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Tracy A. Donsky, J.D.
Mental Health and
Developmental Factors Related
to Juvenile Adjudicative
Competence

ABSTRACT

The current study assessed factors associated with competency to stand trial (CST) for 134 male juvenile offenders. Written reports of each juvenile's competency evaluation provided data on age, educational and family background, mental health, types of offense, and understanding of the juvenile justice system. Various differences emerged between 10-15 and 16-18 year age groups, including behavioral and developmental issues for younger youth, and school and substance use problems among older youth. Psychosis, paternal presence, and understanding of court roles and procedures differentiated the youth determined to be competent to proceed to trial versus those who were not. To a less significant extent, educational status, developmental delay, receipt of special services, taking medication at time of arrest and diagnosis of a mood disorder also emerged as characteristics distinguishing competent and incompetent youth. With respect to differences related to competency between the two age groups, ADHD and education level were both marginally related to competency for the younger juveniles. For the older youth, diagnoses of mood disorders were significantly associated with competency, while developmental delays, and to a less significant extent, psychotic disorders were associated with incompetency. Additionally, the absence of a father in the home, no history of receiving special school services, and taking psychiatric medication at the time of arrest were also significantly associated with competence for

the older youth. Results identify and discuss differences among younger or older delinquent youth deemed CST, and point to next steps for research examining age in relation to other characteristics of youth.

MENTAL HEALTH AND DEVELOPMENTAL FACTORS
RELATED TO JUVENILE ADJUDICATIVE COMPETENCE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

Competency to stand trial (“CST”; “adjudicative competence” or “competence to proceed”) for adult defendants is a well-developed and long-standing concept in both criminal law and forensic psychiatry and psychology, and requires that adult defendants be able to adequately understand and participate in legal proceedings against them. For adolescents, however, this requirement was historically considered unnecessary given the rehabilitative ideals of the early juvenile justice system (Bonnie & Grisso, 2000; Grisso, 1997). However, as the juvenile justice system has become more punitive and adult-like in nature over the past few decades, courts have increasingly required that juvenile defendants must be competent to proceed to trial (*In re Gault*, 1967; Grisso, 2003a; Redding & Frost, 2001).

In extending these requirements to youth, courts have often presumed and expected that youth demonstrate legal competency in the same ways as adults and thus, have applied the same legal standard to adolescents that was conceptualized for adults. At best, the particular legal standard for competence in juvenile court is unsettled (Scott & Grisso, 2005). It has become clear, however, that assessment of juvenile CST involves complex issues beyond those addressed by the legal standard in place for adult assessments. Of particular significance, competency among adults is often statutorily linked to the presence of mental illness (Baranoksi, 2003; Grisso et al., 2003); in children,

however, incompetence to stand trial can arise from immaturities in normal developmental capacities in the absence of, as well as in conjunction with, psychiatric disorders. In other words, because many juvenile defendants have not fully developed their cognitive, emotional and psychological capacities, they may have impaired legal abilities that are a direct result of their youth, rather than any identifiable mental illness or impaired intellect. The complexity of juvenile cognitive development and competencies, in theory and practice, make this area of forensic psychiatry and psychology particularly challenging.

CHAPTER II

LITERATURE REVIEW

Brief History of Juvenile Justice Policy in America

Over the last century, the American legal system has experienced significant shifts in its consideration for and treatment of child and adolescent offenders. With the establishment of the first juvenile court in 1899, the United States adopted the then progressive view that youth who committed criminal offenses should be treated separately and differently from adults (Dreyer & Hart, 2008). This was based on the assumption that youth differed from adults in at least two significant ways: 1) due to less mature judgment, youth were less culpable for their actions; and 2) juveniles were more amenable to treatment and rehabilitation (Scott & Grisso, 1997). Youth criminality was largely attributed to factors beyond a child's control, such as poor parenting and immaturity (Scott, 2000). Consequently, the juvenile court adhered to the philosophy that children can and should be rehabilitated for their crimes, rather than be held morally or criminally responsible for their actions (Mack, 1909; Zimring, 1982; Teitelbaum, 1991; Hemmens, Fritsch, & Caeti, 1999; Scott, 2000).

The focus of the juvenile justice system was rehabilitation, not punishment (Bonnie & Grisso, 2000; Grisso, Miller & Sales, 1987). Accordingly, juvenile court judges were given the freedom to act with the discretion of a benevolent parent and to pursue goals that the judge believed were in the best interests of the child (Savitsky &

Karras, 1984). Legal procedures were informal and dispositions were indeterminate (Scott & Steinberg, 2008). Children appearing in juvenile court were often not provided many of the legal protections of their adult counterparts, such as the right to remain silent, notice, representation by an attorney, an adversarial hearing, and confrontation of accusers (Grisso, 2003b). As a result, the issue of a minor's competency to stand trial was rarely raised (Burnett, Noblin, & Prosser, 2004).

The rehabilitative model of the juvenile court system continued without major changes until the mid-1960s when two landmark cases, *In re Gault* (1967) and *Kent v. United States* (1966) radically changed the premise of the juvenile justice system. The rulings in these two cases required that juveniles should be accorded the same rights of due process as adult criminal defendants, including the right to counsel, the right to avoid self-incrimination, the right to challenge evidence and witnesses in court, and the right to receive notice of the charges against them (Steinberg & Schwartz, 2000; Scott, 2000). A perhaps unintended effect of the *Kent* and *Gault* decisions was the advent of more adversarial approaches to juvenile proceedings, bringing them more in line with adult criminal proceedings (Grisso, 1997). In the wake of *Gault*, the era of rehabilitation and the promotion of juvenile well-being was replaced with a new era in which the primary goals of juvenile justice courts were punishment of the offender and protection of the public (Scott, 2000).

In the 1980s and 1990s, the juvenile justice system experienced a second wave of reform that further altered the nature and process of juvenile court. In response to a perceived "epidemic" of violent juvenile crime, nearly every state changed its laws to align juvenile courts with the more punitive approach of adult courts, with the focus on

protecting society from juvenile offenders, rather than protecting juveniles (Steinberg & Schwartz, 2000). These included changes in state statutes that broaden, and in some cases automatically require, transfer of jurisdiction to criminal court for juveniles at younger ages and for a wider variety of offenses. Some states also created extended sentences for youth who are tried in juvenile court, and have allowed juvenile court hearings to include juries (Dreyer & Hart, 2008). In 1995, the state of Connecticut, for example, passed legislation replacing “court advocates” with “juvenile prosecutors,” (Connecticut P.A. 95-225) and mandating the automatic transfer to adult court of all juvenile offenders age 14 or older who were accused of committing a serious felony (Connecticut General Statute § 46b-127(a), 2008). Connecticut was not alone. During the three years between 1992 and 1995, eleven states lowered the age for transfer, twenty-four states added crimes to automatic/waiver statutes, and ten states added crimes to judicial waiver statutes (Scott & Steinberg, 2008).

Another response to the rise in adolescent crime was an increase in the harshness of sanctions to which juveniles were subjected. These changes stand in sharp contrast to the public perception that juvenile courts provide lenient sentences (Dreyer & Hart, 2008). In reality, three-quarters of youth who come in contact with police are referred for prosecution of an offense; the use of diversionary programs seems to be the exception rather than the rule (Snyder & Sickmund, 2006). In many respects, the reforms of this period have essentially forced children to stand shoulder to shoulder with adults in the context of the criminal justice system, especially when their cases are waived to adult court, thus eroding the boundary between juvenile and criminal court. (Haskins & Steinberg, 2008; Steinberg & Schwartz, 2000; Reppucci, 1999). Youth who are legal

minors for every other purpose are adults when it comes to their criminal conduct. Arguably, these legal changes reflect a broader societal decline in the preservation of childhood as a unique entity in need of special protections.

Once again, however, American juvenile justice policy appears to be in a period of transition (Steinberg, 2008). The public outcry that spurred the “get-tough” reforms of the 1990s and early 2000s appears to have waned and state legislatures across the country appear to be reconsidering punitive statutes enacted in the recent past. Within the past four years, there have been several noteworthy indicators of this shift (Steinberg, 2008). In 2005, the United States Supreme Court, in *Roper v. Simmons*, abolished the juvenile death penalty as cruel and unusual punishment, emphasizing that the immaturity of adolescents made them less culpable than adult criminals. Since that decision, several state legislatures have repealed, or are considering repealing, statutes that impose sentences of life without parole on juvenile murderers (Steinberg, 2008; NJDC, 2007, 2008). Some states have modified automatic transfer laws and many states have increased funding for community-based treatment programs as alternatives to institutional placement (Steinberg, 2008; NJDC, 2007, 2008). Furthermore, in several states where youth under eighteen are prosecuted in adult criminal court rather than juvenile court, effort has been made to increase the age of jurisdictional transfer to eighteen. In fact, in 2007, Connecticut successfully passed legislation that, as of January 1, 2010, raises the jurisdictional age in juvenile court from sixteen to eighteen (Conn. Gen. Stat. § 46b-120 (2008) as amended by section 73 of public act 07-4 of the June special session). Finally, at least one state has enacted legislation that authorizes findings

of incompetence to stand trial on the basis of developmental immaturity (Steinberg 2008; NJDC, 2007).

Adjudicative Competence

Competence to Proceed in Adult Criminal Court

Since as far back as the 17th century, the criminal justice system has required that adult defendants accused of crimes must be competent to proceed to adjudication, a requirement that aims to protect the fairness and accuracy of legal proceedings and defendants' autonomous decision-making (Viljoen & Roesch, 2008; Bonnie, 1992). The modern American legal standard for adult competence to stand trial was formally articulated by the U.S. Supreme Court in 1960 in *Dusky v. United States* ("the *Dusky* standard"). Under *Dusky*, the appropriate test for determining adult competency to stand trial "must be whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and whether he has a rational as well as factual understanding of the proceedings against him" (362 U.S. at 402 (1960)). In addition, recent case law has been interpreted to mean that defendants must also be able to adequately reason about relevant legal decisions (*Godinez v. Moran*, 1993; Grisso, 2003a). Most states adopted language directly from *Dusky* into their statutes regarding adjudicative competence, though statutes vary between states with some states (e.g., Ohio) omitting the "rational" feature and other states adding the requirement that a defendant's incompetence be due to "mental disease or defect." Although each state statutorily defines the process for the assessment of competency, the factors and the methods for measuring abilities have not been proscribed by the courts or the legislatures, but left to the assessors. A general consensus among evaluators is that an adult

defendant's CST requires an ability to 1) understand the charges he/she faces and their potential consequences; 2) understand the roles of court personnel and legal procedures such trials, pleas and plea-bargaining, evidence, oaths, and cross-examination; 3) weigh possible outcomes; 4) communicate with and assist an attorney with his/her own defense; and 5) behave appropriately and manage stress during trial (Grisso, 2000).

