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Competency Status and Juveniles With Pending Sexual Offense Charges

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The Problem

Youth with pending sexual offense charges where the issue of competence to stand trial has been raised, pose special problems. In 2010, the City and County of San Francisco began identifying a growing population of youth where competency determination was pending or youth were found not competent, including those with sexual charges. A variety of concerns were evident:

1. No agreed written standards for competency evaluations and criteria.

2. No protocol for reassessing competency status.

3. No treatment methods established to help youth attain competency.

4. No systematic case tracking or methods to expedite resolution of "not competent" status.

5. No case management for youth to systematically assess treatment Needs, and facilitate outpatient and residential referrals.

6. No payment mechanisms established for residential treatment since their "not competent" status did not make them eligible for the services for youth with sustained charges.

The number of youth in "not competent" status was increasing, without resolving their case or providing services for their multiple family, mental health, and educational problems. Failing to find youth competent also resulted in a longer time in detention and a higher detention census of these youth. When a new offense was committed, disposition of the case was a challenge. Youth with pending sexual offenses were part of this group. Because of their "not competent" status, no treatment to prevent sexual or non-sexual recidivism was being provided either on an outpatient or residential basis.

Traditional treatment for juveniles with pending sexual offenses required a sustained sexual offense in this county for legal, ethical, and treatment reasons.

The Response

In late 2010, the presiding juvenile court judge in San Francisco County convened a committee of stakeholders to address the issue of juvenile competency. The committee included staff of the District Attorney (DA), Public Defender (PD), Juvenile Probation (JP), Department of Public Health (DPH), and the Department of Human Services (DHS). The Juvenile Competency Committee took concrete steps to address the problem of assessing competency, including:

1. *Standards:* Writing standards for competency evaluations and re-evaluations, selecting a panel of psychologists, training the panel, implementing the procedures, and doing quality assurance assessments of the evaluations to see if standards were being met.

2. *Evaluation Criteria:* Implementing evaluation criteria. The evaluation standards included review of records, interview with parents, interviews with PD and JP staff, interview with the youth, comprehensive cognitive and academic testing, measures of adaptive functioning, personality and symptom assessment, and evidence-based

recommendations for treatment or remediation of the youth. In addition a protocol for assessing juvenile competency by Grisso (2005) was included. The protocol was reviewed by a national expert familiar with best practices in this area.

3. *Database:* Establishing a database of "not competent" youth or youth where such status was pending.

4. *Case Management:* Providing case management and tracking, including identifying and linking youth with necessary mental health and educational services.

5. *Caseload Review:* Developing a collaborative court where the entire competency caseload was reviewed. The goal was to resolve cases by dismissing charges, seeing if competency needed to be re-evaluated, facilitating necessary services, or if the youth was found competent, having the charges resolved.

6. *Legal:* Developing legal mechanisms to fund placement through existing laws.

Evaluation Criteria

A key part of the new approach to dealing with competency was the evaluation criteria written by the author (Ralph, 2010). These included:

1. *Checklist for Psychological Evaluations:* This defines the qualities of an adequate evaluation. To adequately assess youth for competency evaluations, we required a full IQ and learning disability battery, and also a measure of adaptive functioning such as the Vineland II (which has both a Parent/Caregiver and Teacher versions). For most youth found "not competent", this is due to some type of cognitive delay or learning disorder, but may also be due to a psychotic condition, brain injury, toxic/metabolic condition, or substance abuse related disorder. An evaluation would be appropriate to attempt with all these conditions, but may not be able to be completed.

2. *Grisso's Model:* This model is described in "Evaluation of Juveniles' Competence to Stand Trial" (Kruh & Grisso, 2009), and the forms and methods are described in "Evaluating Juveniles' Adjudicative Competence" (Grisso, 2005) and the use of the Juvenile Adjudicative Competence Interview (JACI). Grisso's model is based on relevant developmental and cognitive research, a "theory" of competency, a specific methodology for evaluation, and relevant forms. It importantly includes didactic elements to see if youth can learn relevant aspects of the legal processes. Some youth can readily be "taught" the relevant legal information. For some situations (e.g., psychotic patients, etc.), this may not be appropriate, but these should be the exception, not the rule, and the rationale clearly documented.

3. *Remediation Plan*: For youth where there is a finding of "not competent", a Remediation Plan is required. It should address what specific aspects of the youth's functioning can realistically be remediated (or not), in what time frame, and a specific, detailed plan for remediation. The plan should include available resources and time frames, and an estimation of the likelihood of success. The psychologist will be responsible for writing the Remediation Plan, and providing an independent opinion, but should be aware of realistic treatment options. Time frames for remediation should be stated if possible. Also if a youth is not likely to be remediated within reasonable time frames, this also should be stated. For example, a youth with a 45 IQ who is 16 may not be remediable by the time they are 18. The Competency Evaluation should still include evidence-based recommendations, not limited to competency issues, to help improve the overall functioning of the youth, as is now required for all evaluations. The point is not to just answer the narrow legal issue of competency, but identify what should be done to protect community/victim safety and most importantly, help the youth where possible.

Results

The combined effect of these procedures reduced the number of youth in "not competent" status from a high of 47 to the current census of 18. Eleven youth went from "not competent" to "competent" status. Also the service needs of youth were identified and youth were linked directly to services. Case study reviews of youth who were "not competent" indicated a combination of developmental immaturity, family turmoil, learning problems, impulsivity, and emotional lability, but relatively few youth with a diagnosis of mental retardation. For youth who moved from "not competent" to competent status, supportive psychological treatment and for some, psychiatric medications, as well as developing a better fit with

schooling, appeared contributory to aiding the youth's general maturity. Treatment was not directed specifically at understanding the court process related to competency status, but youth developed that as well. This was not directly anticipated, but rather, a fortuitous result of "good treatment and case management."

Youth with Sexual Charges

Of those 18 youth now in "not competent" status, 4 have pending sexual offenses. This was 22% of youth for the County under the supervision of probation with pending or sustained sexual charges. A prosocial treatment model (Ralph, 2012) for these youth was proposed. The model focused on non-sexual aspects of treatment and did not require the youth to admit charges, or even to have sustained charges. The court could order participation in treatment, however. The model involves: (a) increasing prosocial skills and reasoning; (b) reducing non-sexual recidivism; (c) addressing co-morbid psychiatric and chemical dependency issues; and (d) increasing family functioning, all of which would usually be a significant part of treatment for youth with sustained sexual charges. There is reasonable evidence that treatment using this approach would in fact have a therapeutic impact, improve the youth's functioning, and reduce sexual and non-sexual recidivism. If the youth is determined to be competent while in treatment, this new reality could be incorporated into treatment. If charges were dismissed, the option still existed for the youth and family to continued treatment until termination with the focus on promoting prosocial behaviors and preventing recidivism. San Francisco's challenges in this regard are not unique in California, and several other counties are dealing with how best to serve the needs of this population of youth.

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