

## Evaluating for Competence to Proceed in Juvenile Court: Findings with a Semi-Structured Interview

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**Abstract:** Juvenile competence to stand trial (or “competence to proceed”) has been shown to be vulnerable to cognitive impairments, mental illness, and very young age. States have usually defined juvenile competence by applying adult standards without allowing for the effects of normal childhood and adolescent development. Research on juvenile competence issues has usually been conducted with functional assessment instruments standardized on adult populations. This study implemented a semi-structured interview written to allow for youthful vulnerabilities. Findings confirm earlier outcomes for the effects of age and intelligence on competence capacities, and identify particular types of developmental psychopathology that may be associated with psycho-legal deficits.

**Keywords:** juveniles, competence to stand trial, forensic evaluations.

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Substantial progress has been made in the past twenty years regarding issues of juvenile competence to stand trial. The Supreme Court determined in 1967 that youths facing charges in juvenile court were entitled to representation and other due-process protections, such as the right to counsel (*In re Gault*, 1967). A previous opinion by the Court made clear that all defendants have the right to an evaluation of their competence to stand trial amounting to more than a simple mental status examination (*Dusky v. United States*, 1960). Most states have adopted some variation of the Dusky standard that requires “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.”

Many states addressed juvenile competence concerns by a downward extension of their adult statutes to youths facing trial in juvenile court (Redding & Frost, 2002). While this is a reasonable adaptation of procedures, it leaves open several questions regarding the nature of juvenile competence, such as whether the standard of competence necessary for a youth’s case to go forward in juvenile court is the same as that required for an adult. In fact, some states have indicated this is not the case (see, e.g., *Ohio v. Settles*; *In Re K. G.*, *People v. Carey*). In a singular example, one state has determined that

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because of the juvenile court's historical orientation towards rehabilitation, competence to stand trial is unnecessary (*G. J. I. v. State*, 1989).

Local statutes and case law often state that competence impairments must be due to a mental illness or disability; only a few states have developed statutes that indicate that young age or developmental immaturity can be considered a cause of incompetence (Grisso, 2005). The lack of standards allowing consideration of youthfulness or ordinary development as a barrier to competence does not prevent evaluators in clinical settings from attributing deficits to incomplete maturation (Grisso & Quinlan, 2005). This suggests that courts are open to considering youthfulness as a predicate condition to incompetence when appropriate.

Studies of juvenile competence have been conducted against this background of legal ambiguity. A common method of investigation has been to use a functional assessment instrument developed and standardized with adult samples to capture strengths and weaknesses in youthful functioning. Early studies of juvenile competence relied heavily on the McGarry functions, a set of inquiries based on criminal-court competence-related factors identified in the 1970s (Cowden & McKee, 1995; Lipsitt, Lelos, & McGarry, 1971; McKee, 1998; McKee & Shea, 1999; and Savitsky & Karras, 1984). More recently, the MacArthur Competence Assessment Tool, Competence for Adjudication (MacCAT-CA; Poythress, et al., 1999) has been the instrument preferred by researchers (Burnett, Noblin, & Prosser, 2004; Ficke, Hart, & Deardorff, 2006; Grisso et al., 2003; Redlich, Silverman, & Steiner, 2003; Schmidt, Repucci, & Woolard, 2003; Warren, Aaron, Ryan, Chauhan, & DuVal, 2003). Although the MacCAT-CA is also used by juvenile forensic evaluators, the instrument most frequently identified by clinicians was the Competence Assessment to Stand Trial for Defendants with Mental Retardation (CAST-MR; Everington, 1990; Ryba, Cooper, & Zapf, 2003).

The MacCAT-CA was standardized on samples of adults, and there are indications that it may be appropriate to use with older adolescents (Viljoen, Odgers, Grisso, & Tillbrook, 2007). However, like other adult measures, it is not ideal for most juveniles. Adult measures often include questions about jury trials, which are not an option for most juvenile courts. These items have the potential to confuse or mislead juveniles with regard to their own circumstances. While adult instruments may probe for mental-health issues relevant to criminal-court defendants, they are unlikely to explore symptoms that are typical of developmental psychopathology. More importantly, adult measures produce results that are relevant to forming clinical opinions about the level of competence required to proceed in adult criminal court, and, as noted above, that standard is likely to represent better functioning than is required for juvenile court (Redding & Frost, 2002). Thus, research on juvenile competence that uses adult standards as an outcome measure may be exacerbating the ambiguity created when states extend adult competence statutes to juveniles.

A few studies of juvenile competence have used measures other than those intended for adults. One such study compared youths referred by the juvenile court for competence restoration for intellectual disabilities, mental-health diagnoses, or both (McGaha,

Otto, McClaren, & Petrila, 2001). Another used chart-review methods to compare youths referred for competence restoration to those who were found competent to proceed (Baerger, Griffin, Lyons, & Simmons, 2003). A third study used chart-review methods based on a measure developed specifically for juvenile competence evaluations derived from an adult measure and an unpublished juvenile competence interview (Kruh, Sullivan, Ellis, Lexcen, & McClellan, 2006).

