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Thomas Grisso
University of Massachusetts Medical School

Et al.

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Juvenile Court Clinical Services: A National Description

BY THOMAS GRISSO AND JUDITH QUINLAN

ABSTRACT

There have been few studies of the manner in which juvenile courts obtain clinical evaluations and consultation by juvenile court clinicians in order to identify and respond to youths with mental health problems. This study involved a telephone survey of professionals associated with juvenile court clinic (JCC) services in 87 of the largest juvenile court jurisdictions nationwide, providing data on their professional staff, functions, procedures, organizational and financial structures, and methods for providing evaluations to juvenile courts. We identified three models of JCC service delivery systems. Differences between the JCC service models offer hypotheses pertaining to potential differences in efficiency and quality of services and service delivery.

mentor, William James, and by Adolf Meyer, then one of the most prominent figures in psychiatry. Healy and Fernald's detailed clinical methods for developing what they called "individual studies" of youths not only served the court in its case-by-case decisions, but also provided research evidence regarding the causes of delin-

Juvenile courts throughout the nation rely on mental health clinicians to evaluate adolescents in the process of their adjudication on delinquency charges. These evaluations offer courts information about mental status related to forensic questions (for example, competence to stand trial), as well as clinical information to assure that those juveniles receive necessary mental health services. The importance of clinical evaluations for juvenile court decisions is clearly apparent in the *Juvenile Delinquency Guidelines* recently published by the National Council of Juvenile and Family Court Judges (NCJFCJ, 2005). Yet there have been no systematic studies of the structure, funding, and functions of juvenile court clinical (JCC) services. We believe that this article provides the first description of JCC services nationwide.

The first clinical service developed specifically to serve a juvenile court was Chicago's Juvenile Psychopathic Institute, established in 1909 in conjunction with the first juvenile court in the United States, then in operation for about 10 years (Jones, 1999). The Institute's founder was William Healy, a young Harvard-trained neurologist, who was joined by psychologist Grace Fernald. Their efforts were encouraged by Healy's

quency. They soon renamed their clinic the Institute of Juvenile Research, reflecting their rejection of the then-current notion that delinquency was a congenital ("psychopathic") defect and their growing conviction that delinquency had multiple causes that would respond to community interventions (Bennett, 1981).

By the 1930s, most major cities had developed juvenile courts, and juvenile court clinical services became common adjuncts. Psychiatrists, psychologists, and social workers played integral roles in juvenile court functions, evaluating youths and families in order to advise the courts about the placement and treatment of "wayward" and delinquent youths. Today, a large (but unknown) number of mental health professionals devote all or part of their clinical practices to performing court-ordered evaluations to assist juvenile courts in dependency or delinquency cases, often helping them to find or provide mental health services for youths.

Thomas Grisso, Ph.D., is Professor of Psychiatry Director of the Law and Psychiatry Program, and Director of Psychology at the University of Massachusetts Medical School. He has published more than 125 journal articles and 10 books, many of them on issues in the psychological evaluation of youths in the juvenile justice system.

Judith Quinlan, B.A., a graduate of Clark University in psychology and a Research Assistant at the University of Massachusetts Medical School's Department of Psychiatry, was responsible for the data collection and statistical analysis of results reported in this article.

Nevertheless, nearly 100 years after Healy and Fernald opened the doors of their clinic, we have no reliable picture of the nation's JCC services. No literature describes their professionals, their organizational structure, their funding, their functions, or their value. The obscurity in which juvenile court clinical services have functioned is in stark contrast to their enormous impact on the decisions of juvenile courts, the lives of youths and families, and the protection of the public and due process in delinquency cases. Day in and day out, juvenile court clinicians perform evaluations to assess dependent youths' needs for protection and treatment for mental disorders. These clinicians translate the legal criteria for forensic evaluations of delinquent youths' risk of violence (for pretrial detention and secure treatment decisions), competence to stand trial, waiver (transfer) to criminal court, long-term risk of recidivism and criminal careers, and rehabilitation needs during youths' ensuing custody in probation or state youth correctional programs. Typically the evaluations provide juvenile court judges their only source of clinical information about rehabilitation and public safety. For youths who are under-served by their communities' mental health systems, JCC services sometimes are the first and only point of contact with a clinician who can identify a youth's need for mental health services. As such, these services are an integral but often relatively unrecognized part of the overall system of child mental health care in many communities.

