

Competency to Stand Trial in Preadjudicated and Petitioned Juvenile Defendants

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As state legislatures across the United States continue to permit younger juvenile defendants to be tried in adult court, juvenile competence to stand trial has become an issue of increasing legal and forensic significance. This study examined competency to stand trial in a sample of preadjudicated and petitioned juvenile defendants. Results revealed that juveniles deemed unfit to stand trial were younger than their competent counterparts, had more severe special education needs, and had more extensive mental health treatment histories. These results are consistent with those of prior research in this area. Implications for treatment planning and system reform are discussed.

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Juvenile competence to stand trial has become a matter of increasing legal and forensic significance in recent years. Perhaps the most notable trend driving the concern regarding juvenile competence has been state legislative changes aimed at allowing younger juveniles to be tried in (waived to) adult court.^{1,2} For example, in 1994, the number of juveniles prosecuted in adult court was 73 percent greater than the number in 1986.³ As increasing numbers of juveniles are tried in adult criminal court, researchers and child advocates have raised concerns regarding juveniles' competence to participate meaningfully in the judicial process.

Competence to stand trial has historically been a concept applied to defendants in adult criminal court. Nonetheless, "almost without exception, case law supports the use of the [adult] standard in defining the parameters of trial competence in juvenile proceedings" (Ref. 4, p 574). The adult standard for competence to stand trial was defined by the United States Supreme Court in *Dusky v. U.S.*⁵ According to the *Dusky* standard, the inquiry is ". . . whether he

[the defendant] has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against him" (Ref. 5, at p 403).

Several state statutes add to the requirements of *Dusky* that the defendant's deficits in the standard's enumerated abilities be due to an underlying mental disorder. Indeed, judicial opinions have consistently held that the competence question should be triggered by a suspicion or finding of mental illness or mental retardation. Consequently, as Grisso⁶ has noted, it is not sufficient that impairments in competency simply exist in the presence of psychopathology; rather, such impairments must be caused by psychopathology. The issue to be determined is whether and in what manner a defendant's psychopathology or cognitive limitations negatively influence his or her ability to meet the *Dusky* requirements of rational understanding and capacity to consult with counsel. Of course, this requirement of a causal mental disorder for a defendant's incompetence to stand trial has special implications in the juvenile context, in which a child's developmental immaturity or age-appropriate cognitive functioning may result in trial incompetence in the absence of any underlying mental disorder. Only one court has ruled on this matter (*In re Causey*⁷), thereby recognizing

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trial incompetence due to youthful immaturity (or what has also been called “tender years incompetence.”⁸ This perspective, however, has not been discussed or shared by other courts.

In the years following the *Dusky* decision, there have been several attempts to operationalize the psycholegal abilities suggested by the competency standard. Forensic psychologists have amplified the *Dusky* holding by identifying distinct functional (what a defendant can do and comprehend), interactive (the extent of a defendant’s deficiencies given situational demands), and causal (the reason for those deficiencies) aspects of the standard.^{6,9} Courts have typically held that forensic examiners must report on defendants’ specific competence-related abilities and impairments,^{6,10} since competency is considered to be a multidimensional construct¹¹ and since the final determination of a given defendant’s competency is a legal matter.¹²

The most extensive research thus far relating to competency has concerned the psychometric properties of the adult *Dusky* standard.¹³ Researchers have developed a number of assessment instruments that translate *Dusky* into discrete abilities (for example, the Competency Screening Test, the Georgia Court Competency Test [GCCT], and the Computer-Assisted Determination of Competence to Proceed [CADCOMP] inventory). However, critics of this approach have noted that standardized assessment instruments do not accurately evaluate defendants’ decisional capabilities,¹¹ that the instruments do not adequately assess the global, functional competency on which most forensic examiners base their opinions, and that parsing competency into discrete abilities may well result in defendants being held competent to participate in some but not all aspects of a trial. (One instrument that incorporates the formulations of Bonnie¹¹ is the MacArthur Competence Assessment Tool—Criminal Adjudication (MCAT-CA), which is designed to serve as a guide for legal decisions regarding a defendant’s competence.) Nonetheless, the current practice standard is for forensic examiners to address both a defendant’s minimal foundational competence, or the extent to which the defendant can participate in his or her own defense (e.g., capacity to comprehend the charges, capacity to disclose to counsel relevant facts), and a defendant’s context-dependent decisional competence, or the extent to which the defendant can understand and choose among various legal alternatives

