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**PRACTICE PARAMETER FOR CHILD AND ADOLESCENT FORENSIC
EVALUATIONS**

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ABSTRACT

Several key concepts differentiate the forensic evaluation of children and adolescents from a clinical assessment. This parameter addresses these key concepts. There are ethical issues unique to the forensic evaluation. The forensic evaluator clarifies the legal questions to be answered and structures the evaluation to address those issues. The forensic examination may include additional assessments of the child or adolescent and interviews with others. A method of reporting the results should be clarified before undertaking the evaluation. The parameter has relevance to delinquency, child custody, child maltreatment, personal injury and other court ordered evaluations. **Key Words:** practice parameter, practice guideline, child and adolescent psychiatry, adjudication, juvenile delinquent, custody, abuse and neglect, forensic assessment, forensic evaluation, disposition, juvenile justice.

ATTRIBUTION

AACAP practice parameters are developed by the AACAP Work Group on Quality Issues (WGQI) in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the WGQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP components, the AACAP Assembly of Regional Organizations, and the AACAP Council. Responsibility for parameter content and review rests with the author(s), the WGQI, the WGQI Consensus Group, and the AACAP Council.

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1 The AACAP develops both patient-oriented and clinician-oriented practice parameters.
2 Patient-oriented parameters provide recommendations to guide clinicians toward best treatment
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4 consensus (when not), and are graded according to the strength of the empirical and clinical
5 support. Clinician-oriented parameters provide clinicians with the information (stated as
6 principles) needed to develop practice-based skills. Although empirical evidence may be
7 available to support certain principles, principles are primarily based on expert opinion derived
8 from clinical experience. This parameter is a patient-oriented parameter.

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3 **INTRODUCTION**

4 Forensic evaluations of children and adolescents may be requested in a wide variety of
5 legal settings including family, juvenile, civil and adult criminal courts. There are over one
6 million divorces per year and courts may request assistance on custody issues. There continue to
7 be millions of abuse and neglect cases reported annually. A mental health professional may be
8 assigned a role as a forensic evaluator or treating clinician. Each year, over 2.7 million youth
9 under the age of 18 are arrested and over one million will have formal contact with the juvenile
10 justice system. In 2005, 96,000 youth were held in juvenile detention and residential facilities.¹
11 Once in the juvenile detention facilities, there are a variety of roles for child and adolescent
12 psychiatrists, both clinical and forensic. Many youth are evaluated for competency to proceed or
13 insanity. Some cases involving juveniles are transferred to adult court and require forensic
14 evaluations in that setting. Other youth are referred to address psychiatric treatment needs.
15 Expert psychiatric evaluation may also play a role in tort litigation in the assessment of possible
16 injury and psychiatric sequelae of trauma. Child and adolescent psychiatrists may be called to
17 provide expert opinion in adult criminal cases involving child abuse or neglect.

18 The role of the child and adolescent forensic evaluator is distinct and separate from that
19 of a care provider, including those that work in a juvenile facility.² The principal duty of a child
20 psychiatrist serving as therapist is to his or her patient. The forensic evaluator’s duty is that of an
21 expert, with the goal of objective reporting of psychiatric findings to the person or agency
22 requesting the evaluation. The two critical differences between a forensic evaluation and a
23 clinical treatment evaluation are 1) there is no therapeutic relationship with the patient, and 2)
24 there are clear limits to confidentiality. Despite the differences in roles, a child and adolescent
25 psychiatrist conducting a forensic assessment must still be aware of indicated and available
26 treatments.

27 Many of the settings in which a forensic child psychiatric evaluation may be requested
28 are undergoing tremendous changes. Nationally, juvenile and family courts face an increasing
29 volume of cases of complicated youths and families with comorbid medical, psychiatric, and
30 substance use disorders and family, legal, community, and psychosocial adversities. Many states
31 have enacted legislation affecting the handling of delinquency, child abuse and custody cases.

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1 Judicial doctrine has also changed over time with new case precedents questioning previously
2 held positions, such as the “Tender Years Doctrine,” the legal rights of delinquents under
3 “Parens Patriae,” and now the Supreme Court ruling to prohibit the execution of 16 and 17 year
4 olds. Additionally, the courts and social service agencies are faced with a shortage of available
5 programs and shrinking financial resources to support court-ordered placements and treatment
6 programs. Faced with these challenges, some jurisdictions have developed innovative programs
7 including truancy court, drug court, and other diversionary programs for first-time and non-
8 violent juvenile offenders to expedite the court process.

9 This Practice Parameter was written to provide clinical guidelines for child and
10 adolescent psychiatrists completing forensic evaluations, but it has broad applicability to other
11 child mental health professionals. Thus the term “forensic evaluator” will be used to define a
12 child and adolescent psychiatrist or any other licensed child mental health professional
13 conducting an evaluation for the purpose of resolving a legal dispute, rather than for treatment.
14 Psychiatrists who provide treatment in forensic settings, such as juvenile detention centers, are
15 sometimes referred to as “forensic psychiatrists,” but such evaluations conducted for treatment
16 purposes will not be discussed here.

17

18 **METHODOLOGY**

19 The list of references for this parameter was developed by searching *PsycINFO*, *Medline*,
20 *Psychological Abstracts*, and *Legal Abstracts*, by reviewing the bibliographies of book chapters
21 and review articles; and by asking colleagues for suggested source materials. The searches
22 covered the period 1990-2007 and yielded about 500 articles. Each of these references was
23 reviewed and only the most relevant were included in this document.

24

25 **DEFINITIONS**

26 These are general definitions only and the reader should be aware of local differences by
27 jurisdiction.

28 **Adjudication:** A delinquent court proceeding in which a case is reviewed and settled. As
29 used in this guideline, it is the judicial process for determining guilt in criminal or in
30 juvenile/family courts.

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1 **Best Interests of the Child:** The rendering for decisions to fulfill the basic and
2 developmental needs of the child.