In this context, there is a significant need to evaluate the quality of JCC services, especially their use of new technology in juvenile forensic psychology and psychiatry. But evaluation studies to improve the quality of JCC services in their communities cannot be performed until their current structure and functions are known. This initial description was the purpose of the present study.

We defined a JCC service as any ongoing contractual arrangement between a juvenile court and one or more mental health professionals to provide clinical and forensic evaluation services (together with any other services) to assist the juvenile court in its objectives. Two choices guided and limited the scope of our inquiry. First, we sought information only on JCC services for juvenile courts that served jurisdictions with populations over 500,000. Second, we focused our inquiry on

JCC services in delinquency cases. Many juvenile courts also handle dependency cases (e.g., cases involving abuse or neglect, or non-delinquent "status" offenses such as truancy and runaway), for which JCC services perform evaluations of youths and families. Both of these restrictions on our method were dictated by the limits of our resources and by the need to employ a telephone survey procedure that would not be so lengthy that it would place undue strain on the survey respondents.

Method Procedure

A list of the juvenile and family courts in the 100 largest U.S. counties was obtained from the NCJFCJ. Beginning in January 2002, courts were telephoned to identify the primary individuals or groups of individuals responsible for conducting court-ordered mental health and/or forensic evaluations of youths in delinquency cases. Typically, the identification and interview process involved three stages: (a) identifying the relevant JCC clinician; (b) a brief telephone contact with the clinician explaining the project and discussing participation; and (c) administering a semi-structured telephone survey. Survey interviews with the clinicians were conducted from September 2002 to December 2003.

The process of identifying clinicians was multifaceted. The initial telephone call to identify clinicians who had primary responsibility for court-ordered evaluations resulted in any of three outcomes: (a) obtaining the names of one or more clinicians said to be responsible for evaluations for the courts; (b) a referral to another part of the court system or a mental health or welfare agency to try to obtain these names; or (c) determination that the court was unable to refer us to any clinicians or agencies. Wave two of the respondent identification process involved telephone calls to the clinicians, agencies, or facilities to which the courts had referred us. When a referral was not provided, we tried to determine who was responsible for juvenile mental health evaluations in that jurisdiction. This was accomplished by telephoning other parts of the jurisdiction's juvenile justice system (e.g., juvenile detention facilities and probation departments).

After identification of a clinician (either by referral from the court or another agency or by independent investigation), we contacted the clinician and described

the project. With the clinician's permission, we sent a letter providing further information about the nature and goals of the project and the structure and general content of the telephone survey. Approximately one week later, we again contacted the clinician by telephone to address questions or concerns about participation and schedule an appointment for a telephone survey. If the clinician was uninterested or not reachable, we began the identification process again. Generally, 10 to 15 jurisdictions were targeted at any one time; other jurisdictions were not contacted until satisfactory progress was made in identifying clinicians and scheduling interview times for the current 10 to 15.

In 80% of the cases, data from one JCC clinician represented one jurisdiction. However, additional interviews were conducted if a survey respondent had a purely clinical role and was not able to respond to inquiries regarding jurisdictional practices or had an administrative position and did not perform evaluations for the juvenile court. For instance, if a respondent performed only competence-to-stand-trial evaluations we obtained a second respondent to provide data on the administrative and functional dimensions of the clinical service, as well as practices relating to evaluations other than competence to stand trial. If data were collected from more than one respondent in a jurisdiction, these data were collapsed and combined for that jurisdiction, so that each jurisdiction had only one set of data. For purposes of recording respondent demographic characteristics for a jurisdiction when there was more than one respondent, the clinician respondent's demographic characteristics alone were used.

The procedure and survey were approved by our university Human Subjects Committee. Participants were assured that the results would not allow others to identify specific information with specific juvenile courts or themselves, and verbal consent was obtained at the outset of the telephone interview. Participants were offered a \$25 discount coupon on the products of a publisher (Professional Resource Press) of clinical and forensic books, assessment instruments, and practice materials.