Regardless of the competence measure used, or other methodological procedures, a review of juvenile competence studies indicates three major areas of vulnerability: cognitive functioning, developmental immaturity (usually characterized as “age”), and psychopathology. Better cognitive functioning is predictive of intact competence capacities in studies that measure intelligence through testing or diagnosis. As early as 1984, Savitsky & Karras demonstrated an association between juvenile competence and verbal abilities using the Shipley Institute of Living Scale (Shipley, 1940). Later studies used Axis II diagnoses or intelligence screening tools to operationalize cognitive abilities (Cooper, 1997; Ficke, et al., 2006; McKee & Shea, 1999; Grisso, et al., 2003; Kruh, et al., 2006; Warren, et al., 2003). Occasionally, variables such as special-education history, grade retention, or academic performance (e.g., grades) have been used to estimate intellectual abilities (Cowden & McKee, 1995; Redlich, et al., 2003; Kruh, et al., 2006). Overall, findings are consistent with studies of adult competence (see, e.g., Hoge, et al., 1997) and support the expectation that intellectual ability is associated with greater competence capacities, while intellectual disabilities account for many instances of incompetence.

Several studies of juveniles have shown that mental-health symptoms differ between youths who are deemed incompetent and those who were competent when making direct comparisons of the two groups or when reporting preliminary findings. Later analyses by Baerger, et al. (2003) did not find associations more specific than those between a finding of incompetence and a history of either inpatient or outpatient mental-health treatment. Only psychotic disorders were significantly associated with incompetence after controlling for age and intelligence in the sample studied by Kruh, et al., 2006. Both internalizing and externalizing disorders were associated with lower scores on MacCAT-CA subscales in a study of incarcerated juveniles (Ficke, et al., 2006). Warren (2003) and her colleagues found several persistent relationships between mental-health measures and the three subscales of the MacCAT-CA, but their sample was comprised of youths who were psychiatric inpatients. Among youths referred for competence restoration, those with mental illness were most likely to later be found competent to proceed, while those with intellectual disabilities or co-morbid mental illness and intellectual disability were less likely to be restored (McGaha, et al., 2003). The results of Grisso, et al., (2003) indicated that the mental-health screen used was “largely unrelated” to scores of the MacCAT-CA; however, the sample may have represented subjects who were, in effect, prescreened for serious mental-health problems by detention and jail staff who identified potential participants. In general, with the exception of a sample of psychiatric inpatients, mental-health problems have been observed in juveniles with impaired competence, but the associations seem to diminish in the presence of other variables.

In addition to intelligence and mental health, age, which has often been used as an indicator of cognitive development or maturity, has repeatedly been found to predict performance on competence measures. Many states recognize the relevance of maturity when deciding the age at which children and adolescents can be charged in juvenile court (sometimes called “infancy”). By local consensus, it is acknowledged that youths under a certain age do not have sufficient abilities to distinguish right from wrong or otherwise do not possess the relevant capacities to form an intent to commit wrongful behavior. Despite the readiness to define “infancy” based on age, states have been slow to formally acknowledge developmental immaturity as a threat to competence to stand trial.

Increasing age is associated with improved capacities after controlling for intelligence or related factors such as academic achievement (Baerger, et al., 2003; Cowden & McKee, 1995; Cooper, 1997; Ficke, et al., 2006; McKee, 1998; McKee & Shea, 1999; Grisso, et al., 2003; Redlich, et al., 2006; Warren, et al., 2003). Evidence strongly suggests that pre-teens are especially likely to have performance deficits, regardless of whether the measure of competence was originally normed for adults or was a non-standardized measure developed for juveniles. However, this should not be misunderstood as a statement that all adolescents are incompetent to stand trial by virtue of age (see, e.g., Sanborn, 2009). Most studies note that the impairments increase as age declines. Grisso, et al., note specifically that 20% of youths who were 14 or 15 years old had deficits on two of the three MacCAT-CA subscales, while about 33% of youths who were 13 years old or younger had such deficits. Thus, 67% of very young adolescents and 80% of mid-adolescents had adequate abilities.

Across multiple studies, young age, low intelligence, and some types of mental-health symptoms are associated with deficits or impairments to competence, whether the measure of competence is relevant to adult court or juvenile-court procedures. Gender has not been found statistically significant in studies that included females (Cowden & McKee, 1995; Ficke, et al., 2006; Grisso, et al., 2003; Kruh, et al., 2006). Ethnicity produced variable findings in one major study, with no significant relationship to an adult measure of competence (the MacCAT-CA; Grisso, et al., 2003) but with observed differences by ethnicity on decision making (i.e., willingness to disclose to defense counsel) as assessed by a non-standardized measure (the MacJEN; Grisso, et al., 2003). But at least one other study found ethnicity was not significantly associated with competence capacities (Kruh, et al., 2006). Grisso and colleagues accounted for socioeconomic status in all analyses but found no associations with competence.

