

Juveniles Adjudicated Incompetent to Proceed: A Descriptive Study of Florida's Competence Restoration Program

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Although competence to stand trial is perhaps the most studied area of mental health law, most of the research has been focused on adults. This study describes a population of 471 juveniles committed for treatment/habilitation and restoration of their competence to proceed in the delinquency process. This population differed from their adult counterparts in important ways. For example, 58 percent of the juveniles had a diagnosis of mental retardation, and 57 percent of the juveniles with an Axis I diagnosis also had a diagnosis of conduct disorder. Only 17 percent had a diagnosed psychotic disorder. Diagnoses among cohorts of adults found incompetent differ markedly. However, similar to adult defendants who are adjudicated incompetent to proceed, the majority of these children were returned to court after treatment staff determined that they were competent to proceed. Contrary to expectation, there were no significant age-related differences with respect to the recommendation of clinical staff regarding restoration of competence. The data suggest the need for further research examining that subset of children in the juvenile justice system whose competence to proceed is questionable.

J Am Acad Psychiatry Law 29:427-37, 2001

Competence to stand trial is perhaps the most studied area of mental health law.¹ Mental health professionals and legal commentators have studied the characteristics of defendants referred for competence evaluations and adjudicated incompetent to proceed,^{2,3} have developed a number of special instruments designed to assess competence to proceed,⁴⁻⁷ and have offered a legal theory of competence to proceed.⁸

The ability of minors to participate in legal pro-

ceedings has received much less attention, both from legal scholars and mental health professionals, presumably as a result of the unique nature of the juvenile justice system. Because juvenile court proceedings were historically considered to be rehabilitative and nonadversarial, juveniles' competence to participate in the proceedings was considered irrelevant by some.^{2,9} Although the Supreme Court has acknowledged that delinquency proceedings are not necessarily benevolent and has consequently granted juveniles many rights guaranteed adult defendants,^{10,11} whether the Constitution requires that a juvenile be competent to participate in delinquency proceedings has not been decided by the Court.

At the current time, approximately half of the states have recognized the concept of competence to proceed in juvenile court, either by statute or case law.^{2,9} The issue of juvenile competence has gained increasing attention as states have adopted more punitive sanctions in the juvenile justice system and increased the number of juveniles waived into adult court.

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There is a limited body of research examining minors and their understanding of the criminal justice system and juvenile justice process. In an early study, Savitsky and Karras¹² administered the Competence Screening Test (CST⁶) to children aged 12 to 17 years. Performance on the CST (best conceptualized as a test of knowledge of the legal process) improved with age, with 12-year-old children obtaining lower scores than a group of 15-year-old children, who obtained lower scores than a group of adults. Cooper¹³ administered a version of the Georgia Court Competency Test (GCCT; GCCT-MSH¹⁴), another knowledge-based assessment instrument, to a sample of 11- to 16-year-old children who were adjudicated delinquent. Ninety-eight percent of the 112 juveniles ($n = 110$) obtained scores below the suggested cutoff for competency, suggesting the possibility of impaired capacity. In contrast to the findings of Savitsky and Karras,¹² age did not correlate with test performance, although the small number of juveniles in each group may be responsible for this finding.

Cowden and McKee¹⁵ conducted a number of studies examining the abilities of juvenile offenders referred to their institutions for evaluation of competence to proceed and/or mental state at the time of the offense. They described a sample of 136 juveniles between the ages of 9 and 16 referred for evaluation. A multidisciplinary team of forensic mental health professionals evaluated the children and judged them incompetent to stand trial (17%), incompetent to stand trial/competent to stand trial (i.e., minimally competent, with significant impairment that might lead others to conclude they were incompetent; 23%), and competent to stand trial (60%). Age, diagnosis, severity of illness, and history of remedial education were the only factors among a number of clinical (e.g., diagnosis), demographic (e.g., age, race), and criminal justice (e.g., history of arrests, seriousness of charges) variables that differentiated the three groups. Juveniles considered by the multidisciplinary team to be incompetent to proceed were younger, had more severe diagnoses (including mental retardation) and were more likely to have a history of academic difficulties (e.g., grade retention or placement in special classes). Although the number of younger children was small, there was a linear relationship between staff impressions of competence to proceed and the children's age (0% of 9- and 10-year-olds were considered competent, 18% of 11-

year-olds, 27% of 12-year-olds, 64% of 13-year-olds, 84% of 15-year-olds, and 72% of 16-year-olds).