The Survey

A semi-structured interview was developed and substantially revised through piloting with several JCC

professionals. We organized the content chosen to meet the study's objectives within four broad areas, three of which are reported in this article: (a) characteristics of the clinician/respondent (e.g., background, evaluation, and administrative duties); (b) the structure of the JCC service (e.g., number and types of professionals, funding sources, organization, and salary or reimbursement arrangements); and (c) functions of the service (e.g., range of services, types of evaluations, evaluation procedures). Examples of types of evaluations addressed in the survey were understanding of Miranda rights assessments, risk of harm to self or others, competence to stand trial, waiver (transfer) to criminal court, and sex offense recidivism and treatment. (A fourth content area of the survey, involving more detailed inquiry into the JCC services' competence-to-stand-trial evaluations for juveniles, will be described in a future article.)

We separated the survey into discrete sections with standardized sets of questions addressing specific content areas, but its administration allowed for flexibility in respondents' replies. Because there was little empirical information on JCC services with which to anticipate the kinds of responses we might receive, the survey allowed for the individuality of clinicians' practices and methodologies to be revealed, as well as the uniqueness of their terminology and language about their services. Some questions were open-ended so that respondents could clarify and explain their responses, offering more detail if they wished and allowing the interviewer to request elaboration.

The Sample

Survey interviewing was completed for JCC services in 87 jurisdictions, with 85 of the juvenile courts operating at the county level and two at the city level. JCC services in 83 of these jurisdictions were on the list (obtained from the NCJFCJ) of the 100 largest juvenile court jurisdictions in the U.S. We added four jurisdictions not included in the list because, despite the fact that they were not among the 100 largest jurisdictions, they were at the heart of major metropolitan areas. The population of the jurisdictions served by the juvenile courts ranged from 523,124 to 9,213,533, with a median population of 840,879. According to national archives (Stahl, Kang, & Wilt, 2000), the median annual number of delin-

quency cases processed in these jurisdictions was 4,300, and the median annual number of total cases (delinquency, dependency, and status) was 6,689. The sample of 87 jurisdictions included juvenile courts in 31 states across all regions of the U.S. (which are defined in a footnote to Table 3), while the other 19 states did not have jurisdictions of the size included in the sample. The number of court jurisdictions by region was: Pacific = 15, Western = 8, Central = 10, Great Lakes = 13, Northeast = 27, and South = 14.

Results

Respondents

The first column in Table 1 describes the characteristics of the professionals, called "respondents," who provided information for the survey. (The remaining columns are explained later.) For 49 JCC services, the respondents were the heads of the service units (e.g., "Director of the Juvenile Court Clinic"). The remaining respondents provided information for the 38 juvenile court jurisdictions that had no "service unit." Typically the latter were courts that obtained JCC services from private practitioners, and the respondents were the professionals nominated by the juvenile court as one of the more frequent or longer-term providers of JCC services in their jurisdiction.

Most of the respondents were psychologists with Ph.D. or Psy.D. degrees, while about 10% were M.D.s and the remainder were master's degree psychologists or social workers. About three-fourths identified their primary area of training as clinical psychology. As shown in Table 1, almost all had formal training in child and adolescent evaluation and treatment, but less than one-half said that they had formal training in forensic psychology or psychiatry (identified as fellow or post-doctoral forensic training programs, specialized psychiatry residencies, or forensic specialization in graduate school). JCC services constituted full-time work for about one-third of the respondents. About 90% had been in their present positions for more than 2 years, and about 85% had 5 or more years of experience in performing court-ordered evaluations of juveniles.

Organizational Variables and a Typology of JCC Services

Three variables describing organization of JCC services were categorized to define levels of each variable:

Location (2 levels), *Source of Funding* (2 levels), and *Financial Arrangement* (4 levels). These are defined in Table 2, which also shows the proportion of JCC services at each level of the variables for the total sample. About 40% of the JCC services were located in or very near the court building, and about 60% were funded by the juvenile court, with most of the remainder funded by public agencies (state or county) responsible for mental health and welfare services. Concerning financial arrangements, respondents were salaried employees of the courts or mental health agencies in about 40% of the JCC services, individual private-practice clinicians paid per case or per evaluation hours in about 35% of the cases, and salaried or paid by case/hour as part of a vendor group in the remainder of the JCC services.