3 **Disposition:** Placement decision following a finding of delinquency, whether
4 incarceration, residential placement, or placement at home with treatment services. In a more
5 general sense, a placement. For example, a child is placed in foster care after a finding of abuse.

6 **Expert Witness:** A witness determined by the court as having specialized knowledge
7 from training or experience and therefore having opinions that may be useful to the court in
8 making a decision on a case.

9 **Fact Witness:** A witness who has personal knowledge about a case before the court. The
10 testimony includes only those things the witness has directly experienced. It cannot include
11 information told by others (hearsay) or opinions (expert testimony).

12 **Fiduciary Responsibility:** The expectation that someone acts in confidence or trust for
13 the benefit of another within a defined relationship.

14 **Parens Patriae:** The legal principle for the state to act as the authority in order to care
15 for those citizens unable to protect themselves, such as minor children.

16 **Placement:** A court order specifying the location where a youth will reside. Examples of
17 locations may include reception or diagnostic centers, community-based or other residential
18 treatment programs, foster care, or juvenile correctional facilities.

19 **Police Power:** The general power of the state to protect its citizens

20 **Psychological Abuse:** Occurs when a person conveys to a child that he or she is
21 worthless, flawed, unloved, unwanted, or in danger. The perpetrator may spurn, terrorize, isolate
22 or berate the child.

23 **Neglect:** The failure to provide adequate care and protection for children.

24 **Sexual Abuse:** Refers to sexual behaviors between a child and an adult or between two
25 children when one of them is significantly older or uses coercion. The perpetrator may be of the
26 same sex or the opposite sex. In some states (e.g. Wisconsin), if both consenting teens are
27 underage they can be charged as perpetrators or identified as victims.

28 **Tender Years Doctrine:** The concept that young children need to be with their mothers.

29

30 **ISSUES RELATING TO VARIOUS CHILD FORENSIC EVALUATIONS**

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1 The request for a forensic child psychiatric evaluation may come directly from the court
2 or from a participating attorney for the state, plaintiff, or defendant or other agency, such as a
3 school or protective services agency. When a case is referred for evaluation, the expert must
4 clarify who or what agency is authorizing the evaluation, the question being asked, the scope of
5 the assessment, how the results are to be reported, and who is the responsible payee. If the
6 evaluation is court-ordered, it is important for the forensic evaluator to review the actual written
7 order and not rely on a verbal description of its contents. Expert witnesses are typically expected
8 to provide an opinion to a reasonable degree of medical certainty. The current level of
9 antipsychiatric bias and the role of a psychiatrist in the legal system are shown to be as great as
10 ever.³ Medical certainty's precise meaning may change depending on context and the applicable
11 burden of proof in the question being litigated. It is roughly analogous to the level of certainty a
12 clinician would employ after considering the risks, benefits, and alternatives of a particular
13 course of treatment. For example, the level of certainty needed in a risk assessment for a youth's
14 returning to school after making a threat to "blow the place up" is higher than opining that a
15 youth is competent to stand trial in juvenile court on a shoplifting charge.

16

COMMON TYPES OF CHILD FORENSIC EVALUATIONS

Juvenile Justice

19 In most states, the role of juvenile court is to focus on the concept of rehabilitation and
20 helping the children and adolescents that enter its door.⁴ Even the nomenclature for youth is
21 different than for adults. For example, a youth is taken into custody, not arrested, adjudicated not
22 tried, and there is a disposition not a sentence. Youth who have committed particularly violent
23 crimes or, in some states, if the youth allegedly dealt drugs within a close proximity of a school,
24 may be transferred to adult court. There is considerable variation among the states of which
25 age/crime combinations may be waived to adult court. Youth may be waived in different
26 manners: judicial waiver following a hearing; discretionary waiver typically by the prosecutor;
27 and, mandatory waiver in which age of crime plus nature of charge may automatically subject a
28 youth to adult prosecution. Youth who remain in juvenile court will go through the adjudication
29 process. Some youth are found innocent, some plead guilty with the hope of a plea bargain, and
30 others are found delinquent. There are some who are repeat offenders or who have committed

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1 relatively serious crimes that may be sent directly to a youth center or juvenile correction facility
2 without a comprehensive psychological, educational, and psychiatric assessment.

3 There are numerous reasons that a child and adolescent forensic evaluator may consult to
4 juvenile court. These can include: competency assessments, including competency to understand
5 *Miranda* rights and competency to stand trial; evaluation for waiver hearings (transfer); and,
6 even evaluations for whether or not a child should remain in a pre-adjudicatory facility or can
7 return home while awaiting adjudication. Evaluations for the purpose of treatment are the focus
8 of the AACAP *Practice Parameter for the Assessment and Treatment of Youth in Juvenile*
9 *Detention and Correctional Facilities*.⁵

10 Forensic evaluation regarding child and adolescent disposition is one of the most
11 common types of evaluations in juvenile court. It focuses on the balance between a “*parens*
12 *patriae*” model and police power. What this means is there is a focus on the balance of wanting
13 to act as a parent to the child (in the best interest of) in association with needing to protect the
14 constituents of the state. As a forensic evaluator, one needs to balance the treatment needs with
15 the least restrictive settings that will allow a level of protection both for the youth as well as for
16 others. More often than not, the more restrictive settings, such as juvenile or adult correctional
17 settings, have fewer mental health and education services available.

18 Another, at times complicated, component to the evaluation is the need to assess the
19 child’s basic educational needs. At times, additional psychoeducational testing is needed to assist
20 the court. The child’s right to be fairly educated was first established by *Brown vs. Board of*
21 *Education* (USSC, 1954) which resulted in the development of the Individuals with Disabilities
22 Education Act (IDEA Section 504). This was later followed up with the Educational Handicap
23 Act in 1973 (PL94-142). This allowed for the development of the Individualized Education
24 Program (IEP).