The relationship between prior exposure to legal matters and competence has been evaluated and found to be significant in some forms, but not others. Specific instruction about legal matters generally improves functioning in youths (Viljoen, et al., 2007), and the potential for learning through previous arrests has been supported (McKee & Shea, 1999). In contrast, the seriousness and number of current charges has not been predictive of competence (Cowden & McKee, 1995) and prior contact with the justice system was not significant for detained samples (Grisso, et al., 2003). Thus, a youth who

has been arrested previously may not have gained useful knowledge from the experience, while direct instruction is likely a more effective means of improving psycho-legal functioning.

The present study drew on previous experience with youths referred for competence concerns with the goal of developing an interview and report-writing methodology suitable for the juvenile courts in the State of Washington. The Forensic Clinic of the Child Study & Treatment Center (CSTC) provides court-ordered juvenile forensic evaluations to all counties in Washington. The Washington competence statute was originally intended for adult defendants and extended to juveniles through district-court decisions that allow judges to set aside the statute when it serves the best interests of the youth in question (*State v. E.C.*, 1996; *In re Weaver*, 1996). “Incompetency” is defined—consistent with Dusky—as lacking the capacity to understand the nature of the proceedings or lacking the capacity to assist in the defense as a result of mental disease or defect (Criminally Insane Procedures, Chapter 10.77 Regional Code of Washington).

Youths referred to the Forensic Clinic were administered a clinical assessment and interviewed with the Juvenile Adjudicative Competence Interview (JACI; Grisso, 2005). The JACI is a semi-structured interview designed to evaluate a youth’s comprehension of the juvenile-justice process using relevant question areas in a manner that is sensitive to the dynamics of maturation. Items are flexibly worded to accommodate the uneven nature of development in children and adolescents and include elaborations that probe for potential weaknesses due to immaturity.

Information collected with the JACI is used to form opinions regarding the two capacities identified in the statute. We expected to find that impairments to either capacity would be associated with younger age, lower intelligence, and diagnoses of psychotic diagnoses. Due to the variety of mental-health diagnoses within the sample, we considered the possibility that other diagnoses might also predict poorer performance. We additionally anticipated that youths with prior experience in the justice system would have fewer competence-related deficits based on their previous exposure. Generally, we hoped to find that the JACI provided results consistent with previous studies of juvenile competence capacities with elaborations specific to children and adolescents.

## **Materials and Methods**

### **Procedures & Participants**

The data for this study were derived from an administrative database used to track evaluation referrals made to the CSTC Forensic Clinic, which is housed at the state psychiatric hospital for children and adolescents. Primarily an outpatient service, the Forensic Clinic is mandated to provide competence-to-stand-trial evaluations free of charge to all juvenile courts within the State of Washington. The majority of referrals are made by densely populated counties and counties that are located near the hospital. The Forensic Clinic is the only state-supported clinic mandated to provide juvenile forensic-mental-health evaluations in the State of Washington. There are a few private-

practice clinicians within the state who conduct juvenile forensic evaluations, but they are few in number and complete a relatively small number of cases. While we do not have specific data on the number of evaluations conducted by other clinicians, we are anecdotally aware that counties throughout the state consider us their primary resource for evaluations.

The Clinic employs two full-time evaluators who are licensed psychologists, and periodically uses qualified contractors to accommodate unusually high referral rates. The information in the Forensic Clinic's administrative database is used to describe the Clinic's use of resources, such as number of referrals completed annually, staffing requirements to respond to court orders to conduct evaluations, and evaluation methods that facilitate timely completion of reports.

The chart-review procedures used for this study were approved by the Institutional Review Board of the Department of Social and Health Services (DSHS) for the State of Washington, the parent agency of the Forensic Clinic. Variables were extracted for youths who were evaluated at the Forensic Clinic between the years of 2005 and 2008 (n=280). Although some youths received multiple evaluations during that time period (either for multiple charges, or charges from multiple counties, or for evaluations before and after competence restoration), only the first JACI interview for each youth was used in this study.

## **Independent Variables**

**Demographic Variables.** We obtained information on the youth's gender, ethnicity, and age from the state's discovery packet received for each referral. This sample was mostly male (n=245, 88%) and mostly non-Hispanic white (n=174, 62%) (see Table 1). The average age of the sample was 14.26 years (sd = 2.12; range = 8 to 18). Participants were sorted into four age groups: those under 13 (n=60, 21%), 13- and 14-year-olds (n=79, 28%), 15- to 16-year-olds (n=97, 31%), and 17- to 18-year-olds (n=44, 16%). The two 18-year-old participants were youths who had been charged in the juvenile court and had turned 18 before their cases were referred for evaluation.

Table 1 Sample Characteristics

	N (%)
Gender	
Female	35 (12)
Male	245 (88)
Ethnicity	
African-American	48 (17)
Hispanic	30 (11)
Native American	12 (4)
Non-Hispanic white	174 (62)
Other	16 (6)
Age and Age Groups	
8- to 12-year-olds	60 (21)
8	2 (< 1)
9	3 (1)
10	9 (3)
11	19 (7)
12	27 (10)
13- to 14-year-olds	79 (28)
13	38 (14)
14	41 (15)
15- to 16-year-olds	97 (35)
15	45 (16)
16	52 (19)
17- to 18-year-olds	44 (16)
17	42 (15)
18	2 (< 1)
Any Prior Juvenile-Court Charges	166 (59)
IQ Groups	
Intellectually Disabled	76 (27)
Borderline Intellectual Functioning	36 (13)
Low Average to Average	168 (60)

**Justice System Variables.** For each evaluation conducted at the Forensic Clinic, prior charges and dispositions are included in the discovery packets received from the state and added to the administrative database. For each evaluation, a variable was coded to indicate no prior charges or any prior charges with the juvenile justice system.

