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49 Forensic Psychiatry

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Forensic psychiatry is a field within psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts (Rosner 1989, p. 323). Within forensic psychiatry, child and adolescent forensic psychiatry emerged in the last two decades of the twentieth century as a subspecialized area of increased activity, complexity, and utilization (Nurcombe and Partlett 1994; Schetky and Benedek 1985, 1992, 2002). This development paralleled the maturation of the field of child and adolescent psychiatry as a medical specialty with its own research-oriented database (Institute of Medicine 1989), fund of knowledge of human neurobiological development and psychopathology (Cicchetti and Cohen 1995), and more specific clinical application, such as those reflected in the practice parameters published by the American Academy of Child and Adolescent Psychiatry (1995, 1997b, 1997c). This rapidly expanding area of forensics is complex and multifaceted and involves a diverse range of topics paralleling the changes and concerns in American society such as the legal rights of children and adolescents, custody and visitation disputes, child abuse and neglect evaluations, delinquent behavior and the juvenile justice system, mental disability, civil commitment of youths, and special education issues.

In response to the growing demands for recognized competence in this area, the American Board of Medical Specialties officially established forensic psychiatry as a subspecialty in 1992 and directed the American Board of Psychiatry and Neurology to offer certification in this field. The examination requires completion of a 1-year fellowship from a program certified by the Accreditation Council for Graduate Medical Education (ACGME). Currently, there are 37 ACGME-accredited certified fellowships in the United States. The Accreditation Council for Graduate Medical Education (1988) also revised its requirements for child psychiatry training programs to include forensic psychiatry as part of training in consultation. However, teaching and content in forensic psychiatry vary widely among residency programs (Marrocco et al. 1995).

The intent of this chapter is

- To increase awareness and understanding of children's rights
- To provide an overview of relevant legal processes and forensic psychiatry concepts
- To provide an understanding of the essential elements of a forensic evaluation
- To provide an overview of relevant ethical and legal issues in the treatment of minors and to highlight important professional liability concerns
- To highlight some areas of particular activity and concern to child and adolescent forensic psychiatry practice, including issues involving child custody and divorce, child abuse and neglect, the role of children as witnesses, youth violence, the juvenile justice system, civil commitment of minors, and special education
- To provide some guidance for further study and encouragement for seeking consultation with colleagues and counsel

The Changing Status of Children's Rights

Many changes have occurred within American society and the legal system with regard to the recognition

and protection of children's needs, well-being, and rights. One can more fully appreciate these changes by examining the status of children before the twentieth century. For example, children have historically been viewed as property of the family, particularly the father, or wards of the state with no political power and few legal rights (Rodham 1973). They were valued for their economic contributions and were often fully exploited in the workforce before the existence of child labor laws (Nurcombe and Partlett 1994, p. 42). Until 1875, no organization existed for the protection of abused or mistreated children. The first prosecuted case of child abuse had to be taken to the Society for the Prevention of Cruelty to Animals (American Academy of Child and Adolescent Psychiatry 1997c, p. 425). Further evidence of disregard for the special needs of children is apparent in the treatment of juvenile delinquents before the twentieth century, when children over age 7 who were charged with misconduct were subject to the same criminal proceedings and sanctions as adults (Schetky 2002b, p. 4).

Beginning in the later part of the nineteenth century and during much of the twentieth century, private, professional, and political leadership in the United States increasingly expressed its concern for the care and well-being of children. In 1909, the establishment of the first White House Conference on Children and Youth reflected a growing concern for the care of dependent children following the sociocultural changes in American society at the turn of the century. Subsequent White House conferences in each decade focused on child welfare standards; child health and protection; and the rights, needs, and well-being of children (Beck 1974). The White House Conference on Children, convened in 1970 (U.S. Government Printing Office 1971), asserted the following specific rights as central to a child's well-being:

1. The right to grow in a society that respects the dignity of life and is free of poverty, discrimination, and other forms of degradation
2. The right to be born and to be healthy and wanted through childhood
3. The right to grow up nurtured by affectionate parents
4. The right to be a child during childhood, to have meaningful choices in the process of maturation and development, and to have a meaningful voice in the community
5. The right to be educated to the limits of one's capability and through processes designed to elicit one's full potential
6. The right to have societal mechanisms to enforce the foregoing rights

The recent publication of *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services 1999) and the subsequent *Report of the Surgeon General's Conference on Children's Mental Health* (U.S. Public Health Service 2000) highlighted a national agenda to promote awareness of children's mental health issues and needs. This included the reduction of stigma associated with mental illness, continuing to utilize scientifically proven prevention and treatment services in the field of children's mental health; improving the recognition of the mental health needs of children; eliminating racial, ethnic, and socioeconomic disparities in access to mental health care; improving the infrastructure for children's mental health services across professions; and increasing the quality of mental health care services and training providers to recognize and manage mental health issues.

The changes in society's perception and treatment of children during the twentieth century is similarly reflected in the legal system, in which two legal doctrines—*parens patriae* and *the best interests of the child*—were increasingly used by the courts to intervene in private family life for the protection of the child. Parens patriae empowers the state to protect citizens who are unable to protect themselves and has been used to justify state interference with parental prerogatives. The concept of the child's best interest was originally acknowledged in *Chapsky v. Wood* (1881) and has guided lawmakers and courts to prioritize the child's best interests over those of other involved persons, including the parents. Although these concepts have infused the vision of much federal legislation and many appellate court decisions regarding some aspects of child care, education, health, welfare, and juvenile justice, much remains to be accomplished in implementing these principles at a practical and universal level.

Overview of the Legal System

On a pragmatic and somewhat oversimplified level, law can be viewed as anything that a court having juris-

diction will enforce. This process protects an individual's claim to the possession of property or authority or to the enjoyment of privilege or immunity (Rodham 1973). Law in the United States is derived from the U.S. and state constitutions and from federal and state legislation and case law.

Structurally, the court system can be divided into two main categories: state courts and federal courts. The state court system consists of lower courts (or trial courts), higher courts (or appellate courts), and the state's supreme court, which serves a supervisory function over trial court decisions. Most of these courts have general jurisdiction, which means they hear both civil and criminal cases arising under state law. However, some state courts are considered to be specialized and exercise jurisdiction over specific types of cases. Some of the specialized courts especially pertinent to the child forensic psychiatrist include the juvenile and family courts and surrogate courts. Juvenile courts have statutory authority over matters relating to juvenile delinquency, abuse, and neglect. Family courts have statutory authority over divorce and child custody issues. Surrogate courts have authority over matters relating to civil commitment, guardianship, adoption, administration of trusts and estates, and contested wills.

The federal court system consists of federal trial courts, 13 U.S. Courts of Appeal and the U.S. Supreme Court. These courts decide civil and criminal cases arising under the United States Constitution and federal statutes, as well as civil actions in which the parties are of diverse state citizenship. As in the state court system, appellate courts serve a supervisory function over trial court decisions. Unique to the federal court system is the existence of the U.S. Supreme Court, which serves a supervisory function over federal appellate court decisions and has appellate jurisdiction to review any final state judicial decision.

Legal proceedings are essentially of two types: civil and criminal cases. Civil cases consist of breach of contract; property and financial disputes; and torts, including injury, negligence, professional liability, libel, and slander. These cases involve disputes between the plaintiff and defendant, third parties, cross plaintiffs, and cross defendants. The plaintiff must prove the elements of the cause of action. In criminal cases, the state lodges the complaint against the defendant, who is the alleged criminal. As a result of the presumption of innocence, the state has the burden of proving the elements of the charged crime. Both civil and criminal proceedings operate under standard rules of civil procedure and evidence, which provide the mechanism for fact finding, decision making, and enforcement.

One important aspect of the legal process is the standard of proof or the level of certainty required for a judicial decision. The standard of *preponderance of evidence* (or *more likely than not*) is used in most civil litigation. The intermediate standard, *clear and convincing evidence,* is required in cases of deprivation of rights or liberty, such as involuntary civil commitment (*Addington v. Texas* 1979), and in cases of termination of parental rights (*Santosky v. Kramer* 1982). The highest standard of proof, *beyond a reasonable doubt,* is required by law in criminal cases, including juvenile court and delinquency proceedings (*In re Winship* 1970). Physicians who testify in court may also be asked if their opinions are given with a *reasonable degree of medical certainty.* The concept of reasonable medical certainty is not necessarily synonymous with any of the legal standards of proof but rather reflects "that level of certainty equivalent to what a physician uses when making a diagnosis and starting treatment" (Rappeport 1985, p. 9). Clinicians must understand the particular standard of proof that is required by the legal matter at hand and must be able to articulate and demonstrate their medical opinions relative to that standard.

Evidence is of two types: 1) legal fact (i.e., what the court accepts as fact) and 2) expert opinion. Both are presented in the form of witness testimony and exhibits. In this regard, the forensic psychiatrist may be called to testify as a fact witness or as an expert witness. As a fact witness, the psychiatrist testifies to a matter perceived or witnessed. As an expert witness, he or she testifies to matters of special learning and knowledge. Mental health professionals frequently participate as expert witnesses in the legal arena. However, their appropriate role in the courtroom continues to be highly controversial, as demonstrated by the case law on the admissibility of expert testimony.