We created a classification of JCC services using data for these three organizational variables. We initially identified JCC types by locating them in 16 cells formed by a 2 x 2 x 4 grid based on the above variables and levels. We had insufficient data to classify 3 of the 87 JCC services in this grid. The remaining 84 services were located in 9 of the 16 possible cells. These 9 cells were examined for a logical way to reduce them to a simpler typology, resulting in three types in which all but 8 of the 84 courts could be identified. This process led us to propose three types of JCC services.

Court Clinic (CC) Model. Of the 76 classified JCC services, 35 (46%) were in the CC model. In this class, professionals who provide JCC services are located in or very near the juvenile court building, but their financial arrangements vary. They are salaried employees of: (a) the juvenile court paying them with county funds (49% of CC services); (b) a state mental health/welfare agency but working within the juvenile court (20%); or (c) a vendor group receiving mental health/welfare agency funding to work in the court providing court-ordered clinical services (31%).

Community Mental Health (CMH) Model. This structure was employed by 10 (12%) of the 76 classified cases. Most of the cases in this class are located in local community mental health centers, typically a hospital or community mental health clinic, that designate specified salaried clinicians to perform juvenile court-ordered evaluations (therefore, with state mental health/welfare funding). A few cases in this class involved vendor groups that provided community mental health services

TABLE 1
Respondent Characteristics, Total Sample and by JCC Models

CHARACTERISTICS	TOTAL N = 87	COURT CLINIC n = 35	COMMUNITY MENTAL HEALTH n = 10	PRIVATE PRACTITIONER n = 31 ¹
Professional Degree (percent of respondents)				
Ph.D.	70.1	65.7	50.0	77.4
Psy.D.	10.3	11.4	10.0	6.5
M.D.	10.3	8.6	30.0	9.7
MA/MS	3.4	8.6	0	0
MSW	3.4	5.7	10.0	0
Other	2.3	0	0	6.5
Education and Training (percent of respondents)				
Clinical Psychology	71.3	68.6	50.0	71.0
Psychiatry	11.5	8.6	30.0	12.9
Social Work	3.4	5.7	10.0	0
Counseling Psychology	12.6	17.1	10.0	12.9
Educational Psychology	2.3	0	0	6.5
Specialization (percent of respondents)				
Formal training in child/adolescent evaluation/treatment	96.6	97.1	100.0	96.8
Formal forensic training in psychology/psychiatry	39.1	42.9	50.0	32.3
Professional Work and Experience				
Percent of respondents working full-time for juvenile court	34.5	71.4	25.0	3.4
Median years in position (range)	9.5 1-41	9.5 1-28	4.5 2-21	10.0 1-41
Median years performing evaluations of youths for courts	13.0	10.0	6.3	17.0

¹ The N sizes for the three models do not add to 87, because 11 sites were not classified.

with state mental health/welfare contracts, with their duties including juvenile court evaluations.

Private Practice (PP) Model. These 31 services (37% of the classified courts) operate on per-case contracts with private practitioners in the community to provide juvenile court-ordered evaluations. Often the courts use a list of approved clinicians, making assignments on a

rotating basis or by selecting clinicians based on the nature of the case. The clinicians are paid a flat fee or hourly fee per case (sometimes with caps on hours that may be compensated), using county court funds (71% of the PP services), state mental health/welfare agency funds (13%), or county funds not channeled through the juvenile court (e.g., indigent defense funds [16%]).