Competence to Proceed in Juvenile Court

Standards. Whereas competency to stand trial is an uncontroversial right for adults, it is not so for juveniles. Juveniles who are adjudicated in criminal court must presumably, on constitutional grounds, be held to the same legal standard of competence as adults adjudicated in criminal court, meaning that they must be able to understand legal proceedings, consult with counsel and have adequate decision-making capacities (Scott & Grisso, 2005; Viljoen & Roesch, 2008; Viljoen & Wingrove, 2007). For youth tried in juvenile court, however, the picture is less clear. The Supreme Court has never considered whether the Constitution requires that juveniles be extended the competency right in juvenile court and has not explicitly extended it. Despite the Supreme Court's silence, approximately two-thirds of American states recognize the legal concept of adjudicative competence for juveniles, either by statute or case law, and, with the exception of Oklahoma (*G.J.I. v. State*, 1989), all state courts that have considered this issue have held that juveniles who are adjudicated in juvenile court must be competent to proceed (Bonnie & Grisso, 2000; Wingrove, 2007). The particular legal standard for competence in juvenile court, however, remains unsettled (Scott & Grisso, 2005; Redding & Frost, 2001).

Some jurisdictions have not yet established formal competence standards for juvenile court. Of those jurisdictions that have, many have simply adopted the *Dusky* standard of adult criminal court, setting a requirement that youth in juvenile court demonstrate the same legal capacities as adults in criminal courts -- a factual understanding, a rational understanding, and an ability to communicate with counsel (see e.g., Colo. Rev. Stat. Ann. § 16-8-102(3), 2005; Tes. Fam. Code Ann. § 55.31-.32, 2007; *In the Matter of the Welfare of D.D.N*, 1998¹; Redding & Frost, 2001; Viljoen & Wingrove, 2007).

Other courts, however, have attempted to establish more relaxed competence standards in juvenile court, given the less serious penalties associated with juvenile court proceedings (e.g., *People v. Carey*, 2000). One way in which courts have done this is to require lower levels of legal capacities for adolescents than for adults, thus setting a lower threshold for competence. For example, courts in Michigan and Ohio have held that juveniles' competence should be assessed by "juvenile rather than adult norms" (*People v. Carey*, 2000; *Ohio v. Settles*, 1998). Arguably, such a standard implicitly recognizes that juveniles inherently have less developed abilities than adults.

Researchers have proposed that another way to apply more relaxed competence standards is to require that juveniles demonstrate a narrower set of legal capacities than that required for adults (Bonnie & Grisso, 2000; Viljoen & Wingrove, 2007). As Scott and Grisso (2005) emphasize, however, initiating more relaxed competence standards in

¹ The Court noted, "the level of competence required to permit a child's participation in juvenile court proceedings can be no less than the competence demanded for trial or sentencing of an adult" 582 N.W.2d 278 at 281.

juvenile court is constitutionally justifiable only if the consequences of adjudication in juvenile court are actually less severe than those in criminal court.

In addition to the issue of whether to establish a more relaxed standard of competence within juvenile court, courts face the question of whether to allow juveniles to be deemed incompetent on the basis of normal developmental immaturity. Increasingly, courts as well as legislatures specifically identify cognitive or developmental immaturity, in addition to mental illness or mental retardation, as a legitimate basis for adjudicative incompetence in juvenile court proceedings (Grisso, 2005b). In fact, many juvenile courts appear to recognize developmental immaturity as a basis for incompetence even without a specific legal mandate to do so (Viljoen & Roesch, 2008; Grisso, 2005b). At least one recent study reported that neither mental illness nor mental retardation was present in nearly one-quarter of youths found incompetent to stand trial in juvenile court, implying that developmental immaturity was involved instead (Baerger, Griffin, Lyons, & Simmons, 2003). Indeed, Grisso and Quinlan (2005) reported that approximately two-thirds of the evaluators who responded to their national survey of juvenile court clinics indicated that they sometimes recommended to the court that youth they evaluated be adjudicated incompetent to proceed based on developmental limitations, and one-fifth identified this as the most common basis for recommendations of adjudicative incompetence.

Process. When it appears that a juvenile defendant may lack the necessary legal capacities to understand and/or participate in the adjudicative process, the issue of competence must be raised by the defense attorney, judge or prosecutor. It is unclear exactly how commonly the issue of juvenile competence is raised. Two studies of adult

criminal cases have found that attorneys have doubts about the competence of about 10% of their clients, and raise this concern for only 5% of their clients (Hoge, Bonnie, Poythress, & Monahan, 1992; Poythress, Bonnie, Hoge, Monahan, & Oberlander, 1994). To date, there have not been any comparable studies using juvenile samples, but anecdotal evidence suggests that evaluations to determine juvenile CST are ordered relatively infrequently, though the number of requests for evaluations is increasing (Grisso, 1999; Grisso & Qunilan, 2005; Redding & Frost, 2001).

Once the issue is raised, CST assessments are then ordered at the discretion of the court. Typically the issue of competence is raised in an attempt to understand whether mental health issues and/or developmental factors compromise the juvenile in important ways relevant to the court proceedings the juvenile is facing. However, concerns have been expressed that the issue of juvenile competence, as with adults, also may be inappropriately raised to delay the trial or to obtain mental health treatment when more direct means are not easily attainable (Barnum & Grisso, 1994; Grisso, et al., 1987; Roesch & Golding, 1980). Obtaining treatment may be an important goal; however, using competency evaluations to do so may have negative effects such as delaying the trial and leading to possible stigma for the youth.

Although overuse of competency referrals is a serious concern, an equally, if not greater, concern is the under-identification of juvenile defendants who are potentially incompetent (Barnum & Grisso, 1994). Attorneys may be reluctant to request competency evaluations because doing so risks prolonging the trial process, which could result in a more time in detention while the logistics of a competency evaluation are organized, or alternatively, could increase the chances of the juvenile accumulating

additional charges if the youth remains in the community during the delay. An additional reason for not requesting competency evaluations is that a ruling of incompetence may end up leading to more severe consequences than a guilty verdict (Grisso, 1999). In order to prevent under-identification of potentially incompetent youth, Grisso et al. (1987) recommended that a juvenile defendant's competence automatically be evaluated when a youth is 12 years old or younger, has a prior diagnosis of or treatment for mental illness or mental retardation, has intellectual deficits or a learning disability, and/or appears to have deficits in memory, attention, or reality testing.

Once an evaluation of competence is complete, a judicial determination regarding competence is made. Although a judge makes the final determination, research with both adult defendants (Zapf, Hubbard, Cooper, Wheelles, & Ronan, 2004) and adolescent defendants (Kruh, Sullivan, Ellis, Lexcen & McClellan, 2006) has indicated that courts overwhelmingly defer to the opinions of mental health professionals in the vast majority of cases. As with adult defendants, relatively few youth (14-18%) who are referred for competence evaluations are found incompetent (Cowden & McKee, 1995; McKee, 1998; McKee & Shea, 1999).

The assessment of juvenile adjudicative competency involves evaluation of the same types of competence-related legal abilities as must be demonstrated by adult defendants, but it must be done within a developmental framework that necessarily raises questions of baseline expectations and comparative abilities. For example, how does a typical twelve year-old child's understanding of the consequences of a plea bargain offer compare to an adult's understanding? How does it compare to a fifteen year-old's? Are the differences significant enough to necessitate a separate legal competence standard

with different criteria for juveniles than for adults or can the *Dusky* standard, as currently formulated for adults, accommodate the differences and result in developmentally appropriate recommendations? Similarly, do developmental differences between adults and children require different and greater assessment tools designed specially to address issues of cognitive immaturity? Research indicates that clinicians conducting juvenile competency evaluations use techniques similar to those employed in adult CST evaluations, and largely view as essential for inclusion in competency evaluations the same elements as practitioners conducting adult competency evaluations (Ryba, Cooper, & Zapf, 2003). The data from juvenile CST evaluations are an invaluable resource for answering such questions.

Legal Capacities of Juveniles

Child Development and Juvenile Adjudicative Competence

Juveniles' immature developmental status presents an additional set of complications in competency determinations. Children mature at different rates and typically exhibit developmental spurts, delays, and transient regressions. Within the context of normal child development, children may have difficulty transferring abilities from one social context to another. They may exhibit some abilities without retaining them, or retain only fragments of the abilities until full development occurs later. Stress and emotional limitations may interfere with their capacity to apply newly acquired abilities at relevant times (Grisso, 1998). These sorts of typical developmental issues most probably impact adjudicative competence. Indeed, there is a significant body of research to suggest that youth lack some of the capacities required for adjudicative competency as a direct result of youth and normal developmental immaturity, as opposed

to any identifiable mental illness, cognitive disability or retardation (e.g.s., Grisso et al., 2003; Cauffman, Woolard, & Reppucci, 1999; Grisso, 1997, Steinberg & Cauffman, 2000; see generally Grisso & Schwartz, 2000). This is consistent with the substantial number of studies showing age-related differences in juveniles' competence-related abilities (e.g., D. K. Cooper, 1997; Grisso et al., 2003; Warren, Aaron, Ryan, Chauhan, & DuVal, 2003).

Studies on adolescent adjudicative competence have incorporated a wide range of samples, including non-delinquent youth only (see e.g., Dreyer & Hart, 2008); a combination of youth from both within and outside the juvenile justice system (e.g., Grisso et al., 2003), youth referred for competence evaluations (e.g., McKee, 1998; McKee & Shea, 1999), youth adjudicated incompetent to proceed (e.g., McGaha, Otto, McClaren, & Petrila, 2001), and psychiatrically hospitalized youth (e.g., Warren et al., 2003). Collectively, the research has convincingly demonstrated that adolescents, especially young and pre-adolescents, have high rates of deficits in legal competence-related skills in comparison to older adolescents and adults, and that court-related functioning is consistently associated with the age of the juvenile, with older juveniles generally demonstrating more complete understanding, reasoning and appreciation abilities (Boyd, 1999; Burnett et al., 2004; D. K. Cooper, 1997; Savitsky & Karras, 1984; Viljoen & Roesch, 2005; Warren et al., 2003; Baerger, Griffin, Lyons, & Simmons, 2003; Cowden & McKee, 1995; Grisso et al., 2003; Ficke, Hart & Deardorff, 2006; McKee, 1998; McKee & Shea, 1999). This finding is not surprising. Age trends in legal knowledge have been documented in related contexts, such as research on child testamentary capacity (see Grisso, 2000) and children's ability to understand and

appreciate Miranda warnings (Grisso, 1980), and generally finds support in literature on child development (Grisso, 1997). The body of research documenting the relationship between youth and deficits in legal capabilities seems difficult to reconcile with the legal presumption that juvenile defendants, like adult defendants, are competent to proceed with trial unless and until defense counsel overcomes the burden of proving otherwise.

