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Evaluation and Restoration of Competency to Stand Trial

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The right to be competent to stand trial has a rich history that has evolved through legal doctrine identified in 14th century common law (Blackstone Commentaries), through protections identified in the U.S. Constitution (6th and 14th Amendments), and further elucidated in U.S. Supreme Court decisions (*Dusky v. United States*, 1960; *Drope v. Missouri*, 1975), and emergent state law (e.g., Va. Code § 16.1-356). The constitutional basis for adjudicative competence derives from the Due Process Clause in the U.S. Constitution, which requires that an accused person not be deprived of life, liberty, or property without due process of law. With this protection comes the implicit assumption that the individual must have the requisite ability to exercise the rights afforded to them for such rights to be of intrinsic value to the individual and to society.

Adjudicative competency or competency to stand trial is a functional assessment that addresses capacities rather than knowledge, is contextual in nature, and calibrated according to the complexity of the legal situation facing each defendant (Christy, Douglas, Otto & Petrila, 2004; Mossman et al., 2007; Zapf & Roesch, 2006). The test for competence was articulated in *Dusky*, ruling that the defendant had to have and be able to demonstrate “. . . sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and a “rational as well as factual understanding of the proceedings against him(p.402). *Dusky* has been interpreted to include three elements: a *factual understanding* (i.e., the defendant understands the role of legal personnel, procedures, and terms), a *rational understanding* (i.e., the defendant has the ability to apply that information without distortions created by mental illness or developmental immaturity to his/her own situation), and the ability to *assist counsel* (i.e., the defendant understands the privileged nature of the relationship, communicates facts of the case to the attorney, understands and responds to attorney’s inquiries, and collaborates with the attorney in developing a defense). The *Dusky* decision has been further interpreted to include the ability

to reason about decisions and to waive counsel, prompting the U.S. Supreme Court to opine that “the competence that is required of a defendant seeking to waive his right to counsel is the competence to waive the right, not the competence to represent himself” (*Godinez v. Moran*, 1993) (p. 399). While these deliberations were under way by the Supreme Court, Bonnie (1992) offered a related reconceptualization of the standard for competency to stand trial that he called adjudicative competency. This term is now used broadly to refer to competency to stand trial so as better capture the legal decisional requirements of the majority of defendants who never proceed to trial but rather find resolution of their charges through a plea bargain.

Historically, adjudicative competence was relevant only in criminal court. The juvenile justice system was predicated on the legal doctrine of *parens patriae* or guardianship of youth, which derived inclusively from their less mature and more vulnerable condition as children. Consequently, the juvenile justice system was designed and implemented to address therapeutic and rehabilitative goals rather than to serve a deterrent or punitive function as seen in criminal court. Concern over an absence of constitutional protections for youth in the juvenile justice system, however, emerged as the juvenile justice system became more adversarial beginning in the 1960s. In *Kent v. United States* (1966), Justice Fortas observed when considering the transfer of Morris Kent to criminal court 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” (p. 556) A year later, when considering the due process rights of Gerald Gault, Justice Fortas commented, “neither the Fourteenth Amendment nor the Bill of Rights is for adults alone” (*In re Gault*, 1967) (p.13). Based upon this edict, the Court concluded that juveniles subject to delinquency hearings were entitled to notice of the charges against them, the right to legal counsel, the right against self-incrimination, and the right to confront and cross-examine witnesses. In 1970, the court determined in

In re Winship (1970) that every element of an offense had to be proven beyond a reasonable doubt, thereby vacating the previous standard of a preponderance of the evidence and further accentuating issues of guilt and punishment in juvenile court.

Although these decisions helped to change the landscape of juvenile court, as of yet, the U.S. Supreme Court has not ruled on whether juveniles must be competent to proceed to trial (Felthous, 2011; Redding & Frost, 2001; Soulier, 2012; Soulier & Scott, 2010) nor whether and how *Dusky* applies to juveniles (Bonnie & Grisso, 2000; Soulier, 2012). Consequently, there is no single, recognized standard for juvenile competency to participate in a delinquency proceeding (Soulier & Scott, 2010). Furthermore, states vary in whether and how they address juvenile adjudicative competence (Larson & Grisso, 2011; O'Donnell & Gross, 2012; Sanborn, 2009). Nonetheless, perhaps out of concern for or as a strategy to help youth, defense attorneys are increasingly raising the issue of adjudicative competency in juvenile court (Kruh & Grisso, 2009; Larson & Grisso, 2011; Soulier, 2012; Soulier & Scott, 2010).

Although juvenile competency is less settled in the legislative arena, a comprehensive body of research on the clinical and developmental differences in juvenile adjudicative competence has emerged (Fogel, Schiffman, Mumley, Tillbrook, & Grisso, 2013). Two bodies of research, one that has considered chronological age and the other focused on developmental maturity (i.e., incomplete development in one or more domains--neurological, social, emotional--which manifest in functional limitations relative to a specified comparison group; see Grisso, 2005), have converged in recent years, yielding a growing consensus that there are few meaningful differences between older adolescents and adults in their cognitive abilities to reason logically about moral, social, and interpersonal matters (Cauuffman & Steinberg, 2000; Furby & Beyth-Marom, 1992; Sarkar, 2011; Scott, Reppucci, & Woolard, 1995; Soulier, 2012; Steinberg, 2007; Steinberg et al., 2009). In contrast, reasoning--the "cognitive capacities to process information"--and judgment--the "processes of attaching differential importance

to various possible consequences of decisions”--are two integrative functions that are developmentally and age specific. These two functions are central to legal decisional capacity and are pivotal in understanding why adolescents do not reach the same decisions as adults (Bonnie & Scott, 2013; Cauffman & Steinberg, 2012; Grisso, 2000). Further, they help to explain why other aspects of psychosocial development, such as emotion regulation (Mayzer, Bradley, Rusinko, & Ertelt, 2009), can tax the decision making abilities of children and adolescents, particularly when faced with high stress and complex situations (Redlich, 2007).

It is against this backdrop that a juvenile’s adjudicative competence is evaluated and, if deemed incompetent by the court, ordered into restoration services. These topics are addressed in the remainder of this chapter.

Raising the Issue of Adjudicative Competence in Juvenile Court

In most jurisdictions, any member of the court has the option of raising the issue of juvenile competency: the prosecutor, the defense attorney, the judge, or the guardian ad litem (Larson & Grisso, 2011; Viljoen, McLachlan, Wingrove, & Penner, 2010). However, defense attorneys are the primary source for recognizing competence concerns and in the majority of instances bear the burden of proving incompetence when the issue is contested (Redding, 2002).

Viljoen et al. (2010) conducted the only study estimating the percentage of cases in which juvenile competency is raised. In a survey of 214 defense attorneys affiliated with the National Association of Counsel for Children and Youth (NACC) and/or the National Juvenile Defender Center (NJDC), attorneys indicated that they had concern about competency in approximately 10% of their clients. However, only 53% of defense attorneys indicated that they actually sought a competency evaluation when they had such concerns.

Scholars (Jackson, Warren, & Coburn, in press; Varela, Boccaccini, Gonzales, Gharagozloo, & Johnson, 2011; Viljoen et al., 2010) have identified several barriers to raising the issue of competency: some of the offenses are minor; the youth or parents did not want a competency evaluation; a competency evaluation would delay proceedings; there is a belief by the youth or parents that the youth is likely to be found competent anyway; there are insufficiently clear legal standards to know when a juvenile competency evaluation should be requested; there is the desire to avoid the stigma associated with a competency evaluation; some attorneys continue to believe that competence is less relevant in juvenile court; and finally, some judges are characterized as having a resistant attitude to this issue as identified by the defense bar. In addition, high caseloads and limited training in recognizing competency-related issues are also cited as reasons why the issue of adjudicative competency is raised relatively infrequently in juvenile court (Viljoen et al., 2010).

These barriers are used to call for more adequate training and reasonable levels of compensation for attorneys representing youth in juvenile court (Burrell, Kendrick, & Blalock, 2008). Research has suggested that sufficient training affects the outcome of the competency evaluations that are conducted and presented to the court. Finkle, Kurth, Cadle, and Mullan (2009) found that referring defendants to a specialized mental health court increased the finding of incompetency from 43% in the first year of the program to 72% by year three. Grisso (2004) echoes these sentiments, asserting that perhaps the primary obligation owed to delinquent youths is ensuring them access to well-trained and experienced defense attorneys.

In criminal court, the *Pate v. Robinson* (1966) and *Drope v. Missouri* (1975) decisions mandate that if there is a genuine concern, the issue of competence must be raised. This mandate is less clear in juvenile court. In making recommendations for California's handling of juvenile competence, Burrell et al. (2008) recommend that states clearly delineate procedures for raising the issue of competence.

Soulier (2012) has suggested four conditions that should prompt inquiry into a juvenile's competence to stand trial: age 12 or younger; prior diagnosis/treatment for a mental illness or mental retardation; borderline level of intellectual functioning or a record of learning disability; and/or pretrial observations by others that suggest deficits in memory, attention, or appreciation of reality.