In a follow-up study McKee and Shea¹ described the characteristics of a separate sample of 112 juveniles, ages 12 to 16, who were referred for competence evaluations. Eighty-six percent of the juveniles were deemed competent to proceed by the multidisciplinary team, and 14 percent were considered incompetent. Although the two groups were compared on 25 demographic, historical, clinical, and juvenile justice variables the incompetent and competent groups differed on only three variables: age, intelligence, and history of arrests. Juveniles in the competent group were older, more likely to have a prior arrest, and less likely to have a diagnosis of borderline intellectual functioning or mental retardation.

Although investigators have begun to examine the characteristics of juveniles referred for competence evaluations, there are no reports describing the dispositions of children adjudicated incompetent to proceed in delinquency proceedings. Presented herein are data regarding juveniles adjudicated incompetent to proceed in delinquency proceedings who were committed for treatment and restoration in the state of Florida over a three-year period. This is the first report of a statewide sample of juveniles found incompetent to proceed in delinquency proceedings.

Legal Framework

Florida law requires that children who are involved in the juvenile justice system be competent to proceed. Florida's juvenile competence statute tracks the Supreme Court's decision in *Dusky v. U.S.*¹⁶ and directs that children are competent to proceed if they have sufficient present ability to consult with counsel with a reasonable degree of rational understanding and have a rational and factual understanding of the proceedings.¹⁷

In practice, these concepts are operationalized by means of statutorily required elements in the examiner's report on competency. Reports must include the child's (1) appreciation of the charges and allegations and range and nature of possible penalties; (2) understanding of the adversarial nature of the legal process; (3) ability to work with counsel and disclose facts pertinent to the proceedings; and (4) ability to testify relevantly and display appropriate courtroom behavior.¹⁷ Grisso¹⁸ has distilled abilities such as these into four categories: understanding of the

charges and potential consequences, understanding of the trial process, capacity to participate with counsel in preparing a defense, and potential for courtroom participation. In addition, Florida law requires that the examiner, in those cases in which the examiner concludes that the child is incompetent and can be restored to capacity, recommend whether the child requires treatment or training in a residential or nonresidential setting.

In Florida, children who are charged with a felony and are adjudicated incompetent to proceed are committed to the Juvenile Incompetence to Proceed (JITP) program.¹⁷ Juveniles transferred to the adult criminal justice system in Florida (approximately 5,000 per year¹⁹) are not included in this sample, because their competency difficulties are managed by the adult forensic service system. Children who are only charged with misdemeanors or who are adjudicated incompetent to proceed solely due to age or immaturity are also not referred for restoration services, but rather, are diverted to other services or programs.

Multimodal treatment including psychoeducational treatment groups focused on the legal system and its operation, administration of psychoactive medications, case management services, and counseling are offered on an outpatient basis by service providers located throughout the state. Residential treatment programs for juveniles in need of more intensive treatment are also available. The treatment and training provided are based on an individualized service and treatment plan that must be filed with the court, the child's attorney, the State, and the attorneys representing the Florida Department of Juvenile Justice, and the Department of Children and Families. The Florida statute requires that the competence treatment provider make regular reports to the court detailing the child's progress toward competency. Once treatment staff conclude that the child is competent to proceed, the court must be notified so that a competency hearing can be scheduled. The court can also authorize continuing treatment to maintain competency pending the delinquency proceedings.

Materials and Methods

Participants

The 471 participants in this study comprised the entire population of juveniles who were adjudicated

incompetent to proceed in the juvenile justice process in the state of Florida between May 1997 and August 2000 and were referred to the JITP program. (Because of the funding mechanisms for competence evaluations in Florida and the manner in which the data were made available, the research team was unable to identify the percentage that this group represented of the children whose competence to stand trial was evaluated. This group of children did not include (1) those who were transferred to the criminal justice system for prosecution as adults and determined to be incompetent to proceed; (2) those who were charged only with misdemeanors and were judged incompetent to proceed; and (3) those who were charged with misdemeanors or felonies and were considered to be incompetent to proceed for reasons other than mental illness or mental retardation (e.g., age-expected cognitive limitations)). Because 10 children had been in the program twice, data were analyzed on 481 admissions into the program. Males comprised 86 percent ($n = 405$) of the sample. The majority of juveniles were black (62%, $n = 292$), with white (31%, $n = 144$) and Hispanic (6%, $n = 28$) youths comprising the remainder of the population (other/unknown was 1%, $n = 7$).