The traditional standard for acceptance of scientific evidence by expert witnesses has become known as the Frye rule, an opinion that stated in part that "while courts will go a long way in admitting expert testimony deduced from a well recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs" (*Frye v. United States* 1923). In 1975, a new set of federal rules of evidence was adopted. Rule 702 states, in part, "[I]f scientific, technical or other specialized knowl-

edge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, expertise, training or education may testify thereto in the form of an opinion or otherwise" (Zonana 1994, p. 311). The U.S. Supreme Court concluded that the expanded federal rule of evidence superseded the Frye rule and that trial judges have the obligation to ensure that "any and all scientific testimony or evidence admitted is not only relevant, but reliable" (*Daubert v. Merrell Dow* 1993, p. 8). This in effect expands the trial judge's gatekeeping and decision-making functions over the admissibility of scientific knowledge and increases the risk that "junk science" or personal opinions will be admitted into the judicial process through expert witnesses.

In subsequent cases, the Supreme Court upheld the *Daubert* ruling and further elaborated on its proper application. In *General Electric Co. et al. v. Joiner* (1997), the Supreme Court decided that "abuse of discretion" is the proper standard of review of a district court's decision to admit or exclude scientific evidence under the Daubert principles. In *Kumho Tire Co.* (1999), the U.S. Supreme Court held that the Daubert principles apply to all types of expert testimony, gave the trial judge broad latitude in determining the reliability of expert testimony, and emphasized that the Daubert rules should be applied in a flexible manner to the extent relevant in each case. During the past two decades, there has been a burgeoning of civil litigation involving expert opinion, including psychiatric expert opinion, in cases ranging from product liability to abuse and harassment. The full impact of these changes is yet to be felt. Suffice it to say that these changes, while allowing for a larger inclusion of scientific knowledge and expert opinion, also allow for a much closer scrutiny of methodology, validity, relevance, and demonstration of the reasoning supporting the expert conclusions (Zonana 1994).

The Supreme Court discussed psychiatric testimony in *Ake v. Oklahoma* (1985):

> Psychiatry is not, however, an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness. Perhaps because there often is no single, accurate psychiatric conclusion on legal insanity in a given case, juries remain the primary fact finders on this issue, and they must resolve differences in opinion within the psychiatric profession on the basis of the evidence offered by each party.... It is for this reason that States rely on psychiatrists as examiners, consultants, and witnesses, and that private individuals do so as well, when they can afford to do so. (p. 7)

The Forensic Evaluation

A child and adolescent psychiatrist may become involved in a legal matter as 1) an evaluating or treating psychiatrist of a patient who is coincidentally involved in a lawsuit; 2) as a court-appointed expert for a specific case; or 3) as a forensic expert contracted by one party or attorney for the purpose of providing consultation, evaluation, or testimony for one side in a lawsuit.

In the first instance, the requirement for confidentiality may be waived by the patient, parent, or legal guardian; in other circumstances, the therapist or evaluator may be legally required to report or testify, such as when a case falls under mandatory reporting requirements for neglect, abuse, or threat of specific violence, or when a patient places his or her mental condition at issue in a civil suit.

If a subpoena, which is a valid court order, is served, the psychiatrist may be required to release the patient's records to a designated person, and the psychiatrist may also be required to give a deposition or court testimony as to his or her evaluation, course of treatment, or role in the legal matter. It should be noted that this process does not automatically make the treating psychiatrist's opinion expert evidence. To be an expert witness, the court must qualify the psychiatrist as an expert witness in the specific case before the court.

In the second instance, courts may choose from a panel of qualified professionals and appoint an expert to serve as a consultant; to evaluate records or an individual; or to provide consultation, reports, or testimony to the court in regard to a specific matter before the court. Child psychiatrists working in family and juvenile court matters are frequently appointed in this way. Psychiatrists are also chosen by agreement of the opposing attorneys, and a stipulated agreement is made to the court. The psychiatrist should request that this stipulation or court order include

- A statement of the appointment of the expert professional to proceed with the work
- The purpose of the evaluation, including persons to be evaluated and the scope of the evaluator's authority regarding collateral information

- The specification of the person to whom the report is to be made
- The method of payment of fees for the professional services rendered

As in any highly skilled and hazardous professional work, psychiatrists working in the forensic arena are entitled to reasonable and customary professional fees prevailing in their communities for those specific professional services. Fee schedules and methods of payment, including retainer fees, should be arranged in advance of the work provided. If a fee is dependent on the successful outcome of a case, the goal of objectivity and honesty is defeated. According to the Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1994), contingency fees are unethical.

In the third instance, litigants or their attorneys frequently contact forensic experts to become partisan experts for their particular side in a case. The work of the psychiatrist may fall under the duties and obligations of the attorney-client privilege, which is different from the doctor-patient privilege. This may present the psychiatrist with professional and ethical dilemmas that must be clarified with the contracting attorney, sometimes assisted by consultation with professional colleagues or with one's own attorney.

When a psychiatrist is engaged or appointed as a consultant or evaluator in a legal matter, it is essential that the persons being evaluated or interviewed be told and clearly understand the nature and purpose of the interview—it is not a confidential or doctor–patient privileged interview, and the information obtained may be used in a report, deposition, or testimony that the psychiatrist may be required to produce in the legal matter. The expert opinion developed by the forensic expert is rendered in the form of a written report, deposition, or court testimony.

A forensic report should include the following five elements:

1. How one was referred or became involved in the case
2. What the purpose was of the evaluation or the legal issues to be addressed (not an attorney's theory of the case)
3. What procedures were performed, including the dates and locations of interviews, documents reviewed, and collateral information obtained
4. What observations and findings were made
5. What conclusions—in the form of diagnosis, prognosis, opinions, and recommendations—were made based on what specific data and relative to the law and legal guidelines obtaining to the legal matter under consideration

The psychiatrist should clarify any questions or ambiguities regarding the relevant laws, procedures, or legal guidelines with the attorney involved in the case if that communication is appropriate, with the court if the expert is court appointed, or with the expert's own counsel if in doubt.

If a formal diagnosis is used in the report, it should follow DSM-IV-TR format and should be referenced as such (American Psychiatric Association 2000). In developing the expert opinion, the report should reflect the particular case data, relevant scientific knowledge, and applicable law or legal guidelines. The clinical data should show the mental, emotional, and psychological relevance to the legal issues at hand. The opinion should be articulated in a way that clearly reveals to the trier of fact the reasoning and formulation in the matter rather than a simple summary and conclusive opinion. The report should be comprehensive enough to cover the relevant topics, document what occurred, support the conclusions, and reflect the clinical judgment and reasoning, but it should not be so long as to become argumentative, jargonistic, boring, or unintelligible to the court.

A deposition provides court-ordered or subpoenaed testimony under oath to discover or preserve information to be used at trial or to ascertain information that might be used to impugn the credibility of a witness at trial. When an expert is sworn in to a trial, his or her qualifications are presented to be accepted by the court. Only after such acceptance is the direct examination and opinion rendered, followed by cross-examination by the opposing attorney. Redirect questions, recross questions, and sometimes the judge's own questions may follow.

An expert who is to testify in court should 1) be prepared; 2) be professional; 3) be precise; 4 anticipate adverse, hypothetical, and adversarial cross-examination; 5) speak to the finders of fact; and 6) be aware of personal, professional, clinical, and legal pitfalls and vulnerabilities, such as arrogance, ideological argumentation, countertransference issues, or ignorance of the legal and ethical directives and boundaries of the case.

Ethical Issues in the Clinician's Practice

The province of ethics is generally considered the study of moral principles and values that govern behavior rather than statutes or legal regulations. Unfortunately, ethical guidelines for conducting child and adolescent forensic consultations and evaluations have not been firmly established. Therefore, the child forensic psychiatrist must look to a patchwork of resources to find guidance on ethical dilemmas arising in his or her work. The American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry have established ethical standards; however, these standards are limited by the fact that they are based on the guidelines of the American Medical Association with its traditional physician–patient relationship and the hippocratic principles of beneficence and nonmaleficence, which do not exist in the forensic setting (Simon and Wettstein 1997). As described by Applebaum (1990, 1997), in forensic psychiatry no physician–patient relationship is established and the forensic psychiatrist acts not as a healer but as a provider of testimony in court to further the interests of truth and justice. More recently, the American Psychiatric Association has demonstrated an awareness of the critical need for ethical guidelines specific to the rapidly expanding field of forensic psychiatry. Although they are limited in scope, some forensic ethical issues are now addressed by the American Psychiatric Association in its *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (American Psychiatric Association 2001b) and in its periodic publishing of the *Opinions of the Ethics Committee on the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (American Psychiatric Association 2001a).