(e.g., knowledge of legal options, capacity to engage in reasoned choice of legal strategies).^{11,12} The primary reason for this is that courts will honor a defendant’s imprudent or ill-advised decision regarding his or her defense, as long as that decision is based on a rational and adequate understanding of the range of available legal options and the consequences of each strategy.¹⁴

Empirical research regarding juvenile competency to stand trial is scarce. McKee¹³ has hypothesized that the paucity of research on juvenile competency is related to five factors:

- (1) juvenile competency is not explicitly recognized by statute in most states;
- (2) juvenile proceedings are structured to be therapeutic and nonadversarial;
- (3) few juvenile cases are appealed, thus depriving appeals courts of the opportunity to decide the juvenile competency issue;
- (4) many juveniles who are incompetent to stand trial are not identified as needing evaluation; and
- (5) the majority of juvenile cases continue to remain in family court (as opposed to criminal court), thereby vitiating the need for the due process questions routinely raised in criminal court.

The first published study of juvenile competence to stand trial¹⁵ found significant differences among age groups according to juveniles’ scores on a competency screening measure. Specifically, the researchers found that 12-year-olds were not competent to stand trial and that although 15- to 17-year-olds were more competent than 12-year-olds, these older juveniles were still not equivalent to adults in their grasp of judicial proceedings. Cowden and McKee¹⁶ found that competent and incompetent juveniles could be distinguished on the basis of age, severity of diagnosis, and history of remedial education, with less than 60 percent of sample juveniles being judged competent to stand trial by psychiatric examiners. Cooper⁹ found that 110 (98.22%) of 112 delinquent adolescents between the ages of 13 and 16 failed to meet or exceed the cutoff score on a competency assessment instrument that had been modified for use with juveniles, although all of the juveniles exhibited increased understanding after being exposed to structured training. Cooper also found a main effect for age on level of competency. McKee¹³ found that both global competency (e.g., whether the juvenile was considered competent to stand trial) and specific competencies (e.g., whether the juvenile understood the charges and the potential range of penalties, whether the juvenile understood the implications of a plea bargain, and whether the juvenile was capable

of challenging witnesses) increased with age, with youth younger than 13 typically failing to meet the *Dusky* standard, youth between the ages of 13 and 14 displaying an equal mix of competencies and deficits in understanding, and youth between the ages of 15 and 16 appearing equivalent to adults (with the sole exception of their understanding of plea bargaining). Finally, McKee and Shea¹⁷ found that age, intelligence level, and history of prior arrests distinguished between competent and incompetent juveniles in a sample of pretrial juvenile defendants undergoing court-ordered competency evaluations.

The present study adds to the body of research by examining the demographic, clinical, and offense characteristics of a sample of preadjudicated juveniles deemed by their psychiatric or psychological examiner to be incompetent to stand trial (IST). These youth are compared with a sample of delinquent youth who were considered competent to stand trial (CST). On the basis of the research cited herein, we hypothesized that age and history of remedial education would be significantly related to juveniles' competency to stand trial.

Methods

The juvenile sample in the present study consisted of 132 preadjudicatory defendants evaluated as incompetent to stand trial (IST) and 473 petitioned juvenile defendants deemed competent to stand trial (CST). Both groups were drawn from the urban, suburban, and rural counties surrounding Chicago, Illinois. The CST sample in the present study was drawn from a stratified random sample of juvenile petitions received from 1995 to 1996. The IST sample consisted of all youth who had been court ordered to the Illinois Department of Human Services (DHS) for treatment to restore fitness between 1989 and 1999.