This list is supported by a surprisingly small body of research. The few studies that have compared juveniles referred for a competency evaluation compared to those not referred have found that incompetent youth tend to be younger (Baerger, Griffin, Lyons, & Simmons, 2003; Cowden & McKee, 1995; Kruh, Sullivan Ellis, Lexcen, & McClennan, 2006; McKee, 1998; McKee & Shea, 1999), have more severe clinical diagnoses or a history of mental health treatment (Baerger et al., 2003; Cowden & McKee, 1995; Kruh et al., 2006), have a history of special education (Baerger et al., 2003; Cowden & McKee, 1995; Kruh et al., 2006), and have lower intellectual functioning (Kruh et al., 2006; McKee & Shea, 1999). Research indicates that in practice, defense attorneys are more likely to raise the issue of competency when the youth is younger, charged with a serious offense, and has demonstrated more extensive legal deficits (Viljoen et al., 2010). However, defense attorneys are less likely to raise the issue of competency solely for the reason of developmental immaturity (Viljoen et al., 2010).

The role of defense attorneys. Defense attorneys representing juveniles may have a particularly difficult task, as their training often has not encompassed the experiences that are unique to representing children and adolescents in juvenile court (Birckhead, 2010; Frost & Volenik, 2004). Interviewing and collaborating with children and adolescents can prove far more challenging than an inexperienced attorney might anticipate. Defense attorneys are also trained to rely on their client's expressed interest rather than on their best interest, a principle that can be complex in its implementation when working with a vulnerable latency-aged child or a recalcitrant teenager. The degree with which a child of 8 or 9 years can appropriately exercise their decisional autonomy in an age

appropriate manner can make this aspect of representation complex, and is rather fluidly composed of providing information, seeking to advocate for a child, and listening authentically to their preferences and wishes concerning the development of their case. There is currently no privilege that protects a parent from having to testify to information provided to them by their child, as exists between a husband and wife, and the defense attorney must therefore also serve a communicative role to and with the parents (this information simply becoming hearsay if conveyed to the parents by a third party such as the attorney) to protect the child from this type of potentially damaging disclosure.

Judicial responsibility for referring juveniles for a competency evaluation. Once the issue of competence has been raised, the judge is responsible for referring a juvenile for an adjudicative competency evaluation (Finkle et al., 2009; Viljoen & Roesch, 2005). The proceedings are then stayed until an evaluation can be completed and the judge makes a determination concerning competency (Soulier, 2012). Pate held that the trial court has a duty to order a competency evaluation whenever there is a bona fide question about the defendant's ability to proceed (Finkle et al., 2009), although there is no U.S. Supreme Court guidance on this issue in the context of juvenile court.

Juvenile Evaluator Qualifications and Training

The emergence of juvenile competency law has by its very nature created the need for juvenile forensic evaluators who are qualified to offer informed opinions to the court, both when the issue is first raised and after the remediation efforts have been completed. Perhaps the longest-standing training for this type of forensic activity is based at the University of Virginia, where the Institute of Law, Psychiatry and Public Policy (ILPPP) initiated a 6-day training program in 2001 shortly after the juvenile competency laws were implemented on July 1, 1999. The structure of this training built upon the 5-day adult forensic training program that had been offered by the ILPPP since 1981 on contract with the Virginia Department of Behavioral Health and Disability Services. The statutes used for ordering the adult and

juvenile assessments of competency (and sanity) in the case of criminal court contain explicit language requiring that all forensic evaluators who conduct mental health assessments in the Commonwealth of Virginia must have completed a forensic training program recognized and approved by the Commissioner of Mental Health. To attend the basic juvenile forensic training programs, the applicants must demonstrate at least 2 years of prior experience working in a mental health or residential setting with children and adolescents.

The 6-day juvenile training program was designed to capture the distinct processes that characterize the forensic evaluation of children and adolescents. Lectures offered by a multidisciplinary faculty are both generic on the methods of conducting any type of forensic assessment and specific to juvenile topics, including the juvenile justice system, juvenile competency laws in Virginia, research on juvenile competency, developmental issues pertinent to adjudicative competency, psychiatric conditions common to children and adolescents, neurobiological development, clinical issues unique to juvenile defendants, malingering, transfer, expert testimony, and report writing. Cases are also presented of youth aged 8 to 17 years of age to engender a discussion of the calibration issues that can be particularly complex when working with individuals below the age of 18 years. After the completion of the program, all attendees are required to complete a multiple choice open manual exam and submit a work product of a juvenile competency evaluation that is reviewed by faculty before their names are posted to the expert directory maintained by the ILPPP for use by Virginia courts.

Recently, Heilbrun and DeMatteo (2012) attempted to address the issue of establishing professional standards for conducting juvenile forensic mental health assessments. They argue that a juvenile forensic evaluator needs to possess a range of skills that combine experience in working with children and adolescents with knowledge of specific aspects of the legal system, including communication, discovery, deposition, and testimony, particularly those which uniquely apply to the

juvenile system (e.g., shorter timeframes for completing evaluations, less formal rules of evidence, interjection of judge's questions during testimony). They, along with other authors, emphasize the importance of training in human development and the ways that developmental changes may affect legal decisional capacities (see, e.g., Ferguson, Jimenez, & Jackson, 2010; Grisso, 2005; Grisso et al., 2003; Heilbrun & DeMatteo, 2012; Soulier, 2012), the importance of acquiring skill in assessing clinical characteristics of youth taking into account the instability in personal characteristics during adolescence, and the importance of understanding fully the differences between juveniles and adults who are afflicted with mental illness and mental retardation. These are differences that can be expected to play a significant role in their understanding of the legal process (Ferguson et al., 2010). Generally, these authors argue that specialized juvenile forensic training is required to obtain greater consistency and quality across evaluators. However, the more stringent the professional requirements, the more difficulty a state may face in finding qualified evaluators (Larson & Grisso, 2011). Regardless, mental health clinicians are urged to decline a referral when they do not possess the requisite qualifications (Heilbrun & DeMatteo, 2012).

Professional credentials. One issue that has created a considerable amount of debate and controversy, particularly in the juvenile arena, involves the professional credentials that are required in order to be recognized by statute or administrative edict as qualified to conduct juvenile adjudicative competency assessments. Some states such as Virginia, Michigan, Arizona, and Florida have either explicitly included licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists in their statutes or stated more generically that the evaluations will be performed by "mental health experts." Alternatively, states such as Arkansas, Kansas, Minnesota, Ohio, and Idaho require that the evaluations be conducted only by clinical psychologists and psychiatrists. Those who advocate for licensed master-level mental health providers being included in the pool of

evaluators (e.g., Siegel, 2008) point to their broad experience in providing mental health services to youth in community mental health, educational, residential, and detention settings; their skills in working with youth in a family context; their availability in more rural areas where clinical psychologists and psychiatrists are sparse; and their demonstrated abilities when provided comprehensive training on juvenile competency issues. In contrast, advocates who argue for the exclusion of master-level evaluators point to the psychological testing that can be relevant either directly or through reference to earlier reports; the more nuanced clinical skills required to diagnose children and adolescents accurately; the importance of medication management in understanding some aspects of disruptive behavior by youth; the complexity of neurobiological and behavioral research that is central to understanding juvenile competency; and the perceived higher status that accrues in the court when the assessment is conducted by doctorally or medically trained professionals. The experience of each state in developing a juvenile forensic service delivery system, compounded by the lobbying efforts of different professional groups, will undoubtedly continue to affect this national debate and the decisions made in response to it over the next decade. Our experience in Virginia, however, has demonstrated over the past 15 years that it is the quality of training and mentorship that follows that determines the quality of the assessment, report writing, and testimony that follows rather than the professional qualifications of the licensed mental health provider.

The Juvenile Competency Evaluation

Competence to stand trial evaluations are the most common forensic mental health evaluations conducted in the United States for both juveniles (Bonnie & Grisso, 2000) and adults (Melton, Petrila, Poythress, & Slobogin, 2007), with an estimated 60,000 competency evaluations being cited widely as the number of assessments conducted nationally each year (Bonnie & Grisso, 2000). The standard set out

in *Dusky* is generally adopted in the juvenile statutes that have arisen across the country. Specifically, *Dusky* asserts:

“the test must be whether [the defendant] has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against him” (p. 402).