Age data were available for 475 admissions, with 5 percent ($n = 22$) between 7 and 9 years of age at time of admission, 23 percent ($n = 107$) between 10 and 12, 45 percent ($n = 212$) between 13 and 15, and 28 percent ($n = 134$) 16 years and older. The mean age was 14.33 ± 2.45 (SD), with a range of 7.67 to 18.83 years. (Some of these intakes represent the same child, because 10 juveniles had been in the program more than once. The mean age at first intake for these juveniles was 13.31 ± 2.75 years, and the mean age at second intake was 15.30 ± 2.42 years).

Procedure

Data were entered into a database (Access software, Microsoft) by JITP staff from numerous paper documents received relevant to the juveniles' legal cases and treatment. Extensive quality checks were conducted on the data before their analysis, which involved verifying certain data elements and outliers with information in the juveniles' JITP case files.

Results

Demographic Analysis

This sample of children adjudicated incompetent to proceed had a higher percentage of male (86%)

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Table 1 Demographic, Mental Health Historical, and Intelligence Information

	Total (%)	Age (%)			
		7-9 (n = 22)	10-12 (n = 107)	13-15 (n = 212)	16 and older (n = 134)
Gender (% males)	86	100	80	88	85
Race/ethnicity					
Black	63	55	73	59	60
White	30	46	21	33	31
Hispanic	6	0	6	6	8
Other	1	0	1	1	1
Predicate condition*					
MR	30	14	18	37	31
MI	30	76	51	20	26
MR/MI	40	10	31	44	44
Median IQ (n)	61 (n = 386)	78 (n = 17)	68 (n = 84)	59 (n = 173)	60 (n = 107)

* $\chi^2 = 4.15$, $df = 3$, $p > .05$ for predicate condition by age grouping.

and black (63%) juveniles than the total sample referred to the Florida Department of Juvenile Justice in 1999 ($n = 107,095$; males, 71%; black juveniles, 38%; Bureau of Data and Research, Florida Department of Juvenile Justice, 1999). Information by age groupings is presented in Table 1.

Diagnoses

Juveniles are adjudicated incompetent to proceed and are committed to the JITP program for any of three reasons, which we refer to as the "predicate condition"—presence of mental retardation (MR), mental illness (MI), or a combination of mental illness and mental retardation (MR/MI). A large number of children had a predicate condition of MI/MR (40%, $n = 188$). Roughly equal numbers of admissions were children who had a predicate condition of MR (30%, $n = 142$) or MI (30%, $n = 145$; see Table 1) only. Combining these predicate conditions shows that 70 percent of the children had a predicate condition including MI (combining 40% MI/MR and 30% MI) and 70 percent of the children had a predicate condition including MR (combining 40% MI/MR and 30% MR).

Intelligence estimates were available for 93 percent of admissions of children with a predicate condition of MR, 88 percent with a predicate condition of MR/MI, but only 61 percent with a predicate condition of MI. The mean IQ of those juveniles with a predicate condition of MI probably underestimates the population's true mean IQ, because the only children tested were those whose intellectual functioning was identified as a potential problem. Children with a predicate condition of MI had significantly higher

IQs (mean, 79.1 ± 10.93 (SD)), than those with predicate conditions of MR (mean, 55.7 ± 8.7) or MR/MI (mean, 57.6 ± 8.04 ; $F = 210.82$, $df = 2,383$, $p < .001$, Sheffé *post hoc*).

Diagnoses assigned to the children by the forensic examiners are documented in Table 2. The most common predicate condition diagnosed was MR (58%, $n = 278$ of 481 admissions), with mild MR (43%, $n = 205$) the most common, followed by moderate (14%, $n = 69$) and severe (1%, $n = 4$) MR.