The relevant Illinois statute reads as follows: "A defendant is unfit if, because of his mental or physical condition, he is unable to understand the nature and purpose of the proceedings against him or to assist in his defense" (Ref. 18, at P.A. 81-1217). The statute makes no distinction between mental illness, mental retardation, and cognitive immaturity in its requirement that the defendant's incompetence be due to a "mental or physical condition." Similarly, the statute makes no distinction on the basis of the age of the defendant, although at the time of this writing, the state legislature was considering a proposal that

would prohibit the prosecution of any minor under 10 years of age. Although the statute specifies DHS as the treatment provider, current agency policy is to refer these cases to the forensic bureau of the Office of Mental Health (OMH), which is within DHS. Thus, the preadjudicated juveniles in the current sample had already been evaluated and deemed IST by a psychological or psychiatric examiner and were subsequently remanded by a judge to DHS for treatment. At the time of the court order, it was the judge's responsibility to indicate whether treatment would take place on an inpatient or an outpatient basis.

All data used in the present study were contained in the youth's case folders. Because of the retrospective review format of the study, approval to proceed with the research was obtained from the Internal Review Board of the Illinois Office of Mental Health (OMH). The juveniles' case folders contained not only the original court order and forensic mental health (competency) evaluation, but in the case of IST juveniles, also information gathered from a subsequent interview performed by a staff member of the OMH forensic bureau. Information was gathered regarding the demographic, clinical, and offense characteristics of IST and CST juveniles. To be consistent with prior research in this area,^{13,17} and in light of recent recommendations regarding age-relevant psycholegal research with adolescents,¹⁹ juveniles in the present sample were grouped into three age categories: 12 years and younger, 13 and 14 years, and 15 and 16 years. Although both the IST and CST groups contained youth aged 17 years or more, these youth were not included in the present analyses, because prior related studies have treated youth older than 17 years as adults.

The principal analyses in this study were chi-square tests and logistic regression (multivariate prediction). When appropriate, independent-samples *t*-tests were used; when the *F* resulting from Levene's test for inequality of variances was significant at the .05 level, the unequal means estimate of the *t* was used.

Results

Demographic Comparisons

Results of the demographic and clinical comparisons can be seen in Tables 1 and 2.

Most of both the IST and CST samples were male. More IST youth than CST youth were aged 12 years

Table 1 Comparison of Incompetent and Competent Juveniles

	% IST Juveniles	% CST Juveniles	χ^2
Male	85.5	85.0	0.01
Aged 12 or younger	27.4	11.2	19.59***
Aged 13 or 14	24.8	30.5	1.44
Aged 15 or 16	39.3	57.5	12.36***
African-American	76.9	42.1	69.89***
Hispanic	6.0	14.3	5.81**
Parental guardianship	72.6	83.8	7.70**
State guardianship	14.5	5.4	11.59***
Living with parents	76.1	84.0	4.07*
Living in a foster home	4.3	3.2	0.30
Living in a treatment facility	0.9	1.1	0.04
Attending school	88.9	62.9	29.15***
Special education needs	72.4	34.5	45.30***
Alcohol abuse	37.6	35.0	0.27
Cannabis abuse	39.8	38.7	0.12
Drug abuse	13.7	46.2	41.34***
Inpatient substance abuse treatment	0.9	1.7	0.40
Outpatient substance abuse treatment	2.7	4.5	0.77
Inpatient mental health treatment	39.8	6.9	84.95***
Outpatient mental health treatment	24.5	10.2	16.37***
Prior residential treatment	4.5	6.9	0.89
Health problems (mild or acute)	19.7	24.2	1.07
Neglect	38.5	6.0	66.31***
Physical abuse	33.8	5.8	57.00***
Sexual abuse	21.9	2.2	53.33***
Any history of physical aggression	73.5	77.3	0.75
Any history of sexual aggression	38.5	29.8	3.24

