

Witt, P. H. (2003). Transfer of juveniles to adult court: The case of H.H. *Psychology, Public Policy & Law*, 9, 361-380.

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Transfer of juveniles to adult court: The case of H.H.

Historical context

Legal reforms around the turn of the 20<sup>th</sup> century resulted in the state acting as *parens patriae* towards juvenile delinquents to ensure they would receive the rehabilitation services that their delinquent activities required. This guiding philosophy was implemented in the first juvenile court in the United States, Cook County (Chicago), Illinois in 1899 (see Grisso, 1998; Melton, et al., 1997). Juveniles were considered too immature to feel the full brunt of the adult criminal justice system. They were also considered more malleable than adults and therefore more able to benefit from rehabilitation than adults. This rehabilitative model of the juvenile court first articulated in the Cook County system was propagated throughout the United States. Key personnel in the juvenile court were non-adversarial, such as probation officers, social workers, and mental health professionals (Melton, et al., 1997).

Because of the presumed rehabilitative focus of the juvenile court, proceedings tended to be relatively informal, with the court assumed to be acting in the juvenile's best interests. Due process guarantees present in adult criminal proceedings were assumed unnecessary, given the non-adversarial nature of the juvenile proceedings. Since juveniles were not officially found guilty of crimes, but only adjudicated delinquent, the court was given free rein to pass judgment on juveniles without the normal procedural protections afforded adults in criminal proceedings (Grisso, 1998).

By the mid-1960s, however, the rehabilitative assumptions underlying the juvenile court had begun to be questioned. Two landmark U.S. Supreme Court decisions at that time dramatically altered the juvenile court landscape. In 1966, in *Kent v. United States* (1966), the U. S. Supreme Court found that due process protections were warranted in juvenile court with respect to proceedings that could lead to the juvenile's transfer from juvenile court to adult criminal court. Justice Fortas, in a widely cited quote, writing for the majority in *Kent*, stated (1966, p. 566), "There is evidence...that there may be grounds for concern that the child receives the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children." Shortly thereafter, in 1967, the court reinforced the notion of procedural safeguards in juvenile court in *In re Gault* (1967), a case involving a juvenile's competency to waive his rights against self-incrimination, generally referred to as *Miranda* rights, after the leading case on that point (*Miranda v. Arizona*, 1965). Many consider the *Gault* decision the clearest indication that since juvenile courts dispensed penal sanctions, even if under the name of rehabilitation, they required procedural and due process protections for the juvenile (Tanenhaus, 2000).

Criminal (or even juvenile delinquent) sanctions have always been subject to an intuitive proportionality test—the degree of criminal or penal sanction must be proportional to the seriousness of the crime and the extent of culpability of the offender (Allen, 2000). Proportionality sometimes requires longer incarceration than is possible in the juvenile system. For instance, if a jurisdiction can only maintain control of a juvenile until his 18<sup>th</sup> birthday, and the juvenile commits a murder at age 17 years, six months, under most circumstances society will not tolerate such a brief confinement for so serious

a crime. The juvenile court has always been faced with such hard cases, cases in which the maximum penalty the juvenile system can provide is too little or cases in which the crime is so heinous that juvenile sanctions will tarnish the credibility of the juvenile court. One mechanism legislatively provided the juvenile court is to transfer such hard cases to adult court, where more lengthy penal sanctions can be imposed.

Historically, juveniles were transferred judicially to adult court. Usually on a motion from the prosecution, judges held transfer hearings and then had wide discretion to maintain jurisdiction over juveniles or to transfer (alternatively, waive or bindover) juveniles to adult criminal court. Until the mid-1960s, judges' discretion was virtually unchecked, with no guidelines on what criteria constitute valid grounds for transfer.

In *Kent*, the U.S. Supreme Court set forth criteria to guide transfer hearings. Most states model their statutory waiver criteria after the *Kent* criteria. These criteria—actually an appendix to the decision consisting of a 1959 memorandum by a District of Columbia juvenile court judge (Cluasel & Bonnie, 2000)—upon which many states have modeled transfer legislation are, paraphrased in part, the consideration of (Cluasel & Bonnie, 2000; Grisso, 1998; Kruh & Brodsky, 1997; Witt & Frank, 1997):

1. the severity and nature of the juvenile's offense,
  2. community protection from further harm by the juvenile,
  3. the maturity and sophistication level of the juvenile (in the sense of criminal sophistication),
  4. the juvenile's legal history and prior response to juvenile system supervision,
- and

5. the likelihood of the juvenile's rehabilitation with resources available to the juvenile court.

Some of the above criteria are the focus of the court alone, such as the severity of the juvenile's offense. This is a legal issue, not a clinical issue. However, other criteria are clearly clinical issues and form the focus of juvenile transfer psychological evaluations—in particular the ability of the juvenile to be rehabilitated with the resources available to the court by a statutorily specified age. As Melton et al. note (1997, p. 426):

In contrast to the infrequency with which they assess competency and culpability issues, forensic child clinicians are likely to spend considerable time in the evaluation of respondents' amenability to treatment. Indeed, it may be fairly stated that amenability to treatment remains the overriding question in the juvenile process.

#### Problem

The problem, then, for society is to balance the punishment/general and specific deterrent/community protection/just deserts side of the equation against the juvenile rehabilitation side. This balance is done through legislation that either broadens or contracts the range of juveniles likely to be transferred to adult criminal court. Two primary methods of changing the range of transfer are:

- (1) Changing the age range: Transfer statutes typically have a lower age limit, below which juveniles are considered too immature to transfer to adult court, and an upper age limit, above which individuals are treated as adults. By increasing the size of this age window—usually by lowering or raising the

lower age boundary—a state can change the number of juveniles it considers for transfer (Dawson, 2000).

- (2) Creating exclusions: Although the standard method of transfer of juveniles to adult court, at least historically, has been through judicial hearings, increasingly state legislatures are creating classes of juveniles who are excluded from judicial hearings. Legislative exclusions generally list a lower age limit and a list of serious offenses. If the juvenile commits one of the enumerated offenses and is above the lower age limit, then he or she is automatically transferred to adult court. A similar statutory exception to judicial transfers is prosecutorial transfer, in which the legislature devises a statute under which for juveniles above a certain age who commit specific enumerated serious crimes, the prosecutor has the discretion to transfer the juvenile to adult court without a judicial hearing. Increasing use of such exclusions in many states has increased the number of juveniles transferred in many states (Dawson, 2000; Feld, 2000).