The discrepancy between the percentage of children with a predicate condition including MR (70% with predicate condition of MR or MR/MI) and the percentage with a diagnosis of MR (58%) is probably due to the method by which these data were collected. Predicate condition information is recorded by Department of Children and Families district liaisons on a summary worksheet—typically, from information in the court order. In contrast, diagnostic information is gathered from the content of the examiners' reports, which may not match the judicial findings contained in the court order.

Seventy-three percent of the children ($n = 349$) had at least one Axis I diagnosis. Conduct Disorder was the most common (57% of those with at least one Axis I diagnosis) followed by Attention-Deficit/Hyperactivity Disorder (37%), Mood Disorders (35%), Psychotic Disorders (17%), and Adjustment Disorders (15%). The majority of children with a diagnosis of Conduct Disorder (82%, $n = 164$) had at least one other Axis I diagnosis.

Table 2 Diagnoses

	Total (%)	Age (%)			
		7-9 (n = 22)	10-12 (n = 107)	13-15 (n = 212)	16 and Older (n = 134)
Mild, moderate, or severe mental retardation*	58	18	44	67	66
Children with at least one Axis I diagnosis (%)					
Axis I Diagnoses	n = 349	n = 18	n = 83	n = 146	n = 97
Conduct Disorderst	57	61	60	59	51
ADHD	37	89	60	31	18
Mood	35	28	31	34	42
Psychotic Disorders	17	0	14	16	26
Adjustment	15	22	17	15	11
Anxiety Disorders	11	11	11	12	10
Learning	8	6	6	10	4
Drugs	6	0	0	3	14
PDD	3	6	0	5	1
Paraphilia	1	0	0	1	1

* MR was the most common diagnosis, with 58% of juveniles diagnosed with mild (43%), moderate (14%), or severe (1%) mental retardation.
 † The majority of children with a conduct disorder diagnosis had at least one other Axis I diagnosis (n = 164 or 82% of juveniles with conduct disorder diagnoses). The most common diagnoses in combination with conduct disorders were ADHD (n = 72; 37%), mood disorders (n = 61; 31%), anxiety disorders (n = 19; 10%), psychotic disorders (n = 18; 9%), learning-related disorders (n = 13; 7%), drug- and/or alcohol-related disorders (n = 12; 6%), pervasive developmental disorder (PDD) (n = 3, 2%), and paraphilias (n = 1, .5%).

Index Offenses

Offense data were available only for the 361 children admitted to the program through December 1999. The offenses with which these juveniles were charged are listed in Table 3. (The percentage of children with each offense type sums to more than 100 percent, because some children had charges in more than one offense category.) Half of the children (50%, n = 181) were charged with violent crimes against persons. Property crimes were the next most common offense (32%, n = 117), followed by criminal mischief (22%, n = 81) and contact sex offenses (10%, n = 35). Eighteen percent of the children (n

= 65) were charged with at least one offense that involved school personnel or occurred on school property. Approximately two thirds of these children (68%, n = 44) were charged with assaulting or threatening a school employee.

Treatment and Restoration Data

Placement data were available for 463 admissions, with predicate conditions of MR (30%, n = 137), MI (31%, n = 145), or MI/MR (39%, n = 181; Table 4). In some cases, restoration services were initiated in the home while the child awaited a residential placement, and in other cases, children discharged from residential treatment sometimes continued to receive services while at home and awaiting return to court. As a result, some juveniles had one or more placement changes while in the program.

Almost half of the 463 children with placement data (49%, n = 229) received at least some of their treatment in a secure residential facility, with this being a more common occurrence in children with a predicate condition of MI/MR (62%, n = 113 of 181 children), followed by those with predicate conditions of MI (48%, n = 69 of 145 children) and MR (34%, n = 47 of 137 children). More than three quarters (83%, n = 382) of the children received restoration services while residing at home at some time during tenure in the JITP program. Those with a predicate condition of MR (84% were treated in

Table 3 Offense Types for Juveniles Admitted into the JITP through December 1999

Offense Type	n	%
Assault and battery	181	50
Property crime	117	32
Criminal mischief	81	22
Contact sex offense	35	10
Firearms	27	7
Drug possession	22	6
Arson	14	4
Noncontact sex offense	12	3
Drug sales	4	1
Other	2	1
Children with at least one charge incurred at school	65	18

The percentage of children with each offense type sums to more than 100%, because some children had charges in more than one offense type category. Total n = 361.