Collective findings indicate that, on average, a majority of adolescents under the age of 15, as well as 15 and 16-year-olds with sub-average intellectual functioning, demonstrate significant limitations in their ability to understand and participate in the legal process, while most 16 to 17-year old youth typically have capacities comparable to adults (e.g., D. K. Cooper, 1997; Grisso et al., 2003). In the most comprehensive, multi-site study examining juveniles' legal competence-related abilities to date, Grisso and his colleagues (2003) found that 30% of the 11 to 13 year-olds demonstrated significant impairments in understanding of legal proceedings and/or legal reasoning, while only 19% of the 14 to 15 year-olds, and 12% of the 16 to 17 year-olds and young adults demonstrated such limitations. Further, the 16 to 17 year-olds' abilities did not differ significantly from those of the young adults ages 18 to 24. Other researchers have replicated Grisso and colleagues' finding that age 15 represents a significant developmental cut-off for competence-related abilities (Burnett et al., 2004; Redlich, Silverman, & Steiner, 2003; Viljoen & Roesch, 2005; Dreyer & Hart, 2008).

Research has shown that age-related differences in legal capacities stem, in part, from immature cognitive development (Viljoen & Roesch, 2005). In fact, some researchers contend that age simply serves as a substitute for cognitive maturity -- the "true" variable of interest (Ficke et al., 2006). The aspect of cognitive development that

has received the most attention with respect to adjudicative competence is the incomplete maturation of judgment and decision making abilities. Researchers have distinguished between the cognitive component of these capacities – which tends to reach adult levels by late adolescence, and the psychosocial component, which continues to develop significantly through late adolescence (Steinberg & Cauffman, 2000; Buss, 2000). Cognitive development refers to the increased ability to understand and process information and is generally thought necessary for informed decision-making (Grisso, 2005a). Psychosocial development has to do with an individual's impression or perspective of situations and can affect one's reactions or decisions regarding those situations (Grisso, 2005a). Research indicates that adolescents are less developed than adults along four key psychosocial dimensions that are particularly relevant to legal competency: greater susceptibility to peer pressure; lower risk perception; preoccupation with short-term over long-term consequences; and decreased capacity for self-management (Scott, Reppucci, & Woolard, 1995; Reppucci, 1999; Fried & Reppucci, 2001; Haskins & Steinberg, 2008).

Specifically, research has demonstrated that youth under age 15 are less able to evaluate risks inherent in their choices or to consider the long-term consequences of their behavior than older adolescents and adults (Grisso et al., 2003). Further, adolescents are generally more likely than young adults to make choices that comply with adult authority figures, such as confessing to the police rather than remaining silent or accepting a prosecutor's offer of a plea agreement (Grisso et al., 2003). Young adolescents have also been found to be more likely than older individuals to waive their legal rights, such as the right to remain silent and the right to legal counsel (Viljoen, Klaver, & Roesch, 2005).

When adolescents are incompetent because of developmental immaturity, the goal of interventions is to remediate deficits that exist because a youth is at a relatively normal, immature stage of development, rather than to cure a temporary condition (Scott & Grisso, 2005). Research suggests, however, that it may not be possible to accelerate the acquisition of normal developmental capacities (Viljoen & Grisso, 2007).

Cumulatively, these findings suggest that clinicians conducting competency evaluations should be particularly vigilant when examining the legal capacities of young defendants, and be especially mindful of the potential impact of cognitive and psychosocial child development on legal capacities. That being said, research indicates that there can be considerable variability within age categories and consequently, clinicians should not infer incompetence on the basis of young age alone (Viljoen & Roesch, 2005).

Interestingly, despite evidence that youth may have limited legal capacities due to normal developmental factors, it remains to be seen whether courts will recognize adolescents' immature developmental status as a legitimate basis for a finding of incompetence. Currently, some jurisdictions explicitly require that incompetence be due to mental disorders or severe cognitive deficits (Fla. Stat. Ann. §985.19(2), 2006; Tex. Fam. Code Ann. §55.31-.32, 2007). However, at least two courts have recognized developmental immaturity as a basis for a finding of incompetence (*In re Causey*, 1978; *In re Hyrum H.*, 2006) and at least one state has enacted legislation authorizing adjudicative incompetence on the basis of developmental immaturity² (Steinberg, 2008;

² Georgia statutorily defines “mentally competent” as “having sufficient present ability to understand the nature and objectives of the proceedings, against himself or herself, to

O.C.G.A. § 15-11-151, 2009). It is unclear how such legislation and court decisions translate to widespread practice. At least one recent study reports that defense attorneys and judges view developmental immaturity as only moderately important to juveniles' competence and rate it as less important than mental disorders or cognitive impairments; and relatively few judges agree that adolescents should be found incompetent on the basis of developmental immaturity alone (Viljoen & Wingrove, 2007). Conversely, in another recent national study, two thirds of juvenile court clinicians reported that courts in their jurisdictions find youth incompetent on the basis of developmental immaturity, even when there is not a formal mandate to do so (Grisso, 2005b; Grisso & Quinlan, 2005).

Psychopathology and Juvenile Adjudicative Competence

As with adults, mental health issues are strongly implicated in CST determinations among juveniles. Mental illness and, particularly, mental retardation, are the most common conditions underlying juveniles' incompetence (McGaha et al., 2001). The prevalence of mental disorders among juvenile delinquents varies from 62% - 80% of the juvenile populations studied (Riffin, 2006; Wong, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002; Atkins, Pumariega, & Rogers, 1999; Teplin, Abram, and McClelland, 1998; Cowden & McKee, 1995). The rate of mental illness among this population is much higher than among youth in the U.S. general population, where the range is about 15% to 25% (Kazdin, 2000; Grisso, 2008). Further, about two-thirds of

comprehend his or her own situation in relation to the proceedings, and to render assistance to the defense attorney in the preparation and presentation of his or her case in all adjudication, disposition, or transfer hearings held pursuant to this chapter. The child's age or immaturity may be used as the basis for determining the child's competency." O.C.G.A. § 15-11-151.

youth in juvenile justice custody who meet criteria for a mental disorder meet criteria for more than one disorder (Abram, Teplin, McClelland, Dulcan 2003; Grisso, 2008).

Features associated with mental illness more generally, such as poor self-control, limited problem solving skills, and behavioral problems, may also evoke important considerations in CST decisions (Kazdin, 2000). Although the presence of a mental disorder is not sufficient in and of itself to obtain a ruling of adjudicative incompetence (since the abilities and understanding required to stand trial must be impaired), the disturbed processes of thinking and reasoning that accompany many mental disorders renders mental illness one of the most common justifications for findings of adjudicative incompetence (Grisso, 2004; Cowden & McKee, 1995).

Specific mental health factors have been found to relate to CST, legal decision-making and court knowledge in children to varying degrees and with varying consistency. Research generally supports that adolescent defendants with attention deficits and hyperactivity may be more likely than other defendants to have competence impairments, particularly in their ability to communicate with and assist counsel (Viljoen & Roesch, 2005). Interestingly, at least one recent study reported that a diagnosis of Disruptive Behavior Disorders (i.e., Conduct Disorder and Oppositional Defiant Disorder) – a diagnosis which obviously differs significantly from that of ADHD but like ADHD is linked with behavioral disruptions -- was predictive of being found competent. The researchers suggest this result may be due to both genuine between-group differences and/or a diagnostic artifact in that chronic behavior problems may lead to referral for a competence evaluation despite few true competence deficits because of pathologizing

opinions about these youth and/or the successful prospect of obtaining services for “problem youth.”

Research results are mixed as to whether there is an association between adjudicative competence and broad psychological symptoms, such as depression, anxiety, anger and irritability. Viljoen & Roesch (2005) recently reported that they did not find such a relationship – a result that is corroborated by the findings of Grisso et al. (2003). However, researchers have also noted that symptoms of depression, anxiety, and trauma can be linked to impaired legal capacities in youth in less direct ways (see, Grisso, 2005b). For instance, an anxiety disorder may impair a youth’s capacity to testify and communicate with his or her attorney, or depression may cause a youth to be inadequately motivated to engage in his or her defense.

Severe psychopathology appears to be another important risk factor for adjudicative incompetence (Cowden & McKee, 1995; Kruh et al., 2006; Warren et al., 2003). Research suggests, however, that psychotic disorders, which are frequently associated with incompetence in adult defendants (V. G. Cooper & Zapf, 2003), are a relatively rare cause of incompetence in youth (McGaha et al., 2001). This difference is likely because psychotic disorders often do not develop until late adolescence or early adulthood. While severe psychopathology is an undeniable risk factor, it alone cannot automatically be equated with incompetence, given that many youth with severe mental disorders are found competent to stand trial (Viljoen & Roesch, 2008)

Additional Risk Factors and Juvenile Adjudicative Competence

Mental retardation and cognitive deficits are another source of adjudicative incompetence in youth (see Grisso et al., 2003; Warren et. al, 2003). Mental retardation

may be a particularly common cause of impaired legal capacities among adolescents found to be incompetent (Viljoen & Grisso, 2007; Baeger, Griffin, Lyons, & Simmons, 2003; McGaha et al., 2001). Even when children do not meet criteria for mental retardation, they may have other types of cognitive impairments, such as low IQ, learning disabilities, and/or neuropsychological deficits in verbal abilities, abstract reasoning, memory, attention and executive abilities, that could contribute to impaired legal capacities (Grisso et al., 2003; Viljoen & Roesch, 2005). Low IQ and deficits in verbal ability and executive functioning are common among adolescent offenders (Moffitt, 1993).

Not surprisingly, research has consistently demonstrated a relationship between IQ score and competence in both adult (Otto et. al, 1998) and adolescent samples (Savisky & Karras, 1984; Cowden & McKee, 1995; D. K. Cooper, 1997; McKee & Shea, 1999; Evans, 2003; Kruh et al., 2006), with lower IQ scores associated with a determination of incompetency. Research suggests that low intelligence may be a particularly stronger risk factor among younger adolescents than older adolescents, possibly because legal capacities are less ingrained at a younger age and thus more strongly associated with cognitive ability (Viljoen & Roesch, 2005). Additionally, Ficke and colleagues (2006) contend that both cognitive maturity and psychosocial maturity are related to and influenced by intelligence. In a recent study focused on the cognitive capacity of youth referred for competency evaluations, Evans (2003) reported, as expected, that the IQ scores of those found competent were higher than of those found incompetent. However, he also found that the Full Scale IQ scores of those youth who were found competent were still far below the “juvenile norms” expectation of

competency and that no clear “cut-off” score emerged as an accurate predictor of competence, leading him to caution that, while IQ scores are important data, they should not be considered the main factor in evaluations.