Despite the limitations in the code of ethics of the American Academy of Child and Adolescent Psychiatry, it is relevant and useful because it recognizes the special ethical tension present in a clinician's work with children and adolescents. The preamble to the code of ethics states, in part, "The [ethical] issues... must be viewed within the context of the overlapping and potentially conflicting rights of the child or adolescent, of the parents, and of society" (American Academy of Child Psychiatry 1980, p. 2) This tension between legal obligations and ethical responsibilities in the treatment of adolescents has also been highlighted by Berland et al. (1990) and Shields and Johnson (1992), who provide some guidelines for difficult clinical judgment. A landmark special section of the *Journal of the American Academy of Child and Adolescent Psychiatry* (1992) was devoted to ethical issues. Articles contained in this section highlighted the integrity and vigilance needed in clinical practice (O'Rourke et al. 1992) and the ethical and legal conflicts wrought by developing managed care systems and other constraints on the parameters of care imposed by third parties (Geraty et al. 1992); they further explored a variety of other general ethical issues in forensic psychiatry (Schetky 1992). Ethical principles governing research (Munir and Earls 1992) include, among numerous other specific considerations, guidelines for protection of children, appropriate risk–benefit analysis, informed consent and confidentiality issues, and issues regarding scientific integrity. Approaches to teaching ethics in child and adolescent psychiatry (Sondheimer and Martucci 1992) tend to focus on three distinguishing dimensions involved in the care and treatment of children:

1. The child is a minor and parental involvement is necessary to some degree.
2. The child's developmental maturation expands the capacity for understanding and judgment and responsibility for behavior.
3. The child is involved with school and perhaps other social agencies and institutions that require exchange of information and collaboration in the care and treatment efforts.

Perhaps the most significant and comprehensive contribution in this field was the publication of *Ethics and Child Mental Health* (Hattab 1994). This book assembles the work of 35 international child and adolescent mental health authorities and provides a cross-cultural perspective on the vexing ethical issues confronting professionals in their vast array of clinical work, research, and advocacy for children and families.

After the official recognition of forensic psychiatry as a subspecialty in 1992, the American Academy of Psychiatry and the Law (AAPL) established ethical guidelines applicable to general forensic evaluations and developed the AAPL Ethics Committee to assist district branch ethics committees in cases involving forensic psychiatry issues. Although they are lacking in guidance on many ethical issues unique to child forensics, the AAPL guidelines (American Academy of Psy-

chiatry and the Law 1995b) and the published opinions of the AAPL Ethics Committee (American Academy of Psychiatry and the Law 1995a) highlight useful general principles such as the importance of striving for honesty and objectivity in the consultation, avoiding role confusion and conflict of interest, obtaining fully informed consent, and protecting the examinee's privacy and confidentiality to the maximum extent legally possible. Other useful resources further elaborate on these topics (American Psychological Association 1994; Simon and Wettstein 1997) or provide more comprehensive overviews on the variety of ethical issues confronting the forensic psychiatrist (Rosner and Weinstock 1990). With regard to child and adolescent forensics, Schetky (2002a, p. 15) reviewed some important ethical principles and set the stage for further exploration.

Legal Issues in the Clinician's Practice

Although ethics codes govern the moral behavior in a clinician's practice, statutes define and regulate the business and legal aspect of his or her work. Clinical practice is a licensed professional business governed by statutes that define and regulate the nature of the practice as well as the duties and responsibilities of the practitioner (California Medical Association 2003; Caudill and Pope 1995). Professional business practices are subject to a variety of state, city, and county ordinances, as well as federal government regulating bodies such as the Drug Enforcement Administration, Medicare, and the Internal Revenue Service. States vary with regard to laws and rulings governing issues such as confidentiality; informed consent to various types of procedures and treatments; and duties to report, warn, or protect various individuals (Erikson 1995; Neinstein 1987). Clinicians should become familiar with the specific laws governing these issues in their state and locality.

■ Confidentiality, Privilege, and Duty

Although confidentiality and privileged communication in the healing arts have a long ethical tradition, they also are in fact duties and responsibilities created by state statutes to facilitate the communication, trust, and confidence that are necessary for a patient or client to attain health or improvement through seeking professional treatment. The term *confidentiality* refers to the clinician's obligation to hold in confidence information obtained from the patient in the course of the professional relationship. Confidentiality rules govern disclosure of a patient's information to any person other than the patient (Bernet 1998, p. 463). The legal right of confidentiality belongs to the patient and can be waived only by the patient except as provided for by statutory exceptions or court order (e.g., when there is a duty to report or a duty to warn or protect a specific third party or when the patient puts his or her own mental condition at issue in a lawsuit). This basic legal right of the adult person becomes complicated with the legal status of the minor and raises an issue as to who holds the right. In general, a parent legally entitled to authorize treatment for a minor child holds the legal right to full information disclosed by the minor (Macbeth 2002, p. 314). In addition, for most purposes, minors cannot consent to or refuse treatment (Ash and Derdeyn 1997). However, a general trend in the law has increasingly afforded adolescents the rights and responsibilities of adults (Ash and Derdeyn 1997), so psychiatrists must be alert to exceptions and must carefully review the statutes specific to each state. Some jurisdictions now allow minors to hold confidentiality rights based on their age or their ability to consent to certain treatments on their own. In 1990, a California appellate court upheld the principle that even if the patient is a minor, that patient is still the holder of the psychotherapist–patient privilege (*Silva v. Haney* 1990). The increasingly common situations of separation and divorce further complicate this issue. Traditionally, the parent with legal custody held the right, but laws have shown an increasing trend toward protecting the rights of the noncustodial parent to such information (Macbeth 2002, p. 315).

Regardless of whether the parent or the minor holds the right, a clinician may have a legal duty to breach confidentiality, to report the condition to the designated persons or authorities, and to take appropriate actions to restrain the patient and protect others from danger of violence if a patient presents an imminent physical danger to self or others or makes a specific threat of violence against a particular person. Clinicians should familiarize themselves with the specific procedures for notifying authorities and providing involuntary evaluation and treatment in their particular jurisdiction (Caudill and Pope 1995).

During the past two decades, public policy in the

form of legislative enactments and appellate court decisions has tended to shift the scope of duty that requires licensed clinicians to supersede the obligations of confidentiality in favor of duties to report abuse, neglect, or threat of violence. In the landmark case on the duty to protect (*Tarasoff v. Regents of the University of California* 1976), the California Supreme Court ruled

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending on the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever steps are reasonably necessary under the circumstances. (p. 425)

Subsequent appellate court and various state statutes have attempted to define the nature of the dangerousness, its predictability, and procedures for warning or attempting to protect individuals from the threats of dangerous behavior. It appears that the trend is not to require therapists to predict dangerousness or violence in general but rather to impose the duty to protect specifically identifiable individuals who are intended victims by warning them and local police authorities of specific threats of violence. In reference to the behavior of minors in this regard, a California appellate court (*Thompson v. Alameda County* 1980) ruled that a history of delinquent or violent behavior reflecting nonspecific threats of violence not against specific identifiable victims does not give rise to a duty to warn or a duty to protect the community at large.

Makers of public policy continue efforts to balance the rights of patients' privileged communication against the need for disclosure to protect the public, to protect disturbed individuals from themselves, or to protect vulnerable individuals from abuse or neglect by persons responsible for their care. The Child Abuse Prevention and Treatment Act of 1978 provided incentives for states to develop statutes addressing child abuse and neglect. By the early 1980s, each state had in place detailed statutes setting forth specific definitions of reportable conditions, including sexual abuse, sexual assault, sexual exploitation, neglect, maltreatment, willful cruelty, unlawful or unjustifiable corporal punishment, and abuse in out-of-home care (ten Bensel et al. 1985). These statutes (e.g., California Penal Code No. 11165 et seq.) are very specific with regard to the duty of licensed professionals to report what they "know or reasonably suspect" to the locally designated child protective agency, immediately or within a specified time frame. The statutes are equally specific regarding the mode of reporting the suspected abuse or neglect and the duties, procedures, protections, and immunities of the various parties and agencies (California Medical Association 2003; Caudill and Pope 1995). These statutes provide for the conditions of immunity to the licensed professional regarding mandatory reporting, as well as misdemeanor penalties for failure to report. Civil suits against professionals for failure in their duty to report and protect minors have been successful.

Finally, a court may mandate disclosure of confidential information and require the clinician to disclose privileged communication in certain legal proceedings. There is much overlap between the rules of confidentiality and those of privilege, but privilege rules apply more specifically to the disclosure of confidential information in judicial, quasi-judicial, and administrative proceedings. Rules and exceptions to confidential rights and privileges vary between different states, so clinicians should familiarize themselves with the relevant statutes in their jurisdiction. In cases arising under federal law, the federal courts uniformly recognize a psychotherapist–patient privilege (*Jaffe v. Redmond* 1996); however, the scope and limits of this privilege and its exceptions are still evolving in appellate court decisions (Nelken 2000). Frequent exceptions to privileged communication between a psychiatrist and his or her patient include commitment proceedings, will contests, criminal matters, child custody cases, and implicit or explicit waiver of the privilege by the patient or the person authorized to act on his or her behalf (Macbeth 2002).