The problem for the forensic evaluator, however, is different from that of society. The forensic evaluator must determine, first, to what extent the juvenile presents a risk to the community, and, as a corollary, whether the juvenile can be rehabilitated with the resources available to the court by the maximum age determined by statute. The forensic evaluator must predict the future, no easy task: Will this particular juvenile be rehabilitated by the statutory age with the resources available to the court? What criteria can the evaluator use? How certain must the evaluator be? What data exist that can guide the evaluator?

This problem can be approached ideally by some combination of idiographic and nomothetic elements, following Melton et al.'s suggestion (1997, pp. 284-285) of combining "anamnestic" and "actuarial" models (see also Miller and Morris, 1988; Fishman, 1999). That is, the specific characteristics of the juvenile must be examined and explicated in detail, idiographically. Yet, these characteristics must be placed in a broader nomothetic context if one is to develop a statement of future rehabilitation likelihood. Grisso (1998), describes some key variables regarding rehabilitation potential (pp. 217-222):

- (1) Discomfort: A juvenile must be motivated to change delinquent behavior, and discomfort and dissatisfaction with one's behavior is essential in creating motivation. Those juveniles with more narcissistic, psychopathic personalities will likely experience less discomfort with their delinquent behavior, therefore leading to less likelihood of change.
- (2) Potential for adult attachments: Since many types of rehabilitation rely on the formation of a bond between a positive adult figure and the juvenile, the capacity for (or a history of) such bonds is a positive indicator in the juvenile. The juvenile must care about (or have shown past evidence of caring about) adult approval or disapproval. A positive indicator is whether the juvenile has had a trusting relationship with an adult in the past. Among incarcerated juveniles (given that many juvenile in transfer cases are incarcerated in juvenile detention facilities pending resolution of their charges), a positive indicator is sometimes whether the juvenile is now able to establish a positive relationship with education or social service staff.

- (3) **Chronicity:** Delinquent behavior or an antisocial personality style that has a long history is, all else equal, more difficult to modify than one of recent onset. Likewise, clinical and psychological conditions that have early roots are more difficult to modify.

Prediction requires placing the idiographic elements in a nomothetic context. For instance, when one reviews the literature on juvenile recidivism for serious offenses, one finds common threads in descriptions of groups of offenders. Three subpopulations of serious, aggressive offenders can be identified in the literature, and these subpopulations have differing recidivism rates. Juveniles tend to take different paths, or trajectories (Loeber, et al., 1993) with regard to delinquent behavior. These pathways involve a stacking of developmental problems on top of each other as the child enters adolescence (Witt & Dyer, 1997). By determining how well the characteristics of the juvenile being evaluated match one of these subpopulations (or how clearly the juvenile's developmental characteristics place him or her within a given trajectory), one can provide a relative estimate of risk of recidivism and, conversely, a likelihood of rehabilitation. Another way of viewing this problem is as an attempt to determine whether the juvenile belongs to a population or is on a trajectory that suggests he or she will not desist from delinquent behavior naturally, since much delinquent behavior is adolescent-limited (Grisso, 1998; Howell, et al., 1995). These subpopulations are (see Witt & Dyer, 1997, pp. 592-595):

- (1) **Early starters/aggressive versatile delinquents:** Those juveniles who start their criminal careers early, say before age 15, have a higher likelihood of continuing such antisocial behaviors into late teens and adulthood. In such

teens, behavioral non-compliance begins in childhood and escalates as the child enters his or her teens. This group of teens has been referred to variously as early starters (Patterson, Reid, & Dishion, 1992), unsocialized delinquents (Peters, 1991), the crime group (Cornell, Benedek & Benedek, 1989), aggressive versatile path delinquents (Loeber, 1990), or life-course persistent delinquents (Moffit, 1993). Such early starter teens, who frequently present with diagnoses of conduct disorder, are difficult cases, particularly if they have begun to drift away from (and be rejected by) normal teens and begun to associate with antisocial teens, perhaps the strongest predictor of future antisocial behavior (Melton et al., 1997). Such teens may exhibit entrenched antisocial values and tend to show the most deficits in prosocial skills and achievements, such as self-discipline and academic achievement.

- (2) Late starters: By contrast, a second group of teens begins antisocial behavior in adolescence, with few if any signs of serious conduct problems in childhood. Such delinquent teens are referred to variously as late starters (Patterson et al., 1992), socialized delinquents (Peters, 1991), or nonaggressive antisocial path delinquents (Loeber, 1990), and they are at less risk for continuing such behavior as they age. Such teens do not have the early histories of aggressive, disruptive behavior that impair learning, academic functioning, and peer relationships in early starters.
- (3) Conflict-reactive teens: Teens in this group commit an aggressive offense as a response to conflict or perceived threat (Cornell, et al., 1989). Rather than being part of a broader pattern of antisocial behavior, such isolated aggressive

acts may be more likely associated with anxiety, depression, or social withdrawal. However, under circumstances under which the teen feels threatened, aggression may occur. Base-rate data for teens that commit such isolated aggressive offenses indicate lower recidivism than for teens whose aggressive acts are more chronic (Cornell et al., 1989; Dodge, 1991).

### Present Case<sup>1</sup>

In the present case, a 16-year-old girl, H.H., was charged with aggravated assault after she stabbed another female student whom, she believed, was flirting with her boyfriend. She had no prior criminal history, aggressive or otherwise. She was, in fact, an honors student, known for her artistic talent. H.H. is African-American. Since she went to an almost all African-American school and all the major actors in the case were African-American, I did not view race *per se* as an issue in the case.

