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ARTICLE

Juvenile Competency Complications: Protocol, Unmet Needs, Developmental Immaturity, FASD, and Comorbidity

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Abstract

This Article focuses on unifying the protocol for state competency evaluations, but with special concerns about undiagnosed FASD and developmental immaturity in adolescents. States do not mandate any process whereby psychometric tests are first performed prior to psychiatric mental status evaluations, often causing disparities in evaluations which might easily be avoided in court proceedings. Adding to the complications in current competency evaluations are recent studies from Canada and Australia identifying exceptionally high rates of FASD in incarcerated adolescents following multi-disciplinary teams' studies directed at identifying FASD. If these studies' rates of FASD turn out to be similar for children in the U.S. juvenile justice system, then systemic reform is called for as we are failing to identify this congenital condition when adolescents enter the system and then continue on into the adult criminal system without recognition of their prenatal exposure to alcohol.

Keywords: juvenile competency; FASD and juvenile trials; juvenile delinquency; co-morbid disorders and juveniles; delinquency; juvenile justice

As juvenile competency challenges increase in criminal and delinquency cases,[1] various factors impede systemic fairness and improved outcomes: legal protocols, limited availability of mental health professionals, concerns about developmental immaturity, revelations about Fetal Alcohol Spectrum Disorder ("FASD"), comorbid disorders, and systemic dismissiveness toward court-involved juveniles. In jurisdictions with statutory provisions permitting challenges to competency to stand trial, each of these complications merits further exploration. A simple protocol change in the evaluation process might increase consensus building among the diverse professionals charged to evaluate competency. Studies focused on developmental immaturity suggest delays in trials which might take years as adolescents mature and cognitive functions develop, yet legal systems rarely anticipate addressing this factor. Finally, and perhaps most pressing, recent studies reveal a much larger percentage of children with FASD as court involved than had previously been thought.

These factors each complicate the process of raising and responding to juveniles who lack the legal competency to proceed to trial or adjudication. Although legislative input may address some of these factors, increased dedicated resources are necessary to supply a larger number of mental health professionals capable of identifying juvenile competency factors and then in addressing placements and

[1]Nancy L. Ryba, et al., *Juvenile Competence to Stand Trial Evaluations: A Survey of Current Practices and Test Usage Among Psychologists*, 34 Prof'l. Psych.: Rsch. & Prac. 499, 499 (2003) (footnotes omitted) ("Competence to stand trial (CST) is the most frequently requested type of forensic mental health evaluation, with an estimated 60,000 evaluations requested annually.").

treatment regimens for these adolescents and young adults. This Article discusses the legal standard for determining juvenile competency. It then proposes a protocol for the assessment process of adolescents by interdisciplinary teams of mental health evaluators. It discusses the increasing gap of mental health professionals sufficient to evaluate, and then to treat juveniles who become court involved. Finally, it raises concerns about the failure of systemic responses to handle delays inherent to the adolescent maturity process that would better equip juveniles to stand trial, and the complications posed by FASD and comorbid disorders that have been undiagnosed or simply overlooked for decades as more afflicted individuals enter the court system with their legal representatives—and sometimes the mental health evaluators—remaining unaware of the consequences or the presence of prenatal exposure to alcohol.

Juvenile competency continues to attract legal and cultural attention as understandings and appreciations of adolescent development, mental health issues, and prenatal exposure to alcohol have increased. However, state policy advocates are not always supportive or knowledgeable about systemic responses to juvenile misconduct, some professional evaluators are not yet trained to properly identify conditions such as FASD,[2] and in many instances systemic retribution plays a larger role than rehabilitation[3] or preventing recidivist offending patterns in state juvenile justice systems.[4] One group of researchers concluded:

> Significant evolution has occurred since the establishment of the first juvenile court in Chicago in 1899. At its inception, the juvenile court focused on rehabilitation and finding ways to guide wayward youth back to a better path. At present, juvenile courts look and function in ways largely similar to adult criminal courts. Youthful offenders face intense court proceedings, stand to serve lengthy sentences, and a delinquency adjudication can have collateral consequences that reach well into adulthood. As the evolution of the juvenile court has occurred, the issue of competency has become relevant.[5]

Ultimately, this Article argues, the complications surrounding juvenile competency are many, but the solutions are in short supply, and require substantial systemic reform and change.

1) Competency to Stand Trial and *Dusky*

Historically, criminal law recognizes the necessity of a defendant's competency in order to subject them to accountability in a criminal court; forensic experts acknowledge that

> The standard's historical foundations date back to English common law and are embedded in the principle that an individual who is "mad" cannot conduct his/her own defense (Blackstone, 1783). Noting this historical tradition, the United States Supreme Court stated in Drope v. Missouri (1974) that the prohibition against trying an incompetent defendant is ``fundamental to an adversary system of justice" (p. 904). Supporting this position, the American Bar Association (1985) has promulgated standards related to competence to stand trial of mentally impaired defendants.[6]

In the 1990s, when competency to stand trial assessments in criminal cases numbered roughly 25,000 in the United States, it was asserted that ninety percent of the time, mental health professionals were in

[2]*See* Jerrod Brown et al.,, *Fetal Alcohol Spectrum Disorder (FASD) and Competency to Stand Trial (CST): A Call on Forensic Evaluators to become Better Informed*, 19 J. Forensic Psych. Rsch. & Prac. 315 (2019).

[3]*See* John Maki, *Why Juvenile Justice Advocates Shouldn't Ignore Retribution*, Juvenile Justice Information Exchange, The Ctr. for L., Brain & Behav. (Feb. 12, 2014), https://clbb.mgh.harvard.edu/why-juvenile-justice-advocates-shouldnt-ignore-retribution [https://perma.cc/Q3WP-CZ3M].

[4]*See* Mark W. Lipsey, *The primary factors that characterized effective interventions with juvenile offenders: A meta-analytic overview,* 4 Victims & Offenders: An Int'l J. Evidence-based Rsch. Pol'y & Prac. 124 (2009).

[5]Nancy Ryba Panza et al., *Statutes Governing Juvenile Competency to Stand Trial Proceedings: An Analysis of Consistency with Best Practice Recommendations,* 26 Psych. Pub. Pol'y & L. 274, 274 (2020) (discussing the 37 states that currently have juvenile competency to stand trial statutes).

[6]Keith R. Cruise & Richard Rogers, *An Analysis of Competency to Stand Trial: An Integration of Case Law and Clinical Knowledge*, 16 Behav. Sci. & L. 35, 35 (1998).

complete agreement about defendants' competency.[7] By 1996, however, mental health professionals began to question exactly how courts were appointing clinical evaluators, using "open-textured construct [s]" with little to no appellate review of the evaluation process.[8]

The legal standard for determining competence to stand trial is almost universally recognized under the U.S. Supreme Court decision in *Dusky v. United States*,[9] where

> Dusky suffered from long-term mental health issues. He was charged in a federal case with transporting a kidnap victim, a girl, across state lines. At his first trial, Dusky unsuccessfully tried to claim incompetency to stand trial, and was then convicted over his insanity defense and sentenced to 45 years. This conviction was affirmed by the Circuit Court of Appeals. The Supreme Court then reversed and remanded to the trial court for an appropriate competency hearing, setting forth briefly the now famous standard of review.[10]

When the Supreme Court considered the facts in *Dusky*, there was so little on the record below that the Court issued a *per curiam* decision, stating simply enough that

> It is not enough for a district judge to find that "the defendant is oriented to time, place and has some recollection of events," but that the test must be whether he 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.[11]

Although each state is free to adopt its own standard for competency determination, there is relative uniformity throughout the country today, with most states having adopted the *Dusky* language.[12]

Dusky was a *per curiam* decision that simply remanded the case for a trial court to determine very fundamental issues that were nowhere to found in the record below. Yet the Court's language in *Dusky*[13] is cited as the result of intense discussion, legal debate, and extensive briefing, attempting to shape the most important factors for courts to consider when determining whether an individual was competent to stand trial. With no reference to mental health experts' testimony, or professional organizations' input or involvement in crafting standards to apply when determining competency, *Dusky* is repeatedly cited today without consideration of any advances in knowledge about mental illness, developmental immaturity, or any other factors that play major roles in what is now understood about adolescent behavior. Instead of creating an interdisciplinary team or commission to explore whether the *Dusky* language should continue to be the hallmark for determining adolescent competency,[14] lawyers tend to

[7]Ian Freckelton, *Rationality and Flexibility in Assessment of Fitness to Stand Trial*, 19 Int'l J. L. & Psych. 39, 39 (1996).

[8]Bruce J. Winick first identified that competency evaluations were inappropriately being used for strategic reasons rather than a legitimate mental health focus. *See* Bruce J. Winick, *Restructuring Competency to Stand Trial,* 32 UCLA L. Rev. 921, 931-33 (1985).

[9]Dusky v. U.S., 362 U.S. 402, 402 (1960).

[10]Andrew Franz, *Dusky v. United States*, *in* The Encyclopedia of Juvenile Delinquency and Justice (Christopher Schreck ed., 2018).

[11]Dusky, 362 U.S. at 402.

[12]Robert J. Favole, *Mental Disability in the American Criminal Process: A Four Issue Survey*, *in* Mentally Disordered Offenders: Perspectives from Law & Social Science 247, 248 (J. Monahan et al. eds., 1983).

[13]362 U.S. 402 (1960).