■ Informed Consent and Competence

In law, a competent person's prior consent is required before any medical procedure or treatment is undertaken, based on the principle of the patient's right of self-determination. In general, when the patient is a minor, the consent of the parent(s) or legal guardian is required for consultation, evaluation, treatment, or release of information for the minor child unless there are statutory or appellate court exceptions, which are increasingly numerous and varied. Furthermore, the leading appellate court case in the area of consent

(*Cobbs v. Grant* 1972) requires that patients be given sufficient information about complicated procedures to make an informed choice. In clinical practice, informed consent requires several elements, including the following:

- The clinician must inform the patient of the nature of the condition and the recommended treatment, including potential benefits, risks, and potential serious harm explained in layperson's terms. Alternatives to the recommended treatment along with their risks and benefits should also be given.
- The patient's choice is voluntary and is not coerced by the providers of the service.
- The patient has competence and capacity to consent.

In addition to statutory definitions and case law interpretation, the professional practice standard prevailing at the time and in the community is the standard of proof for matters involving informed consent (*Arato v. Avedon* 1993).

Informed consent from the parent(s) or legal guardian for minors should be reflected in the medical records and should include indications for the use of the medication relative to the patient's condition, potential short- and long-term effects, possible side effects, and specific consent for the administration of the medication. As part of obtaining consent for the treatment plan, there should be an explanation of the nature of and necessity for the privileged communication between patient and therapist and, where appropriate, an articulation of the legal requirements that set forth when confidentiality must be broken and when information about abuse or threat or danger to self or others must be reported by the therapist to specific persons or agencies.

In considering a minor's competence to consent to treatment, states provide various statutory exceptions to the general requirement of parental consent. In most jurisdictions, emancipated minors can consent to their own treatment. These include minors who are older than age 15, living away from parents, and economically self-sufficient; married (or divorced) minors; minors on active duty in the United States armed services; and minors who have been emancipated for cause with a specific court order. A "mature" minor or one whom the courts determine is sufficiently mature to appreciate the nature, extent, and consequences of the medical treatment may also consent to his or her own treatment (*Cardwell v. Bechtol* 1987). Following a general trend in the direction of treating minors more as adults, state legislatures are also allowing minors to consent to specific types of medical and psychiatric treatment such as treatment related to sexual behavior (abortion, birth control, sexually transmitted diseases) and time-limited outpatient mental health treatment (Ash and Derdeyn 1997).

The issue of informed consent with minors is problematic because minors may not have sufficient maturity, understanding, or worldly exposure to make an informed judgment about the nature of the condition, complicated procedures, or potential consequences. Explanations should be adapted to their level of comprehension and ability to consent. As a practical matter, psychiatric consultation, evaluation, and treatment with most children and adolescents usually takes place in the interactive context of involvement and consent of the child and parents (or legal guardian), who have usually arranged for the initial consultation and evaluation and who participate in the treatment planning and pay for the services.

■ Civil Commitment

The occasional clinical necessity for hospital treatment of seriously disturbed children and adolescents may bring their rights to liberty and self-determination into conflict with the rights, responsibilities, and duties of parents, legal guardians, and state agencies. Clinical guidelines (American Academy of Child and Adolescent Psychiatry 1989) for such hospitalization includes 1) a qualified psychiatrist's evaluation; 2) diagnosis by DSM criteria; 3) severity of impairment in two or more areas of daily functioning; 4) likelihood of benefit from the proposed treatment; 5) prior consideration of less-restrictive treatment procedures and the judgment that they are inappropriate or inadequate to meet the patient's needs; 6) the child's encouragement to voluntarily participate in the admission, treatment planning, and discharge process; and 7) parents' full information about and participation in the hospitalization and treatment planning decisions.

In the governing U.S. Supreme Court case regarding hospitalization of minors (*Parham v. J.R.* 1979), the right of parents to seek and secure hospital treatment for their minor children was affirmed, provided that independent medical reviews—and not necessarily an adversarial due process legal review—confirm the nature of the illness and the likelihood of benefit from

the proposed treatment. Moreover, this independent medical review must have the power to deny admission if medical standards and legal requirements are not met. In addition, the youth has the right to periodic reviews of treatment procedures and of the hospital confinement. The findings in *Parham* were subsequently extended to a Pennsylvania case, *Secretary of Public Welfare of Pennsylvania v. Institutionalized Juveniles* (1979), in which the Supreme Court decided that the *Parham* procedural safeguards offered sufficient protection of the minors' "liberty interests." However, the Court also concluded that parents cannot waive the rights of minors to due process civil commitment procedures and that minors have the right to challenge the psychiatric diagnosis within 72 hours and a right to a formal adversary hearing within 14 days of hospitalization.

States can afford more extensive due protections than those required in *Parham v. J.R.* (1979). In a California Supreme Court case, *In re Roger S.* (1977), the court gave minors age 14 and over the following procedural safeguards: entitlement to administrative hearing by a neutral fact finder before commitment, notice of the reasons for the proposed action, right to counsel, the opportunity to present evidence and cross-examine witnesses, and proof by a preponderance of the evidence that the minor has a mental illness and will be benefited by the treatment.

■ Professional Liability

During the past two decades, the increase in claims and awards for professional malpractice has not bypassed psychiatrists and other mental health providers. Because of recently expanding case law and legislation in matters such as psychic trauma and legal liability, mental health professionals are increasingly vulnerable to claims and suits based on matters such as abandonment of patients, battery, breach of confidentiality or duty, failure to follow established or community standards of care, failure of duty to report or protect against harassment or abuse of patients, negligence, improper treatment, wrongful injury, or other alleged violations of federal or state laws regarding professional responsibilities and practice.

In accordance with the principles and precedents of tort law or civil wrongful behavior rather than of criminal behavior, a professional practitioner may be liable for behavior that unintentionally resulted in harm or injury to a patient or to a third party that could have or should have been reasonably prevented. The essential elements of professional negligence or malpractice are sometimes referred to as the four *D*'s of negligence:

- Duty—a duty of care was owed to the patient by the physician.
- Dereliction—the duty of care was breached.
- Damages—the patient experienced actual damage due to the breach of duty.
- Direct causation—the dereliction was the direct cause of the damages.

The plaintiff's case must demonstrate these elements to the trier of fact, whereas the defense attempts to demonstrate that one or more of these elements did not or could not have occurred according to the standard of care prevalent in the community at the time. The standard of proof in malpractice cases is preponderance of evidence (i.e., more likely than not). As concepts regarding civil liability have been expanding (Guyer 1990), mental health professionals involved in civil litigation are increasingly involved in the evaluation, treatment, and damage assessments regarding other plaintiffs and defendants (Schetky and Guyer 1990). By the same processes, mental health professionals are having their own professional procedures and behaviors scrutinized for negligence or breach of duty and may find themselves vulnerable to claims for inadequate evaluations, failure to obtain informed consent, or a myriad of other improper actions or omissions. Residency training programs in child and adolescent psychiatry have also been successfully sued for patient mismanagement and other claims involving faculty and trainees (Wagner et al. 1993).

The increasing involvement of mental health professionals in child sexual abuse cases and a growing body of literature on repressed memories and the suggestibility of child witnesses has fueled the emergence of new areas of litigation. One evolving area of litigation involves third-party claims brought by parents against their child's therapists. In 1994, a California superior court allowed a father to successfully sue his daughter's therapist for negligence and intentional infliction of emotional distress after the therapist had suggested memories of sexual abuse to the daughter and encouraged her to confront the father (*Ramona v. Isabella* 1994) The court found that the therapist owed a duty of care to the parent because he was involved in the therapy of the child and had become a client along with the daughter. However, in *Althaus v. Cohen* (1998),

the court found no such duty of care to the parents of an alleged victim of abuse because it would create a breach of the therapist's fundamental duty to her patient and would destroy the therapeutic process. Other new areas of litigation involve claims for implanting false memories of abuse and attempts to overturn previous convictions based on the suggestibility of child witnesses (*Commonwealth of Massachusetts v. Amirault LeFave* 1999). This is a new and evolving area of case law, and the full impact of these decisions is yet to be known.

Another rapidly emerging area of ethical and legal vulnerability for mental health professionals involves the cost-containment purposes of managed care overriding the independent clinical judgment of attending physicians with regard to patient-care decisions. When a managed care company denies coverage for a service for "lack of medical necessity," the physician has four duties: First, the physician should appeal the decision (*Wickline v. California* 1986). Second, the physician should discuss the issues raised by the managed care company with the patient. The patient should be informed that the insurer has refused to pay and that the patient has the option of paying out-of-pocket or appealing the decision. Third, there is always the duty to treat the patient in an emergency, even without payment. Fourth, the physician should develop alternative treatment plans in the face of the denial of a preferred treatment plan by the managed care company.