25 One must understand that the usual doctor-patient privilege that is present in a therapeutic
26 relationship does not exist between the clinician evaluating the juvenile and the client.
27 Nevertheless, one should still understand that the records within juvenile court and the
28 proceedings are kept private and are not open to the public.⁶

29

30 **Child Custody**

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1 The best interests of the child should always be a focus in completing a custody
2 evaluation. The final decision for recommendations will always be up to the finder of fact (the
3 judge, in most jurisdictions).

4 The role of the child custody evaluator is different from a therapist in a clinical setting.
5 The roles need to be kept separate. Trying to do both therapy and a forensic evaluation for the
6 same child or family is generally inappropriate and will complicate both the therapy and the
7 evaluation.

8 A competent child and adolescent forensic evaluator in child custody evaluations requires
9 skill and knowledge in the complexities and dynamics of child custody. There needs to be an
10 understanding of family relationships, interpersonal dynamics, child and adolescent
11 developmental issues, and a familiarity with family law in state and local jurisdictions. A
12 forensic evaluator has the duty to report to the court, or at times to the attorney involved, rather
13 than to the parties being evaluated. At the same time, it is extremely important to be cognizant of
14 the dynamics occurring during the process of the evaluation. Even though one may not be
15 involved in treatment, assuming a humanistic role while completing an evaluation will often
16 offer a greater truthfulness and completeness in a forensic evaluation.

17 There are a variety of ethical considerations, including whether an evaluator feels
18 competent to complete a custody evaluation, that fees are consistent and fair, that the evaluator
19 can remain unbiased to the best of one's ability and unaligned with one side of the case, and
20 lastly, that he or she has sufficiently ruled out any conflict of interest.

21 There are numerous, extremely relevant issues that may arise in child custody disputes
22 and need to be understood: child attachment; the caregivers bond to the child that can include
23 appropriate education, teaching, support, protection, empathic understanding, and care of day-to-
24 day activities; risk of harm to the child; consistency and care; and the ability for a parent to
25 encourage a relationship with the nonresidential parent.⁷ There are often more complex issues
26 dealing with allegations of abuse and neglect or issues of potential alienation.⁸

27 Before one can determine what is in the best interests of a child in addition to
28 understanding the makeup of each parent and the relationship of the child with each parent, one
29 must understand the needs of the child, including the possibility of developmental handicaps,
30 vision and hearing deficits, mental illness, and educational needs. Addressing other issues,
31 including gender issues, siblings' relationships, parent work schedules, the social systems, and

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1 cultural, ethnic and religious issues in attempting to understand how potential legal strategizing
2 may have also had an impact, all play a part. Further details are discussed in the
3 *AACAP Practice Parameters for Child Custody Evaluation.*⁹
4

5 **Child Maltreatment**

6 There are a variety of guidelines that have been published regarding evaluations of
7 children who have been abused. It is important to understand normative behavior in children, in
8 particular in assessing children who have potentially been sexually abused. Firstly, and most
9 importantly, normal sexual play activities between children should not be taken to be sexual
10 abuse. In assessing this issue, the evaluator should consider the age difference between the
11 children, the developmental level of the children, whether one child was coercing the other child,
12 and whether the act itself was intrusive, forceful or dangerous. Typically, children that have been
13 sexually abused manifest more sexual behaviors than normal; as such it is important to know
14 what the baseline behavior was. Working as a forensic evaluator, the practitioner may evaluate
15 children in a private practice for a forensic purpose, evaluate children and collaborate with other
16 mental health professionals in a government agency such as protective services, or work with an
17 interdisciplinary team at a pediatric medical center. The evaluator may assist the court in
18 determining what happened to the child, make recommendations regarding placement or
19 treatment, or offer an opinion on the termination of parental rights.¹⁰

20 It is also important to understand how information can be elicited about incidents in a
21 fashion that does not lead or prompt the child in a way that undermines or calls into question the
22 answers or observations. When an adult asks a child a question, the child will often try to give
23 the answer that he thinks the adult wants. Clinicians must also be aware of the strong feelings
24 that are a natural response towards perpetrators and victims of maltreatment and not let them
25 interfere in providing a careful and objective assessment of all the information available.
26 Evaluations of abuse and maltreatment may be used in a variety of court actions, including
27 custody hearings, termination of parental rights, and prosecution for criminal assault.

28 There are over 3 million reports of abuse and neglect per year. Over one million reports
29 are founded. There is a tremendous need for child and adolescent psychiatrists to assist in this
30 evaluation process, often in collaboration with psychologists, pediatricians, and social workers.
31 Further details on the issues in the critical area of sexual abuse assessment are presented in the

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1 AACAP *Practice Parameters for the Forensic Evaluation of Children and Adolescents Who May*
2 *Have Been Physically or Sexually Abused.*¹⁰ All states mandate reporting suspicion of abuse.

3

4 **Personal Injury**

5 There is a need for the specialized knowledge of a child and adolescent psychiatrist when
6 completing certain types of forensic evaluations. This sometimes requires a level of research
7 experience, work in a particular area, or an understanding of how an injury may have both short
8 and long term sequelae. A child and adolescent psychiatrist may be asked whether or not there
9 could be other etiologies to a child's presentation beyond simply an injury. In personal injury
10 cases, child psychiatrists are typically asked to assess any damage to the child. In addition to
11 determining if a child is suffering from a mental disorder or not, the child and adolescent
12 psychiatrist is expected to evaluate whether or not the alleged injury or incident in question
13 contributed in any way to the current condition of the child. This evaluation requires a thorough
14 knowledge of the onset and course of any symptoms, the experience of the alleged injury and
15 any subsequent actions directly resulting from it, and estimation of the development and mental
16 health prior to the alleged injury. While information about the child's condition prior to the
17 injury can be obtained from parents or other caretakers, it might be biased by current
18 involvement in litigation and retrospective recall. Sources of information not subject to those
19 biases can be found in a comprehensive review of prior educational, pediatric, mental health and
20 family records. Previous school records often provide assessments of the child's behavior and
21 intellectual capacities, indicating if a learning disorder or behavior problem existed before an
22 injury or not. Previous records can also provide a basis of comparison or assessment even if they
23 are not of the child. For example, if one is asked to assess cognitive defects in a child with a
24 history of lead ingestion, the baseline IQ of the parents may be relevant. One will be asked to
25 address short and long term treatment issues and often asked to give a long term prognostic
26 opinion. The expert may also be asked to provide an opinion regarding the need for treatment
27 and estimations of potential outcome with or without treatment.