In line with studies demonstrating that cognitive impairments contribute to impaired legal capacities, research also indicates that a history of special education is associated with a determination of adjudicative incompetence (Cowden & McKee, 1995; Baeger et al., 2003; Kruh et al., 2006). Similarly, average (as opposed to below average) school grades have been shown to predict competence to stand trial (Redlich et al., 2003).

While it is commonly assumed that youth who have been previously arrested or convicted will be knowledgeable about legal proceedings, research has not convincingly supported this assumption. Several studies have demonstrated that prior experience with the juvenile justice system is not significantly correlated with juvenile adjudicative competence scores (Grisso et al., 2003; Cowden & McKee, 1998; Ficke et al., 2006; Redlich et al., 2003), though at least one study did report that history of prior arrests was a factor distinguishing competent from incompetent youth (McKee & Shea, 1999). At a minimum, evaluators should be careful not to assume that youths with prior arrests or convictions are competent. Interestingly, while prior legal knowledge is not strongly associated with competence abilities, at least one study found that “time spent with attorney” was a strong predictor of the legal capacities relevant to adjudication (Viljoen & Roesch, 2005).

Prior research on the relationship, if any, between juvenile adjudicative competence and a number of other variables including gender, race, the seriousness and number of charges, socioeconomic status, education level, and a history of receiving

mental health services, has largely been inconclusive and inconsistent (D. K. Cooper, 1997; Cowden & McKee, 1995; McKee, 1998; Burnett et al., 2004; Viljoen & Roesch, 2005; Grisso et al., 2003), indicating perhaps, that more research in this area is necessary.

In summary, the CST-related abilities of juveniles remain poorly understood, particularly as they are related to other features common in juvenile offenders, such as young age, low intellectual functioning, school failure, and history of psychiatric disorder. These past studies concur that age is related to CST, although no clear age cutoffs have been determined, consistent with differing rates of development throughout childhood and adolescence (Steinberg & Schwartz, 2000). While youth under the age of 12 are generally found incompetent, older youth present a mixed picture with fourteen representing a safer cutoff, but 15-17 year olds also demonstrating incompetence at higher rates than adults, especially when cognitive impairments are present.

The purpose of this paper is to describe the characteristics of male juvenile offenders in Connecticut who were assessed for CST over a two-year period, and to examine specific mental health and developmental factors associated with the court rulings on competency to determine whether factors previously identified emerge as most salient when a wider array of variables are examined and when corollary education, mental health, and law enforcement records are examined in addition to psychiatric diagnoses made during court-ordered examinations. We expected cognitive and mental health factors each to be implicated in differences between youth found competent and incompetent to stand trial. Moreover, we expected different patterns of demographic, mental health, and offense correlates between the two groups, with variables related to developmental and behavioral deficits to emerge as critical for the younger juveniles.

CHAPTER III

METHODOLOGY

Sample

The study sample consisted of 134 male child and adolescent defendants ages 10-18 years who were evaluated for adjudicative competence by a university-affiliated court clinic in Connecticut between March, 1992 and July, 2004 as a result of a court order. The sample was divided into age groups based on both prior research regarding adjudicative competency in youth, which generally shows that adolescents over the age of 15 demonstrate legal competency skills similar to that of adults, while youth under age 15 do not, as well as Connecticut's current jurisdictional age limit in juvenile court. Connecticut requires that adolescents under sixteen years are adjudicated in the juvenile system, while those sixteen or older are automatically tried as adults. However, Connecticut recently passed legislation that, as of January 1, 2010, will raise the jurisdictional age in juvenile court to eighteen (Conn. Gen. Stat. § 46b-120 as amended by as amended by section 73 of public act 07-4 of the June special session). The younger group of boys was 10-15 years of age (n = 38, 28%) and the older group aged 16-18 years (n = 96, 72%). This sample represents the male juveniles referred by 12 courts to a university-affiliated court clinic during that time on whom we had complete data sets. Nine females also were referred for evaluations, as were eight children under the age of ten; these youths were not included in the analyses since there were too few cases in each

subgroup to make any valid statistical inferences about their data. Table 1 provides a summary of racial, educational, residential, and basic mental health characteristics of the sample, as described in more detail in the Results section.

Variables

Variables included in this study were extracted from CST evaluation reports prepared for the courts and from police records. *Demographic* variables included age, ethnicity, with whom the child lived, the presence of a father, and the number of times the child lived in an out-of-home placement. *Developmental history* was assessed in terms of the child's educational level (age-appropriate or delayed, and/or special services). *Mental health history* variables assessed whether a psychiatric diagnosis had been made, the specific diagnosis(es), and treatment history (active treatment, medication, and prior hospitalization). In addition, mental health history included assessment of alcohol and substance use history. *Court and criminal charge* variables included the type of court (juvenile, GA or JD), the number of charges, the seriousness of the charge (felony or misdemeanor), the type of crime for the most serious charge (against person, against property, weapons, drug violation, probation violation), prior arrests, and the type of lawyer (private or public defender). *Legal competence-related abilities* were assessed in terms of each juvenile's knowledge of his attorney's name and how to use his attorney, knowledge of the charges, knowledge of his attorney's and the prosecutor's roles, knowledge of relevant pleas, and ability to estimate potential consequences and tell a coherent story. *Competency/Incompetency* served as the study's dependent variable. Since evaluation recommendations were almost an exact match to

judicial findings (only one case at variance), the assessment of competency was determined by judicial finding.

Procedures

This study was conducted as a retrospective record review of police reports and evaluations for CST reports that were generated by a university-affiliated court clinic and released to the courts. Prior to the review of any records, the study was approved by the Human Investigations Committee at Yale University and the Department of Mental Health and Addiction Services for the state of Connecticut. The evaluations themselves were conducted by court clinic teams that included a psychologist, social worker, and psychiatrist, as statutorily mandated. Evaluations were conducted in three phases. First, the team reviewed arrest reports, and spoke with the defendant's attorney to ascertain the reason for the CST evaluation request. Second, the defendant and a parent (or guardian) were interviewed separately. The evaluation of the defendant consisted of a directed interview in which the purpose and non-confidential nature of the study were explained. The following areas related to CST were addressed in the interview: the defendant's understanding of a) the charges, b) seriousness of the charges, c) roles of courtroom personnel, d) plea options and their consequences, and e) the strength of the case against him. The defendant's attitude toward his attorney was also assessed, with particular focus on his level of trust of, ability to seek advice from, and ability to provide information to his attorney. The other parts of the evaluative interview with the defendant consisted of taking a background history, conducting a mental status evaluation, and assessing his level of moral development. A parent interview was used to gather information about the defendant's developmental, educational, psychiatric,

substance use, and legal histories. Parents were also asked about their child's relationship with his attorney. Parents of defendants who had a psychiatric or substance use history or who received special services were asked to sign a release of information to allow the team access to those records. The last phase of the evaluation involved reviewing school or psychiatric records, police reports if available, and writing a final report on each defendant's CST.

Data Analysis

Data from the evaluation reports were coded for entry into SPSS analysis. Descriptive analysis was used to define sample characteristics. Pearson product moment correlations and pi-serial and point bi-serial correlations were used to assess younger and older group differences in rates of competency/incompetency. In addition, differences between age groups were determined using chi square and t-test analyses. Since the sample size is relatively small (n=134), findings at a significant as well as trend level of significance will be reported.

CHAPTER IV

RESULTS

Summary Characteristics of the Sample

Who Gets a CST Ordered?

Table 1 (see Appendix A) provides a summary of the characteristics of the sample. The ages of the participants ranged between 10 and 18 years. The mean age of participants in the full sample was 16 years (SD = 2.03). Racial composition of the sample was fairly equally distributed among African American (37%), Hispanic (34%), and Caucasian (28%) juveniles, with 2% from other ethnicities. Over three-quarters (76%) of the youth lived with their parents, another 10% lived with extended family, and 14% lived with non-relatives. Fathers were present in the home for 41% of the youths. However, 46% of the youth had at least one former out-of-home placement.

In terms of education, 62% of the juveniles were delayed in their progression through school and 60% had received special services through their school at some point in their schooling. With respect to mental health, 75% of the sample had a prior psychiatric history and almost half (49%) of the sample had been previously hospitalized. Independent of the CST evaluation, 68% of the juveniles had been given a formal diagnosis at some point prior and 37% had been given multiple diagnoses. These diagnoses included: borderline intellectual functioning or mental retardation (34%), attention-deficit/hyperactivity disorder (26%), other aggressive behavioral/conduct

disorders (22%), psychotic disorders (25%), mood disorders (22%), developmental disorders (12%), posttraumatic stress disorder (5%), and personality disorders (3%). Some (22%) of the participants had developmental delays. A history of alcohol abuse was reported for 38% of the sample and of other substance abuse for 54% of the sample. Slightly less than half (46%) of the juveniles were being prescribed behavioral or psychiatric medications and 34% were in treatment at the time of their arrest.

For What Type of Cases and Charges are CST Ordered for Juveniles?

The legal characteristics of cases for which a CST evaluation was ordered were assessed for seriousness and types of charge. Of the entire sample, 23% were under sixteen years of age and involved in juvenile court proceedings, and 77% were older and being tried in adult court. Well over half (65%) of the juveniles had been arrested at least once prior to the arrest associated with the case for which competency was being evaluated. Twenty-four percent (24%) of the participants were charged with misdemeanors and 76% were charged with felonies. The most serious charge for each subject was categorized by type of crime: 1) against person (56%); 2) against property (12%); 3) drug (15%); 4) weapon (5%); and 5) justice (12%), which involved violation of probation, failure to appear or escape. Crimes against persons were most prevalent. On average, the youth each had 5 charges against them in the current proceeding for which competency was being assessed. The vast majority of the sample (85%) were represented by public defenders, as opposed to privately retained attorneys.

The Court determined that a majority (62%) of the defendants were competent to stand trial for their offenses.