■ Child Custody and Divorce

In the past generation, there has been an increase in divorce, remarriage, single-parent families, stepparenting families, and alternative families (Shiono and Quinn 1994). As a result, there is perhaps no issue at the interface of psychiatry and the law that has grown more in volume, permutations of detail, and hostile conflict than the law in regard to child custody, child access, and perhaps parental responsibility and financial obligations (Hyde 1984). This has occurred in the context of the recently burgeoning social science research data on children and families undergoing the process and effects of divorce, especially high-conflict custody divorce cases, which pose a significant workload for the courts (Behrman 1994; Hetherington 1989; Kelly 1988, 2000; Roseby and Johnston 1998; Wallerstein 1991).

The legal doctrine of the best interests of the child is the current guiding principle in deciding child custody disputes (Nurcombe and Partlett 1994, p. 91). The model legislation of the Uniform Marriage and Divorce Act approved by the American Bar Association in 1974 (Group for the Advancement of Psychiatry 1980) contains a section regarding the best interests criteria. According to the relevant section (Section 402), the court shall determine custody in accordance with the best interests of the child and shall consider all relevant factors, including the wishes of the parents and the child; the interactions of the child with those who may significantly affect his or her best interests; the child's adjustment to his or her home, school, and community; and the mental and physical health of all individuals involved (Group for the Advancement of Psychiatry 1980; Nurcombe and Partlett 1994, p. 92).

The majority of states have adapted their statutes (either wholly or in modified form) from the concept and language of the Uniform Marriage and Divorce Act. For example, California Family Code, Section 3011 et seq., concerning the custody of children, provides, in part, "it is the public policy of this state to assure minor children frequent and continuing contact with both parents...and to encourage parents to share the rights and responsibilities of child rearing." In awarding child custody, the court makes a determination in the best interests of the child, considering—among other factors it finds relevant—the health, safety, and welfare of the child; allegations of abuse and neglect; and the habitual or continued illegal use of controlled substances or the continual abuse of alcohol (California Family Code 3011). "The court shall also consider, among other factors, which parent is more likely to allow the child frequent and continued contact with the noncustodial parent...and shall not prefer a parent custodian because of that parent's sex" (California Family Code 3040). Family Code 3042 also states, in part, "if a child is of sufficient age and capacity to reason so as to form an intelligent preference as to custody, the court shall consider and give weight to the wishes of the child in making an order granting or modifying custody."

Despite the general acceptance of the "best interests" principle (Goldstein et al. 1996), the concept remains ambiguous and indeterminate, leaving judges with wide discretion to interpret it in a variety of ways. As a result of this vagueness, the courts have increasingly relied on the expertise of child mental health professionals to assist in the determination of best interests (American Academy of Child and Adolescent Psychiatry 1997b). To promote and maintain stan-

dards of care and assist those engaged in this specialized work, guidelines for evaluating child custody disputes have been published by the American Psychological Association (1994), the American Association of Family and Conciliation Courts (1994), the American Psychiatric Association (1988), and the Judicial Council of California (2002). A number of mental health professionals have also published important guiding principles (Bernet 1998; Herman 1999).

While clinicians and court personnel struggle to ascertain and articulate the "best interests of the child" in any particular case, they may be guided by the commentary of the California Supreme Court's perception (*In re Marriage of Carney* 1979) that

> The essence of parenting...lies in the ethical, emotional, and intellectual guidance the parent gives to the child throughout his formative years, and often beyond. The source of this guidance is the adult's own experience of life; its motive power is parental love and concern for the child's well-being; and its teachings deal with such fundamental matters as the child's feelings about himself, his relationships with others, his system of values, his standards of conduct, and his goals and priorities in life (p. 739).

The application of such wisdom requires careful clinical observation and judgment in the exceedingly complex labyrinth of child custody evaluations and procedures (Ames and Huntington 1991; Ash and Guyer 1986; Herman 1990; Kelly 1991).

Current social forces have engendered special issues in child custody disputes that complicate the evaluation and present additional challenges to the forensic expert. The special issues involve a diverse range of topics such as infant placement and custody (Horner and Guyer 1993), homosexual parenting, rights of stepparents and grandparents, parental kidnapping, the mentally ill parent, sexual abuse allegations, parental relocation (Shear 1996), and controversies arising from advances in reproductive technologies (Bernet 1998; Herman 1990; Nurcombe and Partlett 1994). The highly controversial issue of alienation in children of divorce is currently being reformulated (Kelly and Johnston 2001).

The emotionally charged topic of homosexual parenting is particularly complex and challenging. The mental health literature on homosexual parenting appears to suggest no appreciable differences in parenting abilities or in the psychological health and sexual orientation of the child (Binder 1998). Despite these findings in the literature, legal jurisdictions have taken varied approaches to the issue. Some jurisdictions equate homosexuality with parental unfitness, whereas other jurisdictions have opposed the use of sexual orientation in determining the outcome of visitation or custody disputes (*In re Birdsall* 1988).

Grandparents, stepparents, and other third parties are increasingly seeking visitation rights or custody of children. States vary in their approach to these issues. With regard to stepparents obtaining custody of a child, the general trend in the courts appears to favor the natural parent over the nonbiological parent unless "clear and convincing evidence" (Herman 1990) or "exceptional circumstances" (Herman 1990) support placement with the nonbiological parent. All 50 states have enacted some form of grandparent visitation legislation, but the visitation statutes vary in their degree of permissiveness (Scott 2000). In a recent ruling on this controversy, the U.S. Supreme Court (*Troxel v. Granville* 2000) concluded that the broad language of a Washington State visitation statute allowing "any person" to petition for visitation rights "at any time" unconstitutionally infringed on the parents' "fundamental right" under the Fourteenth Amendment to raise their family free from governmental interference (*Troxel v. Granville* 2000). Future cases will likely continue to attempt to define the boundary between parental autonomy and the state's authority to impose visitation or custody rights of stepparents, grandparents, and other third parties in furthering the best interests of the child.

A tragic outcome of child custody disputes is the serious problem of parental kidnapping. An underground network has even developed to assist parents who are fleeing with their children from what is perceived as an unjust legal system (Herman 1990). Schetky and Haller (1983) reviewed the agonizing conflicts created in the child, the legal aspects of the problem, and attempts to deal with the issue. The forensic examiner confronted with this type of case should be familiar with the relevant state laws, federal laws (Uniform Child Custody Jurisdiction and Enforcement Act and the Parental Kidnapping Prevention Act) and international agreements (1988 International Child Abduction Remedies Act and the 1980 Hague Convention on the Civil Aspects of International Child Abduction) that provide some procedures and sanctions to address this issue (Weiner 2000).

Regardless of whether the evaluation involves general issues or more complex situations as described previously, the examiner should be prepared to deal

with a potentially high-conflict, emotionally intense process. Divorcing parents are often dissatisfied with the adversarial nature, high costs, and inefficiencies of the court system involved with divorce litigation (Pruett and Jackson 2001). Studies have also shown significant negative outcomes on child and parent from the adversarial process (Kelly 2000).

Mediation provides an important alternative to the adversarial process and has increased in availability and utilization in the past decade (Kelly 2000). In several states—including California, Maine, New Mexico, Connecticut, and Maryland—mediation is mandated by the court before custody litigation begins (Herman 2002). The process of mediation differs in the legal jurisdictions throughout the country, but the current literature suggests increased overall satisfaction among the involved parties and more frequent joint custody and cooperation between parents (Ash and Derdeyn 1997).

The child custody evaluator should be knowledgeable about the two usual outcomes of a custody dispute—that is, joint custody or sole custody—and the potential effects of these outcomes on the child. In joint legal custody, both parents have legal decision-making powers regarding the child. In joint physical custody, the parents have responsibility for co-parenting. In sole custody, one parent has this power. Current literature reflects a lack of consensus on the best custody arrangement for children (Binder 1998), but relevant research studies support certain generalizations on this topic. Interparental conflict, the psychological health of the parents, and the quality of parent–child relationships appear to be among the most important predictors of a child's adjustment to divorce (Ash and Derdeyn 1997; Kelly 2000). High levels of interparental conflict—whether in the conflict of the marriage or in high-conflict divorce situations—appear to have an especially negative influence on the psychological adjustment of children (Roseby and Johnston 1998). The effect of the parent's and child's gender on postdivorce adjustment is another increasingly important area of study. The literature appears to suggest that girls are less well adjusted in families with father and stepfather custody, and boys are less well adjusted in mother-custody families (Binder 1998). Furthermore, in mother-custody families, boys may have improved adjustment with regular paternal contact, provided the father is reasonably healthy (Binder 1998).

Child custody evaluations involve a dynamic, exceedingly complicated area of family law. In May 2000, the American Law Institute approved a project called the Principles of the Law of Family Dissolution to examine the present state of legal development in this area of the law; to clarify underlying principles; and to suggest future direction for public policy in the issues of dissolution, child and spousal support, property division, and custody of children (Kay 2000). Twenty-first-century lawmakers should consider the proposed legal framework and standards as they continue to address the constant challenges and complexities of this rapidly evolving area of the law.