[14]*See* Richard Rogers & Jill Johansson-Love, *Evaluating Competency to Stand Trial with Evidence-Based Practice,* 37 J. Am. Acad. Psychiatry L. 450, 450 (2009) ("Applied mostly to treatment and treatment outcomes, evidence-based practice is an attempt to evaluate treatment efficacies systematically via randomized control trials and meta-analyses. These efforts to revolutionize mental health practices are not without critics, who raise problems with research design (e.g., weak outcome measures, diagnostic validity, comorbidity, and sub-syndromal cases). Established practitioners sometimes are slighted by evidence-based researchers, who now feel "entitled to criticize and rectify clinical authorities" perhaps motivated by "an iconoclastic or even patricidal tendency". While the phrase "patricidal tendency" is an overreach, it does capture the concerns of

pressure mental health experts to bend to the will of lawyers,[15] to address legal questions which have nothing in common with their own professional standards, objectives, background or ethical codes.[16] *Dusky* never extended any invitation to psychologists or psychiatrists to participate in defining competence to stand trial. Lawyers are not above pressuring the mental health professionals to speculate or testify in a manner not consistent with the original objective of testing instruments employed in competency evaluations.[17]

Additionally, the legal standards created decades ago by courts regarding juvenile competency often bear nothing in common with the objectives of modern psychological testing, or with the reliability of test results and the manner in which they may be extrapolated by lawyers to argue for or against a legal conclusion[18] that the adolescent is or is not competent. Rarely do legal proceedings examine the foundational objectives of psychometric tests.[19] Once a mental health professional is sworn in to testify, then subjected to cross examination, it tacitly assumed that whatever testimony they offer into the record is substantiated by the test results.[20] That may be true, but most lawyers lack any training in the compilation of these psychological tests.[21] They thus lack the necessary knowledge base to understand how the tests that were once crafted to gather information about individuals in need of professional assistance[22] have morphed into tools used by advocates opposed to one another, seeking some sort of victorious outcome by holding an adolescent charged with acts of misconduct accountable, or excusing the adolescent from the most serious legal consequences assuming there is proof beyond a reasonable doubt of the charges filed by the state.[23]

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seasoned practitioners who see the possibility that their decades of experience will be devalued or even discredited by evidence-based approaches.").

[15]Although a matter of degree to which pressure is exerted by an attorney, such conduct may be violative of the lawyer's ethical duties if practicing in a jurisdiction which has adopted the ABA Model Rules of Professional Conduct as such behavior might violated Model Rule 4.4, "Respect for Rights of Third Persons: (a) In representing a client, a lawyer shall not use means that have no substantial purpose other than to embarrass, delay, or burden a third person, or use methods of obtaining evidence that violate the legal rights of such a person." Thomas D. Morgan, Selected Standards, Professional Responsibility 86 (Foundation Press ed., 2022).

[16]*See* Nola Nouryan & Martha S. Weisel, *When Ethics Codes Collide: Psychologists, Attorneys and Disclosure*, 36 Cal. W. L. Rev. 125, 125 (1999) ("As the use of psychologists as experts in legal proceedings expands, the potential for conflict between attorneys and psychologists increases. There appears to be a lack of understanding between the two professions as to their respective ethical standards. The disclosure of information in a legal setting is one area in which this ethical conflict between the professions appears.").

[17]*See generally* Thomas G. Gutheil & Robert I. Simon, *Attorneys' Pressures on the Expert Witness: Early Warning Signs of Endangered Honesty, Objectivity, and Fair Compensation*, 27 J. Am. Acad. Psychiatry L. 546, 546-52 (1999).

[18]*See* Laurie Ragatz et al., *Competency to Proceed to Trial Evaluations and Rational Understanding,* 59 Int'l. J. Offender Therapy Comparative Criminology 1505, 1505 (2015) ("In *Dusky v. United States*, the United States Supreme Court established 'rational understanding' as a necessary component of a defendant's competency to stand trial. Yet, rational understanding has engendered misunderstanding, stemming from inconsistent court rulings and lack of systematic attention given to definitions of rationality.").

[19]*See* Brian Brooks et al., *Psychometric Foundations for the Interpretation of Neuropsychological Test Results, in* The Little Black Book of Neuropsychology, A Syndrome-Based Approach 918-19 (Mike R. Schoenberg & James G. Scott eds., 2011).

[20]One group studying the psychological assessment tools used in legal contexts concluded that "[t]he public and the courts might assume that psychological tests published, marketed, and sold by reputable publishers are psychometrically strong tests. But not all psychological tests have good technical quality, and the psychometric properties of other tests are unknown. In their systematic review of all 283 psychological assessment test entries in the Sixteenth Mental Measurements Yearbook, Cizek and colleagues found that 59% of the educational and psychological tests were evaluated as either unfavorable, mixed, or neutral by professional reviewers. Likewise. Although noting the data on the issue is limited, Slaney suggested that many tests currently in use have not been sufficiently validated." Tess M. S. Neal et al., *Psychological Assessments in Legal Contexts: Are Courts Keeping "Junk Science" Out of the Courtroom?,* 20(3) Psych. Sci. Pub. Interest 135, 136 (2020).

[21]*See* Gary B. Melton et al., Psychological Evaluations for the Courts, A Handbook for Mental Health Professionals and Lawyers 4-5 (4th ed. 2018).

[22]*See* Leila M. Foster, *Training Lawyers in Behavioral Science and Its Applications*, 4 J. Psychiatry & L. 403, 410-12 (1976).

[23]"The vicious method of the Law, which permits and requires each of the opposing parties to summon the witnesses on the party's own account…naturally make the witness himself a 'partisan'. More modern surveys continue to identify partisan bias as judges' main concern about expert testimony, citing experts who appear to 'abandon objectivity' and 'become advocates' for the

Thus, when lawyers ask mental health experts whether it is more or less likely that a person on trial might likely reoffend, there is some presumption that, acting without powers of clairvoyance, any person is capable of providing reliable information that might be substantiated and replicated by the use of psychometric tests, or that any individual's opinion has some scientific reliability[24] which would be replicated by another expert employing the same approach and data employed by the first expert.[25] This may be asking experts to fill gaps that the have been created by the legal system but which have no counterpart or have not been addressed in the professional training or studies of the mental healthcare workers.[26] And yet, lawyers continue to make such demands—and other, more difficult demands—on experts who may feel compelled to supply answers, even if unsupportable from a scientific perspective.[27]

2) Competency Protocol

Many jurisdictions now recognize defendants' rights to challenge their competency determinations.[28] In some jurisdictions, a competency challenge may be initiated by the defendant, the prosecutor, or even by the court itself. There is no uniformity among state juvenile justice systems regarding how or when a juvenile's competency may be challenged. Many continue to question whether challenges to juvenile competency should ever be considered at all in legal proceedings.[29]

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retaining party." *See* Lucy A. Guarnera et al., *Why Do Forensic Experts Disagree? Sources of Unreliability and Bias in Forensic Psychology Evaluations*, 3(2) Translational Issues in Psych. Sci. 143, 147 (2017).

[24]*See* W. Neil Gowensmith et al., *Field Reliability of Competence to Stand Trial Opinions: How Often Do Evaluators Agree, and What Do Judges Decide When Evaluators Disagree?,* 36 L. & Hum. Behav. 130, 130-31 (2012).

[25]*See generally* Nat'l Acads. Scis., Eng'g, & Med., The Limits of Recidivism: Measuring Success After Prison (Richard Rosenfeld & Amanda Grigg eds., 2022).

[26]"Sometimes physicians are asked to evaluate individuals for legal purposes when there are no specific clinical questions *per se* and no clinical relationship with the individuals being examined. In these situations, we are uninvolved in the formulation of the questions being asked and uninvolved in deciding the rules for how the questions are answered. The physician performing the evaluation is offering an opinion—and that is all. As a result of confidentiality regulations or the limit of the inquiry imposed by the specific question to be examined and answered physicians are sometimes unable to offer an opinion in the fashion or with the conclusiveness the court or a requesting attorney may want. In these cases, there can be a temptation to offer more conclusive statements than are actually justified. In such situations, an awareness of the statutory scheme within which the evaluation takes place plays a crucial role." Seth Feuerstein, *Competency Evaluations, Case Study*, 3 Psychiatry 10, 10 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2957277/ [https://perma.cc/DH9C-X5SL].

[27]*See generally* Mollie Kornreich, *Expert Reports and Communications: Pointers on Privilege and Waiver*, A.B.A Prac. Points (Dec. 12, 2016), https://www.americanbar.org/groups/litigation/committees/expert-witnesses/practice/2016/expert-reports-communications-pointers-on-privilege-waiver/ [https://perma.cc/T9DQ-ZG42].

[28]The recognition of legal rights for children in the U.S. is generally identified as beginning with the Supreme Court's 1967 decision in *In re Gault* when the Court declared "[i]t would be extraordinary if our Constitution did not require the procedural regularity and the exercise of care implied in the phrase 'due process.' Under our Constitution, the condition of being a boy does not justify a kangaroo court." 387 U.S. 1, 27-28 (1967).

[29]"Fundamentally, there is an ongoing debate regarding whether or not juvenile competency should even be considered as an issue. Those who believe the juvenile court continues to operate in accordance with the parens patriae doctrine (the government's interest and duty in protecting youths) would argue that there is no need to consider JCST because the juvenile court is serving the child's best interest. However, those who believe the changes within the juvenile court system have preempted the parens patriae ideal argue that, as a result of the more adversarial nature of juvenile proceedings, safeguards must be instituted to protect juveniles' constitutional rights. A second area of contention is whether different competency standards apply for juveniles being tried in the adult court system versus those who remain in the juvenile court system. Although there does not yet appear to be a definitive answer, Grisso has suggested that the level of competence required should be considered relative to the level of protection required. Thus, a higher standard of competence may be warranted for youths being tried in adult court. Overall, the lack of clarity over these issues has left professionals performing JCST evaluations with limited guidance regarding the standards and procedures to follow when performing these services for the courts. Furthermore, little guidance has been offered by case law and state statutes regarding juvenile competency matters, and only recently have researchers begun to explore the issues specifically related to JCST evaluations and the ways in which these evaluations may differ from adult competency evaluations." Ryba et al., *supra* note 3, at 500 (citations omitted).