While relatively brief in content, this standard contains a number of conceptual components or features that are central to the associated forensic assessment. First, it identifies two prongs that are relevant to the assessment, one being an understanding of the legal process and the respective roles of the various participants, and the other being the ability of the defendant to consult and collaborate with counsel in determining the nature of the defense and the role that the juvenile will play in presenting it. Second, the standard underscores that these abilities are being assessed as they are presently demonstrated, leaving the door open for this competence state to fluctuate over time given changes in mental state, levels of maturity, and situational factors that can affect the functioning and experience of children and adolescents often more extensively than in adults. Third, the *Dusky* standard references the capacity of youth and not the state of knowledge that is manifest at the time of the assessment. This component of the *Dusky* standard is particularly relevant to youth who might, due to their more limited experience, possess a more limited understanding of the court process. It also underscores the importance of trying to educate the youth during a competency evaluation to assess whether the adolescent is able to understand and apply new legal information to their emerging legal situation. Fourth, the standard addresses the need for a factual as well as rational understanding of these different dimensions of the standard. This distinction is often explained in terms of the ability of the youth to both offer a rote definition of various legal terms and to apply legal constructs to their own legal situation. It is this need to extrapolate abstract ideas that most directly relates to the importance

of developmental considerations in the assessment of juvenile competency, as many youth under a certain age will be developmentally limited in their levels of abstract thinking and their attendant ability to apply legal constructs to their own situation (Grisso, 2005). Fifth, in integrating these many considerations into the assessment and the resulting conclusion, it is important to make reference to the requirement that the different capacities identified by *Dusky* are required to a reasonable degree but not an impeccable degree of understanding. This component of the standard is often expressed in the assertion that the standard for competency is not particularly high and varies according to the complexity and seriousness of the legal context that is facing the juvenile. In 1974, the Group for the Advancement of Psychiatry cautioned that a list of competency inquiries was meant only to indicate areas of inquiry and should not leave the impression that “enormous legal sophistication is required of both psychiatrist or defendant” (Melton et al., 2007, p. 128). Finally, the assessment of adjudicative competency is functional and not based on any specific psychiatric, intellectual, or developmental deficit. Recently, Hoge (2012) emphasized that the mere presence of age, mental illness, mental retardation, or developmental immaturity does not equate with or automatically constitute incompetency, asserting that the evaluation must demonstrate the specific functional deficits that link to the *Dusky* standard and prevent the youth from adequately understanding and participating in the legal process.

Time constraints. Tension exists between the needs of evaluators for sufficient time to gather relevant collateral information, and the needs of the courts to have a speedy trial (Larson & Grisso, 2011). A competency evaluation extends the time that the juvenile is in the pretrial legal process and therefore states limit the amount of time permitted to conduct a juvenile competency evaluation and submit a written report to the court, typically ranging from 10 to 45 days (Larson & Grisso, 2011). Virginia statutes (Va. Code §16.1 356), for example, requires that all collateral information must be

provided to the evaluator within 96 hours of the issuance of the court order and that the evaluator must submit the competency report to the court no longer than 14 days after the receipt of all required information. Larson and Grisso (2011) similarly recommend 2 weeks post-court order to complete the evaluation.

Location of the evaluation. In recent decades, states have adopted the “least restrictive alternative” (i.e., least restrictive setting possible), which permits competency evaluations to be performed in the evaluator’s office (i.e., in the community) or in pretrial detention centers (Larson & Grisso, 2011). However, youth hospitalized for a psychiatric illness may have their competency evaluated while residing in a secure setting. For example, one Virginia statute (Va. Code §16.1.356) explicitly states that the evaluation of each youth shall be conducted on an outpatient basis at a community services board, or behavioral health authority, juvenile detention home, or juvenile justice facility unless the court specifically finds that the results of the outpatient competency evaluation indicate that hospitalization of the juvenile is necessary or the juvenile is currently hospitalized in a juvenile hospital. This hospitalization option is used sparingly, primarily in cases where the initial evaluation suggests malingering so further observation and assessment are required.

The right to avoid self-incrimination. The competence evaluation cannot violate the defendant’s 5th Amendment right to avoid self-incrimination. During a competency evaluation, youth are asked to recite the events that led up to their arrest; consequently, important evidentiary information is often obtained during the evaluation. To protect against this type of disclosure, some states include 5th Amendment language in their statutory code while others include it in the model court order that is used in ordering the evaluation by the court. One example of this language states that “[n]o statement or disclosure by the juvenile relating to the alleged offense made during a competency evaluation ordered pursuant to Va. Code §16.1-356 or services offered according to Va. Code §16.1-356

may be used against the juvenile at the adjudication or disposition hearing as evidence or as the basis for such evidence” (Virginia Code 16.1-360). These same protections are integral to the provision or restoration services after a determination of incompetency as the youth is often inclined to discuss the offense with the remediation services provider who works with the juvenile multiple times a week often over a 2- to 3-month period.

The right to counsel. Larson and Grisso (2011) note that youth can undergo a competency evaluation in the absence of counsel — if this stage of the adjudication is determined not to be a “critical stage” of the adjudication (p. 49). However, citing a statute from the Louisiana state code (LA CHC 832,2005), the authors recommend that when a question of competency is raised no further steps in the delinquency proceeding occur until counsel has been appointed and the youth has been determined competent to proceed. Whether to submit to an evaluation may have important implications for the outcome of the case and therefore youth should be able to consult with their attorney about this issue. Melton et al. (2007) address this issues in the criminal context and suggest that professional guidelines and the ABA Criminal Justice Mental Health Standards (1984) agree that a clinician asked to evaluate a defendant acquires an ethical responsibility to ascertain if the defendant is represented by counsel, and if this is not the case, to defer the evaluation until one has been obtained.

The Process of Conducting the Juvenile Competence Evaluation

The majority of evaluations of adjudicative competency are conducted upon a court order and therefore do not technically require the assent of the youth or the consent of a parent or guardian. Ethical considerations, however, require that the evaluating clinician make a bona fide effort to inform the youth of the parameters of the evaluation, its purpose and nature, and the limits to confidentiality that are intrinsic to it. Many clinicians also proceed by obtaining not only the assent of the youth (Soulier, 2012), but also the consent of the juvenile’s parent or guardian. The inclusion of the parent or

guardian may lengthen the preparation time that proceeds the evaluation but is viewed by many as integral in ensuring their cooperation with and contribution to the evaluation process and their involvement with services should the youth be determined incompetent to stand trial.

Prior to completing the assessment, clinicians are advised to speak with the referring party to determine the reasons and behavior that lead to the initiation of a competency assessment. This will most often be the defense attorney, as defense counsel is expected to have had the most contact with the juvenile at this point in the adjudication process and is singularly involved in a privileged, ongoing relationship with the youth. Often by statute or practice standards, the referring party is also responsible for collecting and providing to the evaluating clinician the background collateral information that can be central to understanding the youth's prior mental health treatment, educational/psychological testing, and involvement in special educational services. With youth in particular it is essential that this background material be obtained, as it is often difficult to accurately identify certain mental disorders, assess the significance or applicability of medication compliance to the impairments being observed, and determine the long-standing nature and seriousness of particular disorders without this type of documentation and review. In cases when the attorneys are lax in providing this information, it falls to the evaluating clinician to seek this information avidly in the context of the time limits that are generally associated with competency assessments in juvenile court.

Soulier (2012) outlines the six components of a competency evaluation: assessment of mental disorder or intellectual disability; assessment of functional abilities for adjudicative competence; assessment of developmental status; linkage of deficits to functional abilities for adjudicative competence; an opinion of competence; and the potential for remediation/restoration when the youth is opined to be incompetent. Each of these components requires the integration of clinical observation with the assessment of functional capacities, considering the legal context of the assessment and the

developmental maturity of the juvenile as applied to a reasonable standard of observed capacity and the ability of the youth to remedy deficits in knowledge through simple interactions with counsel. The synthesis that is required to adequately consider all of these elements simultaneously underscores the importance of professional training to ensure calibration between different evaluators working within a single forensic system.

The role of psychological testing in competency evaluations is somewhat controversial, with psychologists possibly exaggerating its importance to an assessment that is functional in nature and for which rather extensive testing appears to be the norm rather than the exception. In a small number of instances, however, further intellectual or neuropsychological testing may be warranted, particularly when the diagnosis is unclear and there is no consistent history to point toward an underlying pathology. In cases in which malingering is suspected, the clinician may also want to use certain tests to help provide more objective evidence of a response style that seems inauthentic (for example, the Test for Memory Malingering (TOMM), the Test of Malingered Incompetency (TOMI), and possibly the Structured Interview of Reported Symptoms (SIRS) with older youth). However, as observed by Melton et al. (2007), routine administration of psychological tests often is not a cost efficient way of gathering information that is directly relevant to competency assessments.

In contrast, structured instruments designed specifically to assist with the competency assessment can serve a useful function in standardizing assessments across clinicians and in assisting in capturing all of the relevant information as part of their evaluation (Kruh & Grisso, 2009; Mayzer et al., 2009; O'Donnell & Gross, 2012). The most common tests used in the field at this time include the MacArthur Competence Assessment Tool – Criminal Adjudication (Hoge et al., 1997), the Fitness Interview Test – Revised (Viljoen, Vincent, & Roesch, 2006), the Georgia Court Competency Test-Mississippi State Hospital Revision (Nicholson, Briggs, & Robertson, 1988), the Competence Screening Test (Lipsett, Lelos,

& McGarry, 1971), the Competency Assessment for Standing Trial for Defendants with Mental Retardation (Everington & Luckasson, 1992), and the Evaluation of Competency to Stand – Revised (Rogers, Grandjean, Tillbrook, Vitacco, & Sewell, 2001). However, none of these instruments were designed for or normed on juvenile samples (Ferguson et al., 2010; Fogel et al., 2013; O'Donnell & Gross, 2012; Soulier, 2012) and many were designed prior to the research on the relevance of developmental immaturity to adjudicative competency in juveniles.