### Legal context

In New Jersey, at the time of this case, a juvenile between the ages of 15 and 17 years old who committed certain statute-enumerated serious offenses could be transferred to adult criminal court upon judicial decision (N.J.S.A. 2A:4A-26[a]). Once it was established that probable cause existed that the juvenile committed one of the enumerated offenses, the burden of proof shifted to the juvenile to establish that he or she could be

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<sup>1</sup> The use of a real case presents obvious difficulties regarding confidentiality. I decided that altering the juvenile's name and using the report without her consent would provide insufficient protection to her confidentiality. One expert I consulted suggested I limit myself to whatever was present in the public record—in this case, in the written trial decision. Another expert suggested I obtain consent from the juvenile, her guardian (her grandmother), the prosecutor, judge, and defense attorney. In the end, I decided the one person to whom I owed a duty of confidentiality was the juvenile herself. Since she is now an adult (and released from incarceration), I felt it sufficient to obtain her consent, and she gave written consent for the use of this report and the discussion of her case. However, some identifying details of the present case have been altered, such as the names of the juvenile's grandmother, aunt, and significant other persons. The juvenile herself is referred to by her initials, H.H., the way in which she is referred to in both the written trial and appellate court decisions.

rehabilitated by his or her 19<sup>th</sup> birthday with the resources available to the court. Even if the court finds that a juvenile can be rehabilitated by his or her 19<sup>th</sup> birthday, the judge may still choose to transfer the juvenile to adult criminal court based upon other factors, such as the seriousness of the crime or the juvenile's prior criminal history.

#### My evaluation and report

My methods of evaluation were straightforward. I interviewed her grandmother (custodian) and aunt in my office, reviewed Discovery materials and school records, and interviewed and tested the juvenile defendant twice, once in my office (January 26, 1999, when I administered the Child Behavior Checklist [CBC] to her grandmother) and once at the juvenile detention center (April 6, 1999, when I administered the Millon Adolescent Clinical Inventory [MACI] to H.H.), where I also interviewed detention center staff regarding her adjustment. I also interviewed an administrator in NJ's juvenile justice commission regarding the availability of juvenile rehabilitation programs for the girl within the juvenile justice system. Rather than reiterate the materials found in my report, I refer the reader to the report [Appendix 1]).

I placed relatively little emphasis on psychological testing in this case. The CBC, after all, is simply a structured tool to obtain the caretaker's description of the adolescent's behavior and personality, information I already had from many other collateral sources. Even the MACI, which provides self-report information concerning personality, was secondary to the extensive information I obtained from other sources. In cases in which testimony occurs, it has been my experience that heavy reliance on psychological testing can alienate the judge or jury. This is particularly true if the test

results are not adequately related to other sources of information, such as historical records and collateral witness accounts of the patient's behavior and personality.

The reader will note that I organize my "Integration of findings and recommendations" section around eight areas generally accepted in the literature to be associated with risk of future aggressive and delinquent behavior in juvenile. These eight areas are based loosely on the Youth Level of Services/Case Management Inventory (Hoge and Andrews, 1996). All else equal, a juvenile who accumulates more risk factors is more difficult to rehabilitate than one who accumulates fewer such factors.

Specifically discussing each of these risk areas lends itself to clear communication to the court regarding the bases for my opinion. After reviewing these risk factors I attempt to place the juvenile in one of the three previously discussed groups of juveniles—early starters, late starters, and conflict/reactive teen offenders—so that I might obtain an assessment of H.H.'s relative likelihood of recidivism. One could characterize my approach to predicting future recidivism as empirically guided clinical prediction. That is, I consider risk factors known to have an empirical relationship to recidivism—therefore, my approach is empirically guided—yet, I do not use (or have available) a prediction formula linking a risk factor combination with a specific recidivism level. Therefore, my approach is not truly actuarial.

The reader will also note that I do not cite references in my report. There are two obvious points where references could be cited:

1. Justifying my list of selected juvenile delinquency risk factors, around which I organize my conclusion, and

2. Supporting my statement that effective treatment methods exist for H.H.'s primary disorder, i.e., depression.

It is rare for references to be used in forensic psychological reports to support general points or conclusions. It is customary to provide such references upon request from the opposing attorney or to be prepared to cite authorities when cross-examined. However, it is common to cite references for specific, technical points. For instance, in other reports, when I have noted that a sex offender defendant obtains a risk assessment scale score equivalent to the average probationer, I cite the study in which that result was found. Similarly, in other reports when I note the cognitive disorientation associated with a specific blood alcohol level, I cite the table commonly used as an authority on that point.

In the present case, I found the teen to have no history of aggression or antisocial behavior and to fall within the conflict/reactive group. She was able to form positive bonds with healthy adult role models—such as teachers, juvenile detention center staff, and her grandmother—and to demonstrate a history of academic achievement, suggesting resiliency. Consequently, I saw her as readily able to be rehabilitated by her 19<sup>th</sup> birthday, the legal criterion of clinical interest in NJ.<sup>2</sup>

Since the offense, until her charges were resolved, H.H. was incarcerated at a juvenile detention center. At her attorney's request, to determine if she was safe to be released to her grandmother's custody, I conducted a second evaluation session with H.H. at the juvenile detention center where she was housed two months after my initial evaluation and report. I rendered a report (Appendix 2) on April 6, 1999. Based on this

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<sup>2</sup> In my first evaluation report, I also addressed the issue of obtaining treatment for H.H.'s depression. I recommended that she be transferred from the juvenile detention center to a nearby psychiatric inpatient adolescent treatment unit, and the judge did so. H.H. was briefly retained at the adolescent treatment unit, stabilized on antidepressant medication, and returned to the juvenile detention center.

second evaluation session, which included additional psychological testing, I found her not to be a threat to herself or others, and I therefore found her clinically appropriate to be released to her grandmother's custody. Nonetheless, the judge chose to keep her at the juvenile detention center until her charges were resolved.

### Opposing evaluation

The expert for the prosecution evaluated the girl using traditional evaluation methods—interview, testing, interview of significant others, and records review.

Although the broad sources of data were similar to those I used, his choice of psychological tests and the conclusions he drew from these tests diverged from mine. The court decision<sup>3</sup> summarizes his test selection as follows (In the interest of H.H., 1999, p. 18-19)

...[I]n making his assessment of H.H. he administered to H.H.: the Bender Visual-Motor Gestalt Test, which measures cognitive and perceptual functioning; Wechsler Adult Intelligence Scale III Edition (WASI III), which measures how well H.H. will do in school and her cognitive ability; Wide Range Achievement Test, which measures intellectual functioning; Millon Adolescent Clinical Inventory (MACI), which is used to develop a personality profile of the child being evaluated; and Rorschach, House Tree Person Projective Drawings.