■ Child Abuse and Neglect

The apparent incidence of child abuse and neglect has dramatically risen since the passage of the Child Abuse Prevention and Treatment Act in 1978 (Larner et al. 1998). After implementation of the federally mandated guidelines, all states passed laws requiring designated persons to report child abuse and neglect (Nurcombe and Partlett 1994, p. 137). Reporting of allegations continues to rise as a result of this federal legislation and increased media attention (Quinn 2002). Failure to report can result in civil liability for negligence and malpractice (*Landeros v. Flood* 1976) or even in criminal penalties as specified by statutes (Nurcombe and Partlett 1994, p. 138). The mandated reporting is an exception to confidentiality, and the reporter is granted immunity from suits for negligence or defamation if the suspected case of abuse is reported in good faith (Quinn 2002). State laws vary in their legal definition of terms related to the maltreatment of children, so clinicians should familiarize themselves with the statutes in their specific jurisdiction. Variability is especially wide in sexual abuse definitions, in which the age of both the child and the perpetrator as well as their relationship determines the nature of the offense and the penalties involved (Quinn 2002).

In child maltreatment cases, the forensic evaluator can perform a variety of functions, including assessment of the nature and extent of harm to the child; evaluation of parental fitness; and recommendations regarding placement, treatment, or termination of parental rights (American Academy of Child and Adolescent Psychiatry 1997c). The forensic evaluation may be used in a variety of legal proceedings, including criminal prosecution, dependency and guardianship actions, custodial dispute, termination of parental rights, and tort litigation (Barnum 1997).

To address questions related to the nature and extent of harm, the forensic examiner should familiarize himself or herself with the clinical patterns associated with child maltreatment. Several authors have provided reviews of the most recent literature regarding the clinical patterns, differential diagnosis, and long-term consequences associated with child abuse and neglect (American Academy of Child and Adolescent Psychiatry 1997c; Bernet 1993; Kaplan et al. 1999; Nurcombe and Partlett 1994). In addition to the clinical patterns of physical abuse, sexual abuse victims manifest a wider and greater frequency of inappropriate sexual behaviors than nonabused children (Bernet 1998). Although physical and sexual abuse have been the focus of most studies, emotional maltreatment is likely the most frequent form of abuse and neglect, with the strongest relationship to long-term psychological functioning (Kaplan et al. 1999). However, relevant studies are lacking because of the perception that it is less damaging than physical and sexual abuse (Kaplan et al. 1999).

Assessment of parental capacity and prognosis is a challenging task, because a clinical consensus on this standard remains to be developed. Barnum (2002), providing the most recent guidance on this issue, offers a theoretical framework for understanding parenting, discusses the impact of developmental issues and parental strengths and weaknesses on parenting capacity, and describes specific techniques for assessment. Clinical opinions regarding this issue will be central to the adjudication and disposition of a child maltreatment case. Based on the findings, the juvenile court may decide to return the child home with further diagnostic or therapeutic interventions or commit the child to custody of the state with a requirement of home-based services and periodic reports to the court (Nurcombe and Partlett 1994, p. 143). However, if parents are deemed incapable of providing a safe environment for the child, the child may be removed from the home and placed in foster care or institutional care with plans for eventual reunification (Wasserman et al. 2002).

Foster care is an increasingly utilized temporary placement option for the child who is removed from the home. Social policy and increasing prevalence of substance abuse, human immunodeficiency virus infection, and homelessness in the late 1980s led to a dramatic increase in the foster care population (Wasserman et al. 2002) and growing concern for the future welfare of these children. Appropriate consultation in these cases requires awareness of the complexities in the system and an understanding of its potential impact on the child. For example, numerous studies have described the difficulties in this population of children, including physical problems, psychological and emotional issues, and academic difficulties (Rosenfeld et al. 1997). The emotional impact of the parent–child separation on the child, contradictory demands on the biological and foster parents, and a system that lacks the resources to address the special needs of this population create an especially difficult situation for a child who already has problems (Rosenfeld et al. 1997). Yet despite this negative perspective, evidence also indicates that foster care can have positive outcomes, including improved health, social functioning, and academic performance (Rosenfeld et al. 1997). The literature also suggests that certain risk factors (e.g., poverty, alcoholism, parent mental illness, low education) and protective factors (e.g., intelligence, positive emotional ties, external support system) likely influence the outcomes of a child's foster care experience (Rosenfeld et al. 1997). Numerous confounding variables make definitive conclusions on this issue difficult. However, the government and social agencies have made some efforts to improve the plight of these children. To address concern about the lack of stable, healthy, consistent attachments in this population, the federal government enacted the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) "to end the drift of children in foster care and encourage plans for permanency." The law mandates social agencies to make "reasonable efforts" to help the biological family remedy the issues leading to removal of the child and, in case family reunification efforts fail, to begin permanency plans within 18–20 months of foster care placement (Rosenfeld et al. 1997, p. 449). Other promising developments include the increasingly popular use of kinship care and therapeutic foster care programs (Rosenfeld et al. 1997; U.S. Public Health Service 2000, p. 176; Wasserman et al. 2002). Unfortunately, positive changes in the foster care system are undermined by a managed care system that seeks to decrease child welfare expenses. Ultimately, public policy makers will have the difficult if not impossible task of allocating diminished resources to provide high levels of special care for a growing population in an already overburdened system.

Although the law mandates that reasonable efforts be made to encourage reunification with the family, the state is entitled to petition for termination of pa-

rental rights if family reunification has failed and the child has been in foster care for 18 months (Adoption Assistance and Child Welfare Act of 1980, P.L. 96-272). Certain crimes (e.g., murder, rape, sexual abuse) even warrant the automatic pursuit of termination of parental rights (Schetky 2002d). The legal standard for termination of parental rights is *clear and convincing evidence* (*Santosky v. Kramer* 1982). Nurcombe and Partlett (1994, p. 147) and Schetky (2002d) described specific criteria to be considered in termination proceedings such as the child's need for permanency, continuity of relationships with siblings and extended family members, special needs of the child, quality of the parent–child relationship, and capacity for attachment and adoptability. The forensic examiner should also be familiar with the various possible outcomes of termination proceedings, including long-term foster care; legal guardianship; emancipation; and closed, open, or kinship adoptions (Schetky 2002d).

The Child as Witness

Because of a frequent lack of physical corroboration, allegations of sexual abuse often require a child's testimony. This is less likely to be the case in allegations of physical abuse because the physician can testify to the abuse based on his or her observations or a medical diagnosis of the battered child syndrome. In sexual abuse cases, the child's testimony can be critical to determining the likelihood of sexual abuse.

A number of widely publicized cases of allegations of sexual abuse in the 1980s and 1990s led to much research on the accuracy of children's memory and the reliability and suggestibility of their statements. From a developmental perspective, the literature suggests that memory—especially short-term memory—and retention begin to exist functionally at age 3, undergo a major developmental shift at age 6, and continue to improve with age (Clark 2002, p. 130). Although research has shown that children are capable of accurately recalling information, studies also indicate that they are highly susceptible to suggestion (American Academy of Child and Adolescent Psychiatry 1997c; Ceci and Bruck 1993). There appear to be significant age differences in suggestibility, with preschool children being disproportionately more vulnerable to suggestion than either school-age children or adults, but the age differences are a matter of degree (American Academy of Child and Adolescent Psychiatry 1997c; Ceci and Bruck 1993). Even adults are susceptible to suggestion, as evidenced by research on the phenomena of "recovered memories" and "repressed memories" (Corelli et al. 1997). The negative consequence of suggestive interviewing techniques includes errors about the source of the information as well as major details of the peripheral and central events, such as falsely reporting that a person had touched their private parts (Bruck and Ceci 2002, p. 139). Several significant contributors to this literature include Loftus (1997), Loftus and Pickrell (1995), and Poole and Lindsay (1995, 2001).

These controversies have led to a large body of literature on the appropriate assessment of allegedly abused children, including appropriate interview techniques to minimize bias and distortion (American Academy of Child and Adolescent Psychiatry 1997c; Bernet 1998). In general, the current literature suggests that interviewers should start with an open-ended question; progress to more focused questions if necessary; and avoid leading questions, repetitive questioning, questions promoting speculation or fantasy, and manipulation of the emotional tone to direct the interviewee (Ceci and Bruck 1993; Schetky and Benedek 2002, p. 154). These studies suggest that memory appears to be most accurate when elicited through free recall without the use of cueing, leading questions, suggestive interviewing, or multiple interviews. Trained child clinicians will find their knowledge of child development most valuable in these interviews, because children have age-related differences in memory, cognitive abilities, language skills, range of experience, and emotional maturity.