The Juvenile Adjudicative Competence Interview (JACI) (Grisso, 2005) has served an instrumental role in explaining the process of the evaluation to new evaluators, in ensuring that the relevant legal inquiries have been made, and in integrating psychopathy and developmental issues into a coherent opinion concerning the functional, causal, and contextual considerations that underlie competency. With the advent of new competency laws, it has served an essential function in guiding the field and providing some standardization across evaluators and states. Its use as a quasi-quantitative instrument with the counting of correct answers is a misuse of the measure, however. The JACI is not normed, prompting scholars to call for new measures of juvenile competency designed to detect deficits in competence-related abilities associated with psychosocial and/or cognitive immaturity and that assess malingering (Ferguson et al., 2010; Fogel et al., 2013; Heilbrun & DeMatteo, 2012; Poythress, Lexcen, Grisso, & Steinberg, 2006; Soulier, 2012; Viljoen, Penner, & Roesch, 2012).

The legal questions that need to be addressed in a competency assessment have been identified by many legal scholars, forensic clinicians, and forensic researchers (Grisso, 2005; Larson & Grisso, 2011; Melton et al., 2007). Soulier (2012) has succinctly suggested that an adjudicative competence evaluation should assess the juvenile's factual and rational understanding of the court proceeding by discussing: (1) the alleged criminal offense, including its relative seriousness and the potential penalties; (2) the roles of all of the participants in a trial, including the prosecutor, defense attorney, judge, and witnesses; (3) the

basic purpose of a trial and the adversarial nature of court procedures; (4) the implications, drawbacks, and benefits of a plea bargain; (5) the trial-related rights including the right to deny an offense and the avoidance of self-incrimination; and (6) the reasoning a juvenile would use if faced with common legal choices and options such as a plea bargain. In assessing the youth's ability to assist counsel, he suggests that the evaluator should discuss: (1) the name, purpose, and relationship of a defense attorney; (2) the level of motivation to help and trust a defense attorney; (3) the youth's ability to communicate, understand, and retain information; (4) the youth's ability to process and respond rationally to new information; (5) the youth's ability to articulate facts pertaining to the alleged offense; (6) the youth's ability to maintain proper courtroom behavior; and (7) the strengths and weaknesses of a potential trial.

It is still unclear to what extent juvenile competency evaluators actually assess maturity and address it directly in their reports to the court (Cox, Goldstein, Dolores, Zelechowski, & Messenheimer, 2012). The rather severe intellectual deficits and significant mental illnesses found among many youth who are adjudicated incompetent suggest that developmental considerations may be overshadowed by the intellectual deficits and clinical symptoms found among this population of youth. The research that has been conducted on this topic has identified many relevant developmental constructs, however, including autonomy, temperance, perspective, developmental stage, judgment, reasoning and decision making ability, future orientation, risk perception, peer influences, the influence of the parental relationship, and suggestibility and compliance with others (Larson & Grisso, 2011; Soulier, 2012). The challenge in juvenile competency assessments involves contextualizing these more subtle influences in the context of rather severe psychopathology and significant intellectual disability according to a legal standard that is rather low in its demands for defendant capacities. However, as noted by Viloen and Wingrove (2007), judges seem poised to consider immaturity in their deliberation of competency, thus obliging evaluators to consider these influences carefully and to educate the court about them when

relevant to the opinion being offered by the expert. This, however, can prove difficult when the very environment in juvenile court is responsive to the immaturity of its constituents, making it necessary to identify specific deficits with a specific impact on the legal decisional capacity of a specific youth. It is also possible that the relatively low standard captured by the competency doctrine makes these developmental issues less compelling in relationship to the significant psychiatric and intellectual deficits that are identified in many youth referred for competency evaluations.

Feigning incompetency. The assessment of malingering is an important consideration in forensic assessments. Youth are also possibly more proficient than adults in passing on information, particularly in detention settings, that can educate and inform other youth as to the nature of the competency assessment and the significant impact it can have on their legal situation should they be found incompetent to stand trial. As in other assessments, malingering is best assessed using information elicited from multiple sources to look for inconsistency, obtaining mental health and educational records to help in assessing an inexplicable deterioration in functioning, and in some instances arranging for an inpatient assessment to provide 24 hour observation of a youth over a period of multiple days. Despite this being a necessary consideration in all forensic evaluations, clinicians seem overly hesitant about identifying malingering, particularly even more so when they are evaluating a child or adolescent. This propensity is further aggravated by some efforts to turn competency assessments into a question-answer session with no effort to explore behaviors and abilities outside the assessment context. As indicated above, some instruments can be used to help assess malingering, but an effective approach to identifying malingering is (a) to carefully observe behavior while exploring different topics, over a number of sessions, and viewed in the context of behavior manifest in all other aspects of the juvenile's life, and (b) to consider the youth's history from multiple sources indicating whether the observed

deficits have been seen by others, and over what period of time, and identify any inconsistency between such history and the current presentation.

Evaluator's opinion. States differ in whether they explicitly require (or permit) the evaluator to offer a conclusion or "ultimate opinion" concerning the juvenile's competence to stand trial (Larson & Grisso, 2011). As competency is by definition a legal determination, some believe the judge should make an adjudication of competency assisted by a description of the defendant's impairments contained in the evaluation report (Tillbrook, Mumley, & Grisso, 2003). Alternatively, proponents of the inclusion of an ultimate legal opinion assert that judges are aided by and often desire the opinions of highly qualified evaluators, and remain free to disagree with the evaluator's opinion (Redding, Floyd, & Hawk, 2001; Rogers & Ewing, 2003). The Specialty Guidelines for Forensic Psychology (American Psychological Association, 2013) does not provide direct guidance regarding answering the ultimate legal question in an evaluation report. One reasonable alternative to providing an ultimate opinion involves offering conclusions which address directly the different components of the *Dusky* standard but which do not include a definite opinion about the defendant's trial competency. This position does not overstep the expertise and role of the evaluator while conveying respect for the decision making autonomy of the court.

Regardless of the inclusion of ultimate or penultimate language in a competency report, the opinion section should serve as an amalgamation of the report that educates the reader and furthers their appreciation of this youth and their unique legal situation. This integration should assimilate diverse behavioral, clinical, and developmental factors with a functional assessment of capacities and skills, calibrating this information according to the different components of the *Dusky* standard. Often included in this section will be an assessment of whether a predicate condition is present (e.g., intellectual disability, mental illness); the different cognitive, emotional, and behavioral ways in which

these impairments manifest and impact specific legal decisional capacities (e.g., lack of knowledge, concrete thinking, flawed decision making, poor impulse control); and the specific ways in which these impairments will adversely affect the juvenile's understanding and effective participation in their trial or other aspects of the legal process (O'Donnell & Gross, 2012). This type of synthesis remains integral to a high-quality report, as it provides both the defense and prosecution the richest opportunity to argue the issue of competency in contested cases before the court. This position has been recently articulated by Rotter and Greenspan (2011) who urge the field to move beyond binary competence and include the complex interplay between symptoms and fitness-related capacities that may be related to adjudicative competence.

Options for opinions. Based upon due consideration of the evidence presented to the court, the judge can determine that the youth is competent, incompetent but amendable to restoration services, or incompetent and unrestorable. If a defendant is adjudicated competent, the case proceeds to trial or alternative disposition. Of cases referred for a competency evaluation, relatively few (14 % - 18%) are found incompetent (Cowden & McKee, 1995; McKee, 1998; McKee & Shea, 1999). However, if the youth is determined to be incompetent but likely restorable, the youth will be ordered into restoration services, usually with the requirement of a regular schedule of review of their progress and status. When the court decides that the youth is unrestorable, most courts (guided by applicable statutes) may order restoration services for a relatively brief trial period or grant a motion to have the charges dismissed.

Predictions of restorability. The U.S. Supreme Court ruled in *Jackson v. Indiana* (1972) that a defendant cannot be held for longer than the reasonable time necessary to determine whether there is substantial probability that they will attain competency in the foreseeable future. Because of this legal constraint, evaluators are often required to predict an adult defendant's probability of regaining

competency at the time of their initial evaluation (Advokat, Guidry, Burnett, Manguno-Mire, & Thompson, 2012; Mossman, 2007; Warren, Chauhan, Kois, Dibble, & Knighton, 2013; Zapf & Roesch, 2011). This requirement is being extrapolated to the juvenile context; it is good practice to include this information in the report to better inform the court at the time of the first competency hearing.