28

29 **PRINCIPLES**

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1 **Principle 1. *The forensic evaluator should know and understand the applicable legal***
2 ***test for the question being evaluated and focus the evaluation on those issues pertinent to that***
3 ***test.***

4 The biggest difference between a forensic evaluation and an evaluation for purposes of
5 treatment is the focus on a legally worded test. Furthermore, the test may differ from jurisdiction
6 to jurisdiction, both in wording or in court interpretations of it. For example, in Michigan, “best
7 interests of the child” has a particular statutory definition comprised of defined factors, many of
8 which have been further interpreted by courts, while other states leave the concept relatively
9 undefined.

10 The nature of the test guides the evaluation and governs what data is relevant and what is
11 not, and has implications as to what areas of functioning need to be examined in detail and what
12 records are especially relevant. For example, in an evaluation for a present state, such as
13 competency to stand trial, if the evaluatee demonstrates competency, historical data is of limited
14 relevance.

15
16 **Principle 2. *The forensic evaluator should have adequate training, background, or***
17 ***professional experience, with an awareness of the differences between clinical/treatment***
18 ***settings and legal/court proceedings.***

19 To perform a competent forensic evaluation within court settings, one must have a
20 minimum set of clinical training and experience, knowledge, requisite skills, and if possible,
21 forensic supervisory training or experience. Due to a national lack of child and adolescent
22 psychiatrists, many child forensic evaluations are performed by adult psychiatrists,
23 psychologists, and other mental health professionals (e.g., social workers, nurses, and other
24 clinicians). The majority of psychiatrists who perform forensic evaluations of juveniles do this in
25 addition to their standard clinical work. Regardless of formal training, the forensic evaluator
26 should have some prior clinical or forensic experience in the area that they are assessing, whether
27 custody, delinquency or liability issues.

28 The child evaluator must have sufficient time to complete the evaluation. The appearance
29 of bias, lack of neutrality or objectivity, prior involvement with any of the parties, and/or the
30 failure to perform a competent evaluation is problematic. It is rarely appropriate for a child
31 psychiatrist to act as a forensic expert and treatment provider for the same youth or family.^{11,12}

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Principle 3. *The forensic evaluator should have an understanding of the operations of the judicial system, including the interface with all other involved agencies' services, and must also have an understanding of existing educational and mental health care systems within the area and supported by the court within the state and out of the state.*

Effective forensic consultation to family, civil, juvenile, and criminal courts requires knowledge of the organizational structure of the courts and related agencies, differences between the courts and clinical settings, the legal process for juveniles, how this differs from adults, and other legal issues such as legal standards, testimony, and court proceedings. Attempting to complete a forensic evaluation within juvenile court without an understanding of the system is a risk both to the evaluator and the youth being evaluated.

Principle 4. *The role of forensic evaluator is distinct from that as treatment provider and all involved with the child must understand and respect the boundary between those functions.*

The forensic psychiatric evaluation of a youth is inherently different from a traditional clinical psychiatric evaluation for treatment purposes. The forensic evaluator's role is to answer a legal question. Specific aims of the child forensic evaluation are (1) to identify the stated reasons and factors leading to the referral, (2) to obtain an accurate diagnostic picture of the youth's developmental functioning and the nature and extent of the youth's behavioral difficulties, functional impairment, and/or subjective distress, (3) to identify potential individual, family, school, peer, or other environmental factors that may account for problems that have resulted in the legal involvement or claimed impairment or distress, and (4) to rely as much as possible on research and scientific studies rather than subjective hunches in coming to an opinion.

In the first meeting or phone contact with the party requesting the forensic evaluation (attorney for defense, state, or plaintiff, or the court itself), the child psychiatrist must identify potential role conflicts, boundaries, and expectations of the proposed consulting relationship to ensure that the evaluator will be able to complete an objective and comprehensive forensic evaluation. The traditional doctor-patient relationship is not developed between the child forensic evaluator and the youth evaluatee. The forensic evaluator's role is that of fiduciary to the court or retaining agency (e.g. law firm, school department), and unlike the treating psychiatrist, holds no

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1 fiduciary duty to the patient. Table 1 illustrates differences between clinical and forensic
2 evaluations.¹³

3 At the onset of the interview, the evaluator should review the following with the child or
4 adolescent and parents: the purpose and process (solo evaluator versus team interview) of the
5 evaluation, agency of the evaluator, whether the evaluation is being videotaped, what will
6 happen to the information obtained (e.g., verbal or written report), and that the evaluation is not
7 for treatment purposes. The examiner should provide these non-confidentiality warnings to the
8 parent and to the youth (according to the youth’s) developmental maturity. Although not legally
9 required, it is advisable to attempt to obtain a youth’s assent to the interview process, and
10 whenever possible, the same explanation should be provided to the parent or legal guardian.

11 Confidentiality is an ethical and legal obligation to not disclose communication by a
12 patient or the person that one is evaluating. Privilege is the legal rule that protects portions of that
13 communication from disclosure in court.¹⁴ A waiver to privilege can be expressed or implied as
14 there is a court order; it is implied that the purpose of the evaluation is for presentation of
15 material to the court and the involved attorneys. Nonetheless, a clear explanation of
16 confidentiality to the evaluatee and then allowing them to explain what they understand is ideal. In
17 association with this, an additional written release of information is best and, with current
18 HIPAA requirements, potentially required.