**Intelligence.** Indications of intellectual functioning were obtained through two sections of the administrative database. The first section is a coded record of intelligence as documented by recent testing. Because many youths evaluated for competence have a history of special-education services, there was data on almost all participants. Intelligence testing is conducted by the Forensic Clinic and coded in this area of the database when there are questions about the availability of records. The second source of cognitive functioning data was Axis II diagnoses such as "Borderline Intellectual Functioning,"

“Mild Mental Retardation,” or “Moderate Mental Retardation.” Youths with no Axis II diagnosis who participated in general education programming (i.e., received no special-education services) were deemed to have at least average intelligence. Based on these sources, intelligence was divided into three categories: Low to Low Average IQ (n=168, 60%), Borderline Intellectual Functioning (n=36, 13%), and Intellectually Disabled (n=76, 27%).

**Diagnoses.** By statute, state-employed forensic evaluators in Washington are required to provide a diagnosis, and by practice, this clinic uses diagnoses from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) of the American Psychiatric Association (2000). The diagnoses in the administrative database were reduced to represent those that were most often reported in this sample. The resulting groups were Attention-Deficit/Hyperactivity Disorder (ADHD), Mood Disorders, Disruptive Disorders (i.e., Conduct Disorder and Oppositional Defiant Disorder), Communication Disorders (e.g., Mixed Expressive Receptive Language Disorder), Learning Disorders, Posttraumatic Stress Disorder (PTSD), other Anxiety Disorders, Psychotic Disorders, Pervasive Developmental Disorders, Substance-abuse Disorders, Child Neglect or Abuse, and Relational Problems.

### **Dependent Variables**

The dependent variables were derived from the evaluators' ratings of competence-related capacities of understanding the proceedings and assisting the defense. Opinions regarding capacity and the associated ratings were derived from the results of a forensic interview with the JACI (Grisso, 2005). Evaluators' dimensional ratings (from no problems to severe problems) were sorted into two levels of “No/Mild Problems,” (able to proceed) and “Moderate/Severe Problems” (requiring clinical intervention before proceeding). Evaluators who contributed data were trained and experienced in performing competence-to-stand-trial evaluations with both juveniles and adults, and were familiar with the local courts' standards of competence for adolescents being processed through the juvenile-court system.

**Capacity to Understand.** Opinions regarding the capacity to understand the proceedings (“Capacity to Understand”) were supported by assessment of both concrete knowledge and the associated implications of the information for relevant areas of courtroom proceedings. Generally, youths were questioned about the charges against them, the pleas they could enter, the trial process, the penalties they might receive, and the roles of courtroom personnel.

**Capacity to Assist.** Opinions regarding the ability to assist in forming a defense (“Capacity to Assist”) were described in terms of responses to interview questions about the relationship with defense counsel, observations of behavior during the interview (e.g., acquiescence or vulnerability to peer pressure), examples of clinical symptoms such as inattention and distractibility, and performance on legal decision-making tasks.



## Results

Preliminary findings showed that, of the 280 cases reviewed, 53% (n=149) would be considered not competent to proceed based on deficits to either the Capacity to Understand or the Capacity to Assist. Most impaired youths (n=123) had problems on both capacities, three had problems only on the Capacity to Understand, and 21 were impaired only on the Capacity to Assist.

A multiple analysis of covariance (MANCOVA) was conducted using Capacity to Understand and Capacity to Assist as dependent variables. Diagnostic categories and history of previous charges were independent variables using covariates for age, gender, ethnicity, and intelligence. There were no significant multivariate effects for gender, ethnicity, or prior charges.

The analysis indicated a significant multivariate effect for age (multivariate  $F(2,260) = 4.03, p < .02$ ), with univariate results for Capacity to Understand ( $F(1, 261) = 8.04, p < .01$ ) and Capacity to Assist ( $F(1, 261) = 4.24, p < .05$ ). Follow-up analyses indicated that 58% of children in the youngest age group (8- to 12-year-olds) had Moderate to Severe Problems with the Capacity to Understand, compared to 47% of the 13- to 14-year-olds, 37% of the 15- to 16-year-olds, and 46% of the 17- to 18-year-olds (see Figure 1). Sixty percent of 8- to 11-year-olds had Moderate to Severe Problems with the Capacity to Assist, compared to 54% of 12- to 13-year-olds, 47% of 14- to 15-year-olds, and 48% of 16- to 18-year-olds (see Figure 2).