As can be seen above, many of his tests focused on cognitive functioning, intelligence, and academic achievement, areas I concluded were unnecessary to evaluate psychometrically given her prior excellent academic record. The court decision itself

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<sup>3</sup> Both the trial and appellate decisions are unpublished. The family court in New Jersey publishes relatively few decisions. Unpublished decisions are considered public record and are available in law libraries; however, unpublished decisions have no precedent value.

noted in the same paragraph (In the interest of H.H., 1999, p. 19) both the focus of these instruments on cognitive functioning and H.H.'s "functioning at an above average level academically, intellectually and in some social spheres."

In addition, the opposing expert used traditional projective instruments—the Rorschach and House-Tree-Person Projective Drawings. He drew significant conclusions in part from these projective instruments—conclusions suggesting, among other things, that H.H. was showing signs of a paranoid personality disorder. During cross-examination, the opposing expert acknowledged that there is significant disagreement in the filed regarding the usefulness and validity of such projective instruments, and this disagreement regarding the usefulness of projective testing was noted by the court in its decision.

The opposing expert was also troubled that H.H. professed to be unable to remember the stabbing itself. Consequently, he wrote in his report that she most likely had a dissociative disorder.

His belief that H.H. had both a dissociative disorder and a paranoid personality disorder led him to opine that she would not be rehabilitated by her 19<sup>th</sup> birthday. The trial judge, in his written opinion, (In the interest of H.H., 1999, pp. 18-22) summarizes the opposing expert's findings:

He bases [his] conclusion primarily upon his concern that H.H. was unable to recall details of her motivation for the stabbing, and secondarily upon his diagnosis of personality disorders he suspects she is suffering from because she was unable to recall such details. In making the diagnosis of personality disorders, Dr. [B.] also relies upon his interpretation of the results of projective

psychological tests he administered to H.H. Unlike Dr. Witt, Dr. [B.] concludes that H.H.'s primary problem is not depression, but rather she suffers from more serious personality problems that require extensive inpatient treatment which, to his knowledge, is not available through the Court system...Dr. [B.] diagnoses H.H. as suffering from Dissociative Amnesia, Depression, NOS, and features of paranoid personality and Parent-Child Problem...Dr. [B.] sets forth a wide-ranging description of H.H.'s personality in his report, concluding that H.H. suffers or may suffer from deep seated and possibly emerging personality problems, such as paranoia. He further concludes or speculates in his 03/31/99 report that H.H.'s future behavior may deteriorate into more aggressive acts stimulated by delusional thinking.

### My Testimony

My testimony<sup>4</sup> during the direct examination closely followed my report. H.H.'s attorney reviewed the sources of my information—interviews, testing, records review—and in particular had me review the eight risk factor areas I used to organize my thinking. This review of how H.H. fared on these risk factors led directly to the questions: Doctor, as a result of this evaluation have you formed an opinion as to whether H.H. can be rehabilitated with the resources available to the court by her 19<sup>th</sup> birthday?" and after my affirmative reply to "What is that opinion?", I opined that based on H.H.'s lack of significant risk factors as well as the presence of protective resiliency factors, such as positive academic achievement and healthy bonds with positive adult role models, she

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<sup>4</sup> A transcript was unavailable to me, so I am reconstructing the major points of my testimony as best I can from memory. Also, I was not present for the opposing expert's testimony, so I will discuss his testimony only as it is referred to in the court's decision.

could be rehabilitated by her 19<sup>th</sup> birthday. I also testified that a treatment plan along the lines I outline in my report could readily be implemented in the juvenile justice system in New Jersey.

During my direct examination, I also briefly addressed points of divergence between my findings and those of the opposing expert. I indicated that despite H.H.'s inability (or unwillingness) to discuss her recollection of the offense, I believed it possible to develop a treatment plan, since other sources of information adequately described the circumstances of the offense and H.H.'s emotional state at the time. Additionally, I indicated that other evidence—such as H.H.'s normal score on a dissociative experiences scale administered during a brief hospital stay—suggested she did not suffer from dissociative amnesia. Finally, I indicated that her history of positive bonds with others was inconsistent with a diagnosis of paranoid personality disorder.

Cross-examination by the prosecutor focused on a few key points. First, I was cross-examined on an article I had previously written on juvenile transfer cases (Witt & Dyer, 1997). Although I had not testified regarding the article during my direct examination, the judge allowed cross-examination on the subject, given its apparent relevance to the case at hand. The prosecutor questioned me regarding a number of details in the report that he believed contradicted my testimony concerning H.H. He, in particular, questioned me regarding whether H.H. showed any protective factors (a topic I addressed in the article), since he believed H.H. lacked many such factors, such as self-esteem and a resilient temperament. I conceded that self-esteem, in general and in H.H.'s case, is indeed damaged in the course of a depression, but I reiterated other protective factors I believed H.H. possessed. For instance, I noted:

1. H.H. had an excellent academic record;
2. She had a stable home environment in which her grandmother, despite her conflicts with H.H., was a responsible, productive role-model;
3. H.H. showed the ability to form positive bonds with healthy, prosocial adults, such as teachers and juvenile detention center staff;
4. Participation in positive activities, such as art and sports.

#### The judge's decision

Approximately six months after my testimony, during which time H.H. remained at the juvenile detention center, the judge, the Honorable James Jackson, issued a written opinion (*In the interest of H.H.*, 1999). In this opinion, the judge (*In the interest of H.H.*, 1999, pp. 13-17) quoted the entire “Integration of findings and recommendations” section from my January 26, 1999 report—including my analysis of risk factors and my placement of H.H. in the conflict/reactive group of teens—suggesting that he found this method of organizing and communicating my findings to be clear in capturing H.H.’s personality.