19

20 ***Principle 5. The evaluator must clarify the question being asked and be sure that he or***
21 ***she has the specific knowledge in the area being opined upon.***

22 It is a common mistake for a novice forensic evaluator to include more in the report than
23 what was asked. This is not helpful to the court and not uncommonly can result in conflict
24 regarding your evaluation and at times confusion for the court. Address only the questions asked
25 within the court order. If additional questions are requested by one or more of the attorneys,
26 request that it be written, preferably within a court order so as to minimize any confusion
27 regarding your role.

28 Having an understanding of the area being assessed and being up to date on the current
29 literature is important in completing a comprehensive assessment. The role of a forensic
30 evaluator can be complicated. Recommendations may have a direct impact on the judge’s
31 decision. As such, one’s evaluation needs to be as thorough as possible. Do not shorten the time

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1 necessary to complete an evaluation. If feeling rushed by an attorney, respond in writing
2 regarding the need for increased time. In association with this, it may also be worthwhile to
3 communicate with the judge regarding why additional time is necessary. Clarifying the
4 multifactorial components of the evaluation is typically helpful. Do not use jargon in the
5 clarification letter. If specific psychiatric terminology is used or needs to be used, define what
6 you are saying.

7

8 **Principle 6. *The forensic evaluator should determine the amount of time, collateral***
9 ***information and resources that are necessary to complete any forensic evaluation.***

10 Focusing on the forensic question (e.g., what is the optimal and least restrictive treatment
11 setting for this youth? what is in the best interest of the child?) and providing information in a
12 manner that is most helpful to the referral/retaining source requires unique skills and a systematic
13 approach. The forensic evaluator must not jeopardize the evaluation by minimizing the need for
14 time to complete the evaluation properly or to collect, review and evaluate all pertinent sources
15 of information. Many times, attorneys will contact forensic experts shortly before a court
16 hearing. In those situations, it is imperative that the forensic evaluator make clear the time
17 necessary to do a proper assessment and suggest that a continuance or delay be sought. It is also
18 equally important for the forensic evaluator to receive previously completed reports, summaries
19 and test results prior to beginning the evaluation. The forensic evaluator must determine what
20 records are necessary, who needs to be interviewed and what further tests or consultations are
21 needed for completion of the evaluation. In some cases this can be done prior to the interview, in
22 others issues may arise during the interview that highlights areas needing to be explored with
23 further outside data. A forensic evaluator may be asked to provide a professional opinion
24 regarding a youth’s future for dangerousness, future criminal behavior, amenability to treatment,
25 and what level of a restrictive environment is necessary both to assist in treatment and to protect
26 the constituents of the state. In a custody evaluation, a forensic evaluator is asked to address
27 custody and the best interest of the child. The balance in giving this opinion is often complex and
28 often is improved upon by one’s level of experience.

29 Forensic evaluations involve the review of all available relevant and necessary records
30 and, when indicated, additional records and data from collateral sources, and serial interviews of
31 the youth. Although the ultimate goal is to conduct an optimal evaluation in order to best address

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1 the legal question posed, the child forensic evaluator must approach each evaluation with
2 sensitivity to unique developmental vulnerabilities. The amount of records and collateral
3 information that should be obtained will depend on the nature of the evaluation and the reliability
4 of information already present. For example, in evaluating an adolescent, pediatric records from
5 the pre-school period may not be very important in assessing a present state such as competency
6 to stand trial, but crucial in special education litigation with a school system involving the
7 question of whether a youth has autism.

8 It typically takes much effort to obtain available collateral information including police
9 reports, educational reports, prior mental health history, medical history, social service
10 evaluations, and prior court hearings. Nonetheless, they may be important to the evaluation. If all
11 the collateral material has not been received and reviewed, begin the evaluation and then
12 determine what else is necessary. To not comment on what is or is not relevant collateral
13 information may have a negative impact on one's presentation and recommendations, and also
14 opens up the possibility of more significant cross-examination in testimony. One wants to be as
15 exact as possible with as much external verification as possible so that one can hopefully make
16 an appropriate recommendation; however, there are many examples where additional data and/or
17 collateral contacts do not add to the report. If additional needed collateral information has not
18 been provided, one needs to send out a written request for the information that is needed. If for
19 some reason a party is refusing to make this information available, the person or agency that
20 made the referral needs to be made aware of this

21

22 ***Principle 7. Forensic evaluators should carefully consider the impact of the presence***
23 ***of parents, guardians, and the youth's attorney during the interview of the youth.***

24 Clarification regarding who will be attending the assessment is important. If the issue is
25 contested, a court may need to clarify. Issues of confidentiality must be established. At times
26 there are conflicts and these conflicts are addressed within court. For example, an attorney may
27 want to be present at the evaluation. Although it is not an uncommon request, it is far less
28 common and typically less useful for the evaluation if an attorney is present. The evaluator must
29 understand the respective state's mental health code and laws, as some states require the youth's
30 attorney to be present. Some have reported a level of skewing of the evaluation that may occur
31 by having the attorney present. If the attorney is to be present, guidelines need to be agreed upon.

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1 For example, it may be agreed that the attorney will sit out of direct sight (e.g., to the side of the
2 youth), will not participate unless invited to do so by the evaluator, and that all observed
3 communication, verbal or nonverbal, between the attorney and the youth will be considered as
4 data in formulating the opinion. At times, it is asked whether or not one would also like to have
5 the parent or guardian present. It is extremely uncommon that a court would require a parent or
6 guardian to be present. Having them present for at least part of the evaluation for obtaining
7 historical information, assessing the interaction with the parent or guardian, and at times for
8 assisting in the evaluation can be helpful. For example, youth being evaluated within juvenile
9 court at times can be resistant and quite guarded in the evaluation process. More often than not,
10 the assistance of a parent or guardian to encourage their cooperation is helpful. Once
11 accomplished, it is typically of benefit to interview the youth alone as well. With custody
12 evaluations, it helps for the evaluator to assess children with each parent so there can be a better
13 understanding of the relationship with each parent.

