researchers are still accumulating initial research evidence for the validity of the RST-I, it has been developed sufficiently to be used cautiously by clinicians in transfer cases. Like most forensic tools, however, it should never be used literally to define who should or should not be transferred.

C. Limits to Assessing Maturity Relevant for Transfer

Although clinicians have many methods for assessing degrees to which youth are immature or have matured, there are many unanswered questions regarding the use of such data in transfer hearings. The questions all pertain to uncertainty regarding how the sophistication-maturity concept is applied.

First, if youth appear to be mature with regard to cognitive, emotional, and social characteristics, does this necessarily mean that they are proper subjects for criminal adjudication? Some youth with better cognitive and decision-making capacities, especially those with little delinquent history prior to their present serious charges, may also be better prospects for rehabilitation in juvenile justice programs because of those very capacities. Their greater capacity to resist acting impulsively may also suggest a reduced risk of future harm to others. Currently, clinicians (and courts) are

102. Laurence Steinberg et al., *Are Adolescents Less Mature than Adults?*, 64 AM. PSYCHOLOGIST 583 (2009).

103. See, e.g., Thomas Grisso et al., *Juveniles' Competence to Stand Trial: A Comparison of Adolescents' and Adults' Capacities as Trial Defendants*, 27 LAW & HUM. BEHAV. 333 (2003).

104. SALEKIN, *supra* note 21.

provided little guidance regarding how to weigh such issues, although the RST-I recognizes that clinicians must somehow distinguish between pro-social and antisocial youth when interpreting the meaning of sophistication-maturity scores for the transfer issue.

Second, what dimensions of maturity are relevant? As noted earlier, developmental psychology has identified many ways to express a youth's degree of maturity.¹⁰⁵ "Maturity" itself is not a unified concept; many youth—especially in later adolescence—may be relatively mature in some ways and not in others. They may be intellectually mature but socially immature; they may have mature decision-making capacities in terms of abilities to consider and weigh options, yet be morally immature in the ways in which they apply those abilities. Clinicians using appropriate methods should be able to describe a youth's development regarding most of these dimensions. How the descriptions can be translated into a conclusion about the youth's "sophistication and maturity" for purposes of addressing blameworthiness is far less certain.

Finally, what *degree* of maturity is relevant for purposes of transfer? Many of the assessment instruments that evaluate cognitive and emotional development have adolescent and adult norms. This allows clinicians to determine at approximately what ages youth's capacities of various kinds reach their adult level, and they allow clinicians to compare individual youth to average performance of their age peers and to adults. This sounds promising until considering the question, "Which adult represents the standard for maturity to which we will compare the youth?" Shall we compare the youth to an 18 year old because that is the state's youngest age for criminal court jurisdiction? Will we use 21 as an age of "majority"? Or shall we use 25 or 30, given that research indicates continuing changes up to that age in development of brain structures that are important for decision making and self regulation?¹⁰⁶ Moreover, the average maturity of young adults in the criminal justice system is likely to be dissimilar to the average maturity of young adults generally. Shall we compare juveniles specifically to samples of adults in the criminal justice system?¹⁰⁷

105. See *supra* notes 97–98 and accompanying text.

106. E.g., Nitin Gogtay et al., *Dynamic Mapping of Human Cortical Development During Childhood Through Early Adulthood*, 21 PROC. NAT'L ACAD. SCI. U.S. 8174 (2004).

107. A decision to do so would create the need for much more research because few measures of maturity that are currently available would have "adult criminal norms."

These questions are posed not to challenge the law to define the concept according to age norms, but to point out the difficulties clinicians face when applying their developmental measures to address the law's interest in a youth's "maturity." Whether clinicians provide non-empirical or empirically-based methods to assess maturity, the vagueness of the concept allows for two or more clinicians to disagree about a given youth's "maturity" because they may be applying vastly different age-development standards to define it.