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Table 4 Placement Data During Juveniles' Tenure in the JITP Program

	Predicate Condition							
	Total		MR		MI		MR/MI	
	N	%	N	%	N	%	N	%
Placement	463		137		145		181	
Ever in the home	382	83	115	84	127	88	140	77
Ever in residential facility	229	49	47	34	69	48	113	62
Ever in detention	21	5	6	4	6	4	9	5
Combination of placements								
Only in residential facility	102	22	23	17	26	18	53	29
Only in home	228	50	87	65	74	52	67	37
Both home and residential facility	127	28	24	18	43	30	60	33

the home; $n = 115$) and MI (88%, $n = 127$), were more likely to have been treated at some time in the home than were those with a predicate condition of MI/MR (77%, $n = 140$). A small percentage of juveniles were treated while in a juvenile detention center (5%, $n = 21$).

The most common treatment pattern was for restoration services to be offered in the home for the entire duration of treatment. Of the 457 juveniles who were treated at any time in the home and/or at a residential treatment facility, half (50%, $n = 228$) were treated only in the home. This was a more common occurrence in children with predicate conditions of MR (65% were treated only in the home; $n = 87$) and MI (52%, $n = 74$), than in those with a predicate condition of MI/MR (37%, $n = 67$). Treatment in both the home and a residential facility was the next most common pattern of service delivery (28%, $n = 127$). Those with predicate conditions of MI (30% treated in both settings; $n = 43$) and MI/MR (33%, $n = 60$) were more likely than those with a predicate condition of MR (18%, $n = 24$) to be treated in both settings while in the JITP program.

Finally, treatment only in a residential treatment facility was the least-common pattern (22%, $n = 102$). Children with a predicate condition of MI/MR (29%, $n = 53$) were more often treated only in residential settings than were those with predicate conditions of MR (17%, $n = 23$) and MI (18%, $n = 26$).

The majority (71%) of children were returned to the court, having been deemed competent. Table 5 details the percentage of children returned to court, having been judged competent to proceed, incompetent to proceed, or of unrestorable competence, as a function of conditions responsible for the referral (predicate condition) and age. Differing rates of competence restoration were obtained as a function of the disorder underlying the referral, because the three predicate-condition groups (MR, MI, MI/MR) differed significantly in recommendations of competence versus unrestorability ($\chi^2 = 35.10$, $df = 2$, $p < .001$). The large majority of children who had a predicate condition of MI who were discharged from the restoration program were discharged as competent to proceed (92%), whereas a small minor-

Table 5 Restoration Data by Age Category and Predicate Condition

	Total	Age (%)			
		7-9 ($n = 22$)	10-12 ($n = 107$)	13-15 ($n = 212$)	16 and Older ($n = 134$)
Competent	71	76	79	69	66
Nonrestorable	29	24	21	31	34
		Predicate Condition (%) ^a			
		MR ($n = 108$)	MI ($n = 108$)	MI/MR ($n = 144$)	
Competent		56	92	66	
Nonrestorable		44	8	34	

^a $\chi^2 = 35.10$, $df = 2$, $p < .001$.

Table 6 Time Span Information for Children Not in Maintenance Training in Days

Age Category	Admission to JITP to Discharge from JITP*			Admission to JITP to Recommendation to the Court for Discharge†			Recommendation to the Court to Discharge from JITP		
	n	M	Mean ± SD	n	M	Mean ± SD	n	M	Mean ± SD
Total	294	217.5	246.6 ± 140.7	325	162.0	184.9 ± 113.3	285	37.0	65.4 ± 82.6
7-9	11	218.0	262.6 ± 109.3	14	174.5	194.0 ± 97.4	11	22.0	86.0 ± 128.7
10-12	60	236.0	265.0 ± 128.4	70	186.0	209.6 ± 103.7	58	36.5	60.5 ± 65.1
13-15	126	234.0	266.9 ± 140.4	138	184.5	201.1 ± 108.5	124	38.5	68.7 ± 88.8
16+	91	190.0	211.6 ± 140.7	97	137.0	147.9 ± 121.0	86	36.0	63.5 ± 79.6