14

15 **Principle 8. *Forensic evaluators should be competent in conducting evaluations in a***
16 ***culturally sensitive manner.***

17 Minority youth in the juvenile justice system in many states are over-represented.
18 Minority youth represents 32% of the population, yet they represent 65% of the juvenile
19 population in secure detention and 68% of youth in secure institution environments, such as
20 training schools.¹⁵ There continues to be a national emphasis on attaining cultural competency.
21 When issues of language or cultural differences arise in any type of forensic evaluation,
22 consultants may be utilized to assist with the evaluation process or specific recommendations
23 related to the evaluation. Simply having someone who speaks the same language or is of the
24 same race is not synonymous with being culturally competent. One also has to realize that there
25 are other components to being culturally competent. Specific issues in child custody requiring
26 specialized levels of cultural competency should be identified early in the evaluation process.
27 Cultural competency is particularly important when making recommendations for specific
28 treatment and placement services, involvement of the family, and other specific mental health
29 and substance treatment interventions. The forensic evaluator should actively consider the
30 possibility of symptom exaggeration or malingering during the assessment.

31

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1 **Principle 9. *A forensic evaluator must carefully consider whether or not to record the***
2 ***forensic evaluation by audio or videorecording.***

3 The American Academy of Psychiatry and the Law (AAPL) developed a statement
4 regarding the use of videotaping because there is no defined standard in adult forensic
5 evaluations, and there is the problematic issue of consent.¹⁶ There are many forensic psychiatrists
6 that videotape or audiotape their evaluations. If given the option, many psychiatrists would like
7 to tape their evaluations, but will complete their evaluations without taping. The general concept
8 that the more information obtained, the more comprehensive the evaluation will be is a
9 worthwhile one. Videotaping and audio taping will help clarify any accusations of
10 misinterpretation or misstatement in the forensic report. However, most evaluations are not
11 taped.

12
13 **Principle 10. *Forensic child and adolescent psychiatrists should have an***
14 ***understanding of psychological testing and make use of it as appropriate.***

15 A forensic evaluator should understand what testing is appropriate for a specific
16 evaluation. Psychological testing is important in some situations, but not in others. For example,
17 in child custody disputes when there are significant allegations and inconsistency in presentation,
18 a comprehensive psychological battery including tests such as the Minnesota Multiphasic
19 Personality Inventory & Millan can be helpful in further assessing personality, deceptiveness,
20 and defensiveness. Cognition, achievement tests and further neuropsychological assessments can
21 be helpful in personal injury cases. The use of specialized psychological tests in assessing
22 juvenile competency and custody may also be of benefit. An evaluator must understand the
23 benefits and limitations of testing when asked about available treatment options.

24
25 **Principle 11. *The forensic evaluator should be aware of the types of and level of***
26 ***supervision in clinical services available, and different indications when making treatment or***
27 ***placement recommendations.***

28 A forensic evaluator needs to have an understanding of available treatment resources.
29 Many youth come to the attention of the juvenile/family courts through waywardness/
30 disobedient petitions, school truancy, neglect and abuse petitions, or violent and non-violent
31 offenses. Attempts are made to refer these juveniles for timely evaluations by forensic

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1 evaluators. The immediate goals are to identify the most appropriate evaluation and treatment
2 services (e.g., mental health, substance abuse, sexual offending, fire-setting, risk assessments for
3 future dangerousness) in the least restrictive manner. A forensic evaluator must know what
4 different types and level of intensity of treatment services and programs are available in the local
5 community or at a state level (e.g., outpatient, day treatment, residential, acute inpatient). The
6 forensic evaluator should also have knowledge of different types of juvenile justice settings and
7 levels of security (facility secure, staff secure, etc.). The evaluator should also have an
8 understanding as to what treatment interventions have research to support its effectiveness.

9 The forensic evaluator is often asked to provide treatment and placement
10 recommendations to the family/juvenile courts, child social services, or juvenile probation. The
11 courts then initiate additional referrals for mental health and/or substance abuse treatment,
12 outreach and tracking, vocational and life-skills training, educational interventions, parenting
13 education, relapse prevention, and other interventions. Based on the evaluator's
14 recommendations, the court might order an out of home placement into a group home, foster
15 care, in-state or out-of-state residential treatment, or other type of treatment program for an
16 identified period of time.

17 Many court-ordered placements are implemented through probation departments,
18 although there may be overlap with the state's Department of Human Services, youth social
19 services, and educational agencies. In many cases, the court may attempt to utilize public sector
20 or private funding such as a youth's available health insurance for treatment services and out of
21 home placements. Some court systems will be able to fund residential facilities, although many
22 are prohibitively expensive, and there is a shortage of available openings. Some states
23 throughout the country have secure residential facilities, but most do not. If a recommendation is
24 made for an out-of-state facility, one must know whether their state allows for children on
25 probation to be placed at out-of-state residential facilities. Open residential facilities will be the
26 next least restrictive alternative.