Despite this requirement, most studies suggest that clinicians' ability to predict competency restoration among adults is limited (Advokat et al., 2012; Zapf & Roesch, 2011), and there is no comparable research regarding juveniles. However, it is unlikely that these predictions would be *more* accurate in the juvenile context, given the added complexity of the developmental issues at play among youth. Research by Morris and DeYoung (2012) has indicated that service providers were able to predict 6-month competency status using data obtained at the 3-month post-restoration review with adults, suggesting that the quality of the predictions improve with time and observation--and that by the 3-month mark, clinicians have well-informed and increasingly accurate opinions of the remediation effort's outcome.

Incompetent but restorable. If the youth is deemed amenable to remediation services, the evaluator is further asked to comment on the type of services they believe would best facilitate the remediation of each youth. Ideally, these recommendations are specific to each of the barriers that have been identified and together describe the best possibility of facilitating the restoration or attainment of each individual youth. Common interventions include psychiatric assessment and medication management, intensive case management, psycho-legal education, medical treatment, the use of an interpreter or more culturally pertinent interventions, the provision of assistive devices such as glasses or a hearing aide, or other interventions such as neuropsychological testing that might help to further the restoration counselor's understanding of the competency-related deficits that are being addressed. To some extent, these recommendations help the judge to understand the process that will be required

to remediate the youth while also offering an intervention baseline to assist providers who are court ordered to deliver remediation services to the youth following an adjudication of incompetency. In developing these laws, however, it has been noted that recommending generic mental health could undermine the specificity of a competency restoration program—and encourage attorneys and families to seek a finding of incompetency as a viable backdoor for attaining treatment for a child in need of broader clinical services.

Unrestorably incompetent. There is no consensus in the literature as to when a defendant should be determined to be unrestorably incompetent. The American Academy of Psychiatry and Law practice guidelines (Mossman et al., 2007) recommends that evaluators indicate whether a defendant has a treatable or untreatable condition interfering with competence. Parker (2012) warns, however, that a court might consider any probability greater than zero sufficiently substantial to justify attempted remediation services.

The U.S. Supreme Court has left it to the states to determine disposition with a defendant who is not able to attain competency (Parker, 2012; Zapf & Roesch, 2011). Virginia is one of the few states to provide explicit statutory guidance regarding the timelines and steps that can be used when diverting an unrestorable youth from the juvenile justice system (Va. Code § 16.1-358). States generally have two options if a youth is unrestorable: the charges may be dropped or the case dismissed with or without prejudice (Larson & Grisso, 2011; Soulier & Scott, 2010; Viljoen & Grisso, 2007). In Virginia, the court is also afforded the right to issue a Child In Need of Services (CHINS) petition allowing it to maintain some degree of supervisory authority over the juvenile even after his/her involvement in the delinquency system has ended. Nevertheless, the reality of having to dismiss charges despite what may have been a serious and potentially dangerous crime can prompt concerns about a poor evaluation leading to a miscarriage of justice, or alternatively, an accurate assessment posing a threat to public safety when a

violent but impaired youth is released back to the community without any further supervision or containment by the court (Viljoen & Grisso, 2007).

Lack of consistency among evaluators and across jurisdictions. Lack of consistency among evaluators regarding juvenile competence has plagued the field and results at least in part from the different methods employed by evaluators (Fogel et al., 2013; Mayzer et al., 2009) confounded by a lack of consensus on standards of practice for the juvenile court (Heilbrun & DeMatteo, 2012; Rogers & Cruise, 1998). In the context of adults, Murrie, Boccaccini, Zapf, Warren, and Henderson (2008) argue that although competency determinations are dichotomous, the capacities underlying competency may be dimensional--and that clinicians may draw the distinction between competent and incompetent at different places within the midrange, accounting for different outcomes.

The lack of well-articulated practice standards further fuels variation within and across states. For example, some states dismiss charges if a youth is found incompetent, other states divert a youth before a finding of incompetency, and still others attempt to remediate almost all youth impaired in their legal decisional capacity. Kruh et al. (2006) reported that youth referred for a competency evaluation in Washington State were more likely to have a mental illness than youth in South Carolina or Chicago, which may result in more youth in Washington State being deemed incompetent. However, Warren, Rosenfeld, Fitch, and Hawk (1997) found that even when state standards were identical, states differed in their rates of referral and interpretation of the legal standards, resulting in different rates of [adult] incompetence. Likewise, Burrell et al. (2008) surveyed counties in California, and among other findings, found large variation in the proportion of juvenile defendants deemed incompetent across counties.

Evaluation report. The juvenile competency report provides the platform through which the evaluator can convey to all parties the relevant information concerning each youth and its integration

into a final opinion concerning competency, treatment, and the potential for attainment of competency in the foreseeable future. When the report is being sent to all parties including the defense attorney, the district attorney, and the judge, regardless of who ordered the assessment it is imperative that no information concerning the offense and the youth's possible involvement in it be included in the report. As with all forensic reports, all the relevant sources of information consulted or used in reaching these opinions should be clearly laid out at the beginning of the report, with each fact being attributed to its appropriate source.

Larson and Grisso (2011) recommend a five-part evaluation report: assessment of mental disorder and intellectual disability; assessment of developmental status; assessment of functional abilities for competency to stand trial; causes of deficits in competency abilities; and potential for remediation/restoration (if in the opinion of the evaluator the defendant is incompetent to stand trial). Sufficient background information is also included to provide context for the clinical information being presented and a summary of relevant mental health treatment and prior educational testing to better inform the description of the current clinical condition. A segment devoted to the evaluator's efforts to obtain informed (and possibly research) assent from the juvenile, and in many instances permission from the parent or guardian, are also commonly included at the beginning of the report.

Over the past decade, some common problems in report writing have been observed among trainees at the University of Virginia's juvenile forensic training program. This observation prompted the development of a report writing checklist that is now required as part of the final submission of the case report for successful completion of the training (Warren, 2013). The most common problem observed was the evaluator's inclusion of information relevant to the defendant's guilt. This error occurred despite lengthy discussions during the training of the importance of excluding this type of information, as well as other types of aggravating information, as the report is not privileged or protected. When this

information is found in the practice reports that are submitted to us, we have observed that this information has often crept in while quoting the youth's ability to describe and convey a memory at the time of the offense, in understanding the seriousness of their crime and possible sentences, or in their description of the evidence that might be relevant to their defense. Unrelated aggravating information is also often found inadvertently in the education and testing sections of the report where aggressive and threatening behavior at school or in other locations has been reported. Whatever the evaluator's motivation for including such information, it provides material for arguing risk for violence in another context. Irrelevant information, gratuitous and imprecise diagnoses (for example, conduct disorder), and non-specific psychological testing are also not uncommon, at times creating the impression of precision and comprehensiveness to more inexperienced readers, but ultimately confusing and at times distorting the competency opinion.

Research concerning the content of competency reports has found that over one third of evaluators fail to provide information on the causal explanation for a youth's deficits, compromising the quality of the reports (Christy et al., 2004; Nicholson & Norwood, 2000; Ryba, Cooper & Zapf, 2003). This lack of integration and explanation may reflect the additional time and independent deliberation needed to consider and explain such deficits. Many forms of psychological assessment require a consistent and structured method for not only collecting data but also for summarizing it into a conclusion. In contrast, competency assessments ultimately involve the presentation of a psycho-legal opinion that requires some ingenuity to integrate the different legal dimensions of competency with the clinical and functional assessment that is unique to each youth. Mental health, developmental, and crime-related factors have to be assessed, not in terms of current ability, but in terms of perceived capacity in the context of a decisional bar that is defined by context. This assessment is compounded by

the necessity of offering opinions on whether the youth is likely to be restored to competency in the foreseeable future and the nature of the needed relevant interventions.

Research has demonstrated that some forensic psychologists use clinical rather than legal information to determine competence (Morris, Haroun, & Naimark, 2004). Larson and Grisso (2011) suggest that greater specificity in the statutory language regarding areas to be considered by evaluators could contribute to greater uniformity in how evaluators assess juvenile competency and write reports. This type of detail, however, is uncommon in most statutes addressing various aspects of mental health law, suggesting that more extensive training and sustained supervision is a more viable option for obtaining a higher standard of practice and reasonable degree of consistency across evaluators and states.

The Competency Hearing and Judicial Orders for Restoration Services

Upon receipt of the juvenile competency evaluation report, a competency hearing is held in which the judge makes a determination of competency. Research has found that a judge's opinion of a juvenile's adjudicative competence is influenced by characteristics of the youth themselves. Older youth and more mature youth are more likely to be deemed competent by judges, suggesting that judges may be heavily influenced by chronological age rather than the detailed descriptions in evaluation reports outlining competence-related capacities (Cox et al., 2012). Furthermore, although judges and attorneys recognize immaturity as a cause for incompetence, they rate it as less important than mental illness or mental retardation (Viljoen & Wingrove, 2007), with only 26% of judges rating immaturity as essential in juvenile competence evaluations (Viljoen, Wingrove, & Ryba, 2008).