M = Median

* Children 16 years old and older spent significantly less time in treatment than 13- to 15-year-olds ($F = 3.18$, $df = 3, 284$, $p < .05$, Scheffé *post hoc*).† Children 16 years old and older spent significantly less time in treatment before the clinical team made a decision about their status than did 10- to 12- and 13- to 15-year-olds ($F = 7.56$, $df = 3, 367$, $p < .001$, Scheffé *post hoc*).

ity were identified as of unrestorable competence (8%) and returned to court for alternative dispositions. Not surprisingly, a greater number of incompetent children whose predicate condition was MR were returned to court subsequent to the treatment staff's concluding that their competence was unrestorable (44%). Thirty-four percent of the children with a predicate condition of MI/MR were identified by treatment staff as of unrestorable competence and returned to court for an alternative disposition.

In contrast, there were no significant age-related differences with respect to the recommendation of clinical staff regarding competence restoration. That is, after a period of treatment, children between the ages of 7 and 9 were as likely to return to be examined by treatment staff for competence to proceed as were their older counterparts ($\chi^2 = 4.42$, $df = 3$, $p > .05$). Three (predicate condition: MR/MI, MI, MR) times two (recommended competent or unrestorable) ANOVAs were conducted on the time spans reported between key dates reported in this section. Because none of these analyses indicated significant main effects or interactions, data have been reported only for the entire group of juveniles. Given the skewed distribution of some of the summary time-span data, the median is the best measure of the central tendency of the data. The outliers for these time-span variables are of note. The short time spans are for the less typical cases, in which children are found to meet competency criteria upon entry into the program—for example, after two days in treatment—or when coordination between the court and the JITP competence program is extraordinarily efficient—for example, no days waiting between date recommended for discharge and discharge from program. The long time spans also represent less typical cases in which juveniles run away and later return to

the program—with the time they were missing not factored out of the treatment time data in the database, thus leading to a long time span between entry into and discharge from the program—or cases in which courts disagree with recommendations for a finding of competency and order more training for juveniles.

Children spent, on average, between five and six months (mean, 184.9 days; median, 163 ± 113.3 days; range, 2–1,096) in treatment before the clinical team made a decision about their status and notified the court (Table 6). These data are similar to the 1998-1999 data from Florida adults who were restored to competency within an average of 178 days.²⁰ Children 16 years of age and older spent significantly less time in treatment (mean, 147.9 ± 121.0 days) before the clinical team made a decision about their status than did 10- to 12- (mean, 209.6 ± 103.7 days) and 13- to 15-year-olds (mean, 201.1 ± 108.5 ; $F = 7.56$, $df = 3, 367$, $p < .001$, Scheffé *post hoc*).

Substantial time elapsed between the court's notification of the treatment team's conclusions regarding the children's competence status and the children's discharge from the program. Children not ordered by the court to receive treatment and/or restoration services while awaiting a return to court on their original charges waited a median of 37 days (mean, 65.4 ± 82.6 ; range, 0–538) from the date when they were recommended for discharge to when they were formally discharged. Because the children's competency hearing dates were not available, discharge from the competency restoration program was used as a proxy for the hearing date for the subset of children who were not ordered by the court to undergo maintenance restoration services while in the community. Anecdotal information suggests that

the hearing date is often close to the discharge date for children not ordered into maintenance training.

The long length of stay in treatment, in combination with waiting periods associated with the legal system's response to recommendations by the treatment program, resulted in extended periods of stay in the treatment program. On average, juveniles committed to the restoration program who did not undergo maintenance treatment or training remained in the program a median of 217.5 days, or slightly more than seven months (mean, 246.60 ± 140.7 days; range, 2–1,096), with some juveniles remaining in the program for more than two years. Children 16 years old and older spent significantly less time (mean, 211.62 ± 140.7 days) in treatment than did 13- to 15-year-olds (mean, 266.9 ± 140.4 days; $F = 3.18$, $df = 3, 284$, $p < .05$, Scheffé *post hoc*).

Maintenance Training

Approximately 15 percent ($n = 51$) of the juveniles judged competent to proceed by the court subsequent to treatment were ordered to receive maintenance services while awaiting a return to court. Such treatment appeared to increase length of stay in the JITP program. Juveniles who received maintenance services waited a median of 89 days (mean, 102.00 ± 70.36 days; range, 25–371) for discharge after clinical disposition, compared with a median of 37 days for children who were not ordered to receive treatment while awaiting case disposition. Their median length of treatment was 258 days (mean, 283.85 ± 105.8 days; range, 116–582), compared with a median of 217.5 days for children not ordered to receive treatment while awaiting a return to court.