TABLE 2
Organizational Dimensions of Juvenile Court Clinical Services (n = 84)

	DIMENSION	PERCENT OF RESPONDENTS
	Location^a	
In court	Evaluation services were located within the court itself or within a one-block radius	41.6
Outside of court	Evaluation services were located further than one block from the court	58.3
	Source of Funding	
Health/Welfare (H/W)	Funding was from a health or welfare agency, most often a state department of mental health	38.1
Juvenile Court (JC)	Funding came directly from juvenile court for which services were provided (typically county funds)	55.9
Other ^b	County funds not provided through juvenile court	5.9
	Financial Arrangement^c	
Group/individual: Salaried	Respondents providing services were employees on salary, and the service was operated by the employer	40.4
Vendor group: Salaried	Respondents providing services were paid a salary by a private provider group (vendor) that had a contract from another entity to supply services (usually H/W or JC)	13.0
Vendor group: Billable	Respondents providing services were paid on billable hours by a vendor that had a contract with another entity to supply services	9.5
Individual: Billable	Respondents providing services were private clinicians who accepted cases on referral	36.9

- ^a When a respondent was representative of an evaluation service that was not a discrete group of professionals, the physical locale where respondents' reports were written was defined as the "service location."
- ^b Other sources of funding were, for instance, non-court county and city budgets and indigent defense funds.
- ^c The manner in which respondents were compensated was dichotomously classified: that is, respondents were coded as either salaried or contracted. "Contracted" respondents did not necessarily have a formal contract to provide evaluation services for the juvenile court but were not salaried employees. They were reimbursed for their services by billing either by the case or by the hour, or were paid for their services on a case-by-case basis. Salaried and contracted clinicians were classified as either working within a vendor group or as an individual that was or was not part of a larger group of professionals providing services to the juvenile court.

As shown in Table 3, different models prevailed depending on the U.S. region. The CC model was most often used in the Northeast and Great Lakes regions, but the PP model was more commonly used in the Pacific-Western and Southern states.¹

Returning to the description of survey respondents in Table 1, three columns show characteristics

of the respondents within each of the three models, identifying few differences across models. Compared to the total JCC sample, the CMH services tended more often to be represented by a psychiatrist, and the CC services were more likely to be represented by a professional who worked full-time providing juvenile court services.

¹ For this comparison across regions, and for later comparisons of the characteristics of various models, we do not provide tests of significance of difference because in many instances the sample sizes were too small for significance tests to be trustworthy.

TABLE 3
Within Regions, Percent of Jurisdictions Using Various JCC Models (n = 76)

MODELS	PACIFIC & WESTERN n = 20	CENTRAL n = 9	GREAT LAKES n = 12	NORTHEAST n = 22	SOUTH n = 13
Court Clinic	15	45	75	68	31
Community Mental Health	5	22	8	18	15
Private Practitioner	80	33	17	14	54

NOTE: The table includes only the 76 courts that were classifiable by the three models. Regions were defined as follows: *Pacific* (Alaska, California, Hawaii, Oregon, and Washington); *Western* (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming); *Central* (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, and Texas); *Great Lakes* (Illinois, Indiana, Kentucky, Michigan, Ohio, West Virginia, and Wisconsin); *Northeast* (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington, D.C.); *South* (Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia). Only 31 of these 50 states were represented in the sample, others not having communities with court jurisdictions of sufficient size. In addition, some states obviously contributed more court jurisdictions than others. We chose not to identify which states were represented in the sample, in order to avoid identification of specific jurisdictions or professionals.

TABLE 4
Percent of JCC Services (CC and CMH Models) Having One or More Psychologists, Psychiatrists, and Master's-Level Professionals

MODEL	DOCTORAL-LEVEL PSYCHOLOGIST			PSYCHIATRIST			MASTER'S-LEVEL PSYCHOLOGIST			MASTER'S-LEVEL SOCIAL WORKER		
	ANY	FULL-TIME	PART-TIME	ANY	FULL-TIME	PART-TIME	ANY	FULL-TIME	PART-TIME	ANY	FULL-TIME	PART-TIME
Court Clinic	94	70	66	47	12	35	66	50	35	57	54	22
Community Mental Health	88	75	69	50	38	38	63	63	13	75	75	25

Professionals in Service Units

We examined the number of professionals—full-time and part-time—performing JCC services for courts as “service units” or teams (n = 53)—that is, excluding cases in which services were provided by private practice clinicians. The median size of a service unit was 8 professionals (the distribution was skewed by a few very large service units). About 44% of the service units consisted of 2 to 7 professionals (including the respondent), an additional 48% ranged in size from 8 to 19, and about 8% included 20 to 29 professionals. About 11% had no full-time professionals, 53% had 1 to 4, 30% had 5 to 10, and 6% had 11 to 23. The total for these service units of the largest U.S. juvenile court jurisdictions was 493 professionals, 46% of whom were full-time. This figure includes neither private practitioners providing court-ordered evaluations outside service units nor clinicians performing evaluations at the request of juveniles’ defense counsel.