In his opinion, the judge then dealt with the instances of divergence between the opposing expert’s opinion and mine. For instance, regarding the opposing expert’s contention that H.H. showed signs of a paranoid personality, the judge stated (*In the interest of H.H.*, 1999, pp. 22-23):

The Court notes that except for statements attributed to H.H. in the police reports and her interviews, there is no evidence presented that H.H. has had great difficulty getting along with teachers or her peers. The Court notes that the police reports contained statements from several of H.H.’s fellow students who stated

they had been friendly with H.H., some of them apparently for several years...The Court also observes that H.H. has been in the Juvenile Detention Facility for several months without a problem. In fact, reports to the Court in testimony during the waiver hearing and before and after the hearings indicate that H.H. has gotten along well with staff and peers at the Detention Facility. Consequently, in the end, the judge reached conclusions similar to my own regarding H.H.'s personality and therapeutic needs. He found her to require treatment for depression and difficulties in anger management. He noted, regarding my report and testimony (*In the interest of H.H.*, 1999, p. 24), "The Court finds the conclusions of Dr. Witt to be based upon objective, professionally accepted criterion [*sic*] and the Court, therefore, finds Dr. Witt's opinion, recommendations, and conclusions to be more persuasive."

However, the Court's finding that H.H. could be rehabilitated by her 19<sup>th</sup> birthday did not end its analysis. As the judge's decision noted (*In the interest of H.H.*, 1999, p. 25):

Since the Court has now determined that H.H. can be rehabilitated within the requirements of N.J.S.A. 2A:4A-26, the Court must now determine whether the prospect for H.H.'s rehabilitation substantially outweighs the reason for waiver. In weighing H.H.'s prospects for rehabilitation against the need for punishment and the deterrence of H.H. specifically, and as a means of generally discouraging others from committing similar crimes, this Court must consider five (5) factors: the commission of a grave offense; deliberateness of conduct; an older juvenile

offender; a past record of infractions; and a background of delinquency and exposure to the juvenile justice system.

The judge concluded his analysis of these factors and rendered his opinion as follows (*In the interest of H.H.*, 1999, p. 27):

While it is not necessary that all five factors set forth ...be present to require waiver...this Court finds that the only factor that is clearly present in this case is the severity of the offense. With the exception of the deliberateness of the act, which is not clear in this case, this Court finds that all of the remaining factors mitigate against waiver. Based upon this finding and this Court's hereinabove finding that H.H. can be rehabilitated within the time required by N.J.S.A. 2A:4A-26, the State's Motion to have this matter waived to the Law Division [Adult Criminal Court] is denied.

The judge's finding was not the end of this case's legal journey, however. The prosecution appealed the judge's decision, contending that even if one were to concede that H.H. could be rehabilitated by her 19<sup>th</sup> birthday, she should still be transferred to adult court. The prosecutor noted that rehabilitative potential is only one factor among many to be considered. He contended that other factors—such as the need for specific and general deterrence—outweighed any rehabilitative potential and that therefore H.H. should be transferred to adult court. He also noted that in New Jersey, the burden of proof is on the juvenile to show that transfer to adult court should not occur. The Appellate Division (based upon a review of briefs, records, and trial transcripts, rather than live testimony), on July 17, 2000 rendered a one sentence opinion on this appeal (*In*

*the interest of H.H.*, 2000), “The judgement is affirmed for the reasons stated in the opinion of Judge Jackson.”

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## Appendix A

**Psychological Report<sup>5</sup>**

**Name:** H.H.  
**DOB:** 1/20/83  
**Age:** 16 years

**Date(s) of Examination:** 1/26/99

**Examiner:** Philip Witt, Ph.D.

**Reason for referral:**

H.H. was referred for a psychological evaluation by her attorney, John Tumelty, Esq., subsequent to having been charged with attempted murder, aggravated assault, and weapons offenses arising out of the stabbing incident that occurred at Shore High School on January 6, 1999. Mr. Tumelty raised two questions:

1. With regard to the prosecution's motion for a waiver, can H.H. be rehabilitated by her 19<sup>th</sup> birthday with the resources available to the court?
2. With regard to her release to her grandmother's custody from the juvenile detention center, would H.H. be a danger to herself, her family, or the community?

**Sources of Information:**

- (1) Individual interview of H.H..
- (2) Joint interview of Lisette Thomas (maternal grandmother) and Mary Hastings (Ms. Thomas' sister, H.H.'s aunt).

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<sup>5</sup> To ease reading of this report, I have corrected typographical errors that, despite my best prior efforts, I found upon rereading the report.

(3) Review of materials provided by John Tumelty, Esq. including juvenile delinquency complaints; police reports; Shore Hospital records regarding H.H.; Family Service Association records regarding H.H.; high school grade transcript and various merit awards.

(4) Consultation with Jack Smith (Assistant Superintendent of Harbourfields Juvenile Detention Center)

(5) Psychological assessment instruments:

-Child Behavior Checklist (CBC) (Grandmother Informant)

The CBC is a 112 item objective personality test that results in descriptions of personality and behavioral characteristics of a child. The test is administered to a parent or caretaker who is asked to respond to the questions and apply the questions to the child being evaluated. Hence, the detailed parental description of the child is translated into the child's relevant personality traits.

### **Background:**

The records indicate that on January 6, 1999, H.H. is alleged to have stabbed another high school student with a 14-inch samurai knife she brought to school. The police report indicates that when the investigating officer came to the school, he found H.H. in a classroom crying. She told the officer that she had no friends except her boyfriend Ken and that she was angry and tired of being lied to. She reported to the officer that Susan, the girl she is reported to have stabbed, have been trying to act like a friend but had been in fact lying to her and trying to keep her and her boyfriend apart. She reported to the officer that she could not remember the actual stabbing incident.