Discussion

This is the first report describing the characteristics of a group of children adjudicated incompetent to proceed with the delinquency process. There are several characteristics of this sample that are worth noting.

First, the distribution of diagnoses is interesting. The prevalence of mental retardation in this sample of children is of particular interest, although, as noted in the results, conflicting information about the diagnostic data needs clarification. Although 58 percent of the children in this sample received a mental retardation diagnosis in the clinical report, 70 percent were identified in the court order as incompetent to proceed due to mental retardation or a

combination of mental retardation and mental illness. Thus, approximately 12 percent of the sample had no mental retardation in their reports but were identified as mentally retarded in the court orders. This discrepancy may be due, in part, to the different data collection methods used and suggests the need for research examining the basis for court orders in at least some of these cases.

However, even the lower estimate of 58 percent with a diagnosis of mental retardation is significant when compared with adults who are adjudicated incompetent to proceed. National data indicate that approximately six percent of adult defendants receiving treatment for competency restoration are incompetent due to mental retardation.³ Florida data from fiscal year 1999–2000 are consistent with this national trend—approximately five percent of adults receiving competency restoration services in Florida institutions had a mental retardation diagnosis.²¹

These data have several implications. Foremost, administrators charged with staffing and developing restoration programs cannot simply look to programs that are in place for adult defendants. In addition to the programming nuances necessary due to the considerable developmental differences between adults and adolescents, the significant percentage of children with mental retardation must be considered when considering staffing and programming.

Although it is not possible at this point to conclude why mental retardation among children in this cohort is so much higher, it suggests that incompetence adjudications might serve different dispositional purposes in the juvenile system than is true in the adult system. For example, assuming that an incompetence adjudication is viewed by judges and lawyers as a nonpunitive disposition, they may be more willing to use mental retardation as a reason to divert minors to a more benevolent disposition in what some perceive as an increasingly punitive juvenile justice system. However, to test this hypothesis, more would have to be known about the ultimate disposition of these cases after treatment for restoration is concluded and the case returned to court.

The high prevalence of Conduct Disorder (57%) is not surprising, given the prevalence of this diagnosis among children in the juvenile justice system generally^{22,23} and may reflect no more than the children's acting out behaviors that brought them into contact with the juvenile justice system. Given that the large majority (85%) of children who received a

Conduct Disorder diagnosis also received another Axis I or Axis II diagnosis, it is unlikely that Conduct Disorder itself was the basis for a finding of incompetence in many children, although a review of the evaluations themselves would provide more information regarding the possibility of such a trend. The relatively small number of children with Psychotic Disorder diagnoses (17%), however, is interesting, when compared with the prevalence of this diagnosis among adults who are adjudicated incompetent to proceed³ and probably reflects the fact that a number of the psychosis spectrum of disorders (e.g., schizophrenia) do not develop until later adolescence.

Second, the findings regarding race and ethnicity of this sample of children who were adjudicated incompetent to proceed is also of interest. When compared with the population of youths in Florida's juvenile justice system, children adjudicated incompetent to proceed and ordered to receive restoration services were disproportionately African American. These findings are consistent with research findings indicating that African Americans are over-represented among adult defendants who are adjudicated incompetent to proceed and committed for restoration services.³ The reasons for these findings are not clear, but the additional research into the use of incompetence adjudications as a dispositional tool is warranted.

Third, the finding that 18 percent of the children were charged with a school-based offense, typically involving a contact offense against a school employee (a felony in the state of Florida) is of note. Given the population, it was expected that some percentage of charges would be school-based offenses. It is not clear, however, whether the percentage of children with school-based offenses in this sample is comparatively high or low. However, that an adjudication of incompetence may result in removal of the child from school raises several policy issues, including the impact of removal from school on the child's educational performance and whether in some cases an adjudication of incompetence may be used as a vehicle to remove a child perceived as troublesome from the school.