The child's credibility is ultimately determined by the judge or jury and not the forensic expert. However, the forensic expert may give expert testimony on this topic. Several authors have described factors that can assess the credibility of a child (American Academy of Child and Adolescent Psychiatry 1997c; Benedek and Schetky 1987a, 1987b; Green 1986; Nurcombe and Partlett 1994, p. 172; Raskin and Esplin 1991). Some of these factors include spontaneity of statements, age-appropriate terminology, general consistency in statements, appropriate affect, and consideration of motivational factors (such as in divorce-related circumstances) (American Academy of Child and Adolescent Psychiatry 1997b; Derdeyn et al. 1994). However, studies have shown that even well-trained professionals cannot reliably differentiate between true and false

reports when these reports have been influenced by suggestive interviewing techniques (Ceci and Bruck 1993). This may be explained by the current scientific literature, which suggests that memory is constructive rather than reconstructive in nature and that retrieval is influenced by current attitudes, feelings, and beliefs (Corelli et al. 1997). Therefore, the factors for assessing credibility cannot be used definitively to determine whether abuse has occurred.

A child's testimony is only valuable if he or she is competent. *Competence* refers to the child's ability to testify in court in a reliable and meaningful manner. Several authors have contributed to the literature on this topic (American Academy of Child and Adolescent Psychiatry 1997c; Nurcombe and Partlett 1994, p. 168). In general, a child's competence is determined by four criteria: the capacity to register the event, the ability to accurately recall and recount the event, the ability to distinguish truth from falsehood, and the capacity to communicate based on personal knowledge of the facts (Nurcombe and Partlett 1994, p. 169).

The evaluation and prosecution of maltreatment cases may subject the child victim to multiple assessments and evaluations in home, school, clinical, or police settings (Arthur 1986) and may require the child to participate in depositions and pretrial hearings and to testify in court as a witness (Office of Juvenile Justice and Delinquency Prevention 1994). In addition to child protective services and juvenile court dependency proceedings, these evaluations and sometimes the child's own testimony as a witness may be required in criminal proceedings against the perpetrator, as well as in civil litigation for claims of psychic damages. There has been concern about the effect of this process on the child witness because of the child's particular level of cognitive and emotional development. A number of suggestions and attempts have been made to reduce the number of evaluations and to modify prosecutorial procedures (Arthur 1986; Office of Juvenile Justice and Delinquency Prevention 1994). The precedent-setting U.S. Supreme Court decision in this area (*Wheeler v. United States* 1895) indicated that a 5-year-old boy "was not by reason of his youth, as a matter of law, absolutely disqualified as a witness" and further ruled that the question of competence "depends on the capacity and intelligence of the child, his appreciation of the difference between truth and falsehood, as well as his duty to tell the former" (p. 254).

During the past decade, the U.S. Supreme Court has decided eight cases that balanced the best interests and cognitive and emotional capabilities of a child witness against the constitutional rights of defendants to protections against self-incrimination (Fifth Amendment), the right to confront and cross-examine witnesses (Sixth Amendment), and due process (Fourteenth Amendment) (Kermani 1991, 1993). In the most recent decision in this series (*White v. Illinois* 1992), the court recognized what amounts to a specific hearsay exception: The testimony of a physician was admitted and did not violate the defendant's Sixth Amendment rights because the child's statement to the physician was "a spontaneous declaration" made to the physician for the purpose of medical diagnosis and treatment. Clinicians working in this area should be aware of additional state and local jurisdiction rulings and of current standards of assessment related to the particular case and status of the child witness.

Youth Violence

The current surge in youth violence in the United States has permeated the national consciousness and media and has prompted school administrators, law enforcement officials, policy makers, and mental health professionals to more closely examine this complex issue. The forensic psychiatrist may serve as a consultants in risk assessment, risk management, and prevention of violence.

A growing body of literature has recently developed, beginning with the neurodevelopmental impact of violence in childhood. Results of the studies suggest that exposure to violence and trauma and the neurophysiological adaptations to this exposure can alter normal development of the child's brain and can lead to changes in physiological, emotional, behavioral, cognitive, and social functioning (Perry 2002, p. 192). Children raised in violent communities or in homes with chronic parental violence appear to be at higher risk for psychiatric disturbances, delinquent behavior, and an increased likelihood of becoming perpetrators of aggressive and violent behavior themselves (Perry 2002, p. 208). A large number of studies on the impact of media violence on children reveal that it increases risk for aggressive behavior (Singer et al. 1998), desensitizes youths to violence in the real world (American Medical Association 1996), creates a perception of the

world as a dangerous and unfriendly place (Singer et al. 1998), and potentially leads to greater risks of psychological and social problems (Singer et al. 1998). However, not all children are similarly affected by violence, and protective factors such as the parent–child relationship and age have also been described (Al-Mateen 2002, p. 220).

The wave of school shootings in the mid and late 1990s fueled a growing concern about school violence and led to much inquiry about risk assessment and prevention of violence in children and adolescents. A growing body of literature has attempted to identify factors associated with aggressive, violent, antisocial, or delinquent behavior. Disruptions in early development, abnormal neurotransmitter levels, mental illness, learning disabilities, exposure to violence, certain parenting styles, substance use, neurological impairment, and socioeconomic class are among some of the causal factors implicated in an increased risk of delinquent or aggressive behavior (Schetky 2002c, p. 234). The wide diversity of the associative factors speaks to the complexity of this issue and may explain why clinicians face a daunting task when trying to identify youths at high risk for violence. Several authors have discussed the limits of the ability to make long-term predictions of violence and have offered more realistic approaches to the problem, such as more ongoing involvement with high-risk students; more frequent assessments targeting risk of imminent danger (rather than long-term predictions); and the creation of a supportive, positive school environment with good communication between school administration and students (Mulvey and Cauffman 2001).

The heightened awareness of school violence has prompted school administrators, policy makers, and mental health professionals to implement a variety of prevention and intervention programs. Schetky and Benedek (2002, p. 239) and Pittel (1998) delineated guidelines for taking a violence and weapons history. Some of the preventive programs that have resulted in positive outcomes include conflict resolution, interpersonal problem-solving techniques, bullying reduction programs, supervised recreation after school hours, mentoring programs, parent management training, and family therapy (U.S. Department of Health and Human Services 2001). Because all of these described programs have practical and methodological limitations that curtail their effectiveness, further research is warranted.

Dependency, Delinquency, and the Juvenile Court

The juvenile court system in the United States originated as a result of the progressive and reform movements at the end of the nineteenth century. The system was seen as a way to move minors out of the adult criminal justice system and into specialized procedures and programs to meet their best interests and rehabilitative needs. This specialized system was developed in every state through enabling legislation that established a local county court with original jurisdiction over the care, rehabilitation, treatment, supervision, and disposition of minors who came to the attention of the juvenile court for the following reasons: 1) dependency, neglect, or abuse; 2) incorrigibility or truancy, now called status offenses; or 3) delinquency offenses, that is, violation of laws that if committed by an adult would be subject to the jurisdiction of the criminal court.

The prevailing concepts of parens patriae in common law provided the justification for the development of this juvenile court and probation system, which exercised responsibility for minors who violated the law, were not properly cared for, or could not otherwise exercise proper control over themselves. Juvenile courts in each county (Edwards 1992; Guyer 1985) had wide discretion, latitude, and encouragement to act in an informal, highly individualized fashion, utilizing a wide variety of procedures and interventions in the care, rehabilitation, "reform," or treatment of the abused, abandoned, neglected, incorrigible, or delinquent minors within their jurisdictions.

If a youth was deemed to be beyond the rehabilitative capabilities of the local juvenile court detention, probation, or state training school facilities, the youth was transferred—or waived—to the jurisdiction of the adult criminal court in that county. In the first juvenile court intervention ruling (*Kent v. United States* 1966), the Supreme Court held that the decision to transfer or waive a juvenile to adult criminal court is "critically important." It therefore must provide fairness and due process involving a fair (though informal) hearing, assistance of counsel with access to social service records, a written record of the proceedings indicating the findings of the court, and a reason for the transfer or certification to the adult criminal court so that the proceedings may be reviewed on appeal.

Substantial reform was brought to the operation of

the juvenile court system in the Supreme Court's second decision on proceedings (*In re Gault* 1967). The court articulated five basic constitutional rights in the adjudicatory phase of the juvenile court procedures:

1. Adequate notice of trial at all stages
2. Right to counsel
3. Right to confront witnesses in cross-examination
4. Privilege against self-incrimination, both before and during trial
5. Proper appellate review, including the right to transcripts of the proceedings

Concerning other procedural matters, the Supreme Court held that a higher standard of proof (i.e., beyond a reasonable doubt) was required in juvenile delinquency adjudications (*In re Winship* 1970). However, there is no constitutional right to a trial by jury in juvenile delinquency adjudication (*McKeiver v. Pennsylvania* 1971). Moreover, state statutes may provide for juvenile pretrial detention when it is determined that a particular juvenile presents a "serious risk" or that the juvenile "may before the return date commit an act which, if committed by an adult, would constitute a crime" (*Schall v. Martin* 1984, p. 2405). Many unresolved and ongoing procedural due process concerns continue to challenge the juvenile justice system, particularly as more juveniles are tried in adult courts. The issue of search and seizure has become increasingly pertinent as schools seek to deal with the presence of weapons and drugs in schools. In *New Jersey v. T.L.O.* (1985), the Supreme Court found no violation of Fourth Amendment rights when a principal searched a student's purse for drugs without a search warrant. Other important controversial areas include confessions and the limits of interrogation.