* $p < .05$. ** $p < .01$. *** $p < .001$.

and younger, and more CST youth than IST youth were aged 15 or 16 years. Overall, the mean age of the CST youth (14.42 years) was slightly greater than that of the IST youth (13.92 years). More IST youth than CST youth had been previously determined to have special education needs, had histories of inpatient and outpatient mental health treatment, and had experienced neglect, physical abuse, and/or sexual abuse.

A surprising finding regarding only the sample of unfit juveniles was that most did not have mental illness. On the contrary, most of the unfit juveniles in

Table 2 Comparison of Mentally Ill and Mentally Retarded Unfit Juveniles

	Mental Retardation	No Mental Retardation	Total
Mental illness	18 (13.6%)	31 (23.5%)	49
No mental illness	52 (39.4%)	31 (23.5%)	83
Total	70	62	132

Table 3 Logistic Regression Comparing Juveniles Deemed Incompetent to Stand Trial With Juveniles Deemed Competent to Stand Trial

	β	SE β	Wald	df	p	R
Special education	-1.29	0.27	22.18	1	.0000	-0.21
Inpatient treatment	-1.57	0.32	24.31	1	.0000	-0.22
Outpatient treatment	-0.89	0.45	3.86	1	.0494	-0.07
Aged 12 or under	-2.34	0.88	7.09	1	.0078	-0.10
Aged 15 or 16	2.39	.86	7.51	1	.0061	0.11

the current sample had a diagnosis of mental retardation in the absence of a co-occurring psychiatric disorder.

Multivariate Prediction

Since the IST and CST groups differed on several variables, logistic regression analysis was performed to determine which factors influenced the determination of incompetency among juveniles in the present sample. The final model, which is shown in Table 3 and which was statistically significant, had an accuracy of 89.66 percent, a sensitivity of 96.38 percent, and a specificity of 51.85 percent. The model revealed that age, a history of special education needs, and prior mental health treatment all had a predictive effect on the determination of trial incompetence. Specifically, youth who were 12 years of age or younger, who had a history of special education needs, and who had received prior inpatient or outpatient mental health treatment were all more likely to have been declared incompetent to stand trial.

Subpopulations of Juveniles Deemed Unfit to Stand Trial

Logistic regression analysis was performed comparing youth who had been arrested for the commission of a sex crime with youth who had been arrested for nonsexual offenses. The final model, which was statistically significant and is shown in Table 4, accurately predicted 81.54 percent of offenses. The model revealed that a prior history of sexual abuse had a significant predictive effect on the commission of a sex crime. This analysis was replicated, comparing youth who had been arrested for the commission of a physically violent crime with those who had been

Table 4 Logistic Regression Comparing Youth Charged With a Sex Crime With Youth Charged With Nonsexual Offenses

	β	SE β	Wald	df	p	R
Sexual abuse	2.06	0.89	5.30	1	.0214	.2251

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Table 5 Logistic Regression Comparing Youth Charged With a Physically Violent Crime With Youth Charged With Nonviolent Offenses

	β	SE β	Wald	df	p	R
Sex	-2.41	0.79	9.22	1	.0024	-.2501
History of physical aggression	0.89	0.24	14.04	1	.0002	.3132
History of special education	-1.79	0.57	9.95	1	.0016	-.2625

arrested for other offenses. The final model, which was statistically significant and is shown in Table 5, accurately predicted 81.05 percent of offenses. The model revealed that being male and having a history of verbally or physically assaultive behavior caused a juvenile to be more likely to commit a violent offense, whereas having a history of special education caused a juvenile to be less likely to commit a violent offense. Finally, logistic regression analysis was performed to determine which factors influence court referral of a youth to inpatient, as opposed to outpatient, treatment. The final model, which was statistically significant and is shown in Table 6, accurately predicted 81.25 percent of all referrals. The model revealed that being in detention at the time of the court order and having been placed on medication by the time of the court order both had a significant predictive effect on being referred for inpatient treatment.