What may not have received the same level of attention and scrutiny, however, is the protocol in jurisdictions that do permit competency challenges surrounding court-ordered evaluations of accused individuals.[30] *In re Gault* marked the recognition and extension of most of "the same procedural safeguards for children that were provided to criminally charged adults."[31]

Having all psychometric tests[32] performed and completed prior to a psychiatric evaluation of a juvenile informs the non-psychologists—usually physicians—prior to conducting the competency evaluation. When a panel of mental health experts is assigned by court order to conduct competency evaluations on an accused adolescent, the various professionals often work independently of one another, sometimes meeting to discuss their individual findings and conclusions (although this may not be required by state statute). Consequently, a mental status exam conducted by a psychiatrist may not have been concluded after psychometric tests performed by a psychologist.[33] Thus, the conclusions reached through psychological testing are not incorporated into the psychiatric evaluation of the adolescent. This disparate approach opens the door for inconsistency among mental health experts' findings, and places mental health care providers in the awkward position of having to defend their conclusions without having had the benefit of reading the psychometric test results[34] of another professional also ordered to evaluate the adolescent.

Such scenarios could be avoided by the adopting statutory language that creates a specific protocol for the competency evaluations. Otherwise, the possibility of contradictory results adds to the complexity and uncertainty of a competency evaluation, and threatening to undermine the reliability

[30]*See generally* Kimberly Larson et al., Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers (2011).

[31]Nancy E. Walker et al., Children's Rights in the United States, In Search of a National Policy 195 (C. Terry Hendrix & Sherrise M. Purdum eds., 1999). *Gault* "became the landmark decision in juvenile law establishing children themselves as worthy of constitutional recognition. The decision marked the distance the U.S. society had traveled from its belief that children were the property of their fathers and, in the father's or his delegate's absence, subject without recourse to the will of the state exercising its *parens patriae* power."

[32]Psychometric tests date back to Sir Frances Galton who defined *psychometry* in 1879 as the "art of imposing measurement and number upon operations of the mind," derived from the Greek *psyche* (soul) and *metro* (measure). *See* Frances Galton, *Psychometric Experiments*, 2 Brain: J. Neurology 149, 149 (1879). By the early 1900s, psychologists applied psychometric assessment tests to quantify people's intelligence, preferences, and behaviors, and are used in schools, the military, mental health clinics, psychotherapists' offices, correctional facilities, and by corporations. *See generally* Leslie A. Miller & Robert L. Lovler, Foundations of Psychological Testing: A Practical Approach (Christine Cardone et al., eds., 5th Ed., 2015). These tests include the Wechsler Adult Intelligence Scale (WAIS) and Wechsler Intelligence Scale for Children (WISC); Bender Visual-Motor Gestalt Test; Minnesota Multiphasic Personality Inventory (MMPI); California Psychological Inventory (CPI); Rorschach Inkblot Test; Thematic Apperception test (TAT); Sentence Completion Test; Goodenough-Harris Draw-A-Person Test; House-Tree-Person Test; Stanford-Binet Intelligence Scale; Strong Interest Inventory; Career Interest Profiler; Career Values Scale; Myers-Briggs Type Indicator; among others. *See What Are Psychometric Tests?*, All Psychology Careers, https://www.allpsychologycareers.com/psychology/psychometrics-tests [https://perma.cc/Q9CF-SMU8] (last visited Sept. 1, 2022).

[33]"One core element of psychology since its founding in the 1800s has been the field's focus on indexing people's emotional, behavioral, and cognitive functioning. From these roots, modern psychometric theories evolved into a set of scientific rules for establishing and evaluating the usefulness of psychological measurements. Today tens of thousands of psychometric tools exist to measure psychological attributes like psychopathology, personality, intelligence, and risk for violence, among others. These tools vary in structure and standardization and serve different functions depending on the approach adopted by a psychologist. Psychologists conducting forensic evaluations often use these tools to structure their evaluations and gather data." Tess M.S. Neal et al., *The Law Meets Psychological Expertise: Eight Best Practices to Improve Forensic Psychological Assessment,* 18 Ann. Rev. L. & Soc. Sci. 169, 170 (2022) (citations omitted), https://doi.org/10.1146/annurev-lawsocsci-050420-010148 [https://perma.cc/7T6F-J3XE].

[34]The U.S. Supreme Court has recognized the use of psychometric properties of psychological assessment tools in some settings. *See* Hall v. Florida, 572 U.S. 701 (2014) (whether a statutory definition of mental retardation that has a bright line cutoff requiring an IQ score of 70 or below adequately captures the constitutional imperative that "mentally retarded" convicted defendants may not be executed); *see also Hall v. Florida*, 128 Harv. L. Rev. 271 (2014).

of any conclusions.[35] This Article suggests that the protocol and order of the evaluations is significant: it serves the interests of the community, the defendant, and even the mental health experts called to perform these evaluations in order to contribute to establishing a best practices protocol.[36] The Article also explores recent studies identifying much larger numbers of adolescents in detention afflicted with FASD, suggesting that competency evaluations must be expanded if this population is going to be identified during competency evaluations. Additionally, the Article posits the complications from co-morbid conditions and developmental immaturity as factors frequently overlooked in state competency evaluations of court-involved adolescents.

The first compilation and review of state statutory enactments addressing juvenile competency to stand trial began just within the past twenty or so years:

> In 2001, Redding and Frost authored a seminal article entitled Adjudicative Competence in the Modern Juvenile Court, in which they reviewed the issue of competency to stand trial for adults, discussed the complications inherent in extending this right to cases in juvenile court, reviewed the empirical research available, discussed competency restoration services for juveniles, and described the state of Virginia's experiences developing and implementing JCST legislation during the mid1990s. Their thorough presentation of these issues included the first compilation of state statutes and case law pertinent to JCST across the nation. In their article, Redding and Frost (2001) identified 22 states that had formal JCST laws and four additional states that incorporated juvenile proceedings into their adult statutes in some way.[37]

Since the 2001 Redding and Frost article, about seven articles have been published focusing on juvenile competency to stand trial, but with major inconsistencies in the laws identified on topic.[38] The instruments used to evaluate competency to stand trial have changed[39] and improved over time[40] as empirical research has contributed to our assessment understanding.

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[35]In the mid-to-late-1960s, it was believed that there was an estimated 90% agreement rate between mental health professionals and court determinations on competency assessments of individuals to stand trial. *See* Keith R. Cruise & Richard Rogers, *An Analysis of Competency to Stand Trial: An Integration of Case Law and Clinical Knowledge*, 16 Behav. Sci. & L. 35 (1998). However, Bruce J. Winick, an internationally known scholar and professor of Psychiatry and Behavioral Sciences, expressed serious criticism about this very high rate of agreement among mental health professionals engaged in competency evaluations. *See, e.g.*, Bruce J. Winick, *Incompetence to Proceed in the Criminal Process: Past, Present, and Future*, *in* Law, Mental Health, and Mental Disorder 310 (B. Sales & D. Shuman eds., 1996); *see also* Bruce J. Winick, *Reforming Incompetency to Stand Trial and Plead Guilty: A Restated Proposal and Response to Professor Bonnie,* 85 J. Crim. L. & Criminology 571 (1995) [hereinafter "Winick, *Reforming Incompetency to Stand Trial*"].

[36]For a "best practices" approach to constructing statutes on juvenile competency, *see generally* Kimberly Larson & Thomas Grisso, *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers*, Models for Change, System Reform in Juvenile Justice (2011); Nancy Ryba Panza et al., *Statutes Governing Juvenile Competency to Stand Trial Proceedings: An Analysis of Consistency With Best Practice Recommendations,* Psych. Pub. Pol'y, & L. (Apr. 9, 2020), https://www.researchgate.net/publication/340542969_Statutes_governing_juvenile_competency_to_stand_trial_proceedings_An_analysis_of_consistency_with_best_practice_recommendations [https://perma.cc/M6T7-Z42L].

[37]Panza et al., *supra* note 5, at 1 (citing Richard E. Redding & Lynda E. Frost, *Adjudicative Competence in the Modern Juvenile Court*, 9 Va. J. Soc. Pol'y & L. 353 (2001).

[38]"[A]t least seven sources have published compilations of JCST statutes. Some of these attempts have simply listed the states that have statutes, while others have gathered information from states with a specific focus on developmental issues. A review of these sources reveals a high degree of inconsistency in the number of laws identified, ranging from a low of 17 states to a high of 45. Part of this variation can be attributed to the criteria for inclusion, as some listed only formal statutes, while others included case law, court rule, or other sources of legislative guidance. However, the discrepancies cannot solely be attributed to differing methodologies, nor can they be explained by the passage of time." Panza, *supra* note 5, at 1 (citations omitted).

[39]*See* Robert A. Nicholson et al., *Instruments for Assessing Competency to Stand Trial: How do They Work?*, 19 Prof. Psychol.: Rsch. & Prac. 383 (1988).

[40]*See* Ron Roesch et al., *Conceptualizing and Assessing Competency to Stand Trial: Implications and Applications of the MacArthur Treatment Competence Model*, 2 Psychol. Pub. Pol'y, & L. 96 (1996).