Table 4 provides one way to describe the profes-

sional composition of the service units. It examines only the CC (n = 35) and CMH (n = 10) services, showing the percentage having at least one of each of various types of professionals. Almost all service units had at least one Ph.D. or Psy.D. psychologist, about two-thirds included the services of professionals with master’s degrees (M.A. or M.S., and M.S.W.), and about one-half included a psychiatrist (M.D.). (Other data, however, revealed that almost all of the service units without M.D.s as unit members had arrangements to obtain psychiatric or medical consultation when needed.) Full-time service commitment of psychiatrists was much less frequent than full-time service of one or more doctoral-level psychologists, but was more frequent for CMH services than for CC services.

Functions

Table 5 shows the reported functions of JCC services. The broader classes of services (evaluations, treatment, and training) varied little across JCC types.

TABLE 5
Services Provided (Percent of Total and of JCC Types), and Percent Performing Various Types of Evaluations

SERVICES AND EVALUATIONS	TOTAL N = 87	COURT CLINIC n = 35	COMMUNITY MENTAL HEALTH n = 10	PRIVATE PRACTITIONER ¹ n = 31
Types of Services				
Evaluations, delinquency	100	100	100	100
Evaluations, dependency	62	74	40	64
Treatment, child/family	22	29	30	16
Training to judges/lawyers/probation officers	74	80	80	68
Types of Delinquency Evaluations²				
Miranda waiver	53	54	17	67
CST in juvenile court	93	97	100	92
CST of juvenile in criminal court	48	32	33	58
Waiver to criminal court	79	59	83	96
Waiver back to juvenile court	28	19	33	33
Criminal responsibility	67	69	67	75
Sex offender recidivism/treatment	82	91	33	92
Post-adjudication disposition	100	100	100	100

¹ The N sizes for the three models do not add to 87, because 11 sites were not classified.

² N sizes differed for types of delinquency evaluations; this category is comprised of 72 cases. Supplemental interviews were conducted to establish the reliability of a respondent's report when the accuracy of the report was uncertain (e.g., the respondent was not aware of the types of evaluations other examiners conducted in that jurisdiction).

Treatment was not frequently provided, but judicial/attorney training was common. Some specific types of evaluations were performed by almost all JCC services in delinquency cases: disposition evaluations (placement, treatment needs, risk of harm), competence to stand trial in juvenile court, and—except for JCC services in the CMH model—evaluations for recidivism or treatment of youths charged with sex offenses.

An examination of Table 5 shows, however, that there was some variation across models for certain specific types of evaluations performed in delinquency cases. These differences need to be considered cautiously. For example, the fact that a service might indicate that it does not do some types of evaluations does not necessarily mean that the service is neglecting that evaluation issue, because in some jurisdictions the legal issue itself is not raised (e.g., in some jurisdictions there is no legal process for “waiving youths back” to juvenile court

from criminal court). Moreover, care must be taken not to read these figures as “frequency of evaluations,” but rather as “frequency of JCC services indicating that they do such evaluations.” For example, criminal responsibility evaluations are very rare in juvenile court; the high percentages in Table 5 for this evaluation simply indicate that two-thirds of the JCC services performed these rare evaluations if and when they were needed, not that they performed many of them.