Discussion

Consistent with prior research, the juveniles in the current study who were incompetent to stand trial (IST) were significantly younger than their competent counterparts. They were more likely to be in state custody and less likely to be in the guardianship of their parents. Although they were more likely to be attending school regularly at the time of their arrest, they had a much higher rate of special education needs. They were less likely to show evidence of drug abuse problems, but more likely to have received prior inpatient and outpatient mental health treatment. Finally, they were more likely to have suffered neglect, physical abuse, and sexual abuse.

Significantly, multivariate prediction revealed that being 12 years of age or less, having a history of special education needs, and having a history of inpatient or outpatient mental health treatment all had a predictive effect on a court's decision to hold a juvenile incompetent to stand trial. In contrast, lo-

gistic regression analysis revealed that being 15 or 16 years of age had a predictive effect on a court's decision to consider a juvenile competent. To our knowledge, this is the first time that multivariate prediction methodology has been used to model judicial decisions regarding the competency of juvenile defendants. Moreover, it is important to note that these findings are consistent with prior research in this area, which has also found that age and history of special education needs are significantly associated with juvenile trial incompetence. Essentially, the results of the present study confirm that the younger the juvenile defendant, the less likely he or she will be to manifest the type of cognitive understanding sufficient to satisfy the requirements of the *Dusky* standard (see, for example, Billick²⁰).

Results of the present study indicate that the average youth in the present sample deemed incompetent to stand trial was a 14-year-old, African-American male. He had a history of special education needs, currently attended classes in special education or for the learning disabled, and had a Full Scale IQ that placed him in the mildly retarded range of intellectual functioning. He was in good physical health, although he may have had significant problems with alcohol or cannabis abuse. At the time of his arrest, he was in the legal and physical custody of his biological mother, and he was likely to have been arrested at least once before. After his arrest, he was probably held in a juvenile detention center.

Although this is the profile of the average youth deemed unfit to stand trial, further analysis of the current sample revealed two distinct groups of adolescents. The first group comprised IST youths who had been charged with a sexual offense and who seemed to be different from the stereotypic juvenile sex offender. Although these youths demonstrated histories of both sexual abuse and prior sexual acting-out behavior, they also manifested a number of other characteristics that were inconsistent with the typical juvenile sex offender profile.²¹ For example, they tended to have no prior history of delinquency or police involvement, and they did not display physi-

Table 6 Logistic Regression Comparing Youth Referred by the Court for Inpatient Treatment With Youth Referred for Outpatient Treatment

	β	SE β	Wald	df	p	R
Detention	3.04	0.56	29.10	1	.0000	.4177
Medication	2.18	0.58	13.97	1	.0002	.2777

cally aggressive or assaultive behavior. They were likely to be significantly cognitively impaired, and they typically scored within the moderately retarded range of intellectual functioning. Thus, the average juvenile sex offender deemed unfit to stand trial was a nonviolent adolescent with no history of delinquency, a moderate history of sexual acting-out behavior, and significant cognitive impairments. It is conceivable that many of these adolescents are therefore appropriate for sexual education services designed for developmentally disabled youth.