In jurisdictions that recommend or require a panel of experts to examine and evaluate a youthful offender, many statutes allow for the empanelment of psychiatrists,[41] psychologists, and /or physicians (without the psychiatric residencies or board certifications[42]) in a panel which then communicates and attempt to reach a consensus as to whether the juvenile is competent or not competent.[43] In these jurisdictions, often little attention has been paid to the sequence of the evaluations, or the manner of the interactions among the expert mental health witnesses. The proposed protocol calls for a sequencing of examinations and then a sharing of data prior to the deliberation and determination of the panelists as to whether the juvenile is competent or not. If a psychiatrist initially examines the juvenile, prior to any psychological testing, then that doctor must base their conclusion upon whatever amount of time they are able to devote to the evaluation. If the youth is first evaluated and subjected to psychometric tests,[44] then there will be objective data available[45] to all evaluators who follow in sequence with their interviews, mental status exams and determinations.[46]

This simple sequence of ordering the various mental health experts serves multiple purposes. First, it provides the greatest amount of objective data about the juvenile's performance on psychological tests prior to any assessments or findings.[47] Second, it helps those professionals who do not utilize or are not trained in administering psychometric tests to better consider the objective data.[48] Third, it can help to rule out some behavioral or mental illness concerns based on which tests have been administered and

[41]One summary of psychiatrists' involvement in competency evaluations concluded "psychiatrists who provide mental health expertise concerning adjudicative competence give trial courts information needed to assure that defendants can appropriately protect themselves and that criminal proceedings will be accurate, dignified, and just." Douglas Mossman et al., *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial,* 35 J. Am. Acad. Psychiatry & L. S3, S58 (2007), http://jaapl.org/content/35/Supplement_4/S3 [https://perma.cc/KQB2-VXEN].

[42]"Besides the unreliability that may be intrinsic to a complex, ambiguous task such as forensic evaluation, research has identified multiple extrinsic sources of expert disagreement. One such source is imited training and certification for forensic evaluators. While specialized training programs and board certifications have become more commonplace and rigorous since the early days of the field in the 1970s and 1980s, the training and certification of typical clinicians conducting forensic evaluations today remains variable and often poor." Lucy A. Guarnera et al., *Why Do Forensic Experts Disagree? Sources of Unreliability and Bias in Forensic Psychology Evaluations,* 3 Translational Issues in Psychological Sci. 143, 145 (2017).

[43]*See generally* Thomas Grisso, *Five-year Research Update (1986-1990): Evaluations for Competence to Stand Trial*, 10 Behav. Sci. & L. 353 (1992).

[44]This is not to suggest that psychometric tests used in forensic settings are not susceptible to error or are not subjective: "Psychometric and technical properties are often reported in specific test manuals; in the primary research literature; and in secondary aggregated compendiums and reviews, such as the Mental Measurement Yearbook and the Compendium of Neuropsychological Tests. This means a wealth of knowledge is available about aspects of the foundational validity of many tools psychologists routinely use when conducting forensic evaluations. But, importantly, the performance of many tools is either unknown or inadequate. Indeed, Neal et al. found that only approximately 40% of tools psychologists reported using in legal cases have favorable measurement properties…. All subjective, or judgment-based procedures are susceptible to error." Neal et al., *supra* note 20, at 174.

[45]Again, this assumes that the instruments employed have been validated. *See* Steven K. Hoge et al., *The MacArthur Adjudicative Competence Study: Development and Validation of a Research Instrument*, 21 L. & Hum. Behav. 141 (1997).

[46]The experts must first be accepted by the trial judge and the basis of the testimony is subject to scrutiny by the court to ensure compliance with the legal requirements of expert testimony as put forth by Federal Rule of Evidence 702: "[I]n North America, judges are expected to consider the reliability (i.e., validity) of expert evidence before allowing it into court. In practice, these evidence admissibility evaluations usually occur only when requested by one of the parties. In those evaluations, judges can consider whether the method used by the expert has ever been tested, whether it has been subjected to peer review, its error rate, and whether it is generally accepted by other experts in the field. *See, e.g.,* Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993); Frye v. United States, 293 F. 1013 (D.C. Cir. 1923). Considerations like these can inform assessment of the quality of experts and their methods." Neal et al., *supra* note 20, at 173.

[47]Having made this assertion, it should also be noted that "there is presently no accepted objective ground truth for most forensic psychological assessments, and thus no real way to know whether or how accurate they are. However, assessments of current functioning (e.g., competence to stand trial) are assumed to be more accurate than assessment of past states (e.g., mental state at time of offense) or future states (e.g., violence risk)." Neal et al., *supra* note 20, at 177.

[48]*See generally* Svetlana Popova et al., Fetal Alcohol Spectrum Disorder Prevalence Estimates in Correctional Systems: A Systematic Literature Review, 46 Alcohol & Alcoholism 490, 490-97 (2011), https://academic.oup.com/alcalc/article-pdf/46/4/490/17047278/agr029.pdf [https://perma.cc/KR3U-WCP2].

evaluated.[49] Fourth, it can also help to identify additional inquiries or tests which might be useful to better complete the evaluation process.[50] Ultimately, this protocol should help to inform all of the evaluators prior to their making a legal conclusion or suggesting a legal conclusion as to whether the juvenile is or is not competent to stand trial.

Without a sequential protocol for the evaluations, the administering of psychological tests may occur after the psychiatrist or physician (say a general practitioner) has examined the juvenile and formulated an opinion without the benefit of the test data.[51] Whatever limited court funds might be available for these competency determinations, the impact of the psychological tests will not have been shared with the other panel members prior to their individual conclusions being reached. Additionally, even within forensic psychology, interrater reliability— the degree of consensus among multiple independent raters who perform routine evaluations in general—"is either unknown or far from perfect."[52] Sequential forensic evaluations used in competency determinations might increase the probability of consensus outcomes from the various members of the competency panel.

Once a professional has invested the time and energy into seeing and evaluating the youth's competency, they often feel compelled to defend their professional conclusions, even without having had the benefit of exchanging information with the other mental health experts first.[53] This can cause embarrassment among the professionals, but more importantly, it can result in a split of opinion among the experts in their individual assessments of competency simply because not all the mental healthcare experts had not been supplied with the same materials, the same screenings, and the same psychometric test results.

Taking the steps to reduce split opinions among expert witnesses at this stage of the proceeding (i.e., usually in a pre-trial or pre-adjudication hearing), the outcome of the evaluations offered by experts from different professions (psychiatrists, psychologists, general practitioners, social workers) also helps to reduce the costs of these contested hearings, and it can also prevent the hearings form turning into a display of adversarial gamesmanship with the party who moved to challenge competency being pitted against the party who seeks to have the trial or adjudication hearing go forward with no undue delay.[54] The sequential process of obtaining the psychometric test results first[55] and then disseminating the results and the interpretation of test results[56] can help eliminate, or at least reduce, the disagreement among the expert witnesses brought into the court process to inform the lawyers about their opinion as to the issue of the juvenile's competency to proceed to trial.

Protocols for mental health evaluations of court-involved juveniles have evolved[57] to the point where best practices in forensic mental health assessments have been published.[58] Establishing standards for the contents of forensic reports which get submitted to the courts[59] must be included in any protocol

[49] *See generally* Jennifer L. Groscup et al., *The Effects of Daubert on the Admissability of Expert Testimony in State and Federal Criminal Cases*, 8 Psychol. Pub. Pol'y & L. 339 (2002).

[50] *See generally* Kirk Heilbrun et al., Foundations of Forensic Mental Health Assessment (2008).

[51] *See* Stephen J. Lally, *What Tests Are Acceptable for Use in Forensic Evaluations? A Survey of Experts*, 34 Pro. Psych.: Rsch & Prac. 491 (2003).

[52] Guarnera et al., *supra* note 24, at 144.

[53] "[D]espite temptation to give authoritative opinions when testifying or providing opinions in a legal setting, it is better to offer only what is within our skill set and abilities. We are merely playing a part in proceedings in which we do not make the final determination." Feuerstein, *supra* note 27, at 14.

[54] *See* Guarnera et al., *supra* note 24, at 148 ("Only a handful of field reliability studies exist for a few types of forensic evaluations (i.e., adjudicative competency, legal sanity, conditional release), and virtually nothing is known about the field reliability of other types of evaluations, particularly civil evaluations.")).

[55] *See* Kirk Heilbrun, *The Role of Psychological Testing in Forensic Assessment*, 16 L. & Hum. Behav. 257 (1992).

[56] *See* Lally, *supra* note 52.

[57] *See* Ames Robey, *Criteria for Competency to Stand Trial: A Checklist for Psychiatrists,* 122 Am. J. Psychiatry 616 (1965).

[58] *See* Antoinette Kavanaugh & Thomas Grisso, Evaluations for Sentencing of Juveniles in Criminal Court (Oxford Univ. Press 2021).

[59] "Even within the category of structured tools, research shows that forensic assessment instruments with explicit scoring rules based on objective criteria yield higher field reliability than instruments involving more holistic or subjective judgments." Guarnera et al., *supra* note 24, at 146.

suggestions[60] for the jurisdictions[61] which do not specify information which need be included in the evaluations.[62]

3) Unmet Needs

In many communities in the United States, the availability of mental health professionals has been stretched thin. This is not a resource problem limited to adolescents living in the United States:

> More than 13% of adolescents worldwide live with a diagnosed mental disorder, yet access to care remains limited, according to the first United Nations State of the World's Children report to focus on mental health. The report documents the hefty toll mental illness takes on young people globally. One in 5 children and adolescents self-report feeling depressed or losing interest in activities. Suicide claims the lives of nearly 46 000 youth aged 10 to 19 years each year and is the fourth leading cause of death among teens aged 15 to 19 years. In addition to the intangible costs for these young people and their families, the report estimates poor mental health among youth and its economic effects cost the world $387 billion a year. Yet countries invest just 2% of their average health expenditures on mental health care, the report notes. The small investment contributes to shortages of child psychiatrists in wealthy and low-income countries, which severely limits access to care.[63]

For those individuals who exhibit signs of mental illness, or developmental immaturity,[64] or for reasons unknown appear unable to assist their counsel after being charged with delinquency or criminal charges, a preliminary finding that the individual lacks competency to proceed to trial may be as important or perhaps more important than the outcome of their actual trial. Should the individual be declared not competent, they will not go forward in the justice system until they are found to be competent.[65] In some instances where juveniles may not be "restored" to competency, judges may dismiss the petitions against the adolescents, or reduce charges down to misdemeanors or status offenses, or initiate civil commitment proceedings against the juveniles.[66]

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[60]"[A] clear recommendation for improving evaluator reliability is that states without standards for the training and certification of forensic experts should adopt them, and states with weak standards (e.g., mere workshop attendance) should strengthen them. What is less clear, however, is what kinds and doses of training can improve reliability with the greatest efficiency." *Id.* at 148-49.