Figure 1. Percent Performance on Capacity to Understand the Proceedings by Age Group

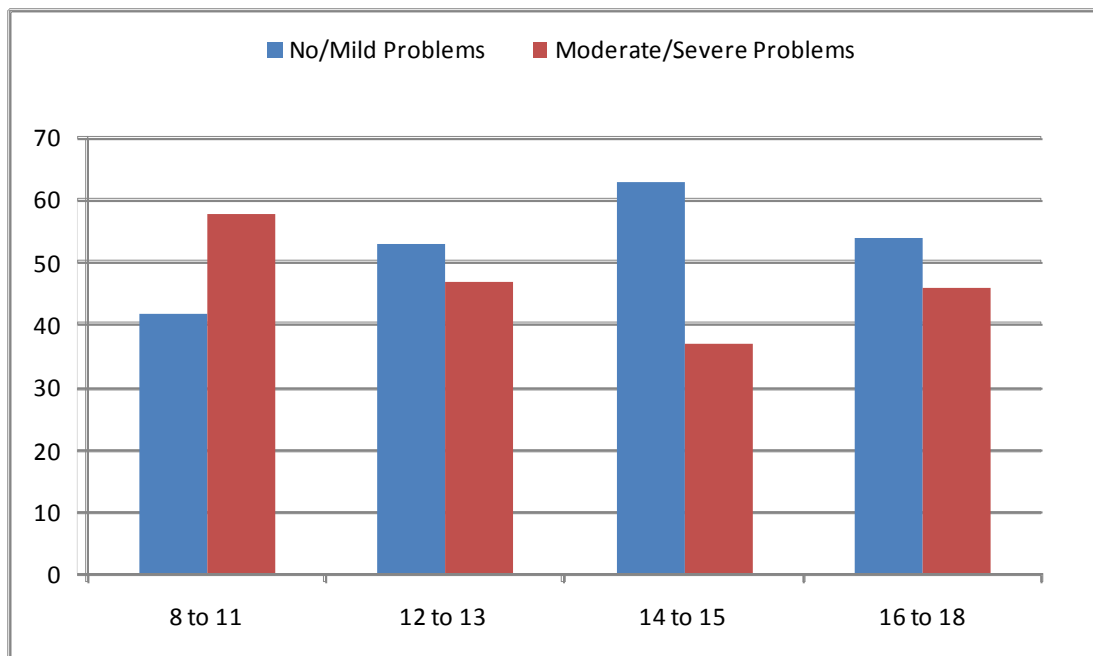
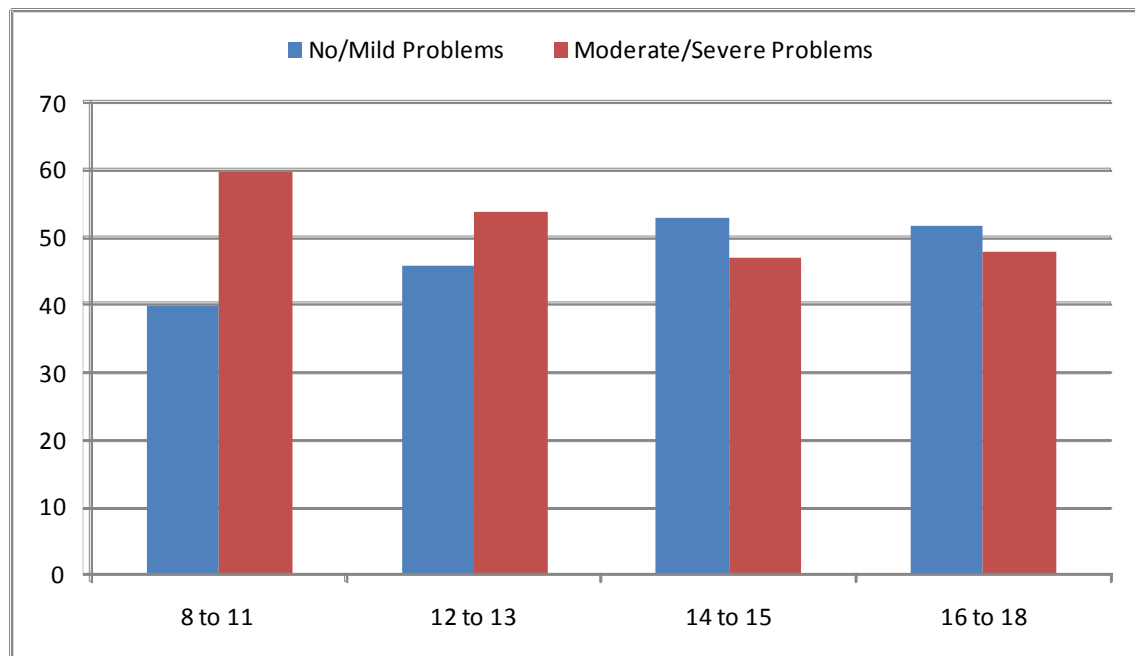


Figure 2. Percent Performance on Capacity to Assist the Defense by Age Group



There was a significant multivariate effect for intelligence (multivariate  $F(2,260) = 29.6$ ,  $p < .01$ ), and univariate results for Capacity to Understand ( $F(1, 261) = 57.2$ ,  $p < .01$ ) and Capacity to Assist ( $F(1, 261) = 46.4$ ,  $p < .01$ ). Follow-up analyses indicate that increasing intellectual abilities were associated with fewer problems on both capacities (see Figure 3 and Figure 4). However, a surprising number of youths with Low Average to Average intelligence (> 30%) had Severe Impairments on one or both capacities.