Fourth, the young age of a number of these children (5% were between seven and nine years of age when admitted for restoration services) raises questions regarding the appropriateness of adopting the *Dusky* (adult) standard for use in children in the juvenile justice system. Other researchers^{1,12,15} have

reported an inverse relationship between age and competency in minors, and Bonnie and Grisso⁹ have advocated the creation of more developmentally sensitive competency standards for juveniles. Florida's statute does not bar a finding of incompetence based on age or immaturity but prohibits commitment for competency restoration if a child is found incompetent on those grounds or any grounds other than mental illness or mental retardation.¹⁷ This may create an incentive to assign a diagnosis, particularly in a young child, as a vehicle for making the child eligible for treatment services. It also raises a larger question regarding the appropriateness of finding very young children incompetent for delinquency proceedings and committing them for restoration services when their inability to participate in the juvenile justice process is due to normal developmental limitations.

Fifth, many children are committed, during at least some portion of their treatment for restoration, to outpatient care. This contrasts with adult offenders, who at least in Florida (and from our experience, in other states as well), are most often committed to inpatient care for the purpose of competency restoration. Although Florida's ability to keep 50 percent of the children adjudicated incompetent out of residential placements is worth noting, it is also worth noting that the state of Virginia has been able to avoid residential placement of any of the 130+ children who have been adjudicated competent to proceed and ordered to receive treatment services in the past year.²⁴

Finally, worth noting is the apparent ability of treatment staff to provide services necessary to return the children to court. As is the case in adult defendants adjudicated incompetent to proceed, the majority of children committed for restoration services were returned to court as competent to proceed within a year.²⁰ As might be expected, a greater proportion of children who were identified as being incompetent to proceed as a function of mental retardation or mental retardation in combination with mental illness were considered to be permanently incompetent to proceed, compared with those who were considered incompetent to proceed solely as a function of mental illness. An unexpected finding was that there were no age-related differences with respect to competence restoration. That is, there was no relationship between the juveniles' ages and the clinical staffs' opinions regarding restoration and restorability of competence. This finding is in conflict

with the literature regarding the relationship between competence to proceed and age in younger children. One possible explanation of this finding is that treatment program staff were willing to recommend as competent to proceed equal proportions of children regardless of age, by adopting competence standards that vary as a function of age, contrary to Florida law regarding competence of juveniles. Of course, whether this is the case is unclear, based on these preliminary data.

The preliminary nature of these data means that further refinements of data collection and new data collection efforts can provide more complete information about children referred for competency restoration treatment. For example, time span information, such as length of time in treatment and length of time from recommendation of discharge to release, can provide valuable information about the interaction of the courts and the JITP program. However, as was alluded to earlier, a number of factors can inflate these time spans, including incorrectly worded court orders that delay the entry of a child into a program, difficulty in locating and transporting the juvenile to the program, elopement, and court decisions to continue juveniles in treatment contrary to the recommendations of treatment staff. Our experience with the data highlights the need to collect some of these contextual variables systematically in the database, so that they can be factored into the analysis and interpretation of these timelines.

In addition to the collection of this more nuanced timeline information, more can be learned about the competency restoration of juveniles with information about the process by which juveniles are referred for competency restoration. Varying motivations of the multiple players in the process may result in failure to refer some incompetent children for evaluation and treatment and some competent children receiving incompetency adjudications—for example, in an attempt to get the child into the treatment system.¹⁸ Research examining the evaluation and report-writing process is also essential. The methods by which children are assessed can affect the examiner's opinions and the legal dispositions. The diagnostic data in this study should be interpreted with the realization that the process, completeness, and appropriateness of evaluation methods for the reports from which these data were gathered was not investi-

gated. In addition, these are state-specific data that may differ from the experience of other jurisdictions.

Data about mental health or developmental disability-related treatment either before or at the time of arrest were not available. This information, in addition to information about juvenile justice involvement and treatment after discharge from the JITP program, will provide the data necessary to describe the treatment history of this population and to explore the relationship of involvement with the JITP program to subsequent treatment.

This report is necessarily preliminary in nature, but provides information for the first time on juveniles found incompetent to proceed in the juvenile justice process. Given the increasing attention that the issue of juvenile competence is gaining nationally, reports from other jurisdictions are important. In addition, we hope to learn more about the legal dispositions of individuals in this group after they are returned to court.

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