[61]*See* Casey LaDuke et al., *Toward a Generally Accepted Forensic Assessment Practice Among Clinical Neuropsychologists: A Survey of Professional Practice and Commion Test Use,* 32 Clinical Neuropsychologist 145 (2018).

[62]*See generally* Randy Borum & Thomas Grisso, *Establishing Standards for Criminal Forensic Reports: An Empirical Analysis*, 24 Bull. Am. Acad. Psychiatry L. 297 (1996).

[63]Bridget M. Kuehn, *Lack of Adolescents' Mental Health Care is a Global Challenge*, 326 JAMA 1898 (2021), ttps://jamanetwork.com/journals/jama/fullarticle/2786232 [https://perma.cc/N9DP-9KJN].

[64]The number of jurisdictions that recognize developmental immaturity as a basis for declaring a juvenile not to be competent varies depending on the source of interpreting the enacted statutes. For further analysis of these discrepancies, *see* Panza et al., *supra* note 6, at 274-75.

[65]This also touches upon a detainee's right to refuse medical treatment, including psychotropic medication in the event that the individual has been declared incompetent. For some early work focusing on individual's right to refuse psychotropic drugs in the incompetency-to-stand-trial process, see, e.g., Bruce J. Winick, *Psychotropic Medication and Competence to Stand Trial*, 2 Am. Bar Found. ResRsch. J. 769, 810-14 (1977). *See* Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 Nw. U. L. Rev. 461 (1977).-1978). The Supreme Court's decision in *Riggins v. Nevada*, 504 U.S. 127 (1992), however held that due process was violated when a defendant was forced to stand trial as he was taking large doses of antipsychotic medications that had a negative effect on his demeanor and ability to participate at trial. *Riggins* 504 U.S. at 135, 137.

[66]"If restoration appears impossible, some states allow the judge to dismiss the petition with or without prejudice;" or to reduce charges "to misdemeanors and status offenses. Three states permit the judge to convert some delinquency charges into status offenses, but another four require competency to stand trial in all cases. Some jurisdictions allow the civil commitment of youths who are permanently incompetent to stand trial." Joseph B. Sanborn, *Juveniles' Competency to Stand Trial: Wading Through the Rhetoric and the Evidence*, 99 J. Crim. L. & Criminology146, 146-47 (2009).

However, "[i]n a study by Whitney and Peterson published online February 11[2019], in *JAMA Pediatrics*, the researchers found that about half of U.S. children who had a treatable mental health disorder didn't receive treatment from a mental health professional."[67] So, even if a court is located in a community where mental health evaluators might be available to determine an adolescent's competency to stand trial, there might not be sufficient professional mental health providers to treat the adolescent following a determination that the adolescent is not competent.[68] Providing mental healthcare services to children at school rather than at mental health clinics is thought to help reduce the stigma associated with attending a mental health clinic and for those living in poverty depending upon Medicaid reimbursements, the only available treatment requires a psychiatric diagnosis a problem for many parents who try to avoid having their children received a psychiatric diagnosis.[69]

The Covid-19 pandemic has only exacerbated the lack of resources, causing the U.S. Surgeon General to issue a rare public advisory in December, 2021, warning of the "devastating" mental health crisis among American teens due to depression, and anxiety with cases having doubled during the pandemic, and with seventy percent of U.S. counties not having a single child psychiatrist, and more than sixty percent of youth with severe major depression not receiving any mental health treatment.[70] With the limitation of resources and mental health care providers, only about twenty percent of children with mental with mental, emotional, or behavioral disorders currently receive care from a specialized mental health care provider.[71]

The lack of resources and mental health professionals available to provide treatment to individuals, let alone to adolescents and young adults, has an immediate impact on not just treatment availability, but upon competency evaluations as well. Most of the members of a competency evaluation team will be unavailable to provide any sort of treatment to the adolescents for whom they perform competency evaluations, because of the professional ethics code governing their respective field. For instance, psychologists with membership in the American Psychological Association, a voluntary membership organization, must comply with the Association's Ethical Principles of Psychologists and Code of Conduct which includes Ethical Standard 3.05:

> 3.05 Multiple Relationships
>
> (a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.
>
> A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in

[67] Roxanne Nelson, *Mental Health Care is Lacking in Children and Adolescents*, 119 Am. J. Nursing 17 (2019)

[68] *See id.* at 17 ("According to *America's Health Rankings Annual Report 2018* from the nonprofit United Health Foundation, the southeastern states have some of the lowest health rankings, based on 35 measures including behaviors, community and environment, policy, clinical care, and outcomes data. Alabama, for example, was found to have the lowest concentration of mental health providers (85 for every 100,000 people).").

[69] *Id.* at 18 (quoting Deborah Gross, Stulmann Endowed Professor in Psychiatric and Mental Health Nursing at the Johns Hopkins School of Nursing, Baltimore, Maryland).

[70] Cat Wise, *Lack of Adequate Mental Health Care Places Heavy Burden on Young People*, PBS NewsHour (June 29, 2022), https://www.pbs.org/newshour/show/lack-of-adequate-mental-health-care-places-heavy-burden-on-young-people [https://perma.cc/954V-36CC].

[71] *Improving Access to Children's Mental Health Care, CDC 24/7: Saving Lives, Protecting People* (April 27, 2022), https://www.cdc.gov/childrensmentalhealth/access.html [https://perma.cc/HAU3-3QK9] ("Nearly 1 in 5 children have a mental, emotional, or behavioral disorder, such as anxiety or depression, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder (ASD), disruptive behavior disorder, or Tourette syndrome).

> performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.
>
> Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.[72]

Thus, a psychologist who performs an assessment on an adolescent to determine competency to stand trial would not be available to provide mental health treatment for the same individual, absent some specific exception. This further complicates the availability of licensed professionals necessary to participate in cases involving adolescents exhibiting signs of possible competency to stand trial considerations. This ethical concern also imposes the greatest burden on communities already experiencing shortages of professional mental health care providers including many urban areas as well as rural and suburban communities.

For psychiatrists seeking to comply with their ethics codes, Section 5(2) of the Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry provides:

> In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her. 3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead. 4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment. 5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he or she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.[73]

Thus, the psychiatrists seeking to comply with their ethics code must not "delegate" to psychologists any matter requiring the exercise of medical judgment. The issue must be addressed as to whether physicians consider competency assessments as medical issues, or medical-legal issues, or just legal issues. In any event, the physician is not ethically obligated to ignore a psychologist's psychometric test results, and there is no language in the medical ethics code that suggests a physician/psychiatrist may not be

[72] Am. Psych. Ass'n, Ethical Principles of Psychologists and Code of Conduct3.05 (including 2010 and 2016 Amendments) (2017), , available online at https://www.apa.org/ethics/code?item=6#305c [https://perma.cc/UR8D-HHEE].

[73] Am. Psych. Ass'n, *The Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry*, Sec. 5(2) Principles with Annotations, AMA Principles of Medical Ethics (2010, 2013 ed.).

informed by the test results performed by other professionals who are not licensed to practice medicine. Additionally, physicians are bound by the Hippocratic oath to follow a duty of benevolence and non-malevolence when deciding upon treatment which might not be in the patient's best interests.[74]

4) Developmental Immaturity

Development-based approaches to juvenile justice acquired great legitimacy following the multi-year study of the MacArthur Foundation competency study in multiple jurisdictions.[75] But MacArthur was not alone in focusing on developmental factors that would impact a juvenile's competency to stand trial.[76] Essentially, if a juvenile's competency determination rests upon developmental immaturity, it would seem reasonable to assume that as the child matures, it is more likely he will eventually become competent to stand trial. Should the child be nine or ten years of age when initially petitioned for the delinquency offense, then it might require years of delay before the juvenile is re-evaluated and found to be legally competent to stand trial. Criminology scholar Franklin E. Zimring has noted that:

> The consideration of immaturity as a species of diminished responsibility has some historic precedent but little analytic history. Children below age seven were at common law not responsible for criminal acts by reason of incapacity, while those between seven and fourteen were the subject of special inquiries with respect to capacity. Capacity in this sense was not a question of degree, but an "all or nothing" matter similar to legal insanity….[77]

An additional factor is what happens where an adolescent is found not to be competent to stand trial due to developmental immaturity, and then the adolescent is ordered to undergo some form of mental health regimen (not just allowing sufficient time to expire in hopes that the child will mature sufficiently to be competent to stand trial).[78] Does the adolescent have the right to refuse treatment,[79] or has this individual lost the capacity to consent or refuse to consent to a regimen of treatment?[80] Assuming the basis for determining that the child is not competent is solely due to the child's developmental immaturity[81] and not mental illness of a congenital disorder such as FASD, courts must appreciate whether or not adolescents and

[74]Cos Hippocrates, the Father of Medicine (470-380 B.C.E.), is credited with creating the physician's oath: "I swear by Apollo the Physician, by Asclepius, Hygeia, Panaceia, and all the gods and goddesses, making them my witnesses, that I will fulfill this oath and this covenant according to my ability and judgment: To regard him who teaches medicine as equal to my parents…I will apply therapeutic measures for the benefit of the sick, refraining from all intentional wrongdoing and misconduct, particularly from sexual involvement with persons of either gender….I will not divulge anything of a private nature regarding people's personal lives that I see or hear….". The familiar precept, *First, to do no harm* (often quoted in Latin,"primum non nocere") is of unknown origin, but it is not part of the Hippocratic oath. Steadman's Medical Dictionary 890-91 (28th ed. Lippincott Williams & Wilkins, 2006).

[75]Thomas Grisso et al., *Juveniles' Competence to Stand Trial: A Comparison of Adolescents' and Adults" Capacities as Trial Defendants,* 27 Law & Hum. Behav. 333 (2003) [hereinafter *MacArthur Study*].