Most judges appear to agree with or possibly abdicate to clinicians' opinions in determining competence (Melton et al., 2007; Morris et al., 2004). In one study directly comparing a judge's competency decision to that of the evaluator's recommendation, Kruh et al. (2006) found 91%

agreement for incompetence and 99% agreement for competence, with an overall agreement of 95%. This underscores the importance of the accuracy of the forensic clinician's opinion in the evaluation report. If the judge deems the youth incompetent but amenable to treatment, the judge will very likely order remediation services for the youth.

Remediation Programs

As of yet, few integrated remediation programs have been developed specifically for youth. To some extent this may reflect the complex intermingling of mental health, intellectual, and developmental issues that need to be addressed using multidimensional programming that is relevant to different aged youth (Schwalbe & Medalia, 2007; Scott, 2003; Viljoen & Grisso, 2007; Viljoen, Odgers, Grisso, & Tillbrook, 2007). It may also reflect the rather nascent stage of juvenile competency legislation and the current focus on defining the law rather than providing the services that are responsive to it. Experience has demonstrated, however, that youth require a different array of services to be assisted in attaining competency than adults and that the experience gained in providing services to the latter is not particularly useful in designing responsive programming for the former.

Remediation programs typically tend to emphasize one of four approaches: psychotropic medication, educational treatment, treatment programs geared towards those with intellectual deficits, and interventions for youth with developmental immaturity (Viljoen & Grisso, 2007; Zapf & Roesch, 2011). Ultimately, programming that is truly responsive to youth of varying ages requires that all of these components be integrated into a single program with trained service providers administering a tailored intervention to each youth individually as they progress through remediation services.

Medication issues. In some instances, medication management can be relevant or even central to the remediation process. In *Sell v. United States* (2003), the U.S. Supreme Court held that antipsychotic drugs could be administered against the adult defendant's wishes for the purpose of

restoring competency, but only in rare, limited circumstances (Slobogin, 2012). In most instances, the issue with youth does not reach the level of forcing medication, but rather providing assistance to the youth and the family in obtaining and dispensing the proper medication. This goal may require arranging for a psychiatric assessment, obtaining support for the family in paying for the medication, and assisting the family in transporting forgotten or lost medication to the location where the youth is residing. It might also entail encouraging or educating the youth and family about the importance of full compliance with prescribed medication and checking to ensure that the youth has taken prescribed medication prior to attending any hearing. Growing sophistication in identifying the prodromal symptoms of schizophrenia and other psychotic disorders also requires the ongoing training and education of remediation service providers so they can be aware of and sensitive to the more subtle indices of serious mental illness in youth.

Educational issues. Educational treatment programs are designed to increase a defendant's understanding of the legal process or remedy situations that prohibit in some way the defendant from participating in the defense (Zapf & Roesch, 2011). In their review of the literature, Zapf and Roesch (2011) concluded that the research could not determine at this point whether education programs that teach adult defendants about their legal rights are any more effective than individualized treatment programs that target specific underlying deficits. Viljoen et al. (2007) compared pre-post training items from the MacCAT-CA on a sample of 11-24 year olds. Participants younger in age and those with lower IQs showed less improvement on MacCAT-CA scores after participating in the program, although minority participants showed greater improvement. Findings by Viljoen et al. (2007) further suggest that some concepts are easier to learn than others. They found considerable variability in the improvement of participant scores across six concepts. For example, 73.5% of participants who were taught about the consequences of conviction improved after teaching, while only 26.8% who were taught about the

consequences of a guilty plea showed improvement. This is consistent with a satisfaction survey of youth receiving remediation services in Virginia. Jackson et al. (in press) found that some concepts were self-reported by youth as more difficult to learn (e.g., plea bargain) than others. Importantly, rote memorization of responses is inadequate to demonstrate competence (*United States v. Duhon*, 2000).

The complexity underlying these processes of learning involves ensuring that the learning is not only factual but also rational in nature as required by the *Dusky* standard. This element of rational understanding has been interpreted widely as the ability to apply the information to one's own situation and to use it to inform the decisions that are being made by the youth. This interplay between teaching, extrapolating, and reviewing the impact of this new knowledge on the behavior and decision making of youth is best observed in a one-to-one relationship that allows an iterative process specific to each child and which is sustained and internalized over time.

Special needs issues. Many youth who are found incompetent to stand trial suffer from varying levels of intellectual disability and different elements of the communication and relational impairments associated with the autism spectrum of disorders (Warren et al., 2009). Some of these youth can respond to interventions that are interactive, repetitive, and in which information is presented in narrative form. However, the available research indicates that this group of juveniles is the least likely to attain competency despite the type and length of services offered to them (McGaha, Otto, McClaren & Petrila, 2001; Warren et al., 2009).

When working with this group of youth, service providers must skillfully balance attempts to provide services and gauge progress while constantly remaining aware of the ruling in *Jackson* stating that a defendant cannot be held for longer than the reasonable time necessary to determine whether there is substantial probability that they will attain competency in the foreseeable future. Practice standards in Virginia require that eight sessions be provided to all youth even when all evaluators have

opined that the youth is likely unrestorably incompetent, so as to demonstrate conclusively that progress cannot and will not occur. With less impaired youth, progress is assessed every 3 months to ensure that there remains a possibility that progress and attainment is possible. If this is not the case, an independent evaluation is ordered to determine whether the youth should be returned to the court as unrestorably incompetent.

Developmental immaturity issues. It was initially believed that incompetence predicated on developmental immaturity would require the passage of time to remediate (O'Donnell & Gross, 2012). However, Kivisto, Moore, Fite, and Seidner (2011) found that the relationship between age and competence was partially explained by the development of a future orientation (i.e., the extent to which long-range consequences influence decision making processes), suggesting that while age is untreatable, methods for facilitating future orientation are potentially possible. Similarly, the construction of interactive programming at the University of Virginia has demonstrated that when developmental issues such as future orientation, peer influence, and risk perception are included in the narratives and exercises used to teach youth legal constructs, progress can be made in helping younger youth separate their initial age appropriate thinking from the approach that might be more advantageous to them in court (Warren, 2013). This process seems to be significantly mediated by intelligence, with youth of higher intellectual capacity better able to grasp a new or different perspective and apply it to their unique situation in court, while those with more limited cognitive abilities are not able to attain this level of abstraction and learning (Warren, Aaron, Ryan, Chauhan, & DuVal, 2003; Warren et al., 2009).

Remediation service providers. The remediation service providers who deliver the direct services to youth undergoing remediation services generally hold a Bachelor's degree in psychology, social work, criminal justice, or education and have had some prior experience working with children or adolescents. In Virginia, remediation service providers are referred to as Restoration Counselors.

Restoration Counselors undergo a 3-day training prior to being contracted to provide services and are supervised by a Restoration Supervisor in the field at least once every 30 days. Larson and Grisso (2011) emphasize that remediation service providers must possess specialized knowledge of the developmental capabilities of youth, as well as methods for teaching youth information related to their state's definition of competence.

Location of remediation services. Remediation services for youth are increasingly offered in the least restrictive setting allowed by the court. Such settings include the youth remaining at home, with a relative, in a foster home, or possibly in a group home. When mandated by the court, youth will be placed in detention due to security concerns, with services optimally being provided to them in this setting until their security risk diminishes and they return home. This emphasis on the least restrictive setting is particularly appropriate for youth, as it allows them to stay in their homes with access to school and other community supports while their remediation is implemented (Burrell et al., 2008; Ferguson et al., 2010). In contrast to incompetent adults who often suffer from treatment resistant psychosis or refuse medication, most youth do not suffer from mental health conditions that warrant inpatient hospitalization--and the majority can be assisted with medication management in the community. When outpatient programs are compared with programs using residential treatment, the cost of the services is reduced substantially.

Length of remediation services. Some states specify a period of time during which services must be provided and completed, while others use a formula based on the offense (for example, one-third the time the defendant would have served if convicted of the same crime; Finkle et al., 2009). The inclusion of a periodic review is also embedded within most of the state statutes. There has been little research comparing juveniles to adults to determine the length of time juveniles take to attain competency. Warren et al. (2009) found that the majority of youth were restored within 90 days while

McGaha et al. (2001) found that most youth who were restored in a secure setting were restored within 217 days. Among adults, the majority (75%) of incompetent defendants are returned to court as competent within 6 months (Bennett & Kish, 1990; Morris & Parker, 2008).

Four Juvenile Competency Remediation Services Programs

Four longstanding juvenile competency remediation services programs are situated in Virginia, Florida, Maryland, and Louisiana. Each program is briefly described in the following sections.