Figure 3. Percent Performance on Capacity to Understand the Proceedings by IQ Group

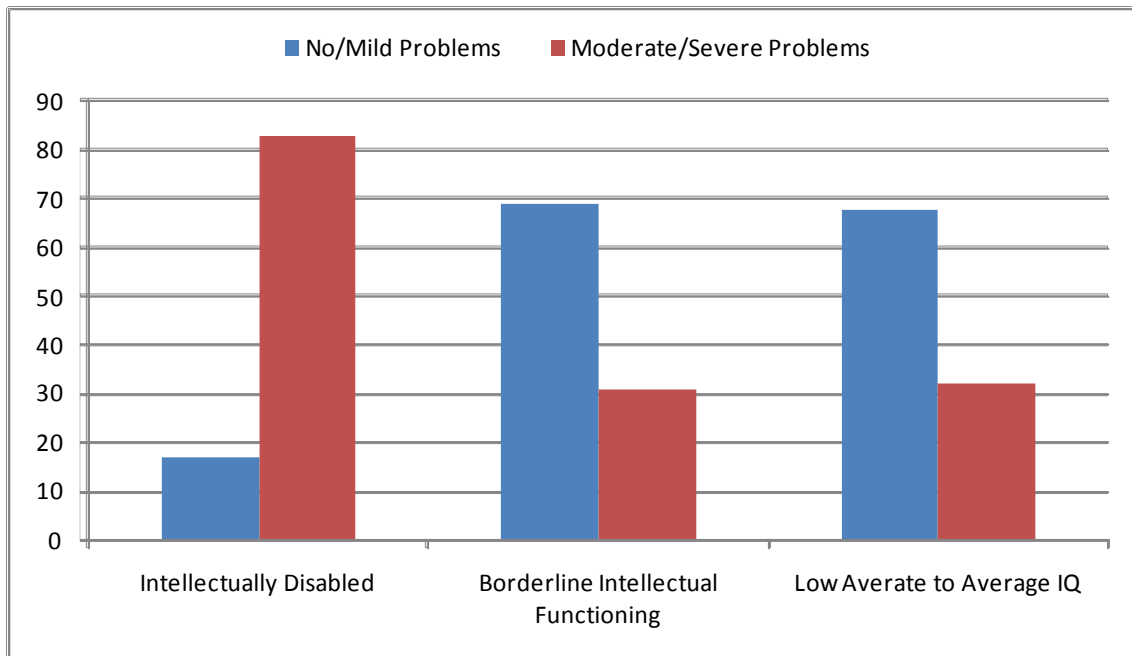
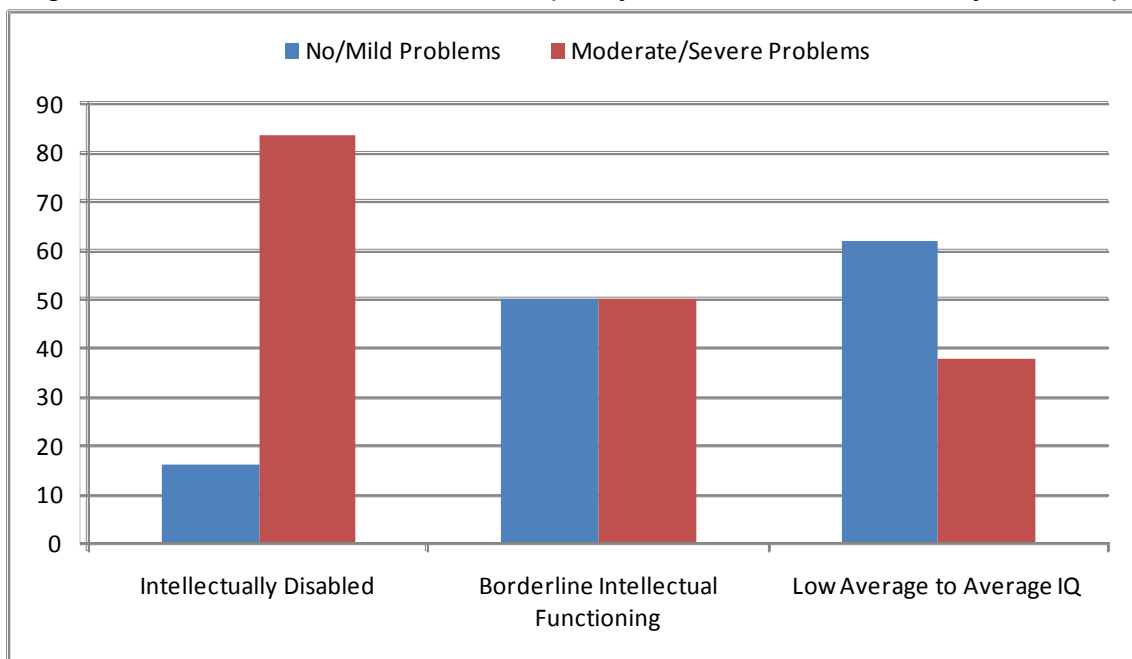