V. IMPLICATIONS FOR DISCRETIONARY TRANSFER

This Article examined the prospects for clinical forensic evaluations of youth to assist courts in making decisions in discretionary (judicial) transfer and reverse transfer proceedings. It is offered at a time in history when the juvenile justice systems are rethinking their heavy reliance on statutory exclusion as a primary transfer mechanism. The values and limits of clinical transfer evaluations are relevant to consider in that context, because part of the debate will focus on balancing concerns for the welfare of juveniles and public safety. These concerns are embodied in transfer standards themselves, and clinical evaluations of youth to address those standards place such evaluations within the scope of the policy discussion.

A. Summarizing the Values and Limits of Transfer Evaluations

This review offers no evidence for the quality of *actual* transfer evaluations as they occur nationwide because there are no data to address the issue. Instead, it analyzes the tasks that transfer evaluations require and then describes which of those tasks clinicians can or cannot do with integrity if they select and apply the best methods currently available. This analysis presumes that clinicians should employ evidence-based practices—those with known reliability and validity—whenever possible. The review suggests that some values and limits of clinicians' transfer evaluations are relevant for both juvenile court transfer cases and criminal court reverse-transfer cases.

Regarding values, there is a consensus about the legal standards that clinicians are asked to address. The specific meanings of those standards continue to be elusive, but legal and psychological analyses have identified types of information that—if not definitive—are at least relevant. Moreover, recent years have provided clinicians with far better assessment methods to identify these types of information than were available before the year

2000.¹⁰⁸ Special advances have been made in the development of reliable and valid methods for assessing short-range risk of future harm to others, symptoms of mental disorders, criminogenic needs upon which rehabilitation can focus, and factors that may increase or decrease youth's responsiveness to rehabilitative interventions. The ability of these instruments to assist clinicians in describing these characteristics to the court in reliable ways would warrant their use, their admissibility under rules of evidence, and their relevance.

The limits associated with transfer evaluations, however, are especially important in light of the bottom-line questions in transfer cases. Clinicians' methods for assessing short-range risk offer "general" risk estimates, by and large, rather than differential risk estimates associated with various settings (e.g., with residence in unstructured settings in contrast to institutional, structured settings associated with custody in secure juvenile facilities). Clinicians do not yet have reliable methods for identifying those youth who have embarked on a long-range, violent criminal career that will continue into adulthood. They know which treatment methods "work," but they have only questionable methods for identifying which youth will prosper or fail in which types of interventions, as well as the likelihood that they will do so. Moreover, clinicians are without reliable methods for addressing questions about the length of time that rehabilitation will require.

Thus, clinicians have reliable methods for *describing* characteristics of youth and rehabilitation settings that are relevant for courts to consider when applying transfer standards. In contrast, they do not yet have reliable methods to use those data to answer—on a case-by-case basis—the ultimate risk, amenability, and sophistication questions at the heart of transfer decisions. The logic that connects the reliable and relevant data to opinions about the three standards often must be supplied by clinical judgment rather than empirically verifiable methods.

Some would argue that this state of affairs should limit clinicians' testimony in transfer or reverse-transfer hearings to descriptions alone. They would ask clinicians to refrain from moving on to make inferences about how the data they have described can be combined to reach risk, amenability, or maturity conclusions. A legal analysis of this assertion would require an interpretation of standards for admissibility of expert testimony

108. For example, most juvenile risk instruments currently available were developed within the past decade. See HANDBOOK OF VIOLENCE RISK ASSESSMENT, *supra* note 31.

under applicable rules.¹⁰⁹ But such an analysis is likely to be little more than an intellectual exercise. Courts have long allowed clinicians to offer expert opinions concerning which their own professional associations have disavowed any special expertise.¹¹⁰ As long as clinicians' data are reliable and relevant, their own professional organizations would allow them to go beyond mere description of data, forming opinions based on the theoretical and logical use of their data. However, practice standards require that clinicians clearly inform the court regarding the logic they use to arrive at their opinions, and they must disclose any limitations in their logic.¹¹¹

B. Relevance for Policy about Transfer Mechanisms

Transfer evaluations have some implications for policy regarding the alternatives of discretionary transfer in juvenile court and "reverse transfer" decided in criminal court. Both juvenile court transfer and criminal court reverse transfer recognize the need for discretionary, individualized decisions regarding whether to adjudicate a youth in juvenile or criminal court. From a clinical perspective, however, the circumstances of the two jurisdictions are quite different, and the better place for transfer evaluations and the decisions that they inform is in juvenile court.