27

28 **Principle 12. *The structure of the forensic report differs from clinical evaluations.***

29 The report should document the source of the referral, the forensic question being
30 addressed, sources of information, including dates, duration, and participants of all interviews
31 and documents reviewed, what was told to the evaluatee and parents regarding the evaluation,

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1 including notice of the limits of confidentiality and what consent or assent was obtained,
2 summary of pertinent findings, including all data that constitutes the bases for the opinion being
3 rendered, the forensic opinion on the questions asked, and the reasoning used in moving from the
4 data to the opinions. It is important to separate the data section from the opinion section. Most
5 forensic psychiatrists agree that no new data should appear in the opinion section of the report. In
6 cases where the forensic test is comprised of several factors or prongs, each prong should be
7 addressed separately. For example, in a jurisdiction in which the *Dusky* test is used for
8 competency to stand trial, the opinion section should address first whether the defendant
9 understands the nature of the charges against him and second whether he can assist his attorney
10 in his defense. Some authors prefer to place a brief statement of the opinion near the beginning
11 of the report, while others prefer not to mention the opinion until after the bases for it are
12 presented. There is variation among reports and variation in what judges expect to see in reports

13 Make sure that all questions asked by the court are addressed. There are times when
14 specific questions asked by the court cannot be answered. For example, it should be explained to
15 the court when specific questions cannot be answered. In addition, sometimes the responses
16 might appear somewhat more complex than what was requested by the court. If this is the case, it
17 should be explained why the answers may be more complex. Review the report carefully for
18 typographic and grammatical errors.

19 When writing a report, do not speak in the vernacular and do not use medical language
20 that would be difficult for the court and others to understand. If specific medical, psychiatric, or
21 psychological terminology is used, it must be defined. The information can either be defined in
22 the text or defined at the bottom of the page. Having a reference section at the end of the report
23 makes the report somewhat cumbersome and difficult to read. However, at times, may be needed
24 and have specific relevance to the question being requested. (See Table 2.)

25

26 **Principle 13. *An evaluator must be prepared to testify in depositions and in court.***

27 One who has not previously been in court, would likely benefit from going to court on at
28 least one or preferably more occasions to observe expert testimony. Having spent some didactic
29 time or having practical experience in a supervisory setting is recommended.

30 Appropriate professional attire is necessary for court appearances. An expert should
31 usually direct his or her responses to the finder of fact -- the judge in a bench trial or the jury in a

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1 jury trial. One will sometimes be put in an awkward position where it is difficult to face the
2 judge. An attempt should be made to focus in the appropriate direction. Do not nod in response
3 or use words such as “uh-huh.” Articulate your responses. Responses should be well thought out.
4 In cross-examination, if pressured for quick responses, do not follow this lead, take your time.
5 Be particularly cautious in any type of leading question. Respond directly to the questions being
6 asked. If one is asked a yes or no question but one cannot answer, attempt to explain to the court
7 that it is not a yes or no answer and let the court determine whether or not you can further
8 explain your answer. Attempt to remain consistent in your responses. Regardless of how many
9 times a question is asked or how it is framed, be consistent in your response. At the same time,
10 there are questions that may be asked that potentially could change an opinion. It is reasonable
11 with these types of questions to respond with a probability or a possibility type response. At the
12 same time, when hypothetical responses are being asked, pause before responding to allow
13 counsel to potentially object. Even though the court is an adversarial system, do not get into an
14 argument; listen to the question being asked, pause, think about the question and then respond.
15 Most forensic psychiatrists recommend that a witness not respond in an antagonistic way. Be
16 cautious if more than one statement is being asked. One can ask to repeat the question if it is not
17 understood.

18 Depositions take place out of the presence of the judge. Because there is no judge to rule
19 on objections, the general rule following an objection is for the witness to answer the question
20 after an objection is made, on the theory that a judge can later rule on the objection and the
21 admissibility of the answer. However, if the attorney that retained the expert directs the expert
22 not to answer, an answer need not be given. It is important to remember, however, that the
23 retaining attorney’s duty is to his client, not to the expert. Situations can arise in depositions in
24 which the expert may refuse to answer even though the retaining attorney does not object,
25 generally on the grounds that the question is overly personal and not relevant. Such questions
26 may revolve around income (in most jurisdictions, witnesses need to answer questions regarding
27 their fees in the case and the percentage of their income derived from forensic work, but not
28 questions about total income), or questions about private history. The relevance of personal
29 details often depends on the case. Asking an expert whether she has been sexually abused as a
30 child may be relevant to bias in a case involving sexual abuse of a child, but not relevant in a
31 case involving malpractice for a patient’s suicide.

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1 The Federal Rules of Civil Proceedings states that experts should keep a record of all
2 cases in which they provide testimony. The Federal Rules of Civil Procedure (citation) require
3 that the expert submit a list of all testimony provided in the previous four years. Failure to
4 provide such a list will disqualify the expert from testifying. Many state jurisdictions have
5 adopted the federal rules, or developed similar requirements.

6 Testifying is often quite complex, although one can read much about this topic, one's
7 ability improves as an expert witness with experience.

8 9 **Principle 14. A treating psychiatrist may be pressed to testify as a fact witness.**

10 An expert witness can testify to opinions; a fact witness can not. Physicians may be
11 subpoenaed as fact witnesses, in which case they do not need to be paid. Expert witnesses
12 typically can not be subpoenaed unless they have previously agreed to be involved in the case. If
13 one is subpoenaed as a witness, it is important to clarify what role one is in. As a treating
14 psychiatrist you may be court ordered, subpoenaed, or asked by your patient to testify on a
15 particular question. The request for testimony could be through a report, affidavit, deposition,
16 and or through court testimony. What one thought as a treater, what treatment one provided, and
17 what one wrote in the record are facts. One's current views of the patient's prognosis or one's
18 opinion on the forensic issue before the courts are opinions.

19 Key points for treating psychiatrists when asked to testify:

- 20 • Clarify whether one is being called as a fact witness or expert witness.
- 21 • Remember that one has not conducted a forensic evaluation and so is under no obligation
22 to have a forensic opinion. For example, if one is treating a child and subpoenaed in a
23 child custody dispute, one is under no obligation to form an opinion as to what custodial
24 arrangement is in the best interest of the child. You won't look stupid for not having an
25 opinion.
- 26 • Some states do not require you to respond to a subpoena request. Some response is
27 mandatory. It may require only objecting to the subpoena or filing a motion to quash, but
28 simply failing to show leaves one wide open for a contempt of court action.
- 29 • All states require a response to a court order,
- 30 • A deposition is given under oath, as is court testimony,
- 31 • Know your state mental health code and laws.