In contrast to this group of sex offenders, IST youth in the current sample who had been charged with a physically violent offense seemed to be similar to the stereotypic violent juvenile offender. For example, they had significant delinquency histories. They had notable academic difficulties and truant behavior, and they struggled with drug abuse problems. Perhaps not surprisingly, they were both verbally and physically aggressive. Interestingly, they were less cognitively impaired than the rest of the current sample, typically scoring within the low borderline range of intellectual functioning. They were also less likely to receive special education services. Thus, the average violent offender deemed unfit to stand trial was a physically aggressive adolescent with a significant delinquency history, notable academic difficulties, drug abuse problems, and mild cognitive impairments. Many of these adolescents therefore seem to be appropriate for services for “mainstream” juvenile offenders, such as structured ecological or multisystemic treatments.²²

Multivariate prediction revealed that the court criteria for making an inpatient versus an outpatient treatment referral were based primarily on whether the youth was in detention at the time of the court hearing. Referral decisions were based secondarily on whether the youth had been placed on medication by the time of the court order. Hence, youth who were confined to a detention center at the time of the court order were more likely to be placed in an inpatient facility, whereas youth who had been released into the community were more likely to be referred to community-based treatment. In addition, youth who had been placed on medication by the time of the court order were more likely to be placed in an inpatient facility. Notably, other seemingly relevant factors—including the presence of a psychotic disorder, prior treatment history, the severity and the type of crime, and a history of violent behavior—did not

have a predictive influence on referral or placement. Thus, it seems that the court’s referral decisions were reflecting security concerns, as well as a given youth’s pharmacological needs.

There are several limitations to the present study that can clarify directions for future research in this area. First, since this study was based on retrospective file reviews, there was a limit on the amount and type of information gathered. Future studies investigating juvenile competence to stand trial could be enhanced by including interviews with youth. Moreover, the present study could be replicated using a prospective design. Second, this study used no standardized assessment instruments with participants, as there existed no standardized competency measure for juveniles at the time this study was conducted. Finally, this study relied on prior examiners’ written conclusions regarding the diagnostic profiles of sample youth. Including self-report and corroborative measures of psychiatric pathology in future studies could offer increased validity to descriptive information about the delinquent population, which could then be compared with data collected on normative samples.

Nonetheless, it is important to note that given the limitations inherent in a retrospective analysis, the level of special education need found in the current sample serves as compelling evidence for the prevalence of developmentally based disorders among the juvenile IST population. Even when examining records not specifically prepared or maintained for clinical or diagnostic purposes, it was possible to discern a high level of cognitive impairment among pre-adjudicated and petitioned adolescents. While the retrospective design may underestimate the true level of need among this group, the results of the current study are consistent with prior research in revealing a significant history of special education need among delinquent IST youth.

Moreover, this high level of cognitive impairment among juvenile defendants—particularly among those charged with a sex offense—indicates that automatic transfer of all juvenile sex offenders might be premature or deleterious. Our data suggest that, given the subsection of cognitively impaired or developmentally delayed juveniles charged with sex offenses, these persons in particular may benefit from being evaluated on an individual basis, rather than triggering automatic waiver.

Of course, prevalence estimates of the types of disorders manifested by delinquent juveniles have important implications for treatment. Despite the common assertion during the 1970s that treatment of juvenile delinquents was uniformly unsuccessful, more recent research indicates that this is far from true.²²⁻²⁴ Therefore, to the extent that the juvenile justice system serves as a *de facto* institutional intervention for a large number of adolescents in need of care, the locus of the detention center may be critical to accurate and timely evaluation, diagnosis, and treatment planning. Comprehensive intake assessments, cognitive functioning evaluations, and substance abuse screenings can serve to identify youth in need of treatment. Moreover, integrated services models that link youth to needed services can have a mitigating effect on subsequent recidivism.

Conceptualizing the juvenile justice system as a focal point for assessment and intervention may in fact necessitate a paradigm shift. Despite the fact that the justice and social service systems have traditionally had divergent and at times conflicting goals, increased service coordination seems critical to both prevention and rehabilitation for juvenile offenders. Since the juvenile court system is likely to continue to function both as a gatekeeper and a repository for youths with considerable cognitive, mental health, and substance abuse treatment needs, comprehensive and integrated services can serve to identify, evaluate, and treat youths involved in these multiple-service systems.

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