Figure 4. Percent Performance on Capacity to Assist the Defense by IQ Group



Closer review of youths with Low Average to Average IQ and Moderate to Severe Problems on the Capacity to Understand revealed differences in diagnostic categories across age groups. Children aged 8 to 12 years were more likely to have a diagnosis of ADHD ( $\chi^2 = 12.54, p < .01$ ) compared to other age groups. The two younger age groups (8 to 12 and 13 to 14) were more likely to have Disruptive Disorder diagnoses

( $\chi^2 = 8.79, p < .04$ ). The two middle age groups (13 to 14 and 15 to 16) were more likely to have Communication Disorders ( $\chi^2 = 8.19, p < .05$ ). The two older age groups (15 to 16 and 17 to 18) were more likely to have Substance-Abuse Disorders ( $\chi^2 = 12.34, p < .01$ ) or to have Psychotic Disorders ( $\chi^2 = 10.71, p < .02$ ). A review of youths with Low Average to Average IQ and Moderate to Severe Problems on the Capacity to Assist produced similar findings.

The same analyses of youths with Borderline Intellectual Functioning and Moderate to Severe Problems on either the Capacity to Understand or the Capacity to Assist resulted in no significant differences in diagnostic categories across age groups.

Several diagnostic categories were significant after accounting for the contributions of age and intelligence. There was a significant multivariate effect for Psychotic Disorders ( $F(2, 260) = 3.60, p < .03$ ), with univariate effects for the Capacity to Understand ( $F(1, 261) = 6.70, p = .01$ ) and the Capacity to Assist ( $F(1, 261) = 6.12, p < .02$ ). The proportion of youths with Psychotic Disorders who had Moderate to Severe Problems on the Capacity to Understand (57%) was not significantly different from those of other diagnostic groups (45%;  $\chi^2 = .75, p = ns$ ). A similar result was found for the Capacity to Assist: 61% of youths with Psychotic Disorders had Moderate to Severe Problems, compared to 52% of other diagnostic groups ( $\chi^2 = .62, p = ns$ ).

There was a significant multivariate effect for Pervasive Developmental Disorders ( $F(2, 260) = 3.17, p < .05$ ), with univariate effects on Capacity to Understand ( $F(1, 261) = 4.34, p < .04$ ) and Capacity to Assist ( $F(1, 261) = 6.32, p < .02$ ). Follow-up comparisons found that 75% youths with PDD diagnoses had Moderate to Severe Problems, compared to youths with other diagnoses (44%;  $\chi^2 = 5.86, p < .02$ ; significant after Bonferroni correction of  $.05/2 = .025$ ). Similarly, those with PDD diagnoses were more likely to have Moderate to Severe Problems with the Capacity to Assist (88%) than youths with other diagnoses (50%;  $\chi^2 = 8.5, p < .01$ ; significant after Bonferroni correction of  $.05/2 = .025$ ).

Two additional diagnostic categories trended toward significance. A diagnosis of Child Neglect or Abuse approached significance for a multivariate effect ( $F(2, 260) = 2.91, p = .056$ ), with univariate results for the Capacity to Understand ( $F(1, 261) = 5.74, p < .02$ ) and the Capacity to Assist ( $F(1, 261) = 2.72, p = .10$ ). Follow-up comparisons showed that 66% of youths with a history of neglect or abuse had Moderate to Severe Problems on the Capacity to Understand, compared to 43% of youths without that diagnosis ( $\chi^2 = 5.11, p = .024$ ; significant after Bonferroni correction of  $.05/2 = .025$ ). The same proportion of neglected or abused youths had problems with the Capacity to Assist, but a larger proportion (51%) of those with other diagnoses had similar problems ( $\chi^2 = 2.32, p = ns$ ).

Substance Abuse was the second diagnostic category that approached significance for a multivariate effect ( $F(2, 260) = 2.60, p = .076$ ), with univariate results for the Capacity to Understand ( $F(1, 261) = 2.20, p = .14$ ) and the Capacity to Assist ( $F(1, 261) = 5.05, p < .03$ ). Additional review found that only 26% of youths with a Substance-abuse diag-

nosis had Moderate to Severe Problems on the Capacity to Understand, compared to 50% of youths with other diagnoses ( $\chi^2 = 8.3, p < .01$ ; significant after Bonferroni correction of  $.05/2 = .025$ ), with similar findings for the Capacity to Assist (28% with a diagnosis of Substance Abuse had Moderate to Severe Problems, compared to 50% of other youths;  $\chi^2 = 11.96, p < .01$ ; significant after Bonferroni correction of  $.05/2 = .025$ ).

No additional diagnostic categories attained significance in the multivariate analyses or trended towards significance.