Restoring Youth in the Community. The Restoring Youth© program was developed in Virginia through a 4-year grant awarded to the University of Virginia by the Virginia Department of Criminal Justice Services in collaboration with the Virginia Department of Behavioral Health and Disability Services (see www.juvenilecompetency.com). Building upon the original community-based program established in 2000, it was formalized into a theory-based program (Lipsey, Howell, Kelly, Chapman, & Carver) that is built upon the System of Care framework (Finkle et al., 2009; Keith Matthews, Krivelyova, Stephens, & Bilchik, 2011; Pires, 2002) that is increasingly used in the context of the juvenile justice system (Burrell et al., 2008; McKinnon-Lewis, Kaufman, & Frabutt, 2002). It is based upon differentiated (Santamaria, 2009; Smith, 2011; Smith & Throne, 2007; Tomlinson, 2000) and personalized (Corno & Snow, 1986; Jenkins, 2000; Keefe & Jenkins, 2008) instruction research. The program is currently being replicated in other locations with the goal of establishing it as an evidence-based practice by 2020.

The Restoring Youth© program is based on eight service-related principles dictating that services be time-sensitive, community based, individualized and integrative, developmental and culturally appropriate, dyadic in nature, training based, dose sensitive, and data driven. The program is manualized with ongoing training and supervision, and includes a toolkit of activities to teach juveniles of varying ages the skills necessary for adjudicative competence (Warren, 2013). Each activity can be adapted to appeal to a variety of interests and learning styles (e.g., tactile/kinesthetic, visual, auditory)

and unique developmental, cognitive, and/or cultural requirements. These educational tools include digital (animated) storytelling with a multicultural cast of characters (DJ & Alicia DVD) that serves to amalgamate storytelling and learning (Figg, McCartney, & Gonsoulin, 2009). There are a variety of media (flashcards, workbooks, coloring books) that appeal to individual interests and are designed to reinforce concepts learned in the digital stories. There is a courtroom board game to teach courtroom personnel roles, and a range of other engaging and developmentally appropriate materials that have been created for use with youth of different ages.

Barriers to competency, such as a mental health disorder, are addressed through intensive case management in which Restoration Counselors make referrals for services to mitigate identified barriers. The dosage of education required depends upon the youth. On average, however, each juvenile participates individually in two to three 1-hour face-to-face restoration sessions per week with their Restoration Counselor for an average of 116 days (range from 2 weeks to 6 months). Services are provided in the least restrictive setting allowed by the court (typically in the home), thus eliminating unnecessary hospitalizations or residential placements while facilitating parental involvement (Tomlinson, 2000). Importantly, the successful transfer of knowledge depends upon highly skilled Restoration Counselors who are able to identify different learning styles and adapt to the needs of each youth (Tricarico & Yendol-Hoppey, 2012), requiring strict adherence to training requirements for Restoration Counselors.

The Restoring Youth© program is also supported by the Restoring Youth© case management software, which contains all the information relevant to the care of each youth and the operation of the overall program (see www.juvenilecompetency.com-software). Developed by custom application designers at the University of Virginia, this software allows for web-based storage of all records and documents concerning each individual youth; the detailing of individual sessions and progress notes for

each contact with the youth; the documentation and saving of all reviews, reports, documents, and decisions submitted to and reviewed by the court; and the barriers to competency that are being addressed with each youth by the Restoration Counselor. The software allows for different levels of access: Restoration Counselors have access to all case notes and information relevant to their individual caseloads; Restoration Supervisors have access to all the cases under their direct supervision; and the Program Administrator has access to all cases that are currently active (or closed) within the system. The 24-chapter interactive CD, entitled *DJ and Alicia*, has been programmed to allow users to download the performance of each youth during each session for research purposes--for example, how youth of different ages with different types of impairment learn the different legal constructs and demonstrate the ability to apply that information to their own legal situation.

Florida's restoration services program. Florida's Juvenile Incompetence to Proceed (JITP) program was developed in 1997 in response to the juvenile competence legislation that was passed that same year. The JITP provides competency restoration services to youth who have been found incompetent due to a predicate condition including mental illness (Chapter 394 & Chapter 916, Florida Statutes) or intellectual disability or autism (Chapter 393, Florida Statutes). The principles of the program require that the restoration services are provided with dignity and fairness and in the least restrictive setting allowed by the courts; some juveniles receive services in a community outpatient setting and some in a secure residential placement. The goal of JITP is identified as helping each youth to become knowledgeable about the delinquency process and their legal situation so as to best ensure appropriate due process in the legal system.

Youth receiving services in the community receive services in their home, detention, or at their school by Twin Oaks Forensic Outpatient Services (TOFOS), a private corporation that provides case management and competency training as needed by youth of varying ages. Mental health services are

not provided directly, but rather are coordinated through a case manager who arranges for referral to the statewide Agency for Persons with Disabilities (APD). Youth receiving services in a secure residential setting are served at Apalachicola Forest Youth Camp (AFYC) located in Liberty County, Florida. AFYC is a 39-bed facility operated by Twin Oaks Juvenile Development, Inc. under contract with the Department of Children and Families. It is located on a 78-acre site in a wilderness area. Security measures include cameras and a 14-foot high fence. The buildings are constructed as log homes. The facility consists of six 7-8-person cabins with individual bedrooms, an education building with six classrooms, a professional building with 24-hour nursing coverage, and an administrative building.

Maryland's remediation program.ⁱ Maryland's juvenile competency attainment program was established in October 2006. Since that time, approximately 350 youth have been served with all except 75 youth having attained competency and returned to court, most within 3 months of referral. Maryland's competency attainment program was modeled on Virginia's program described above. The program is administered by the Office of Forensic Services, within the state's Mental Hygiene Administration (the state's mental health authority). The Director of the program is a social worker who is assisted by a part-time consulting psychiatrist with Board certification in child and adolescent psychiatry and forensic psychiatry. The program contracts with a cadre of community-based psychiatrists and psychologists who conduct evaluations of youth referred by the courts. In addition, the program contracts with a dozen professionals who provide competency "attainment" services for youth found incompetent to proceed. These professionals include social workers, licensed professional counselors, and special educators, all of whom receive specialized training in the provision of attainment services.

Nearly all attainment services are provided on an outpatient basis in the community. A child found incompetent may not be placed in a psychiatric hospital except pursuant to civil admission

procedures. Except for a small number who were hospital patients at the time they were found incompetent (and remained afterward), no youth have been hospitalized for attainment services. Further, no child found incompetent may remain in or be placed in a juvenile justice detention facility. If a child is in detention when found incompetent and continues to meet criteria for detention, the court may order the child to a “facility for children.” The Mental Hygiene Administration uses beds at a state-operated residential treatment center for this purpose. Only about 45 youth have been admitted in the 7 years that the program has been in place.

Youth referred for competency attainment services are assigned a competency attainment provider. The provider meets with the youth 2-3 times per week. If the youth is in the community (85% are), these meetings occur most often in the youth’s home. Sometimes providers will meet with youth at their schools. If a youth is in the facility for children, the provider meets with the youth there. Providers take a psycho-educational approach to competency attainment. Relying in part on materials developed by the Maryland Administrative Office of the Courts for general use by youth in the juvenile justice system (and their families), providers educate the youth about juvenile justice charges, procedures, and dispositions. A provider may arrange for a youth to watch a television show or movie with courtroom scenes and discuss what they have seen. Sometimes a provider will use flash cards to test a youth’s understanding of terminology. If a youth has special needs (e.g., medication), the provider will work with the family to ensure that the needs are met. In nearly all such cases, the youth already will have been referred for services and the encouraging of family cooperation becomes an important part of the attainment provider’s role.

Maryland law requires dismissal of the charges if a youth has not attained competency within 6 months (most misdemeanors) or 18 months (felonies and some serious misdemeanors). Of the approximately 20% of youth who do not attain competency within this period (or are found not to be

attainable sooner), 35% were diagnosed with mental retardation or borderline intellectual functioning, 26% had cognitive disorder NOS, 9% had ADHD (as a primary diagnosis), 7% had a psychotic disorder, 6% had a communication or language disorder, 4% had a mood disorder, 4% had a learning disability (as a primary diagnosis), and the remaining youth had a variety of other diagnoses or disabilities. The average GAF score was 54.4. Of the 72% for whom an IQ score was reported, the average was a full scale IQ of 64. Case reviews indicated that 87% of the sample had an individual education plan in place when the charges were lodged. Twenty-five percent were living with a non-parental guardian.

Louisiana's remediation program. The Louisiana Juvenile Competency Restoration Program was developed in 2006 in response to the Louisiana Children's Code 837.1-2 (Year?). The code provides the qualifications necessary for providing services to incompetent youth with these differing based upon the underlying impairment that is contributing of the limitations in the youth's legal decisional capacity. For those incompetent due to an ignorance of court procedures and legal rights, psychiatrists, psychologists, medical psychologists, certified educational teachers, social workers and counselors are identified as qualified to provide services and submit review reports to the court. For those youth suffering from some form of mental illness or intellectual deficit, the list of qualified providers includes psychiatrists, licensed psychologists, medical psychologists, licensed clinical social workers, qualified mental retardation professionals, and licensed professional counselors, all of whom have been involved in the provision of clinical services to youth in the immediate three years and who have specific expertise in child development specific to severe disabilities in children. The code identifies the process by which a restoration provider will submit a report to the court, district attorney, and defense counsel every 90 days describing the services provided to the youth including medication, education, and counseling; the likelihood that the mental capacity to proceed will be restored in the foreseeable future; and the progress the youth has made in the intervening period on 12 specific abilities. This section of the

Louisiana Children's Code also requires that if the youth has been placed in an out-of-home placement, the report will include an assessment of the danger the child poses to himself and others and the appropriateness of the placement. A section pertaining to 5th Amendment protections against self-incrimination affirms that testimony from a restoration service provider cannot include any statements from the youth concerning the alleged delinquent behavior and that no such statements can be used in subsequent court proceedings.