The records regarding H.H. from Shore Hospital indicate that she was admitted on September 29, 1998 after a suicide attempt in which she took 30 Tylenol. Reportedly, a prior suicide attempt had been stopped by her boyfriend. She was kept in the hospital until October 3, 1998, when she was discharged to outpatient care at Family Service Association. Reportedly, there is a history of depression in the family. H.H.'s mother, reportedly a cocaine addict, had been murdered one-and-a-half years before in Atlantic City. In fact, H.H.'s mother had never raised H.H.; H.H.'s maternal grandmother, Lisette Thomas, had raised H.H. from a young age. The Family Service Association report of January 1999 indicates that H.H. had been struggling with moderate to severe depression. In fact, on January 4, 1999 she was found to be severely depressed, and her therapist recommended she see a psychiatrist for antidepressant medication. Ms. Thomas told the therapist that she would take H.H. to the family doctor to be evaluated for antidepressants either that night or the following day. Two days later, the stabbing incident at school occurred.

The school records regarding H.H. indicate that she has been an excellent student. Her grades during 1997 and 1998 are in the 80s and 90s, and she had numerous academic, sports, and extra-curricular merit awards dating back to 1996.

### **Joint interview of Lisette Thomas and Mary Hastings:**

During the joint interview, Ms. Thomas provided the majority of the information. She reported that she has raised her granddaughter, H.H., for almost all of H.H.'s life. H.H.'s mother – Ms. Thomas's daughter – had numerous legal and drug abuse problems, and consequently was not able to care for H.H.. H.H.'s mother lived in the Thomas household intermittently until perhaps 1987, when she left the household for good. In 1987, Ms. Thomas also obtained official legal custody of H.H.. H.H.'s mother was murdered in an as yet unsolved crime in June 1997. The children knew about the murder, and apparently other children did as well, since H.H. was teased and taunted at school regarding her mother's death.

Ms. Thomas reported that H.H. was in many ways a model child:

H.H. was always a good child, good in school. No behavior problems. No delinquent behavior, no running away...She got lots of awards. Always been very mature for her age...Very independent. At 14 she went every place looking for a job. Nobody would hire her because she was 14, but eventually somebody hired her. Taco Bell. Also she was working at the school office during the summer through a program. She doesn't like asking me for money. She had her goal set for college and her goal set for marrying this boy, Ken...

Ms. Thomas indicated that although H.H. does not have a lot of friends, she has had a steady boyfriend for two years and she has one close female girlfriend. In fact, her girlfriend's mother has reportedly offered to allow H.H. to stay in her home when Ms. Thomas is unable to care for her should H.H. be released from the juvenile detention center.

Ms. Thomas indicated that for reasons she does not fully understand, in September 1998, H.H. began showing signs of depression. Ms. Thomas suspects that it may be her reaction to H.H.'s mother's murder the prior year. Regardless of the reason, in September 1998, H.H. began having nightmares and requesting to sleep in Ms. Thomas's room. As noted in the records, in late September, H.H. also attempted suicide by overdosing on Tylenol. After the overdose and brief hospitalization, H.H. was in outpatient treatment. Ms. Thomas was unhappy with her therapist. Reportedly her therapist cancelled appointments on a number of occasions, not providing H.H. with the continuity of care that Ms. Thomas would have liked. Apparently since September 1998, H.H. had begun withdrawing from her grandmother. Her grandmother reported:

Since September, it's been hard talking to her. She says, "You don't listen to what I say. You don't understand." She would take everything I say literally.

Apparently, there were some conflicts regarding restrictions that Ms. Thomas placed on H.H.. Ms. Thomas is a religious woman and in fact serves as a minister. As a result, she was not willing to allow H.H. to stay out late at parties with boys. Although H.H. was generally compliant with Ms. Thomas's request – typically coming in promptly at her curfew hour of 10:00 p.m. – nonetheless H.H. apparently resented some of these restrictions.

Ms. Thomas and Ms. Hastings indicated that the family has a close network of relatives in the immediate geographic area in which Ms. Thomas lives. Consequently, should H.H. be released to her grandmother's care, even during those times in which Ms. Thomas is not physically able to be with H.H. due to Ms. Thomas's job as a real estate agent, other family members – particularly various aunts – would be more than happy to care for H.H..

#### **Interview of Jack Smith (Assistant Superintendent of Harborfields):**

Mr. Smith reported that H.H. has been depressed since her arrival at Harborfields. She initially would not eat. She is on suicide watch. H.H. has presented no conduct problems at Harborfields. She cooperates with staff and has had no conflicts with other residents.

#### **Interview of H.H.:**

H.H. presented as a tall African-American teenager. She was oriented to time, place, and person. Her thought processes, as assessed through the interview, were relevant and coherent. There were no signs of hallucinations or delusional thinking. In summary, there was no evidence of a thought disorder.

H.H. denied any current suicidal ideation. She did, however, acknowledge numerous signs of depression. She has little appetite, and her sleep is disturbed. Her mood is chronically dysphoric. She lacks energy.

H.H. reported that her depression began shortly before her mother's murder, in June 1997. Her mother was in constant conflict with her grandmother, and apparently this family conflict was the initial precipitant for H.H.'s depression. Shortly after, H.H.'s mother was murdered, and H.H.'s depression deepened. She experienced some relief from her chronically low mood when she became romantically involved with her boyfriend. However, she remained vulnerable to depression, and any conflict between her and her boyfriend led to crying and dysphoria.

H.H. described the normal conflicts with other teenagers, but she gave these conflicts added significance. She feels abused, mistreated, and betrayed by others. She reacts strongly to these perceived betrayals, in part because she is already emotionally vulnerable due to her dysphoric mood during the past one-and-one-half years. It was conflicts with her boyfriend that led to her two suicide attempts, and it was her perception

that the victim of the instant offense was “messaging with” her boyfriend that led to initially an argument and then to the stabbing.

H.H. reported no recollection of the offense. She recalled arguing with the victim, as well as her boyfriend. But she did not specifically recall taking the knife and stabbing the victim.

I questioned H.H. about why she was carrying a knife in the first place. She reported that her boyfriend gave her the knife for self-protection and encouraged her to carry it with her at all times. She had had the knife in her book-bag since he gave it to her for Christmas. She denied specifically bringing the knife to school that day with any intent to harm the victim.

H.H. expressed remorse regarding stabbing the victim. Some of her remorse was understandably self-centered, i.e., unhappiness about the serious consequences to her, such as incarceration. However, she appeared genuinely concerned and regretful about the consequences to the victim.