Comparisons among Age Groups

Table 1 shows significant differences between the older and younger age groups. The older youth were more likely to be delayed in their educational level ($p = .001$) and to have histories of alcohol ($\chi^2 = 13.18, p = .004$) and substance abuse ($\chi^2 = 34.47, p = .000$). The older youth were also more likely to be represented by a private attorney as opposed to a public defender ($p = .014$). These older youth tended to have had more than one out of home placement during their life ($\chi^2 = 5.60, p = .061$). The younger children, on the other hand, were more likely to be receiving treatment at the time of arrest ($\chi^2 = 10.38, p = .001$), and to have diagnoses pertaining to developmental delay ($\chi^2 = 4.94, p = .026$), ADHD ($\chi^2 = 7.02, p = .008$), other aggressive behavioral/conduct disorders ($\chi^2 = 6.38, p = .012$), developmental disorders ($\chi^2 = 6.96, p = .008$), or PTSD ($\chi^2 = 4.54, p = .033$). The younger youth also were more likely to have fewer charges ($t = -4.403, p = .000$) and fewer previous arrests ($\chi^2 = 6.17, p = .013$). A weaker finding, significant at a trend level, indicated that the younger children were somewhat more likely to have been taking medication at the time of arrest ($p = .086$). The groups differed in terms of the nature of their offense ($\chi^2 = 10.27, p = .036$): the largest discrepancies indicated that younger offenders were more likely to commit crimes against persons, while older youth were more likely to commit drug-related offenses.

It is notable that age group was not related to findings of competency or incompetency.

Comparisons of Competent versus Incompetent Juveniles

Table 2 (see Appendix B) shows competency differences among the subjects as a total group. Incompetency was found to be significantly associated with psychotic

disorders ($p = .026$) and having a father living at home ($\chi^2 = 3.97, p = .046$). In addition, several variables, including educational levels (delayed or appropriate) ($p = .061$), receipt of special services ($p=.096$), presence of a developmental delay ($\chi^2 = 2.74, p = .098$), taking medication at time of arrest ($p=.099$) and mood disorders ($p = .077$) almost reached significance, indicating that cognitive functioning, as determined by educational and developmental performance, plays a role in determining competency. In terms of the comprehension variables that are assessed to determine CST, every comprehension variable, with the exception of knowing the attorney's name, distinguished competent from incompetent youth at a highly significant level.

Next, we looked at the criteria that distinguished youth found to be competent from those found to be incompetent within each of the two age groupings (10-15 and 16-18) to see if any differences emerged between the older and younger youth (see Tables 3 and 4, Appendices C and D, respectively). Several age differences were found. Mood ($p = .025$) disorders, as well as no developmental delays ($.017$), no history of receiving special school services ($p = .029$), absence of a father ($\chi^2 = 4.06, p = .044$) and taking medication at the time of arrest ($\chi^2 = 4.858, p = .028$) were associated with competence to stand trial among the older youth. Also, there was a finding of psychotic ($\chi^2 = 3.52, p = .061$) disorder being marginally related to competency, but the actual numbers of psychotic youth found to be competent ($n = 12$) versus incompetent ($n = 13$) is nearly identical and a much larger sample would be needed to confirm or disconfirm this finding, in particular. With respect to the younger juveniles, ADHD ($p = .088$) and appropriate educational level ($\chi^2 = .357, p = .059$) were associated with findings of competence, and only at a trend level of significance.

CHAPTER V

DISCUSSION AND CONCLUSIONS

In order to explore the role of age in relation to adjudicative competence, the current analysis focused on comparing younger and older juveniles evaluated for CST on characteristics relating to demography, education, mental health, offense, and competence-related legal abilities. Both younger and older juveniles were found by a judge to be competent more often than not. Additionally, older youth were not determined to be competent significantly more often than were younger youth. Different factors emerged as more highly related to CST in younger juveniles as compared to older ones.

Age Comparisons

As predicted, behavioral and developmental factors were more salient among the younger participants, as indicated by the higher likelihood of diagnoses of ADHD, other aggressive behavioral/conduct disorders, developmental delays, and developmental disorders among the younger youth. Results in the present study imply especially problematic histories in the younger youth who were referred for CST evaluations. These youth were more likely to have a diagnosis of PTSD and to have committed offenses despite the increased probability of being in treatment and the somewhat increased chance of being on medication at the time of arrest. The finding that the younger children were somewhat more likely to be on medication at the time of arrest may be a

by-product of the greater likelihood that the younger offenders had diagnoses of PTSD, developmental disorders, ADHD, other aggressive behavioral disorders or developmental delays, all of which are frequently treated with medication. The offense characteristics of these younger youth arguably suggest an earlier criminal, and perhaps more violent, trajectory: while they were more likely to have fewer charges leveled against them and fewer prior arrests, disturbingly, however, they were as likely to be in court for felony offenses as the older youth, and they were more likely to have committed crimes against persons. These findings make sense in light of the research indicating that youth with PTSD are susceptible to responding to threats aggressively and unexpectedly (Charney, Deutch, Krystal, Southwick, Davis, 1993) and that youth with disruptive behavior disorders, such as the type of conduct disorders identified in this sample, and ADHD demonstrate substantially increased rates of physically aggressive behavior (Grisso, 2008; Barkley, 1996).

In contrast, older youth were more likely to be educationally delayed rather than in age appropriate grades at school – a result that is consistent with Warren et al’s (2003) and Grisso et al’s (2003) findings of cognitive impairment and lower IQ scores, respectively, among their samples, and which more generally is supported by research consistently demonstrating that most youths in the juvenile justice system are below age level in their basic educational achievements (Warren et al., 2003) and score lower on intelligence tests than demographically comparable youth from the community (Grisso et al., 2003). Substance abuse histories emerged as an important characteristic among the older age group, in contrast to other kinds of behavioral disorders found among younger arrestees. Histories of alcohol and drug abuse, and drug-related crimes significantly

differentiated the older from younger groups in this study. This finding is not surprising given the substantial evidence for a relation between substance use disorders and delinquent behavior (Chassin, 2008; Grisso, 2008). In addition, the older youth were more likely to be represented by a private attorney as opposed to a public defender, which may be a result of having had a greater number of prior arrests and more charges, and thus more familiarity with the penal system, as well as the added possibility of facing greater consequences.

Competence versus Incompetence to Stand Trial

In addition to the age differences described above, differences in findings of competency were examined among the entire sample and between the two age groups. Presence of a father in the home stood out as an important correlate of findings of incompetency. Interestingly, the results showed that competency was related to *not* having a father living at home. The relevance of not having a father in the home to findings of competence can only be conjectured from these data, but it raises interesting possibilities for further examination. One supposition is that the court and/or evaluators may assume that a paternal presence suggests the existence of authoritative parental support which perhaps leads those decision-makers to believe that the youth's problems may have a more decided mental health bent than a "mere" behavioral one. In other words, if a youth can get into trouble even while having a father (as well as a mother) in the home, evaluators may be more inclined to question the origin and severity of the youth's issues, thus raising concerns regarding competency. Conversely, the absence of a father in the home might lead evaluators to more readily assume that delinquent behaviors are the result of problematic family dynamics and inadequate supervision

rather than deeper mental health issues; that the youth “knew better,” but was acting out, and consequently that he is more likely responsible for his actions and competent to proceed to trial. It would be interesting in subsequent research to find out how the father’s presence translates directly, if at all, to parental involvement in court proceedings, or advocacy on behalf of the child with the court. This seemingly small finding is interesting given the robust connection between father involvement and reduced delinquency and aggression among youth (see Pruett, 2000). The role family structure and involvement plays – both assumed and real -- in decisions to hold juveniles more or less responsible for their illegal actions offers a fertile field for further study of this vulnerable, problematic population.

A second finding that psychotic youth were more often found incompetent is consistent with prior studies (Cowden & McKee, 1995; Kruh et al., 2006; Warren et al., 2003), although several studies that directly compared the contributions of cognitive deficits versus mental illness found that cognitive deficits play the larger role (McKee & Shea, 1999; Warren et al., 2003). In particular, Cowden and McKee (1995) found that far fewer juveniles with severe mental disorders were found competent (28%) than juveniles with no diagnosis or with a moderate diagnosis (72% and 83%, respectively). Cowden and McKee did not specify which disorders were considered severe, however, psychosis would certainly have been included in that category. Studies of adult competency have found that schizophrenia is the most common disorder among adult defendants who are found incompetent, followed by mental retardation (Nicholson & Kugler, 1991). The larger sample size of older adolescents in this sample may have contributed to these findings having similarities to the findings from adult samples.

The comprehension variables that were used to assess the youths' understanding of their charges and the proceedings were associated with a finding of competency at a highly significant level, with the exception of the youths' knowledge of their attorney's name, which was not significantly associated with competency. In light of the *Dusky* standard and its emphasis on a defendant's factual and rational understanding of the legal proceedings and their consequences, this result suggests that the *Dusky* standard is in fact being invoked and met in these cases. There seems to be an implicit recognition that a youth's familiarity with his attorney's name, or lack thereof, is not a reflection of the youth's overall understanding of the proceedings or his ability to assist and make use of his attorney. Given the number of adults that a youth in custody is likely to interact with and the incredible amount of stress the youth is under, on the one hand, it makes sense to not put significant weight on a youth's ability to remember his attorney's name. On the other hand, however, such a variable might deserve more attention given the fact that at least one study found that "time spent with attorney" was a strong predictor of the legal capacities relevant to adjudication (Viljoen & Roesch, 2005). That a youth might not know his attorney's name does not necessarily mean that the attorney has not spent adequate time with the youth; however, it does bring up questions regarding the nature of the attorney-client relationship. Some research has indicated that juvenile defendants from ethnic minority groups may have lower levels of trust in their attorneys than White defendants (Pierce & Brodsky, 2002), and are less likely to report that they would disclose important information to their attorneys (Viljoen et al., 2005). Given this possibility, juvenile defendants' relationships with their attorneys might be an especially important area to assess.

Educational status (delayed or appropriate), the presence or absence of a developmental delay, whether or not a youth had received special services at school or was taking medication at time of arrest, and a diagnosis of mood disorder all emerged as other distinguishing characteristics related to a finding of competence, though they did so at the trend level of significance. In the present study, a youth was somewhat more likely to be found competent if he was in age-appropriate school level, if he did not have a developmental delay or did not receive special services at school, if he was taking medication at the time of arrest or if he had a diagnosis of a mood disorder. The emergence of the first three variables – educational status, receipt of special services and presence of a developmental delay -- is consistent with prior research that has found a history of special education to be associated with a determination of adjudicative incompetence (Cowden & McKee, 1995; Baeger et al., 2003; Kruh et al., 2006) and average (as opposed to below average) school grades to predict competence (Redlich et al., 2003). Interestingly, the results of this study were significant in the opposite direction of many, but not all, studies. That is, many studies report that children with delayed educational status and/or histories of special education needs are more likely to be incompetent. In the current study, however, and consistent with the findings of Redlich et al. (2003) and Kruh et al. (2006), the absence of these characteristics were related to a finding of competency, as opposed to their presence being related to a finding of incompetency. Arguably, *lacking* a history of either delayed educational status or receipt of special school services may be an important historical consideration for examiners. While it is not clear from these results exactly what delayed educational status or receipt of special services are proxies for in terms of other developmental issues, difficulty

succeeding in school is suggestive of cognitive difficulties, although behavior and attitudes leading to lower school attendance may also have been implicated. Thus, impaired cognitive capacities found in prior studies may also be linked to findings of incompetency to stand trial in this sample.