We also examined whether there were U.S. regional variations across the total sample in the services shown in Table 5. In general, regions did not differ remarkably from percentages reported in Table 5 for the total sample of court services, with only a few exceptions: (a) most Northeast and South jurisdictions reported engaging in judicial/attorney training, compared to only about two-thirds of jurisdictions in each of the other regions; (b) no South JCC respondents reported engaging in

TABLE 6
Procedures for Delinquency Evaluations (Percent Responding "Yes")

PROCEDURAL ISSUES	TOTAL N = 87	COURT CLINIC n = 35	COMMUNITY MENTAL HEALTH n = 10	PRIVATE PRACTITIONER ¹ n = 31
Referral questions received are clear and specific	47	43	40	55
Ways exist to clarify referral questions	80	83	80	74
Every evaluation is performed using same protocol	15	9	30	16
Every evaluation is a comprehensive study of the child	42	34	50	52
Report is written in most delinquency evaluations	94	89	100	97
Testimony provided in most delinquency evaluations	9	11	20	3
Family typically given feedback on evaluation results	28	40	40	13

¹ The N sizes for the three models do not add to 87, because 11 sites were not classified.

child and family treatment; and (c) issues that would pertain to youths being tried in criminal court (criminal responsibility, youths' competence to stand trial in criminal court) were more often a part of JCC functions in the South region than in the other regions.

Evaluation Procedures

Finally, Table 6 shows the proportion of JCC services responding affirmatively to a series of questions about the process of performing evaluations in delinquency cases. Less than one-half of the JCC services said that they received clear and specific referral questions from their judges or probation staff, and about one in five said that the system did not provide a good way to clarify the referral questions they received. Court Clinic JCC services appeared to be more flexible in their approaches to evaluations. Only 9% in the CC model said they used the same "standard protocol" for every case (in comparison to 30% of CMH model), and only about one-third of CC services required a "comprehensive study of the child" in response to every request for an evaluation (compared to about one-half of JCC services in the other two types). Respondents said they performed written reports for almost all

cases but that testimony was required only rarely. A little less than one-half of CC and CMH services said that they typically gave evaluation feedback to parents of the youths who are examined, compared to only 13% of PP services.

Discussion

We believe that this is the first national description of juvenile court clinical services in the U.S. At the broadest level, it identifies a large body of specialized mental health professionals, with doctoral-level psychologists providing much of the administrative guidance and, together with psychiatrists and master's-level professionals, a range of clinical and forensic evaluation services. About 500 professionals were involved in JCC services in the jurisdictions surveyed that used service units or teams. The number of JCC professionals in jurisdictions that used private practitioners is not known; but if their average number were similar to that for the service unit sites, the total JCC professionals in the jurisdictions surveyed would be about 750. This is not, however, an estimate of the number of professionals providing JCC services in the U.S., because the survey was restricted to the largest metropolitan areas. In Massachusetts, for

example, 50 professionals were reported in JCC services in the court jurisdictions large enough to be included in this survey, but those were only five JCC services among a larger number in Massachusetts. According to records associated with the state's process of certification of juvenile court clinicians, there are actually almost twice as many (92) mental health professionals working in the sum of Massachusetts' juvenile court clinics.²

The results of the survey are useful for identifying both similarities and areas of diversity among these JCC services. The similarities tend to focus on purpose and function—basically, JCC services' responsibilities. These similarities are of interest if one seeks to identify JCC services as a class with a common objective. But diversity was apparent in their organization and process—essentially, how they discharged their responsibilities. Diversity is interesting because it provides the opportunity to evaluate the effectiveness of various methods and, eventually, the development of best-practice models and practice standards.

Regarding *similarities*, the types of evaluations that JCC services perform are relatively similar across jurisdictions and, indeed, across the three service models. Training of the court's legal professionals is part of the court's mandate, and evaluation functions tend to dominate over treatment functions. Most JCC services are responsible for evaluations in both delinquency and dependency cases. Almost all of the respondents (typically the directors of services or the primary juvenile court-related private practitioner in the community) were specialized by training in child and adolescent clinical psychology or psychiatry. Almost all JCC services working as service units (rather than as individuals in private practice) were interdisciplinary. JCC services also tended to have similarities in terms of certain fundamental concerns—for example, difficulties in getting clear referral questions from the court, time pressures, and maintaining quality services in the context of difficult budgets.