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- 1 • Always contact your patient regarding the content of your testimony. In some states,
2 testimony or records cannot be provided without the patient’s consent. Before releasing
3 records, one should give the patient the opportunity to object to the subpoena.
- 4 • Do not make a custody or visitation recommendation regarding a patient.
- 5 • If you have questions regarding your appropriate role, consider retaining an attorney to
6 represent you.

7

8 **Principle 15. *Even though ethical issues in child and adolescent forensic psychiatry***
9 ***are not well-delineated, one must adhere to the ethical guidelines of the AACAP.***

10 The ethical principles that should apply to forensic evaluations are controversial. Stone¹⁷
11 has argued there is no consensus regarding ethical principles for forensic psychiatry, while
12 others¹⁸ have made various proposals regarding underlying ethical principles.¹⁹ There is very
13 little commentary on how these proposals might be applied in the forensic evaluations of
14 minors, where such issues as consent, susceptibility to leading questions, and deference to an
15 authority figure are considerably more problematic than they are with adults.

16 There continues to be controversy and debate as to whether forensic psychiatry is
17 considered the practice of medicine. In 1998, the American Medical Association passed a
18 resolution stating expert testimony is the practice of medicine. The AAPL policy is that forensic
19 psychiatry is not the practice of medicine.¹⁹ However, the AACAP has no policy on this. One
20 needs to attempt to remain objective, honest and to remain confidential within the legal context.
21 It is important to know the laws in states outside of where an expert may be testifying to
22 determine whether one needs to be licensed in that state to interview a youth and to testify. This
23 has particular relevance to medical-legal issues. Important ethical issues can include:

- 24 1) personal conflicts of interests,
- 25 2) previously or currently being involved as a treater,
- 26 3) involvement in any type of interrogation, or
- 27 4) reimbursement issues, such as contingency payments.

28

29 **Principal 16. *Careful consideration should be made as to whether a child should***
30 ***testify.***

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1 The forensic evaluator, when indicated, should consider making a statement on issues
2 relevant to whether the child should be allowed or required to testify, including such factors as
3 the psychological risks and benefits to the child (for example, the effects of testifying about
4 sexual abuse in the presence of the accuser), and factors bearing on the reliability of a child’s
5 testimony. There should be consideration of alternatives to face-to-face testimony, such as video
6 recording the evaluation and using closed-circuit video monitoring of testimony, consistent with
7 local law.

8

9 **PARAMETER LIMITATIONS**

10 AACAP practice parameters are developed to assist clinicians in psychiatric decision-
11 making. These parameters are not intended to define the standard of care; nor should they be
12 deemed inclusive of all proper methods of care or exclusive of other methods of care directed at
13 obtaining the desired results. The ultimate judgment regarding the care of a particular patient
14 must be made by the clinician in light of all the circumstances presented by the patient and
15 his/her family, the diagnostic and treatment options available, and available resources.

16

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Table 1. Differences between Clinical and Forensic Evaluations

	Traditional Diagnostic “Clinical Evaluation”	Forensic Evaluation
Purpose	Relieve suffering	Answer a legal question
Relationship	Doctor-patient	Evaluee-evaluant
Client	The patient	The court or retaining agency
Agency	Fiduciary duty to the patient/ Duty to the patient’s best interests Patient’s welfare first	Fiduciary duty to retaining source (e.g., attorney, court)
Objective	Help heal the patient	By report or testimony: inform and teach the fact- finder (e.g., judge, jury) or retaining agency
Confidentiality	Essential	Lack of confidentiality
Process	Establish diagnosis and treatment plan	Conduct objective evaluation, diagnosis may be nonessential
Treatment	Treatment rendered	No treatment rendered
Sources	Self report, occasional information, some collateral records	Exhaustive attempt including serial interviews, interviews of additional historians, review of collateral data
Bias	Therapeutic bias exists: desire for patient to get better, serve as patient advocate	Attempt to be neutral and objective, lack of bias; no investment in outcome
End product	Establish a therapeutic relationship	Answer the referral question either in the form of a verbal or written report to retaining source, deposition, and or testimony

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Table: Penn JV, 2005

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Table 2

Forensic Evaluation Template

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- 1) Type of Evaluation
- 2) Case Name with case number
- 3) Date of Report
- 4) Referral Source
- 5) Referral Question
- 6) List of Parties Interviewed
- 7) Dates and time spent with interview
- 8) Limits of Confidentiality
- 9) List of Collateral Information
- 10) Body of Report
 - Option 1 – Historical Background referencing major issues such as who reported the information or what document was the information taken from.
 - Option 2 – a) Review pertinent information from each document. (Review of collateral information)
b) Interview section where each interview is summarized
- 11) Option 1 – Assessment Section – Briefly summarize the facts which culminate in understanding of ones opinion.
 - Option 2 – Delete Assessment section and in each opinion support it with the specific documentation.
- 12) Opinion Section (optional)
 - 1) List specific opinion
 - 2) Opinions may be included in the recommendation section.
- 13) Recommendation Section (optional)

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- 1 1) Recommendations may be inclusive within the opinion section
- 2
- 3 2) List specific recommendations
- 4
- 5 14) Reference Section (optional)

Practice Parameter Member Comment Form

**PRACTICE PARAMETER FOR CHILD AND ADOLESCENT FORENSIC
EVALUATIONS**

*Please write your comments below, noting a specific page and line if appropriate. Please focus your feedback on content rather than editorial issues; the parameter will be professionally edited prior to approval. All comments are reviewed and discussed by the authors and the Work Group on Quality Issues. Please fax your comments to 202-966-9518 or email jmedicus@aacap.org **by January 23, 2008**.*

Name: _____ Date: _____ Email: _____