First, transfer evaluations must be conducted by psychologists or psychiatrists who are both child and forensic specialists. The importance of a developmental psychological perspective has been evident throughout this review. Risk and amenability factors are not the same for adolescents and adults. They have a different research literature, are influenced by different developmental assumptions, require different interviewing skills, and employ entirely different assessment tools. Risk of future harm as a transfer concept is unlike the concept of risk of future harm for purposes of adult civil commitment or criminal sentencing. And, of course, assessing maturity and immaturity requires significant specialization in developmental and clinical practice.

109. FED. R. EVID. 702; *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993); *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

110. See, for example, *Barefoot v. Estelle*, 463 U.S. 880 (1983), in which the United States Supreme Court ruled that experts' predictions of dangerousness are constitutionally admissible despite the American Psychiatric Association's claim that psychiatrists could not offer such reliable predictions.

111. See, e.g., Comm. on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655 (1991).

Therefore, forensic clinicians who provide services primarily in criminal courts are unlikely to have the training and background for performing transfer evaluations. The majority of them will not be child-specialized in their professions. In contrast, forensic clinicians serving juvenile court clinics typically will better understand the developmental dynamics and specialized assessment methods appropriate for forensic evaluations of juveniles. To the extent that criminal courts rely on their forensic examiners to perform transfer evaluations, there is a high risk of inferior quality that will jeopardize public safety and fail to protect youth from inappropriate criminal adjudication.

Second, to be useful, transfer evaluations must be understood by those for whom they are performed. Juvenile court judges, prosecutors, and defense attorneys have the backgrounds to grasp the nature of the developmental and clinical evidence that clinicians offer in transfer evaluations. In contrast, criminal court judges and attorneys are less likely to be familiar with the developmental context in which the transfer concepts must be addressed.

Finally, research to inform transfer evaluations, and development of improved methods, are more likely to be enhanced if the question of discretionary and individualized decisions about jurisdiction are made in the juvenile court. For criminal court clinicians, transfer evaluations do not rise to the level of importance of the more common evaluations that they are asked to perform—for example, adult competence to stand trial or criminal responsibility evaluations. Reverse-transfer evaluations have a very short history and no tradition in criminal court. In contrast, juvenile court clinicians are likely to perceive transfer evaluations as among the more complex and demanding of the domain of evaluations that they are asked to provide. All of the research on transfer criteria and methods, and all of the articles on transfer noted earlier, have arisen in the context of transfer in juvenile court.¹¹² Criminal court reverse transfer is less likely to offer a context in which any meaningful advances in assessment methods will be realized.

The quality of transfer evaluations, of course, is not the only factor to be considered when contemplating policy reform regarding mechanisms of transfer. But the likelihood of better quality in juvenile court offers one reason to favor reforms that locate transfer in juvenile court judicial discretion, rather than relying on statutory exclusion and criminal court options for reverse transfer. Some will favor transfer mechanisms that file

112. See *supra* note 19.

directly in criminal court because reverse transfer locates the burden of proof with the defense. But if arguments for that burden are compelling, one need not use statutory exclusion mechanisms to apply it. The burden may be adjusted when applied in a juvenile court transfer proceeding. Evaluations to address transfer's primary objectives—the welfare and rehabilitation potential of youth, and public safety—are more likely to serve their purpose with integrity if reform in transfer policy adopts a greater reliance on discretionary transfer in juvenile court than on statutory exclusion and its reverse-transfer mechanism.