## Discussion

The usual limitations associated with chart-review studies must be applied to consideration of these findings. The youths in this study were referred from within a single state, and represent those youths whose general appearance raised concerns in the minds of non-clinicians, specifically, lawyers, parents, or judges. By virtue of having been identified for referral to CSTC, this sample of youths is different from many studies of juvenile competence. The data collected from these evaluations reflect the opinions of clinicians working independently without peer review or consultation. While the clinic is mandated to provide services to the entire state of Washington, the cases in this study represent only those referred to the clinic, and not those relatively few cases referred to forensic evaluators in private practice.

Despite these caveats, the current sample represents a unique dataset of results from evaluations conducted with a unique semi-structured interview, the JACI. The JACI uses questions specific to juvenile court and allows evaluators to explore for deficits associated with developmental immaturity. The information obtained during the interview was conceptually derived from a statutory definition of two competence-related capacities, adding greater specificity to the description of competence findings.

In general, the results echo previous findings that age, intelligence, and mental-health symptoms influence juvenile competence to stand trial. Although there was a general association between increasing age and improved functioning, there were indications that Low Average to Average intelligence had fewer benefits for youths with certain types of psychopathology. Pre-adolescents and young teens with adequate intelligence who demonstrated significant problems with competence-capacities had diagnoses of externalizing disorders such as ADHD, Oppositional Defiant Disorder, or Conduct Disorder. This is similar to the results of Ficke, et al., although that study used an assessment instrument rather than diagnosis to identify externalizing behaviors. Young- and middle-adolescent youths with impaired capacities and average intelligence were likely to have communication disorders such as Expressive Language Disorder. The older adolescents who had competence deficits despite their average intelligence had mental-health problems such as psychotic disorders and chemical dependencies. The mental-health problems of the younger age groups (e.g., ADHD and Disruptive Disorders) compared to those in the older group (e.g., substance abuse and psychosis) suggest that developmental psychopathology—not just developmental immaturity—is a relevant area of concern for forensic evaluators who work with juveniles.

Consistent with studies of adults evaluated for competence, psychotic symptoms were likely to impair juvenile capacities. The age of onset for many psychotic disorders is late adolescence to young adulthood. Therefore, the psychotic youths in this sample represent a group with an atypical progression of symptoms; however, youths with psychotic disorders tended to be older than other subjects. All of the psychotic youths had problems with both the Capacity to Understand and the Capacity to Assist, suggesting that their symptoms affected multiple areas of cognitive, social and communication abilities.

Pervasive Developmental Disorders (PDD) were associated with problems on both capacities. The signs and symptoms of PDD are similar to two other diagnostic categories in this study, Psychotic Disorders and Communication Disorders. Differential diagnosis of PDD and early onset psychosis has been a challenging endeavor for many years, and recent studies have shed light on the similarities and differences between the two. While adults with autism-spectrum disorders often describe experiences similar to auditory or visual hallucinations, they are frequently reporting other types of unusual sensory experiences that are difficult for them to describe because of the communication problems associated with PDD (van der Gaag, Caplan, van Engeland, Loman, & Buitelaari, 2005). In addition, formal thought disturbances can occur in people with autistic symptoms without additional manifestations of psychosis (Solomon, Ozonoff, Carter, & Caplan, 2008).

Communication deficits, specifically, those associated with social-skills deficits, are hallmark indicators of PDD. In this study, communication disorders such as Expressive Language Disorder did not significantly predict problems with either competence capacity. This suggests that the combination of social interaction impairments and inadequate communication skills are especially likely to interfere with the necessary abilities to proceed when impairments are due to a PDD diagnosis.

The trends toward significance for Substance-Abuse disorders and child neglect or abuse are similar to past studies of juvenile competence. Kruh, et al. (2006) noted that substance abuse was predictive of *better* psycho-legal functioning in preliminary analyses, although the association was not significant after controlling for other factors. Kruh, et al., suggested that youths with substance-abuse problems were referred for assessment because of non-specific concerns about alcohol and drug abuse that might have suggested the possibility of other mental illnesses. In the current sample, it appears that substance-abuse disorders were especially likely to occur among older juveniles, and this relationship may cause the association between chemical dependency and competence to proceed when controlling for age.

An apparent trend for child neglect and abuse to affect competence is similar to the preliminary findings of Baerger (2003) and colleagues, who observed that competent youths were likely to be living with their parents, and their parents were likely to have legal guardianship. In the same study, state agencies were more likely to be guardians of youths who were found incompetent. Neither of these variables attained significance

in Baerger's final analysis, but the likelihood that adults in the environment may influence a juvenile's psycho-legal functioning remains an intriguing possibility.

Additional studies are needed to further increase the body of knowledge regarding the competence-related capacities of juveniles. This study confirmed findings of earlier studies of both adults and minors, concurring that age, intelligence, and certain types of psychopathology are especially likely to affect a youth's ability to proceed to trial in juvenile court. Results of the present study support the need for forensic evaluators who work with juveniles to be conversant with developmental psychopathology as well as developmental immaturity as they relate to the lower standards of competence required in juvenile court. Future research should focus on consistent and effective means of identifying mental-health symptoms and associating them with specific deficits to competence. In addition, more work is needed to adequately describe age-related cognitive vulnerabilities associated with specific aspects of juvenile competence, such as the possibility of environmental influences on decision making.

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