An alarming increase in youth violence in the past decade had led to a movement away from the rehabilitative ideal of the original juvenile court system toward the direction of holding more violent youths responsible as adults. Many states have passed "get tough" laws allowing more juveniles to be tried in adult court (Snyder and Sickmund 1995). Some of these laws—such as the 1996 Michigan Juvenile Justice Reform Legislation (Clark 1996)—automatically place a juvenile in adult court for certain violent offenses, and others increase the number of offenses for which a juvenile could be waived at the discretion of the district attorney (direct file waiver) or after a judicial hearing. Most recently, the California Supreme Court affirmed that specific charges against minors age 14 years and older may be filed directly in a court of criminal jurisdiction without a judicial determination of unfitness under the juvenile court law (*Manduley v. Superior Court of San Diego* 2002).

The increased readiness to waive juveniles to adult court has resulted in a heightened concern about the issue of competence in the juvenile. The current standard for competence to stand trial is "whether a defendant has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him" (*Dusky v. United States* 1960). A number of screening instruments can assist the examiner in determining a juvenile's competence: the Georgia Court Competency Test, the MacArthur Competence Assessment Tool, and McGarry's Competency Assessment Interview. Other authors have also made important contributions to the literature on this topic (Grisso 1998a; Ratner 1992).

Although competence to stand trial is the most common competence referral, competence to waive Miranda rights and to be executed are becoming significantly more important as more juveniles are transferred to adult court. In *Fare v. Michael* (1979), the U.S. Supreme Court determined that the juvenile's waiver of his Miranda rights must be determined in light of the totality of the circumstances, including factors such as the individual's comprehension of the warning and the context surrounding the confessions. Grisso (1998b) elaborated on this issue and developed four standardized tools to assist the examiner in this question. The constitutionality of executing a juvenile is variable based on the juvenile's age and the jurisdiction. In two separate cases, the U.S. Supreme Court held that execution of an offender age 15 or younger is unconstitutional (*Thompson v. Oklahoma* 1988) and that a juvenile may be subject to the death penalty for crimes committed at age 16 or 17 (*Stanford v. Kentucky* 1989). States with the death penalty statute vary in their minimum age requirement, but the range is between ages 16 and 18 years.

In many of these waiver cases, child and adolescent psychiatrists are often called on to evaluate and provide testimony to the court regarding the juvenile's degree of dangerousness to the community, risk assessment, and the juvenile's amenability to treatment or rehabilitation (Barnum 1987). Although realistic limitations prevent mental health professionals from mak-

ing actual predictions about an individual's future violent behavior, several studies have identified both risk factors and protective factors that are generally associated with chronic delinquency and increased rates of violence (Deprato and Hammer 2002, p. 268; Hoge et al. 1996; Kirkish et al. 2000; Steiner 1997). Many studies have focused on the high prevalence of mental disorders in this population (Deprato and Hammer 2002, p. 269; Foley et al. 1996; O'Shaughnessy 1992). Although no assessment instrument exists to accurately predict future violence, several instruments assess mental and personality disorders, including the Minnesota Multiphasic Personality Inventory—Adolescent, the Millon Adolescent Clinical Inventory, the Child Behavior Checklist, the Hare Psychopathy Checklist—Youth Version, and the Massachusetts Youth Screening Instrument (Grisso et al. 2001; Scott 2002, p. 293). Practice guidelines have also been developed for assessing these youths and can assist the forensic examiner in his or her work in these cases (Ash and Derdeyn 1997, p. 1498).

Consultation on the disposition of the youth from the juvenile court system involves a comprehensive knowledge of both current disposition options and effective treatment models. Dispositions to be considered include waiver to adult court as described above, diversion before adjudication, probation, community placement, and commitment to a correctional facility (Sacks and Reader 1992). Diversion programs defer the youth's adjudication and offer an opportunity for dismissal of the charges if the juvenile can successfully complete a treatment program such as an individual and family counseling, educational, vocational, or recreational intervention or rehabilitation for substance abuse in cooperation with the juvenile drug court (Nurcombe and Partlett 1994). Probation is multifaceted and can include drug counseling, weekend confinement in a local detention center, and community and victim restitution (Snyder and Sickmund 1995). Twenty years ago, the literature on delinquency presented a pessimistic view on the outcomes of treatment and interventions. Treatment programs such as residential treatment centers failed to consider the multifaceted nature of delinquency and tended to approach the problem in a fragmented and unidimensional manner (Deprato and Hammer 2002, p. 274). The youth often reverted to antisocial, delinquent behavior once he or she returned to his community. As described in the report of the Surgeon General's Conference on Children's Mental Health (U.S. Public Health Service 2000), the development of newer interventions such as multisystemic therapy and therapeutic foster care has improved outcomes and has led to a more optimistic outlook on the future of this growing population.

Clinicians providing consultation, forensic assessment (O'Shaughnessy 1992), evaluation, or treatment services in the juvenile court system (Kalogerakis 1992) should be familiar not only with the general philosophy of laws and procedures but also with the local complexities and cross-currents that animate or confound cities and communities and that are reflected and acted out—sometimes with a vengeance—by the participants in the juvenile court setting. The Task Force on Juvenile Justice Reform (American Academy of Child and Adolescent Psychiatry 2001) provided the most recent initiative, with specific recommendations regarding areas such as determinations of competence and standards for treatment within the juvenile justice system.

School-Related Legal Issues

In the American tradition, education of children and adolescents has been the province and responsibility of families and local government through parochial or nonsectarian private schools or through the local public school districts, which operate through enabling state legislation. It was not until the latter half of the twentieth century that the federal government provided more than statistical information about the condition of education (U.S. Department of Education 1993).

In the landmark Supreme Court decision ending segregation as a legal policy in public school (*Brown v. Board of Education* 1954), the court affirmed the principle that education is a "right which must be made available to all on equal terms." The rights of the handicapped were established by Congress with the passage of the Civil Rights Act of 1973, Section 504, which states, in part, "No otherwise qualified handicapped individual in the United States...shall solely by reason of her or his handicap be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance." These principles were articulated relative to schools and handicapped children by Congress in the Education for All Handicapped Children

Act of 1975 (P.L. 94-142, Section 611, 88 stat 579 et seq), which stated that the purpose of the act was to ensure that "all handicapped children have available to them a free appropriate public education which emphasizes special education and related services designed to meet their unique needs." Public Law 94-142 provided for the definition of various handicapping conditions, including but not limited to learning disabilities, serious emotional disturbance, mental retardation, and speech and language impairment. It also provided numerous procedural processes, including that "free and appropriate public education" and "related services" be assessed and provided through an "individualized educational plan" in the "least restrictive environment" with procedural rights and protections, including written notice, parental consent, due process administrative review, and judicial review after all administrative remedies are eliminated. In 1991, Congress amended this law, changing the name of the statute to the Individuals With Disabilities Education Act (IDEA) (P.L. 102-119), and declared its purposes:

1. To provide assistance to states to develop early intervention services for infants and toddlers with disabilities and their families and to assure free appropriate public education to all children and youth with disabilities.
2. To ensure that the rights of children and adolescents with disabilities from birth to age 21 and their families are protected.
3. To assist states and localities to provide for early intervention services and the education of all children with disabilities.
4. To assess and assure the effectiveness of efforts to provide early intervention services and educate children with disabilities.

IDEA also requires yearly reports to Congress on the progress of these special education programs (U.S. Department of Education 1998). The specific meaning and applicability of these concepts have been the subject of numerous appellate court decisions (*Board of Education v. Rowley* 1982; *Polk v. Central Susquehanna Intermediate Unit 16* 1988). Further federal legislation (Americans With Disabilities Act of 1990, P.L. 101-336) may be utilized to provide accommodations within school and institutional settings.

Clinicians evaluating or treating children and adolescents with disabilities under Social Security (U.S. Department of Health and Human Services 2003) must follow guidelines and procedures published periodically by the Social Security Administration (American Academy of Child and Adolescent Psychiatry 1997a). Clinicians consulting with school programs (Behrman 1996; Berkovitz 2001a, 2001b; Berkovitz and Sinclair 2001; Jellinek 1990; Sikorski 1996) should be aware that DSM-IV-TR diagnostic criteria are not synonymous or interchangeable with the educational code definitions used by the local and state educational authority (California Department of Education 2002). Each state must develop implementing legislation and codes of regulations that follow federal law to be eligible to receive federal supplemental education funding. In 2002 the 108th Congress was scheduled to reauthorize these and other discretionary programs and the federal funding stream to these programs that define, support, and advance the educational and related services to children with defined disabilities.

Conclusion

Clinicians working at the interface of law and psychiatry should proceed with caution, maintain a current knowledge base in their areas of clinical work, develop systems of maintaining awareness of the relevant laws in their local jurisdiction, and exercise sound clinical judgment. If in doubt, they should seek the consultation of experienced colleagues or the advice of their own counsel.

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