Diagnosis of mood disorders and taking behavioral/psychiatric medication at the time of arrest were both associated with a finding of competency at the trend level of significance. These findings may reflect a belief by examiners that mood disorders in juveniles, unlike other mental health disorders, do not diminish competency-related abilities. Kruh et al. (2006) similarly found that incompetent youth were less likely to have a diagnosis of a mood disorder and more likely to have a diagnosis of a psychotic disorder. With respect to taking medication, examiners may assume that if a youth is taking medication, his mental health and/or behavioral problems have already been previously addressed and should be adequately controlled by that medication. Consequently, examiners may presume that any delinquent behaviors that occur while on medication must be the result of willful volition, as opposed to untreated mental health or cognitive issues, and therefore, the youth is capable of taking responsibility for his actions and proceeding to adjudication.

CST Differences Among Age Groups

Next, we examined differences among older and younger youth on characteristics that differentiated competent from incompetent youth. Several significant differences emerged. Among the younger youth, ADHD and education level were both marginally related to competency. Interestingly, young juveniles with ADHD were more likely to be found competent. Prior studies have likewise found ADHD is a distinguishing factor for

adjudicative competence, however, Viljoen & Roesch (2005) reported, as perhaps would be more commonly expected, that adolescents with ADHD are more likely, not less, to have deficits in competence. Although a substantial proportion of the juveniles under the age of 16 had a prior diagnosis of ADHD reported, other behavioral disorders and mental illnesses were also prevalent. None other than ADHD, however, was associated with competency in the younger juveniles. The most frequently occurring disorders included aggressive behavioral disorders such as conduct disorder or oppositional defiant disorder (37%), borderline intellectual functioning/mental retardation (32%), followed by mood (29%) and developmental (24%) disorders. These other disorders can be quite severe in their behavioral manifestations, and may result in symptoms that are viewed as more clearly detrimental to competency, such as cognitive limitations or inappropriately aggressive conduct. ADHD, however, is usually associated with fidgety behavior and difficulty concentrating -- behaviors that affect impulsivity but may not be viewed as impacting moral judgment in the same way. Thus, the juveniles are found accountable despite their impulsiveness. Youth with ADHD can potentially present as unfocused, but less dangerous and more able to speak about their crimes as compared to the young juveniles with severe cognitive deficits or developmental delays. Educational level also emerged as a factor somewhat related to competency for the younger youth, with younger youth in appropriate school level being more likely to be competent, while those youth with delayed education status were somewhat more likely to be held incompetent.

For the older youth, diagnoses of mood disorders were significantly associated with competency, while developmental delays, and to a less significant extent, psychotic disorders were associated with incompetency. The role of ADHD and educational delay

among younger youth, compared to psychosis and developmental delay among older youth possibly could be understood as one potential pathway into criminal involvement. While we can only conjecture without longitudinal research, the developmental trajectory from younger juvenile with a history of behavioral problems to an older juvenile diagnosed as having specific thought disorders and identified developmental limitations, may be associated with concurrent slippage into more criminal activity. In addition to being older and having more time to get into legal difficulty, a greater number of charges and prior arrests further suggest this downward slippage. The first signs of psychosis may be evident in behaviors that are more likely to result in arrests. In addition, the relationship of psychosis and developmental delay to incompetency among older youth may reflect a not unexpected referral trend: older youth are more likely to be referred for CST evaluations for reasons more similar to adults – major mental illness and/or major developmental limitations. In light of developmental considerations, this referral trend seems appropriate.

The presence of a father in the home, the receipt of special school services, and taking medication at the time of arrest were all significant for the older youth in the same manner in which they were significant for the group overall: older youth who did not receive special services in school were more likely to be competent, as were older youth who did not have a father at home or older youth who took psychiatric medication. If we follow the reasoning set forth above – that older youth are referred for more severe presentations -- the absence of a history of special services in school may indicate to examiners that an older adolescent is not actually so impaired as to have compromised competency abilities. With respect to a father's presence in the home, the same reasoning

discussed above in connection with the sample overall would apply, with even more conviction, to the older adolescents. Namely, evaluators may assume that in a mother-only home, criminal behaviors by older adolescents are linked more readily to inadequate supervision or the lack of an authority figure than to mental health issues or cognitive limitations. Similarly, the fact that a youth was taking psychiatric medication at the time of arrest may lead examiners to assume that mental health problems have been previously identified and addressed, and thus any illegal behaviors are the consequence of poor decisions for which the youth can and should be held responsible.

For both age groups, all of the comprehension variables, except for knowledge of the attorney's name, were highly significantly correlated to a finding of competency.

The Role of Age

Contrary to previous research (e.g.s., Grisso et al., 2003; Cowden & McKee, 1995), the current study did not find age to be directly associated with competency determinations, despite significant differences found between age groups on variables identified in previous research as important in the process of distinguishing competent from incompetent youth. One possibility is that Connecticut is highly selective in their referral of younger youth for CST evaluations, such that despite expectable developmental differences across age groups, the youth have already been largely selected out beyond that characteristic. In addition, the greater incidence of educational delays, mental retardation, psychosis, and developmental delays among the older group might also imply a lower functioning, more cognitively impaired group, such that typical age-related differences are washed out. Furthermore, the small sample size of younger youth may have obfuscated otherwise significant developmental findings. Further

research is needed to determine why this group differs from the samples in most other studies with respect to the role of age in competency findings.

Public Policy Implications

Based on the results of the current study, age alone is a poor measure of the abilities juveniles require for adjudicative competency. Since many of these abilities are also relevant to other activities regulated by the law, the current study raises important questions about the structure of laws based on age in the United States that govern the rights of children. For example, in the United States, adolescents are generally not considered competent to purchase alcohol (age 21), to enter into binding contracts (age 18), to join the United States military (age 18 without parental consent), or to vote (age 18). Yet all juveniles are automatically considered competent to stand trial unless a judge or lawyer specifically introduces the issue of potential incompetence (Baranoski, 2003). In Connecticut, juveniles aged 14 and above are automatically transferred to adult court if they are accused of committing a Class A or Class B felony (Conn. Gen Stat. § 46b-127(a) (2008)), and according to the American Academy of Matrimonial Lawyers, children are capable of managing their own representation in custody proceedings from age twelve onwards (Dolgin, 1999; American Academy of Matrimonial Lawyers, 1995). Not only does age seem be a flawed standard by which to measure competency or maturity, but the inconsistency of our expectations of children's capacities with respect to age further undermines the rationality of current practices.

Along with age, mental health has traditionally been a critical component of competency theory. Even apart from the associations between mental health and competency that emerged, the current study paints a vivid picture of the centrality of

mental health to juvenile defendants for whom competency evaluations are ordered. Seventy-five percent (75%) of the current sample was found to have a psychiatric history, with an even higher percentage among the younger group (82%). These statistics are similar to those found in other populations of juvenile delinquents. Cowden and McKee (1995) reported that 69% of their sample had a psychiatric diagnosis, and in other studies 80% of the youths met diagnostic criteria for a mental disorder (Teplin et al., 1998; Kazdin, 2000). In contrast, the prevalence of mental disorders (developmental, emotional, or behavioral) among non-delinquent children and adolescents is typically between 15% and 25% (Kazdin, 2000; Grisso, 2008). Previous research (Teplin et al., 1998) that assessed juvenile delinquents as a broader spectrum, rather than just candidates for competency evaluations, suggests that the high rate of symptomatology found in the current study is indeed what could be expected among whole populations of juvenile delinquents.

The high prevalence of mental health issues among juvenile delinquents creates a challenge for detention facilities. Juveniles who are detained pre-trial or post-conviction often receive inadequate psychiatric care. One study of multiple facilities found that only 73% of detainees received a basic psychiatric screening (Office of Juvenile Justice and Delinquency Prevention, 1994). Another study found that across multiple facilities only 56% provided clinician evaluations beyond an initial entry screening (Goldstrom, Jaiquan, Henderson, Male, & Manderscheid, 2000). The effectiveness of treatment in these settings is not well documented, and in fact, there seems to be confusion over what responsibility juvenile detention facilities actually have to provide treatment and what the goals of that treatment should be (Desai et al., 2006).

The importance of the developmental and traumatic histories of the younger group may signal an avenue through which these children become judged to be competent. Overall, the younger offenders referred to CST evaluations are less likely to be functioning below their age in terms of school achievement as compared to older delinquents; in other words, they are competent and functioning to the extent that children their age are and do. However, when the younger children are having behavioral impairments, then a competency determination may be viewed as valuable or necessary to tease out the extent to which these other problems are debilitating to the child's capacity to accept responsibility for his illegal actions. It is possible that competency evaluations may be requested more readily for juveniles with these types of conditions because such symptoms can be obvious cues and easy justifications for attorneys and judges to use when raising the competency issue. Immaturity, the other main cause of incompetency, may escape notice frequently due to its more subtle manifestations, particularly in adolescents.

Limitations of the Study

This study focuses on the male juvenile offender population that was referred for CST evaluation to a university-affiliated court clinic in Connecticut during a twelve year time span, as the overwhelming majority of CST evaluations ordered by the participating courts were ordered on males. In fact, only seven CSTs during that time were completed on females by the clinic at issue. This obviously leaves many questions about the comparability and applicability of the results to a female juvenile population, an important question given the increased female presence in the juvenile criminal system for serious crimes. Similarly, the sample of youth under the age of 16 years old was

substantially smaller than the sample of youth ages 16 – 18, which made comparisons between the two age groups less reliable. Additionally, in terms of representative samples, this study does not address the need for national scale studies on the subject of juvenile CST to understand how the mental health needs and trends identified in Connecticut are symptomatic of a larger problem across the country. This study also includes all of the limitations of retrospective chart review methodology. Only the variables available through the reports are examined in this study. Other variables of developmental and psychiatric relevance await further study.

Future Research

Particular research attention should be paid, both in the continuation of the current research and in future studies, to relationships between age and restorability. The current study challenged previous research with respect to age and competency, and the reported results should be investigated further as well as replicated in order to increase their reliability. Restorability is an adjunct of competency that will need to be included in subsequent studies. A greater understanding of how decisions about restorability are made will enhance overall understanding of how courts view juveniles and what expectations they have of them.