[76]*See* Nat'l Rsch. Council, Reforming Juvenile Justice: A Developmental Approach (Richard J. Bonnie et al. eds., 2013).

[77]Franklin E. Zimring, American Juvenile Justice, 56-57 (Oxford Univ. Press 2005).

[78]*See* Samantha Michaels, *Kids with Cognitive Problems Can be Locked Up for Years Without a Trial,* Mother Jones, (Aug. 29, 2018), https://www.motherjones.com/crime-justice/2018/08/competence-california-trial-mental-cognition-reform/ [https://perma.cc/7QCQ-ZTLZ].

[79]*See generally* Linda C. Fentiman, *Whose Right Is It Anyway?: Rethinking Competency to Stand Trial in Light of the Synthetically Sane Insanity Defendant*, 40 Miami L. Rev. 1109 (1986).

[80]*See* Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment,* 319 New Eng. J. Med.1635 (1988); *see also* Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 New Eng. J. Med. 1834 (2007).

[81]*See generally* Nancy Ryba Panza & Theresa Fraser, *Effects of Age, Adaptive Behavior, and Cognitive Abilities on Competence-Related Abilities in Children and Adolescents*, 15 J. Forensic Psychol. Pract. 138 (2015).

young children[82]—or their parents—possess the ability to withhold informed consent[83] for a regimen of treatment recommended by a mental health professional.[84] In some instances, religious beliefs[85] or philosophical beliefs[86] might direct the adolescent's decision making,[87] thus raising possible first amendment challenges to mental health treatment while an adolescent is not found to be competent to stand trial,[88] despite the 1944 ruling of the U.S. Supreme Court in *Prince v. Massachusetts*.[89] If the child is fifteen or sixteen years of age, assuming that the child has already been found to not be competent to stand trial, it might still require a year or more before the child can be re-evaluated and determined to be legally competent.[90] And that last assertion presupposes that the child can ever be declared competent to stand trial.[91]

5) FASD, Intellectual Disability

Although not entirely dispositive of a person's legal competency, should the child's evaluation reveal intellectual developmental disorder, or intellectual disability according to the Diagnostic and Statistical Manual of Mental Disorders (5th Ed. Text Revision) [hereinafter "DSM-5-TR"],[92] this may cause the

[82] *See* Thomas Grisso, Juveniles' Waiver of Rights: Legal and Psychological Competence (Springer 1981).

[83] *See id.*

[84] Appelbaum & Grisso, *supra* note 27, at 1635 (quoting John Ruark & Thomas Raffin, *Initiating and Withdrawing Life Support: Principles and Practices in Adult Medicine, Stanford University Medical Center Committee on Ethics*, 318 N. Eng. J. Med. 25 (1988)) ("Ordinarily, the assessment of a patient's decisionmaking capacity is an implicit part of the doctor–patient interaction, often taking place without either party's awareness. Unless substantive questions arise about the patient's competence as a result of considerations other than the content of the patient's decisions, the physician should accept the patient's wishes. The law, too, presumes patients' competence. When a patient's mental state is called into question, however, particularly in the context of a decision with serious consequences, a more thorough assessment is required. For example, the legitimacy of a patient's refusal of life-sustaining care may turn on careful judgment of decision-making capacity, as may the acceptability of allowing family members to make medical decisions on the patient's behalf.")

[85] *See* Eileen Wang et al., *Nonmedical Exemptions from School Immunizations,* 104 Am. J. Pub. Health 62 (Nov. 1, 2014), https://doi.org/10.2105/AJPH.2014.302190 [https://perma.cc/A7YJ-QPF4].

[86] *See* JosephThompson et al., *Impact of Addition of Philosophical Exemptions on Childhood Immunization Rates,* 32 Am. J. Preventive Med. 194 (2007).

[87] Rita Swan, *Faith-Based Medical Neglect: For Providers and Policymakers*, 13 J. Child & Adolescent Trauma 343 (2020), https://link.springer.com/epdf/10.1007/s40653-020-00323-z?sharing_token=OsSgghVhyfkWManuxjOa6_e4RwlQNchNByi7wbcMAY6BQ4JfE19QE_ElYMEppq2D-Rrd4FHh-emWWATkJyzBYK4sxtGGz8omEiQoRPByM-RYz-cFbNDGeVgfoReCzRsuha75rwWZl9xIMmv_wGU-l-Vs9AHR2RWTQ6DRdYiwBeU%3D [https://perma.cc/UF3Q-R3T9] ("A substantial minority of Americans have religious beliefs against one or more medical treatments. Some groups promote exclusive reliance on prayer and ritual for healing nearly all diseases. Jehovah's Witnesses oppose blood transfusions. Hundreds of thousands of schoolchildren have religious or conscientious exemptions from immunizations. Such exemptions have led to personal medical risk, decreases in herd immunity, and outbreaks of preventable disease. Though First Amendment protections for religious freedom do not include a right to neglect a child, many states have enacted laws allowing religious objectors to withhold preventive, screening, and, in some states, therapeutic medical care from children.").

[88] By "religious beliefs," this generally means parental religious beliefs as minor children may have had no role in determining what religion they have been raised to believe. Legal exemptions in many states continue to provide exemptions for children to be vaccinated against contagious and preventable childhood diseases such as measles. *See* Varun Phadke et al., *Association Between Vaccine Refusal and Vaccine-Preventable Diseases in the United States: A Review of Measels and Pertussis*, 315 JAMA 1149 (2016).

[89] 321 U.S. 158, 166-67 (1944) ("the right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death…").

[90] *See generally* Nancy L. Ryba & Virginia G. Cooper, *Juvenile Competence to Stand Trial Evaluations: A Survey of Current Practices and Test Usage Among Psychologists,* 34 Prof. Psychol.: Rsch. & Prac. 499 (2003).

[91] *See generally* K.L. Ustad et al., *Restoration of Competency to Stand Trial: Assessment with the Georgia Court Competency Test and the Competency Screening Test*, 20 L. & Hum. Behav. 131 (1996).

[92] Am. Psychiatric Ass'n, Diagnostic & Stat. Manual of Mental Disorders 5TH Ed. Text Rev. 37 (2022) [hereinafter "DSM-5-TR"]. Diagnostic criteria for intellectual developmental disorder (intellectual disability) is a "disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains," requiring three criteria: (A) Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized , standardized

child not to likely become legally competent in the near or even foreseeable future,[93] depending on the level of disability, mild, moderate, severe, or profound. Although once believed to be measured by low IQ scores,[94] the DSM-5-TR clarifies that levels of severity are based on "adaptive functioning" rather than IQ scores, because "IQ measures are less valid in the lower end of the IQ range."[95]

The prospect of delaying the trial process creates a burden on the adolescents accused, the victims of the offenses, the prosecutors handling the delinquency or adult criminal charges, and the community in which the adolescent resides. States must anticipate that larger numbers and expenses associated with adolescents who are court-involved will likely demonstrate fetal alcohol spectrum disorder[96] or fetal alcohol syndrome[97] as the evaluation methods for making such diagnoses improve[98] and more professionals become better informed[99] and receive training[100] and become better equipped to render such diagnoses.[101] Costs associated with children in care with FASD are quite high.[102] The condition and consequence of prenatal alcohol exposure is described as:

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intelligence testing; (B) deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community. (C) Onset of intellectual and adaptive deficits during the developmental period." *Id.* at 37. The DSM continues to explain: "The term *intellectual developmental disorder* is used to clarify its relationship with the WHO-ICD-11 classification system… . The medical and research literature use both terms, while *intellectual disability* [emphasis added] is the term in common use by educational and other professions, advocacy groups, and the lay public. In the United States, Public Law 111-256 (Rosa's Law) changed all references to 'mental retardation' in federal laws to 'intellectual disability.'" *Id.* at 38.

[93]*See* Popova et al. *supra* note 49.

[94]*See* Sarah N. Mattson et al., *Heavy Prenatal Alcohol Exposure With or Without Physical Features of Fetal Alcohol Syndrome Leads to IQ Deficits*, 131 J. Pediatrics 718 (1997), (although "intellectual disability" may not be measured solely by low IQ scores, we now know that prenatal alcohol exposure does cause IQ deficits, regardless of whether physical features of fetal alcohol syndrome occurs.).

[95]DSM-5-TR, *supra* note 94, at 38. The once used DSM term "mental retardation" is no longer applied, and the measurement for severity is based upon adaptive functioning, not low IQ scores.

[96]Albert E. Chudley et al., *Fetal Alcohol Spectrum Disorder: Canadian Guidelines for Diagnosis,* 175 Can. Med. Ass'n. J. 172 (2005) ("The prevalence of FAS in the United States has been reported as 1–3 per 1000 live births and the rate of FASD as 9.1 per 1000 live births. However, diagnosis may often be delayed or missed entirely.").

[97]*See* Diane K. Fast et al., *Identifying Fetal Alcohol Syndrome Among Youth in the Criminal Justice System.* 20 J. Developmental Behav. Pediatrics 370 (1999).

[98]*See, e.g.,* Albert E. Chudley et al., *supra* note 38 ("Since FAS was first described in 1973, it has become apparent that it is complex; affected people exhibit a wide range of expression, from severe growth restriction, intellectual disability, birth defects and characteristic dysmorphic facial features to normal growth, facial features and intellectual abilities, but with lifelong deficits in several domains of brain function. FASD requires a medical diagnosis in the context of a multidisciplinary assessment. FASD itself is not a diagnostic term.").

[99]*See* Brown, et al,, *supra* note 3.

[100]*Id.* at 316 ("It is imperative that mental health professionals become informed about the symptoms that would help identify FASD. Through general training on the topic and specifically addressing ND-PAE criteria, evaluators will be better equipped to provide thorough and accurate assessments of the person's abilities to participate in the criminal justice system, particularly with regard to CST.").