Compared to these similarities, however, the more remarkable results of the survey pertained to *diversity* of organization and process among JCC services nationally. Diversity is conveyed in part by the three basic types of JCC services that we identified, based on their location, funding, and financial arrangements. But an

examination of our descriptions of each type indicates that each is far from homogeneous. For example, while the CC model accounts for 49% of the classified JCC services, only about one-half of CC services are funded by county court funds, while most of the remainder are funded by public mental health agencies outside the court system. Moreover, JCC services with the latter funding arrangements are split concerning whether the professionals are employees of the public mental health agency or of vendor groups on public agency contracts. Such variations in the CMH and PP models produce even more diversity. When all of these variables are used to create subtypes, the largest subtypes are relatively small—PP services paid with county court funds, and CC services paid with county court funds—representing only 28% and 22% of the total classified JCC services respectively.

These data generate two questions. First, how and why did the major urban centers of the U.S. develop such diverse approaches to the delivery of juvenile court services? Our data provide no indication. But the fact that the three primary models are not found in equal proportions across regions (Table 3) suggests some regional influences on choices in the location, organization, and financing of JCC services.

Second, is there a relation between models for delivery of services and the quality of those services? Is any particular model measurably more effective or efficient than another? Intuitively, one might expect that JCC services located in the juvenile court itself (the CC model) offer certain advantages. For example, compared to PP respondents, the CC respondents more often reported that their JCC services provided feedback to families on the results of their evaluations and were somewhat more likely to be involved in mental health training for legal professionals in their juvenile courts. Compared to CMH respondents, the CC respondents reported more often being responsible for dependency as well as delinquency evaluations, which may foster a more focused developmental perspective on youths coming before the court. In contrast, CMH services tended more often to have psychiatrists as directors (Table 1) or full-time members (Table 4) of their teams, which could foster a

² The Massachusetts Department of Mental Health has provided permission for us to reveal its identity as a state participating in the survey for the limited purpose of reporting these figures.

more interdisciplinary approach. Moreover, CMH and PP services are more obviously part of the community's child mental health system, so they might have certain advantages over CC services that are more isolated from the community in general.

Data in Table 6 provide a "hint" of greater efficiency or flexibility in evaluations by CC model professionals. Respondents in services using the CC model less often reported using a single protocol across cases (which would suggest greater focus on specific demands of different referral questions), and more often suggested selectivity in their decisions about the scope of the evaluation (not "comprehensive" unless the case required it). On the other hand, PP respondents sometimes reported spontaneously that their per-case financial arrangements were very modest, so that JCC services might be less expensive in PP arrangements than in CC or CMH services. However, PP respondents also reported that their reimbursement sometimes made it difficult to perform evaluations that met their own standards. For example, one jurisdiction provided \$150 for an evaluation that might require 5 or more hours in order to obtain essential data and provide a written report.

With regard to all of these speculations, the survey data do not document very great differences between models, and the inferences offered here are only hypotheses, not interpretations. The models offer a starting point for future research to examine the relative efficiency and effectiveness of various mechanisms for providing JCC services.

The results of the survey are limited in three main ways. First, we could not corroborate the respondents' answers to the survey questions, because in most cases no one else would have had sufficient knowledge of the JCC services to provide more reliable information. Second, PP respondents sometimes were unable to offer detailed information about other professionals in their community who provided JCC services. In some cases we were able to augment their information by interviewing people at the courts who had contact with the broader range of private practitioners serving the court, but often they did not have certain kinds of information on the specific clinical practices of their private practitioners. Finally, the results cannot be generalized to all U.S. JCC services, because the sample included only major urban communities (counties with populations over 500,000). One could encounter very different circumstances and arrangements for JCC services in communities with small and moderate populations.

Nevertheless, this study provides a foundation on which further research can examine whether different models of JCC services are more or less efficient and effective in providing juvenile courts with important clinical information about youths about whom they make decisions. Refinement of JCC services is important not only to inform juvenile court decisions, but also to identify youths entering the juvenile justice system whose clinical needs have escaped notice in their communities.

AUTHORS' ADDRESS:

**Direct correspondence to:
Thomas Grisso, Ph.D.
Professor of Psychiatry
Department of Psychiatry
University of Massachusetts Medical School
55 Lake Avenue, North
Worcester, MA 01655**

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