Future research should focus on using national samples of youth and increasing the diversity of the participants, especially with respect to age and gender. There is still relatively scant information on the adjudicative competency of females and youth under the age of 14. In addition, future research on juvenile competency should include gathering more comprehensive information about judges' and examiners' approaches to each individual case. Future research should also further examine which youth get

referred for evaluations and which ones do not, to better understand the kinds of triggers that raise concerns for judges, attorneys and evaluators beyond cognitive impairments and obvious psychosis. Research on CST has been slow to accumulate, but a significant body of basic, foundational research has been established. Efforts should now be made to broaden its scope wherever possible.

On the most general level, this study emphasizes the importance of approaching juvenile defendants as individuals. Ultimately, there were relatively few significant predictors of competency, which suggests that the way in which a multitude of factors, including family background, mental health, and an individual's developmental trajectory, happen to align for each juvenile ends up being very important for competency determinations. Each juvenile's uniqueness highlights the vital role that high quality and consistent competency evaluations play in ensuring justice.

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Appendix A

Table 1. *Characteristics of the Male Sample by Age Group*

Characteristic	Full Sample n = 134 %* (n) or mean (s.d.)	Ages 10-15 n = 38 %* (n) or mean (s.d.)	Ages 16-18 n = 96 %* (n) or mean (s.d.)	<i>t</i> or χ^2	<i>p</i>
<i>Age</i>	16.1 (2.03)	13.32 (1.51)	17.21 (0.72)		
<i>Race</i>				3.66	.301
African American	36.6 (49)	26.3 (10)	40.6 (39)		
Hispanic	33.6 (45)	42.1 (16)	30.2 (29)		
Caucasian	28.4 (38)	31.6 (12)	27.1 (26)		
Other	1.5 (2)	0.0 (0)	2.1 (2)		
<i>Education</i>					
Current School Level				-.1	.001
Delayed	62.1 (82)	37.8 (14)	71.6 (68)		
Appropriate	37.9 (50)	62.2 (23)	28.4 (27)		
Receipt of Special Services				-.1	.248
Receiving services	60.4 (81)	68.4 (26)	57.3 (55)		
Not receiving services	39.6 (53)	31.6 (12)	42.7 (41)		
<i>Family Structure History</i>				.190	.910
Living with:					
Parent(s)	76.0 (95)	78.4 (29)	75.0 (66)		
Extended Family	9.6 (12)	8.1 (3)	10.2 (9)		
Other	14.4 (18)	13.5 (5)	14.8 (13)		
Out of Home Placements				5.60	.061
None	54.5 (73)	68.4 (26)	49.0 (47)		
One	26.9 (36)	13.2 (5)	32.3 (31)		
Greater than One	18.7 (25)	18.4 (7)	18.8 (18)		
Father's Presence at Home				-.1	.687
Father is present in home	40.7 (50)	37.1 (13)	42.0 (37)		
Father not present in home	59.3 (73)	62.9 (22)	58.0 (51)		
<i>Mental Health</i>					
No Diagnosis	32.1 (43)	26.3 (10)	34.4 (33)	-.1	.417
Multiple Diagnoses	36.6 (49)	44.7 (17)	33.3 (32)	1.526	.217
Receiving Treatment at time of arrest	34.4 (45)	55.3 (21)	25.8 (24)	10.38	.001
Taking Medication	45.9 (61)	57.9 (22)	41.1 (39)	-.1	.086
<i>History</i>					
Psychiatric History	75.4 (101)	81.6 (31)	72.9 (70)	-.1	.367
Prior Hospitalizations	49.3 (66)	50.0 (19)	49.0 (47)	.012	.913
Substance Abuse History	53.8 (70)	22.2 (8)	66.0 (62)	34.47	.000
Alcohol Abuse History	38.1 (45)	20.6 (7)	45.2 (38)	13.18	.004

<i>Specific Psychiatric Diagnosis</i>					
Developmental Delay	21.6 (29)	34.2 (13)	16.7 (16)	4.94	.026
Mental Retardation	33.6 (45)	31.6 (12)	34.4 (33)	⁻¹	.841
ADHD	26.1 (35)	42.1 (16)	19.8 (19)	7.02	.008
Other Behav./Conduct Disorder	22.4 (30)	36.8 (14)	16.7 (16)	6.38	.012
Psychotic Disorder	25.4 (34)	18.4 (7)	28.1 (27)	⁻¹	.279
Mood Disorder	21.6 (29)	28.9 (11)	18.8 (18)	1.67	.196
Developmental Disorder	11.9 (16)	23.7 (9)	7.3 (7)	6.96	.008
PTSD	4.5 (6)	10.5 (4)	2.1 (2)	4.54	.033
Personality Disorder	3.0 (4)	2.6 (1)	3.1 (3)	⁻¹	1.0
<i>Court</i>					
Court Type				105.6	.000
Juvenile	23.1 (31)	81.6 (31)	0.0 (0)		
GA (Part B)	61.2 (82)	5.3 (2)	83.3 (80)		
JD (Part A)	15.7 (21)	13.2 (5)	16.7 (16)		
Attorney Type				⁻¹	.014
Public Defender	84.7 (111)	97.2 (35)	80.0 (76)		
Private Attorney	15.3 (20)	2.8 (1)	20.0 (19)		
<i>Charges</i>					
Number of Charges	4.92 (3.98)	3.13 (2.21)	5.63 (4.30)	$t = -4.403$.000
Most Serious Charge Type				.173	.677
Felony	76.1 (102)	73.7 (28)	77.1 (74)		
Misdemeanor	23.9 (32)	26.3 (10)	22.9 (22)		
Crime Type for Most Serious Charge				10.27	.036
Drug	14.9 (20)	0.0 (0)	20.8 (20)		
Justice	11.9 (16)	13.2 (5)	11.5 (11)		
Person	56.0 (75)	68.4 (26)	51.0 (49)		
Property	11.9 (16)	10.5 (4)	12.5 (12)		
Weapon	5.2 (7)	7.9 (3)	4.2 (4)		
Prior Arrests	65.2 (86)	48.6 (18)	71.6 (68)	6.17	.013
<i>Competency, Court's Decision</i>					
Competent	62.4 (83)	63.2 (24)	63.4 (59)	.001	.976
Incompetent	36.1 (48)	36.8 (14)	36.6 (34)		

* The percentages shown are valid percentages, taking into consideration missing data.

¹ A Fisher's Exact test was used.

Appendix B

Table 2. *Comparison between Competent and Incompetent Overall*

Characteristic	Incompetent n = 48 %* (n) or mean (s.d.)	Competent n = 83 %** (n) or mean (s.d.)	t or χ^2	p
<i>Age</i>	16.21 (2.13)	15.99 (1.98)	<i>t</i> = .596	.552
<i>Race</i>			.517	.915
African American	38.3 (18)	61.7 (29)		
Hispanic	37.8 (17)	62.2 (28)		
Caucasian	32.4 (12)	67.6 (25)		
Other	50.0 (1)	50.0 (1)		
<i>Education</i>				
Current School Level			-. ¹	.061
Delayed	43.8 (35)	56.3 (45)		
Appropriate	26.0 (13)	74.0 (37)		
Receipt of Special Services			-. ¹	.096
Receiving special services	42.5 (34)	57.5 (46)		
Not receiving special services	27.5 (14)	72.5 (37)		
<i>Family Structure History</i>				
Living with:			1.81	.405
Parent(s)	40.2 (39)	59.8 (55)		
Extended Family	25.0 (3)	75.0 (9)		
Other	27.8 (5)	72.2 (13)		
Out of Home Placements			.050	.975
None	36.1 (26)	63.9 (46)		
One	38.2 (13)	61.8 (21)		
Greater than One	36.0 (9)	64.0 (16)		
Father's Presence in Home			3.97	.046
Father is present in home	49.0 (24)	51.0 (25)		
Father not present in home	31.0 (22)	69.0 (49)		
<i>Mental Health</i>				
No Diagnosis	37.2 (16)	62.8 (27)	.009	.925
Multiple Diagnoses	41.7 (20)	58.3 (28)	.824	.364
Receiving Treatment at time of arrest	33.3 (15)	66.7 (30)	-. ¹	.847
Taking Medication	44.3 (27)	55.7 (34)	-. ¹	.099
<i>History</i>				
Prior Psychiatric History	36.4 (36)	63.6 (63)	.013	.908
Prior Hospitalizations	35.9 (23)	64.1 (41)	-. ¹	1.0
Substance Abuse History	33.8 (23)	66.2 (45)	.813	.666
Alcohol Abuse History	31.1 (14)	68.9 (31)	3.11	.376
<i>Specific Psychiatric Diagnosis</i>				
Developmental Delay	50.0 (14)	50.0 (14)	2.74	.098
Mental Retardation	45.5 (20)	54.5 (24)	2.22	.137
ADHD	31.4 (11)	68.6 (24)	-. ¹	.541

Other Behav./Conduct Disorder	33.3 (10)	66.7 (20)	-. ¹	.830
Psychotic Disorder	53.1 (17)	46.9 (15)	4.96	.026
Mood Disorder	21.4 (6)	78.6 (22)	-. ¹	.077
Developmental Disorder	50.0 (8)	50.0 (8)	1.40	.237
PTSD	33.3 (2)	66.7 (4)	-. ¹	1.0
Personality Disorder	25.0 (1)	75.0 (3)	-. ¹	1.0
<i>Court</i>				
Court Type			3.40	.182
Juvenile	41.9 (13)	58.1 (18)		
GA (Part B)	39.2 (31)	60.8 (48)		
JD (Part A)	19.0 (4)	81.0 (17)		
Attorney Type			-. ¹	.616
Public Defender	38.5 (42)	61.5 (67)		
Private Attorney	30.0 (6)	70.0 (14)		
<i>Charges</i>				
Number of Charges	4.44 (3.96)	5.17 (4.02)	t = 1.01	.315
Most Serious Charge Type			.075	.784
Felony	36.0 (36)	64.0 (64)		
Misdemeanor	38.7 (12)	61.3 (19)		
Crime Type for Most Serious Charge			.608	.962
Drug	36.8 (7)	63.2 (12)		
Justice	43.8 (7)	56.3 (9)		
Person	35.1 (26)	64.9 (48)		
Property	33.3 (5)	66.7 (10)		
Weapon	42.9 (3)	57.1 (4)		
Prior Arrests	37.3 (31)	62.7 (52)	-. ¹	1.0
<i>Comprehension</i>				
Knowledge of Charges	14.6 (14)	85.4 (82)	-. ¹	.000
Knowledge of Judge's Role	21.0 (21)	79.0 (79)	-. ¹	.000
Knowledge of Attorney's Role	24.3 (26)	75.7 (87)	-. ¹	.000
Knowledge of Prosecutor's Role	16.8 (16)	83.2 (79)	-. ¹	.000
Knowledge of Relevant Pleas	12.1 (11)	87.9 (80)	-. ¹	.000
Knows Attorney's Name	25.9 (14)	74.1 (4)	1.49	.223
Knows How to Use Attorney	4.9 (4)	95.1 (78)	-. ¹	.000
Accurately Estimates Potential Consequences	12.1 (7)	87.9 (51)	25.8	.000
Can Tell a Coherent Story	14.8 (13)	85.2 (75)	-. ¹	.000

* The percentages shown are valid percentages, taking into consideration missing data.