[101]Recent studies published from Canada (*see* Mela Mansfield et al., *Rates and Implications of Fetal Alcohol Spectrum Disorder Among Released Offenders with Mental Disorder in Canada*, 40 Behav. Sci. & L. 144-53 (2022),and Australia (*see* Carl Boweret al., *Fetal Alcohol Spectrum Disorder and Youth Justice: a Prevalence Study Among Young People Sentenced to Detention in Western Australia*, 8 BMJ Open, 1-7 (2018) document large percentages of adolescents already convicted of delinquency or criminal charges had not been diagnosed until after they were incarcerated and then found to have FASD. It may well be the case that their legal counsel were unaware of the clients' diagnosed conditions, or perhaps none of the families were aware of the children's congenital exposure to alcohol. In any event, these two studies strongly suggest that other nations may also have large segments of adoloscents in detention facilities or jails who may be diagnosed with this congenital disorder over which they have no control and for which very little research or literature currently exists as to effective treatment modalities or behavioral therapies demonstrating success in altering the behaviors that may result in life-long involvement with criminal justice systems.

[102]A Canadian study from 2014 found "an estimated number of children in care with FASD ranged from 2,225 to 7,620, with an annual cost of care ranging from $57.9 to $198.3 million Canadian dollars (CND). The highest overall cost ($29.5 to $101.1

> FASD is the result of maternal alcohol consumption during pregnancy and has implications for the afflicted person, the mother, the family, and the community. Since FAS was first described in 1973, it has become apparent that it is complex; affected people exhibit a wide range of expression, from severe growth restriction, intellectual disability, birth defects and characteristic dysmorphic facial features to normal growth, Facial features and intellectual abilities, but with lifelong deficits in several domains of brain function. FASD requires a medical diagnosis in the context of a multi-disciplinary assessment. FASD itself is not a diagnostic term.[103]

Nevertheless, "[b]ecause of limited capacity and expertise and the need to involve several professionals in a comprehensive multidisciplinary diagnostic evaluation [for FAS/FASD], only a fraction of those affected currently receive a diagnosis."[104] Additionally,

> [p]renatal alcohol exposure can affect any organ or system of the fetus, therefore, individuals with FASD may have a broad array of physical defects, cognitive, behavioural, emotional, and adaptive functioning deficits, as well as congenital anomalies, such as malformations and dysplasia of the cardiac, skeletal, renal, ocular, auditory, and other systems. These impairments are likely to have lifelong implications.[105]

Thus, adolescents demonstrating one of the four categorical diagnostic entities including fetal alcohol syndrome (FAS), partial FAS, alcohol-related neurodevelopmental disorder, and alcohol-related birth defects will not likely resolve themselves over time but will more likely require additional treatment and services over their lifespan.[106]

One of the more challenging issues facing juvenile justice systems will be what to do and how to handle the juveniles for what might become an extended period of time during which there has been no adjudication,[107] and while the juvenile continues to be legally presumed innocent until proven guilty?[108] Additionally, the developing body of literature on FASD and FAS afflicted juveniles will require additional resources to handle the population afflicted with FASD and their families,[109] but also to help prevent future generations from this affliction,[110] and to ensure that siblings of the

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million CND) was for 11-15 year-olds." Svetlana Popova et al., *Canadian Children and Youth in Care: The Cost of Fetal Alcohol Spectrum Disorder*, 43 Child Youth Care F. 83-84 (2014).

[103]Chudley et al., *supra* note 98, at 1.

[104]*Id.* at 2.

[105]Popovaet al., *supra* note 95, at 84.

[106]*Id.*

[107]Sue Burrell et al., *Incompetent Youth in California Juvenile Justice*, 19 Stanford L. & Pol'y Rev. 198 (2008) ("…while the presence of a mental disorder, developmental disability, and/or immaturity does not automatically render a juvenile incompetent, the presence of these factors triggers the need for further inquiry. At the very least, these youth present serious challenges for the system in case processing and provision of services; at the most, the system must recognize their incompetence and prevent their cases from going forward.").

[108]*See generally* David R. Katner, *The Mental Health Paradigm and the MacArthur Study: Emerging Issues Challenging the Competence of Juveniles in Delinquency Systems*, 32 Am. J.L. & Med. 503 (2006).

[109]"Fetal Alcohol Spectrum Disorder (FASD) is a permanent disorder caused by prenatal exposure to alcohol (PAE).It is often undiagnosed or misdiagnosed so that individuals who have deficits related to PAE are often misunderstood and not provided with early interventions necessary to assist them in developing age-appropriate and expected functional abilities. FASD encompasses a range of symptoms including cognitive (e.g., intelligence, executive control, and memory), social (e.g., communication skills and suggestibility), and adaptive (e.g., decision making ability and capacity to solve problems) deficitsThe impairments can manifest in a range of presentations from more pervasive (e.g., severe intellectual disabilities, facial dysmorphology) to those with complicated but less obvious deficits (e.g., social functioning impairments) and no obvious physical signs of the disorder.". Brown et al., *supra* note 3, at 316 (citations omitted).

[110]It should be noted that alcohol consumption during pregnancy is not limited to families in the U.S. *See* Ann-Charlotte Mårdby, *Consumption of Alcohol During Pregnancy—A Multinational European Study,* 30 Women & Birth 207 (2017) ("Almost 16% of women resident in Europe consumed alcohol during pregnancy with large cross-country variations.").

Thus, the same issues present in the U.S. criminal and juvenile justice systems related to high rates of FASD adolescent are likely to be seen in European populations as well.

FASD-diagnosed adolescents are not also afflicted with FASD.[111] As one group of researchers commented:

> Clearly, funding for development, training and maintenance of multidisciplinary diagnostic teams is necessary so that major centres will have the expertise and capacity to serve their communities. To optimize the outcome of the diagnosis, the community and the family must be prepared, ready to participate in, and be in agreement with the diagnostic assessment. The diagnostic process should be sensitive to the family's and the caregiver's needs. In each community, referrals must be evaluated and their level of priority established. The family and guardian must be in agreement on the purpose of diagnosis. They must be made aware of the potential psychosocial consequences of a diagnosis of FASD (e.g., increasing a sense of guilt and anger, especially with the birth mother, or potential stigmatization of the child). The family or guardian will likely need help to move confidently through the diagnostic process. This help might include some preparatory education concerning FASD and linking them with community supports and resources.[112]

The developing body of literature about FASD in adolescent and adult populations should not be ignored, because this one congenital condition is likely to result in discovering larger numbers of juveniles who are not competent to stand trial for charged misconduct, and it seems unlikely that they will be "restored" to competency given the deficits caused by prenatal alcohol exposure, especially heavy alcohol exposure.[113]

The costs of employing interdisciplinary teams will undoubtedly generate a great deal of opposition, as interdisciplinary teams of physicians, lawyers, psychologists, social workers and whatever other licensed professionals who by statute are permitted under state laws to engage in doing competency evaluations of juveniles will simply increase the burden on the state seeking to enforce laws that were adopted without any understanding or knowledge of congenital factors such as FASD or without regard to developmental immaturity.[114] Given the nature of the legal profession, it is likely to assume that lawyers will continue to disregard the advancements and understanding of prenatal exposure to alcohol, and such stubbornness or notion that our system is perfectly fine, working well, and in need of no reconsideration would be shortsighted.[115]

While it is true that high functioning FASD afflicted adolescents—"an estimated 73% of individuals meeting criteria for FAS and 91% of individuals meeting criteria for FASD have intellectual abilities above that typically considered intellectually disabled"[116]—may be found competent to stand trial,[117]

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[111] *See* Susan J. Astley et al., *Fetal Alcohol Syndrome (FAS) Primary Prevention Through FAS Diagnosis: I. Identification of High-Risk Birth Mothers Through the Diagnosis of Their Children,* 35 Alcohol & Alcoholism 499 (2000).

[112] Chudley et al., *supra* note 95, at 3.

[113] Brown et al., *supra* note 3, at 315 ("… it is estimated that 60% of those who have FASD will become involved in the criminal justice system at some point in their life. Given the high percentage of those with FASD who become involved in the criminal justice system and the significant functional deficits that they experience, it is essential that forensic evaluators become familiar with FASD.").

[114] *See generally* Suzanne Bell et al., *A Call for More Science in Forensic Science*, 115 Proceedings of Nat'l Acad. of Scis. 4541 (2018).

[115] Maki, *supra* note 4.

[116] Brown, et al., *supra* note 3, at 316.