The educational content of the restoration program is based on the Bennett Criteria, which are specific abilities and capacities identified in the landmark case *Louisiana v. Bennett* (1977). These 12 criteria include a number of factual criteria such as understanding the nature of certain legal rights, the delinquency allegations, the range of possible dispositions, the different legal defenses that are available to the youth, the underlying adversarial nature of the court process, and the roles of the judge, defense counsel. It also underscores the importance of the youth disclosing all the relevant facts to the defense attorney, being able to testify at trial, maintaining appropriate courtroom behavior, listening effectively to witness testimony for errors, and being able to comprehend their situation in relation to the proceedings. The program was designed to educate youth aged 9-17 years. It provides repetition and simplicity so children and adolescents with developmental or mental health diagnoses will be able to engage with the material and proceed through consecutive steps that progress from the more simpler concepts (for example, appropriate attire for court) to the more complex (for example, plea bargain).

To promote this progression of learning, a training manual was created and approved by the Louisiana Department of Health and Hospitals. It includes 10 lesson plans including a pre and posttest for each youth. If the juvenile is unable to read, the Restoration Service Provider reads each lesson and uses visual aids for additional assistance. The lessons consist of matching, filling in the blanks, and short

answers. The Competency Restoration Providers are encouraged to be creative by gearing the program to each individual's specific need.

The Louisiana Juvenile Competency Restoration Program provides competency restoration services to approximately 40 youth each year in 10 different regions of the state, with sessions being provided both individually and in a group format. The meetings occur once a week for 1 hour and include both the review of information covered previously and progressively more complex information. The average length of competency restoration services is 10 weeks, with the majority of youth being restored to competency. Each month statistical data are reported to the program director, including the number of juveniles served for the month, race, age, charge, and parish/county and the number of youth who have been completed the program through a final decision by the court.

Juvenile Competency Restoration Services Research

According to Heilbrun and Brooks (2010), the field of forensic psychology has focused on legal decision making to the exclusion of other pertinent inquiries. This may help explain why so little is empirically known about restoration services for adult (Pinals, 2005) as well as youth (Grisso, 2004; Scott, 2003). Only two studies have examined restoration services programs as they pertain to youth being adjudicated in juvenile court. McGaha et al. (2001) examined over 400 youth ordered into restoration services in Florida. The most common diagnosis was Conduct Disorder (57%), followed by Attention-Deficit/Hyperactivity Disorder (37%). Only 17% of the juveniles carried a psychotic diagnosis. Each of these juveniles was subject to residential treatment in a secure setting, averaging 217.5 days (per youth) of restoration treatment. After this type of restoration effort, the majority (71%) of youth were recommended by the evaluating clinician and determined by the court to be competent. Ultimately, 44% of the juveniles with mental retardation (without a co-occurring diagnosed mental

illness), 34% with a co-occurring mental illness and mental retardation, and 8% with a mental illness only were found to be unrestorably incompetent following treatment.

Most recently, Warren et al. (2009) examined the restoration outcomes of 563 youth referred to the program in the Commonwealth of Virginia. Among this group, 73% were determined to have been restored to competence after services had been provided for between 61 and 90 days. No juveniles were admitted for inpatient hospitalization for the purpose of restoration; only 5% were hospitalized based upon civil commitment criteria for further psychiatric evaluation or stabilization. Warren et al. (2009) found the highest rate of achieved competence among youth without a mental illness or mental retardation (91%) and the lowest rate of achieved competence among youth with mental retardation (47%).

Post-Juvenile Competency Restoration Services

Among adults, 80 to 90% are restored to competence, with approximately 7% remaining unrestorable (Pinals, 2005). Among juveniles, on average 71% are returned to the court as competent after receiving restoration services (McGaha et al., 2001; Warren et al., 2009). McGaha et al. (2001) speculate that the rates of restoration are lower among juveniles because of the higher rates of mental retardation, a condition that is generally resistant to intervention, with developmental immaturity further increasing the rate of incompetency among juveniles. Viljoen et al. (2012) also suggest that restoration rates may in fact be lower but that pressure is at times exerted on the evaluator to deem a youth competent so that the trial may proceed, even when the youth's competence remains in question.

After a specified period of time, or periodically, the youth is returned to court for a competency hearing so the court can either opine on the juvenile's competence or to check the status of their progress. Because of the fluidity of competency, Finkle et al. (2009) recommend that competency

hearing be held as soon as possible upon completion of the post-restoration services evaluation. For example, Seattle has adopted a competency court model in which competency hearings can be scheduled in as little as 2 hours.

Relevant Policy and Research Directions

There are several policy issues to emerge from this chapter. First, there is a need for greater clarity in raising the issue of competence. When defense attorneys were asked what would help them better defend a youth who might be incompetent to stand trial, half identified better access to mental health evaluations and over one third sought better guidance about when to request a competency evaluation (Viljoen et al., 2010). Second, because of differences among juvenile competency evaluators, some youth are being tried who may not have the capacities to be considered competent by many judges. Greater statutory clarity and practice guidelines would facilitate improved consistency among and between evaluators and jurisdictions. Finally, this approach should be augmented with an abundance of formal training and certification.

Cultural competency is another significant but seldom articulated barrier to optimal service delivery with incompetent youth and their families. With few exceptions (i.e., Heilbrun & Brooks, 2010; Viljoen & Roesch, 2007), academics or practitioners seldom mention or address culture, whether in the context of evaluation practice, assessment of competency via clinician judgment or assessment tools, or remediation services. And yet, the majority of juveniles who are arrested are of minority status and increasingly are non-English speaking. While practice standards are beginning to appear concerning the exclusive use of court-certified interpreters, and some of the restoration tools are being translated into Spanish, the more subtle aspects of culture and how youth from different countries proceed through the adjudicative process in America remains a largely unexplored area of practice.

The current chapter clearly identifies a number of areas requiring further research. The vast majority of youth whose competence is questioned are recommended as competent to stand trial after a competency evaluation. Future research should test the degree of concordance between attorney's perceptions of juvenile's incompetence to stand trial and the clinician's competency evaluation opinion to identify the level of consistency between these two sources of information (Viljoen et al., 2010). An important component of a competency evaluation involves making a prediction of restorability, yet there is limited research available--all pertaining to adults--that identifies factors relevant to the prediction of restorability by mental health clinicians (Parker, 2012; Warren et al., 2013). Scholars are also advocating the development of new juvenile competence instruments that assess for developmental immaturity, are normed on youth of varying ages, and include an assessment of malingering (Heilbrun & DeMatteo, 2012). Standardized instruments in conjunction with more rigorous training of evaluators would undoubtedly facilitate greater consistency among juvenile competence evaluators within and across the various states that recognize juvenile competency.

Finally, although more courts are recognizing juvenile incompetence, most states lack a uniform or empirically sound programmatic response to it (Viljoen et al., 2012). Current remediation models are based primarily on incapacity predicated on mental illness or intellectual deficits, and even in these domains little is empirically known about the process and outcome that is relevant to these particular populations. There is also little research into remediation for immaturity. A further standardization and the establishment of best practices could ensure the development of more effective, efficient, and cost effective programming for youth.

Conclusions

The study of adjudicative competency in juvenile court is one of more interesting and evolving areas of forensic practice and research today. It is replete with legal ambiguities, unanswered questions

concerning forensic assessment and opinion formation, insufficiently articulated standards for training, and an emerging legal mandate with few youth-specific tools and programs designed to respond to it. Despite its nascent stage of development, it has been enriched by sophisticated research that has provided important insight into the impact of development on the competency of some youth. As observed by Scott and Steinberg (2008), however, these advances must now be integrated into our juvenile justice policy and the programming that is embedded in it.

The current challenge clearly lies in the development of well-trained juvenile forensic evaluators and remediation service providers coupled with creative, flexible, and compelling interventions that respond to youth of all ages and cultural backgrounds. Only through these practice enhancements can we ensure that competency is not an empty right, but rather an extension of established law into a new context capable of protecting the integrity and fairness of our juvenile justice system. Embedded in all of these challenges is the need to integrate the best of what we have learned in diverse fields such as education, mental health, neurobiology, human development, legal decision making, forensic assessment, program development, and the development of evidence-based practices to create an exciting new frontier in the field of forensic research and practice that is responsive to youth of all ages.

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