¹ A Fisher's Exact test was used.

Appendix C

Table 3. Comparison between Competent and Incompetent, Ages 10-15

Characteristic	Ages 10-15		<i>t</i> or χ^2	<i>p</i>
	Incompetent n = 14 %* (n) or mean (s.d.)	Competent n = 24 %* (n) or mean (s.d.)		
<i>Age</i>	13.29 (1.54)	13.33 (1.52)		
<i>Race</i>			1.09	.579
African American	40.0 (4)	60.0 (6)		
Hispanic	43.8 (7)	56.3 (9)		
Caucasian	25.0 (3)	75.0 (9)		
Other	0.0 (0)	0.0 (0)		
<i>Education</i>				
Current School Level			.357	.059
Delayed	57.1 (8)	42.9 (6)		
Appropriate	26.1 (6)	73.9 (17)		
Receipt of Special Services			.175	.675
Receiving special services	34.6 (9)	65.4 (17)		
Not receiving special services	41.7 (5)	58.3 (7)		
<i>Family Structure History</i>				
Living with:			3.67	.159
Parent(s)	44.8 (13)	55.2 (16)		
Extended Family	33.3 (1)	66.7 (2)		
Other	0.0 (0)	100 (5)		
Out of Home Placements			1.15	.563
None	42.3 (11)	57.7 (15)		
One	20.0 (1)	80.0 (4)		
Greater than One	28.6 (2)	71.4 (5)		
Father's Presence in Home			.326	.568
Father is present in home	46.2 (6)	53.8 (7)		
Father not present in home	36.4 (8)	63.6 (14)		
<i>Mental Health</i>				
No Diagnosis	50.0 (5)	50.0 (5)	1.01	.315
Multiple Diagnoses	47.1 (8)	52.9 (9)	-.1	.318
Receiving Treatment at time of arrest	33.3 (7)	66.7 (14)	.248	.618
Taking Medication	36.4 (8)	63.6 (14)	.005	.943
<i>History</i>				
Psychiatric History	32.3 (10)	67.7 (21)	1.52	.218
Prior Hospitalizations	36.8 (7)	63.2 (12)	.000	1.0
Substance Abuse History	25.0 (2)	75.0 (6)	1.99	.369
Alcohol Abuse History	28.6 (2)	71.4 (5)	.427	.808

<i>Specific Psychiatric Diagnosis</i>				
Developmental Delay	30.8 (4)	69.2 (9)	-.1	.728
Mental Retardation	41.7 (5)	58.3 (7)	.175	.675
ADHD	18.8 (3)	81.3 (13)	-.1	.088
Other Behav./Conduct Disorder	28.6 (4)	71.4 (10)	-.1	.501
Psychotic Disorder	57.1 (4)	42.9 (3)	1.52	.218
Mood Disorder	36.4 (4)	63.6 (7)	-.1	1.0
Developmental Disorder	44.4 (4)	55.6 (5)	.293	.588
PTSD	50.0 (2)	50.0 (2)	.333	.564
Personality Disorder	100.0 (1)	0.0 (0)	-.1	.368
<i>Court</i>				
Court Type			2.12	.346
Juvenile	41.9 (13)	58.1 (18)		
GA (Part B)	0.0 (0)	100.0 (2)		
JD (Part A)	20.0 (1)	80.0 (4)		
Attorney Type			-.1	1.00
Public Defender	40.0 (14)	60.0 (21)		
Private Attorney	0.0 (0)	100.0 (1)		
<i>Charges</i>				
Number of Charges	2.50 (1.29)	3.50 (2.55)	t = 1.602	.118
Most Serious Charge Type			-.1	.715
Felony	39.3 (11)	60.7 (17)		
Misdemeanor	30.0 (3)	70.0 (7)		
Crime Type for Most Serious Charge			2.03	.567
Drug	0.0 (0)	0.0 (0)		
Justice	20.0 (1)	80.0 (4)		
Person	38.5 (10)	61.5 (16)		
Property	25.0 (1)	75.0 (3)		
Weapon	66.7 (2)	33.3 (1)		
Prior Arrests	38.9 (7)	61.1 (11)	.016	.898
<i>Comprehension</i>				
Knowledge of Charges	17.9 (5)	82.1 (23)	-.1	.000
Knowledge of Judge's Role	25.0 (7)	75.0 (21)	-.1	.014
Knowledge of Attorney's Role	26.7 (8)	73.3 (22)	-.1	.034
Knowledge of Prosecutor's Role	16.7 (4)	83.3 (20)	-.1	.001
Knowledge of Relevant Pleas	12.5 (3)	87.5 (21)	-.1	.000
Knows Attorney's Name	38.5 (5)	61.5 (8)	-.1	.666
Knows How to Use Attorney	4.5 (1)	95.5 (21)	-.1	.000
Accurately Estimates Potential Consequences	0.0 (0)	100.0 (12)	13.24	.001
Can Tell a Coherent Story	18.2 (4)	81.8 (18)	-.1	.001

* The percentages shown are valid percentages, taking into consideration missing data.

¹ A Fisher's Exact test was used.

Appendix D

Table 4. *Comparison between Competent and Incompetent Ages 16-18*

Characteristic	Ages 16-18		<i>t</i> or χ^2	<i>p</i>
	Incompetent n = 34 %* (n) or mean (s.d.)	Competent n = 59 %* (n) or mean (s.d.)		
<i>Age</i>	17.41 (.657)	17.07 (.740)		
<i>Race</i>			.239	.971
African American	37.8 (14)	62.2 (23)		
Hispanic	34.5 (1)	65.5 (19)		
Caucasian	36.0 (9)	64.0 (16)		
Other	50.0 (1)	50.0 (1)		
<i>Education</i>				
Current School Level			-.1	.237
Delayed	40.9 (27)	59.1 (39)		
Appropriate	25.9 (7)	74.1 (20)		
Receipt of Special Services			-.1	.029
Receiving special services	46.3 (25)	53.7 (29)		
Not receiving special services	23.1 (9)	76.9 (30)		
<i>Family Structure History</i>				
Living with:			.883	.643
Parent(s)	38.1 (24)	61.9 (39)		
Extended Family	22.2 (2)	77.8 (7)		
Other	38.5 (5)	61.5 (8)		
Out of Home Placements			.642	.725
None	32.6 (15)	67.4 (31)		
One	41.4 (12)	58.6 (17)		
Greater than One	38.9 (7)	61.1 (11)		
Father's Presence in Home			4.06	.044
Father is present in home	50.0 (18)	50.0 (18)		
Father not present in home	28.6 (14)	71.4 (35)		
<i>Mental Health</i>				
No Diagnosis	33.3 (11)	66.7 (22)	33.3 (11)	.660
Multiple Diagnoses	38.7 (12)	61.3 (19)	.093	.761
Receiving Treatment at time of arrest	33.3 (8)	66.7 (16)	.018	.894
Taking Medication	48.7 (19)	51.3 (20)	4.858	.028
<i>History</i>				
Psychiatric History	38.2 (26)	61.8 (42)	-.1	.635
Prior Hospitalizations	35.6 (16)	64.4 (29)	-.1	1.0
Substance Abuse History	35.0 (21)	65.0 (39)	.061	.970
Alcohol Abuse History	31.6 (12)	68.4 (26)	3.11	.375

<i>Specific Psychiatric Diagnosis</i>				
Developmental Delay	66.7 (10)	33.3 (5)	-. ¹	.017
Mental Retardation	46.9 (15)	53.1 (17)	2.24	.135
ADHD	42.1 (8)	57.9 (11)	.317	.574
Other Behav. Disorder	37.5 (6)	62.5 (10)	.007	.932
Psychotic Disorder	52.0 (13)	48.0 (12)	3.52	.061
Mood Disorder	11.8 (2)	88.2 (15)	-. ¹	.025
Developmental Disorder	57.1 (4)	42.9 (3)	1.38	.240
PTSD	0.0 (0)	100.0 (2)	-. ¹	.531
Personality Disorder	0.0 (0)	100.0 (3)	-. ¹	.297
<i>Court</i>				
Court Type			-. ¹	.104
Juvenile	0.0 (0)	0.0 (0)		
GA (Part B)	40.3 (31)	59.7 (46)		
JD (Part A)	18.8 (3)	81.3 (13)		
Attorney Type			-. ¹	.791
Public Defender	37.8 (28)	62.2 (46)		
Private Attorney	31.6 (6)	68.4 (13)		
<i>Charges</i>				
Number of Charges	5.24 (4.40)	5.85 (4.32)	t = .654	.515
Most Serious Charge Type			.464	.496
Felony	34.7 (25)	65.3 (47)		
Misdemeanor	42.9 (9)	57.1 (12)		
Type of Crime for Most Serious Charge			1.98	.739
Drug	36.8 (7)	63.2 (12)		
Justice	54.5 (6)	45.5 (5)		
Person	33.3 (16)	66.7 (32)		
Property	36.4 (4)	63.6 (7)		
Weapon	25.0 (1)	75.0 (3)		
Prior Arrests	36.9 (24)	63.1 (41)	.000	.992
<i>Comprehension</i>				
Knowledge of Charges	13.2 (9)	86.8 (59)	-. ¹	.000
Knowledge of Judge's Role	19.4 (14)	80.6 (58)	-. ¹	.000
Knowledge of Attorney's Role	23.4 (18)	76.6 (59)	-. ¹	.000
Knowledge of Prosecutor's Role	16.9 (12)	83.1 (59)	-. ¹	.000
Knowledge of Relevant Pleas	11.9 (8)	88.1 (59)	-. ¹	.000
Knows Attorney's Name	22.0 (9)	78.0 (32)	.820	.365
Knows How to Use Attorney	5.0 (3)	95.0 (57)	-. ¹	.000
Accurately Estimates Potential Consequences	15.2 (7)	84.8 (39)	13.89	.001
Can Tell a Coherent Story	13.6 (9)	86.4 (57)	-. ¹	.000

* The percentages shown are valid percentages, taking into consideration missing data.

¹ A Fisher's Exact test was used.