[117] *Id.* ("Another common myth is that those with PAE will be intellectually impaired. While those with FASD have shown a range of intellectual abilities, an estimated 73% of individuals meeting criteria for FAS and 91% of individuals meeting criteria for FASD have intellectual abilities above that typically considered intellectually disabled. However, research has indicated that even those with PAE without intellectual disabilities have deficits well beyond those of a similar IQ with regard to cognitive, behavioral, emotional and social domains. In other words, those with FASD may demonstrate some abilities that appear average while other abilities are deficient. Additionally, it is not unusual for those with FASD, at least as measured in childhood, to have variable functioning so that sometimes the same functional deficits are more obvious than at other times.") (citations omitted).

states must still be prepared for the increase in diagnosed cases involving FASD[118] and the prospects that these children will not benefit from routine competency restoration services in the United States. such as classroom instruction which identifies the parties in a court proceeding and which seek to inform the children what their legal rights might involve. This population may never be competent to stand trial, as we are just beginning to see with large scale studies of the children in detention facilities in other nations such as Canada[119] and Australia[120] where the diagnoses were unknown at the time of their adjudications and dispositions or sentencing.[121]

6) Comorbidity

Yet another factor to analyze with this population is the co-morbid disorders FASD afflicted adolescents (and adults) may have:

> In combination with co-occurring disorders (e.g., ADHD, autism spectrum disorder, depression, anxiety, and substance use), the identification and assessment of FASD can become a complicated endeavor (Brown, Freeman, Pickett, Watts, & Trnka, 2018; Brown, Rich, & Freeman, 2016; Weyrauch, Schwartz, Hart, Klug, & Burd, 2017). To help address these complexities, evaluators should become familiar with Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure (ND-PAE). This disorder was identified as a disorder for future study in the *Diagnostic and Statistical Manual-5th Edition* (*DSM-5*; American Psychiatric Association, 2013). ND-PAE provides mental health professionals with specific guidance in determining if a person may qualify for a diagnosis related to PAE and may help identify the majority of people with FASD (Burd, 2016). Nonetheless, many cases of FASD still go unidentified (Chasnoff, Wells, & King, 2015). This can be particularly problematic because the disorder increases the likelihood of involvement in the criminal justice system (Popova, Lange, Bekmuradov, Mihic, & Rehm, 2011; Streissguth, Barr, Kogan, & Bookstein, 1996). Further, the symptoms of FASD may interfere with an individual's ability to participate in the criminal justice system (i.e., waive rights, enter pleas, stand trial, and abide by community supervision) (Conry, Fast, & Loock, 1997; Conry & Lane, 2009; Freckelton, 2016; McLachlan, Roesch, Viljoen, & Douglas, 2014). It is likely due to these wide-ranging deficits and misinformation that mental health professionals may fail to identify possible FASD in defendants. Additionally, the lack of formal training specific to FASD for mental health professionals contributes to the lack of FASD identification (Chudley et al., 2005). Consequently, this population is often overlooked with regard to mental health evaluations, particularly within the criminal justice system (Conry & Fast, 2011).

For those juveniles who are not competent to stand trial for charged misconduct-- and for whom it seems unlikely that they will be "restored" to competency-- given the deficits caused by prenatal alcohol exposure, especially heavy alcohol exposure,[122] the evaluators must rule out comorbid conditions in addition to the FASD if the court intends to compel involvement in competency restoration interventions. Medical scholars focusing on FASD have found that over 300 disease conditions coded in the International Classification of Diseases occur in individuals with FASD.[123] This may result in appointing interdisciplinary teams to provide accurate diagnoses of FASD and whatever other comorbid conditions the

[118] *See* Kathryn Page, *The Invisible Havoc of Prenatal Alcohol Damage*, 4 J. Ctr. for Families, Child. & Cts. 67, 72 (2003).
[119] *See generally* Mansfield et al., *supra* note 103.
[120] *See generally* Bower et al., *supra* note 103.
[121] *Id.*
[122] Brown et al., *supra* note 3, at 315 ("it is estimated that 60% of those who have FASD will become involved in the criminal justice system at some point in their life. Given the high percentage of those with FASD who become involved in the criminal justice system and the significant functional deficits that they experience, it is essential that forensic evaluators become familiar with FASD.").
[123] Popova et al., *supra* note 104, at 84.

adolescent might exhibit. The costs of employing interdisciplinary teams will undoubtedly generate a great deal of opposition, as interdisciplinary teams of physicians, psychologists, social workers and whatever other licensed professionals—perhaps even third party lawyers-- who by statute are permitted under state laws to engage in doing competency evaluations of juveniles will simply increase the burden on the state seeking to enforce laws that were adopted without any understanding or knowledge of congenital factors such as FASD or without regard to developmental immaturity. Without an accurate diagnosis for this population, they are likely to develop "secondary disabilities such as mental health problems, trouble with the law, school drop-outs, unemployment, homelessness, and/or alcohol and other drug problems."[124]

Identifying professionals with the appropriate training to diagnose individuals afflicted with FASD is an initial hurdle, but then ruling out co-morbid disorders masked by the symptoms of FASD creates yet another hurdle to overcome. All of this presupposes that lawyers will have sufficient understanding about FASD to raise the issue in court by filing a competency challenge, and this is a major assumption given the limitations of legal education and the lack of training available to lawyers who are most likely to encounter the clients afflicted with this congenital condition. Pretending that these children are simply "bad actors" or that they have an attitudinal problem ignores the very condition caused by prenatal exposure to alcohol and it tends to lay blame or responsibility on the person least capable of altering their cognitive deficiency, or altering their behaviors, their susceptibility to manipulation or higher levels of suggestibility and difficulty appreciating the consequences of their actions.[125] Systemic responses have included transferring such adolescents out of juvenile courts and into adult criminal courts for prosecution, especially for more serious offenses.[126] While it is true that high functioning FASD afflicted adolescents—"an estimated 73% of individuals meeting criteria for FAS and 91% of individuals meeting criteria for FASD have intellectual abilities above that typically considered intellectually disabled"[127]—may be found competent to stand trial,[128] states must still be prepared for the increase in diagnosed cases involving FASD and the prospects that these children will not benefit from routine competency restoration services in the U.S. such as classroom instruction which identifies the parties in a court proceeding and which seek to inform the children what their legal rights might involve. This population may never be competent to stand trial, as we are just beginning to see with large scale studies of the children in detention facilities in other nations such as Canada and Australia where the diagnoses were unknown at the time of their adjudications and dispositions or sentencing.

Conclusion

Systemic change requires focusing on the establishment of universal protocols for performing competency evaluations of juveniles in delinquency and adult criminal courts. Uniformity in and of itself accomplishes nothing or results in disastrous outcomes if the protocol is flawed. Developing protocols jointly with cooperating forensic mental health organizations and individuals is crucial to help ensure that

[124] *Id.*, at 84.

[125] *See* Jerrod Brown et al., *Fetal Alcohol Spectrum Disorder (FASD) and Suggestibility: A Survey of United States Federal Case Law.* 80 Int'l J. L. & Psych. 2, 2 (Jan.-Feb. 2022).

[126] Maki, *supra* note 4.

[127] Brown et al., *supra* note 3, at 316.

[128] Brown et al., *supra* note 3, at 316 ("Another common myth is that those with PAE will be intellectually impaired. While those with FASD have shown a range of intellectual abilities, an estimated 73% of individuals meeting criteria for FAS and 91% of individuals meeting criteria for FASD have intellectual abilities above that typically considered intellectually disabled (Sampson, Streissguth, Bookstein, & Barr, 2000). However, research has indicated that even those with PAE without intellectual disabilities have deficits well beyond those of a similar IQ with regard to cognitive, behavioral, emotional and social domains (Quattlebaum & O'Connor, 2013). In other words, those with FASD may demonstrate some abilities that appear average while other abilities are deficient. Additionally, it is not unusual for those with FASD, at least as measured in childhood, to have variable functioning so that sometimes the same functional deficits are more obvious than at other times (Ali, Kerns, Mulligan, Olson, & Astley, 2018; Simmons, Thomas, Levy, & Riley, 2010)."

evidence-based practices and appropriate evaluation instruments are utilized exclusively.[129] Oftentimes, when legal systems are "reformed" or systemic change is sought, legislative proposals may fall within the exclusive province of lawyers while licensed professionals in other relevant fields are excluded while legislation is drafted. This process minimizes the input of trained professionals with actual training and background to address whatever legal question must be addressed, sometimes resulting in legal foucs on issues far beyond the ability or training experts might be comfortable or even competent in addressing.[130] The creation of protocols for conducting competency evaluations is not a panacea for filling all gaps in competency determination,[131] but it is one step in creating a more universal approach to obtaining evaluations which reduce some of the vagaries and clumsiness[132] often caused when professionals are deprived of the opportunity of collaborating with one another before testifying in court and possibly resulting in a more consenus driven evaluation.[133] Not perfect, but better than the status quo.

Given the recent studies about child competency including developmental immaturity and FASD, perhaps a newly created protocol to help measure competency is not enough to steer us in the right direction as our appreciation of Piaget's developmental stages of childhood[134] may lead our juvenile justice system in an entirely new direction recognizing the congenital limitations of some while delaying proceedings for others due simply to their immaturity. Or perhaps we could simply pretend that on the train of justice, all is well; just sit back and relax as the train of juvenile justice jumps the tracks altogether.

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[129]For FASD diagnosis protocols, *see generally* S.J. Astley, *Diagnostic Guide for Fetal Alcohol Spectrum Disorders: The 4-Digit Diagnostic Code* (3rd ed., Seattle: Univ. of Wash. Pub. Serv. 2004).

[130]Guarnera et al., *supra* note 99, at 143-44 ("The forensic evaluator has been tasked with answering a difficult psychological question about you and your case. For example, 'Were you sane or insane at the time of the offense? How likely is it that you will be violent in the future?' … The forensic evaluator interviews you, reads records about your history, speaks to some sources close to you, and perhaps administers some psychological tests. The evaluator then forms a forensic opinion about your case—and the opinion is not in your favor. You might wonder whether most forensic clinicians would have reached the same opinion. Would a second (or third or fourth) evaluator have come to a different, perhaps more favorable conclusion?").

[131]*See* Elyn Saks, *Retributive Constraints on the Concept of Competency: the Required Role of 'Patently False Beliefs' in Understanding Competency to be Executed*, 27 Behav. Sci. L. 1 (2009).

[132]Guarnera et al., *supra* note 84, at 148 ("…[I]ncreased standardization of forensic methods has the potential to ameliorate multiple sources of unreliability and bias [of forensic evaluations].").

[133]"One likely reason why training and certification increase interrater reliability is that they promote standardized evaluation methods among forensic clinicians. While there are now greater resources and consensus concerning appropriate practice than even a decade ago, forensic psychologists still vary widely in what they actually do during any particular forensic evaluation…This diversity of methods—including the variety and at times the total lack of structured tools—is likely a major contributor to disagreement among forensic evaluators." *See* Guarnera et al., *supra* note 84, at 145.

[134]*See generally* Jean Piaget, The Child's Conception of the World (Routledge & Kegan Paul, London 1929); *see also* Susan Carey et al., *Theories of Development: In Dialog with Jean Piaget*, 38 Dev. Rev. 36 (2015).

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