She reported that she still has goals for the future. She hopes to be an engineer or architect. She believes that her task-orientation and clear goals will keep her from any future aggressive acts.

### **Psychological test results:**

On the CBC completed by Ms. Thomas, she described H.H. as an academically and socially involved teenager, participating in a higher level of social, intellectual, and athletic activities than the typical teenager. Regarding problem areas, Ms. Thomas reported no evidence of externalizing problems, such as delinquent or aggressive behavior. Additionally, she reported no evidence of what are termed mixed problems, such as social problems, thinking problems, or attention problems. Ms. Thomas did, however, characterize H.H. as having a significant amount of internalizing problems. In particular, Ms. Thomas reported that H.H. has a very high level of somatic complaints, complaining of dizziness, weariness, aches, and headaches, as well as other physical symptoms. Additionally, she described H.H. as anxious and depressed, crying, being perfectionistic, and struggling with feelings of worthlessness.

### **Integration of findings and recommendations:**

H.H. is a 16-year-old with a variety of serious charges stemming from an incident in early January when she is reported to have stabbed another high school student. Regarding H.H.’s risk to the community, I will organize my findings along eight major factors that have been found to be related in the literature to risk of future serious offenses:

1. **Prior offenses/delinquent behavior:** Early contact with the criminal justice system, chronic delinquent behavior, and a variety of situations delinquent and rule-breaking

behavior occur (such as at home, in school, and in the community) are risk factors in this area.

H.H. shows none of the chronic conduct problems that are typical of most juvenile waiver cases I have seen. She has no history of prior contact with the law, no history of conduct problems as a child or adolescent, and no history of school-related difficulties, such as suspensions or disciplinary problems. On the contrary, she has been a model student and model child through most of her life.

2. **Family circumstances/parenting:** Inadequate parental supervision, inappropriate or inconsistent discipline, a chaotic, disrupted family environment, and a poor relationship between the teenager and his or her parents are common family-related risk factors.

Although H.H.'s father reportedly has little contact with her, and H.H.'s mother had significant criminal and drug abuse problems, neither H.H.'s mother nor father had been primary caretakers for H.H.. The primary caretaker for H.H. has been H.H.'s grandmother, Lisette Thomas, and Ms. Thomas shows no criminal or drug abuse history. Ms. Thomas is a stable, well-adjusted individual with strong moral and religious values. Her employment history is stable. Ms. Thomas takes parenting seriously: she appropriately monitors H.H.'s whereabouts, enforces a curfew, and holds H.H. to appropriate standards of behavior.

H.H.'s immediate family is not without problems, however. She feels misunderstood and unsupported by her grandmother. She described the communication between them as poor.

3. **Educational/employment stability:** Disruptive classroom behavior, low achievement, disciplinary infractions at school, truancy, and problems with teachers, or a poor and unstable job history (if the teenager has been working) are typical risk factors in this area.

H.H. shows no problems in this area. Her grades are excellent. She has numerous certificates of merit and achievement, ranging from athletics to peer leadership to computer club involvement. H.H. hopes to go to college, and her academic achievement supports this goal as a reasonable one. She shows none of the disruptive school behavior, disciplinary problems at school, or poor achievement that are more typical of juvenile waiver cases.

4. **Peer relations:** Lack of friends or association with delinquent friends are peer-related risk factors.

The evidence here is mixed. On the one hand, H.H. has had some difficulties relating to peers. She feels rejected and taunted by others. She is not a teenager with a wide circle of friends. Although her level of interpersonal conflict with peers is well within normal limits for a teenager, her level of reaction is intensified by her pre-

existing depression. Nonetheless, she has maintained a long-term romantic relationship and has at least one close female friend, whose mother in fact is willing to provide care for H.H. should H.H. be released from the juvenile detention center. H.H. shows none of the association with delinquent peers that is typical of juvenile waiver cases I have seen.

5. **Substance abuse:** Drug or alcohol abuse (or even significant use short of abuse in younger teens) and association with substance abusing peers are risk factors in this area.

H.H. shows no history of substance abuse whatsoever.

6. **Leisure recreation:** Limited (or lacking) positive organized leisure activities, and lack of positive personal interests are risk factors in this area.

H.H. shows a wealth of healthy, age-appropriate, productive leisure activities. Her numerous certificates of merit from school document her positive leisure activities. Additionally, she has also been employed, despite her youth.

7. **Personality functioning:** Inflated self-esteem, physical or verbal aggressiveness, a short attention span, poor frustration tolerance, and exploitiveness are typical personality risk factors.

H.H. shows none of the aggressiveness, exploitiveness, or self-centered attitude that would indicate chronic risk for aggression. On the other hand, during the past six months, H.H. has shown a number of signs of substantial depression. This depression is H.H.'s major risk factor regarding her potential to harm herself or others. During the past six months, she has had two suicide attempts – one serious, requiring hospitalization – and one instance of assaulting another – the instant offense. Her depression during this period has become increasingly severe to the point where just a few days prior to the instant assault, her therapist recommended she receive a medical evaluation for antidepressant medication. Although it is difficult to fully understand her reasons for stabbing the other teenager, particularly since her ability to recall and recount the actual assault is partial at best – nonetheless it is clear that this behavior is quite aberrant for H.H.. Her depression, in my opinion, both clouded her judgment and lowered her ability to control her aggressive actions, both towards herself and towards others. Her depression also has intensified her reaction to the normal peer conflicts of adolescence. It is this depression that requires treatment.

8. **Attitudes/orientation:** Antisocial/procriminal attitudes, defiance of authority, callousness towards others, and rejection of assistance are typical risk factors in this area.

H.H. shows no evidence of the kind of antisocial, procriminal attitudes frequently

evident in juvenile waiver cases. She has always been a compliant, cooperative child and teenager whose behavior and attitudes reflect a pro-social orientation.

In summary, the one major risk factor for H.H. is her depression. This depression has led to attempts to harm herself as well as, in the instant offense, another individual. Her depression has clouded her judgment.

I will address the referral questions in turn:

*1. With regard to the prosecution's motion for a waiver, can H.H. be rehabilitated by her 19<sup>th</sup> birthday with the resources available to the court?*

It is my opinion with a reasonable degree of professional certainty that H.H. can be rehabilitated with the resources available to the court by her 19th birthday. H.H.--as detailed above--shows none of the chronic aggressive, delinquent behavior typical of juvenile waiver cases. Her aggressive act was an aberration, precipitated by interpersonal conflict intensified by H.H.'s depression. It is primarily her depression that requires treatment. I recommend the following:

1. Psychiatric evaluation: H.H. may benefit from antidepressant medication. She should be psychiatrically evaluated for the appropriateness of such medication.
2. Individual psychotherapy: H.H. is open to receiving psychotherapy. She wants someone to talk to and confide in, which she has found lacking in her life.
3. Family therapy: Part of H.H.'s difficulties lie in her troubled relationship with her grandmother, her primary caretaker. H.H. feels unsupported by her grandmother. Any successful treatment will necessarily include her grandmother.

Fortunately, depression is a treatable disorder; there are empirically supported methods available for treating depression, including antidepressant medication, cognitive therapy, and interpersonal therapy. Assuming H.H.'s cooperation with the above treatment plan, her prognosis is good.

I understand that there are legal as well as clinical considerations, and the legal considerations are beyond my purview. However, clinically, once H.H.'s mood has been stabilized through inpatient treatment and medication, the remainder of the treatment plan could be implemented on an outpatient basis.

*2. With regard to her release to her grandmother's custody from the juvenile detention center, would H.H. be a danger to herself, her family, or the community?*

Given the seriousness of her actions – including both her attempts to commit suicide and the instant offense – it is my opinion that she requires a structured treatment environment as a transition to the community. Consequently, I do not recommend that she be released immediately to her grandmother's care. I recommend that to ensure that her depression

adequately stabilized and treated prior to her full release to the community, she initially be released to an inpatient adolescent treatment unit. On this unit, she could receive the intensive, daily treatment and the medication she needs to adequately stabilize her mood. Once she has become stabilized, she could then be released to her grandmother, assuming that H.H. has adequate aftercare, including both psychotherapy and medication.

I have discussed H.H.'s case with the admissions coordinator at South Jersey Hospital's adolescent inpatient unit in Bridgeton. He has given tentative approval for H.H.'s admission to the unit, pending further information and evaluation.

**DSM diagnosis:**

**Axis I:** 296.22 Major depressive episode, moderate

**Axis II:** no diagnosis

**Axis III:** diagnosis deferred

**Axis IV:** Severe stressors, including mother's murder, suicide attempts, and stabbing leading to incarceration

**Axis V:** GAF: 55 (moderate impairment)

Philip Witt, Ph.D.

*Diplomate in Forensic Psychology, ABPP*

Date: 1/26/99

## Appendix B

4/6/99

John Tumelty, Esq.  
539 S. Shore Road  
Palermo, NJ 08223  
fax: 609-390-0722

RE: H.H.

Dear Mr. Tumelty:

You have asked me to address whether H.H. is safe to release to the community in her grandmother's custody, pending resolution of her charges. On today's date, I have interviewed H.H. in person, interviewed H.H.'s grandmother by telephone, and interviewed the juvenile officer who brought H.H. to my office (who indicated she is in charge of H.H. at the juvenile detention center). I also reviewed records from Family Service Association records and South Jersey Hospital records. Finally, I administered an objective personality test for adolescents—the MACI—to H.H..

H.H. presented for the present interview with a very different demeanor than during my prior evaluation of her in January 1999. During the January interview, H.H. was obviously depressed. Her affect was flat, her expression downcast. During the present interview, H.H. was animated, expressive, and showed an appropriate range of emotion. She laughed and smiled at humorous moments during the interview, and was appropriately serious when discussing, for example, her offense. Her thinking was clear. She reports that since she has been taking antidepressants—Zoloft and Trazadone—her mood has stabilized and she no longer experiences the chronic depression from which she suffered. She stated:

Since I've been on the medication, my moods have been better. I'm not crying anymore. Used to cry all the time. I can think clearly now. I can take problems as they come now instead of being all confused.

She reported that her appetite has returned and her sleep is good. She no longer has suicidal thoughts. She is productive at the juvenile detention center. She is teaching herself Spanish.

H.H. is now able to accurately describe negative consequences of her past and potential actions far better than during my first interview of her in January. For instance, she stated:

If I committed suicide, first, I'd go to hell. And my grandmother wouldn't take that well. She could leave and there wouldn't be anyone to take care of my brother and sister...[Examiner: What do you think the girl you stabbed experienced?] Put her through hell, pain. I would guess she's mad at me now and hates me...I remember how I was feeling when I was in the hospital [after the suicide attempt], and I don't want to put anyone through that pain.

H.H. hopes that upon her eventual release to go to a two-year college, then a four-year college, and eventually to pursue a career in art. She plans to obtain her GED as a first step.

H.H.'s grandmother, Lisette Thomas, corroborated much of H.H.'s account. Ms. Thomas visits H.H. twice per week. She has noticed considerable stabilization in H.H.'s mood during the past few months that H.H. has been taking antidepressants. She reported that H.H. has also received counseling at the detention center from outside staff. Ms. Thomas indicated that H.H. would hopefully be released to her custody on home detention, with Ms. Thomas' sister caring for H.H. during the day (when Ms. Thomas works). The juvenile worker who brought H.H. to my office also corroborated H.H.'s account that she has been stable and her depression abated.

On the MACI, H.H.'s results are mixed. She shows a complaining tendency, focusing on problems and faults. Her profile still shows evidence of significant peer insecurity, depression and anxiety, indicating that these difficulties require further treatment. On the other hand, there are no signs of impulsivity, hostility, or aggression in her profile. Her personality style is anxious, inhibited, and submissive. She presents as a shy teenager with substantial anxiety about rejection by others.

In summary, H.H. appears to have responded well to her antidepressant medication and whatever counseling, however intermittent, she has received at the juvenile detention center. It is my opinion that H.H. could be safely released to her grandmother and aunt's custody pending resolution of her charges. Naturally, she requires continued treatment—both psychological and pharmacological—upon her release.

Yours truly,

Philip Witt, Ph.D.

*Diplomate in Forensic Psychology, ABPP*