5-22-2011

Diagnosing Delinquency: A Study of the Overrepresentation of Children With Disabilities in the Juvenile Justice System

Vicki Jaye Morris
Dickinson College

Follow this and additional works at: http://scholar.dickinson.edu/student_honors
Part of the Juvenile Law Commons, and the Law and Society Commons

Recommended Citation

This Honors Thesis is brought to you for free and open access by Dickinson Scholar. It has been accepted for inclusion by an authorized administrator. For more information, please contact scholar@dickinson.edu.
Diagnosing Delinquency:
A Study of the Overrepresentation of Children with Disabilities
in the Juvenile Justice System

by

Vicki Jaye Morris

Submitted in partial fulfillment of Honors Requirements
for the Program in Law and Policy

Professor Douglas Edlin, Supervisor

May 3, 2011
Table of Contents

Chapter 1: Introduction........................................................................................................4
  1.1 The issue......................................................................................................................4
  1.2 Origins of the Juvenile Justice System.......................................................................7
  1.3 Traditional Philosophy: *Parens Patriae*...................................................................8
  1.4 Modern Philosophy: "Tough on Crime".................................................................8

Chapter 2: The Legal Gap: Current Law & the Issue of Competency...............................11
  2.1 Current Law...............................................................................................................11
      2.1.1 Section 504 of the Rehabilitation Act of 1973..........................................12
      2.1.2 Individuals with Disabilities Education Act (IDEA)...............................13
      2.1.3 Civil Rights of Institutionalized Persons Act (CRIPA)............................15
  2.2 Failure of Compliance with Existing Laws............................................................16
      2.2.1 Legal Ambiguity..............................................................................................17
      2.2.2 Other Barriers..................................................................................................20
  2.3 Widening the Gap: The Competency Issue............................................................21

Chapter 3: The Relationship between Disability and Delinquency..................................26
  3.1 Theories......................................................................................................................27
      3.1.1 Susceptibility Theory......................................................................................28
      3.1.2 Student Risk Theory......................................................................................30
      3.1.3 Differential Processing Theory.......................................................................31
      3.1.4 Insufficient Knowledge: A Fourth Theory...................................................33

Chapter 4: The Advocacy Gap: Inadequate Representation of Children with Disabilities at all
Levels of the Juvenile Justice System and among Child-Serving Agencies..................38
  4.1 Opportunities at the Different Stages of the Juvenile Justice System.....................38
      4.1.1 Inadequate Intervention...............................................................................39
      4.1.2 Trouble with Treatment...............................................................................43
  4.2 Other Opportunities...................................................................................................48
      4.2.1 Representation...............................................................................................49
      4.2.2 Research.........................................................................................................51
      4.2.3 Resources.......................................................................................................53
  4.3 Conclusion.................................................................................................................54

Chapter 5: Current Solutions............................................................................................55
  5.1 School-Based Prevention..........................................................................................55
      5.1.1 Positive Behavioral Intervention and Support Treatment............................57
  5.2 Legal Prevention........................................................................................................58
  5.3 Intervention through Mental Health Screening and Assessment............................60
  5.4 Treatment Strategies...............................................................................................62
      5.4.1 Professional Mental Health Training............................................................62
      5.4.2 Information Sharing......................................................................................64
      5.4.3 Aftercare.........................................................................................................66
      5.4.4 Multi-systematic Wraparound Services.......................................................67
  5.5 Separate Specialized Mental Health Court..............................................................70
  5.6 Conclusion................................................................................................................73

Chapter 6: Conclusions and Recommendations..............................................................74
  6.1 Legal Gap Recommendations..................................................................................75
  6.2 Advocacy gap Recommendations..........................................................................75
  6.3 Intervention Recommendations.............................................................................75
  6.4 Treatment Recommendations................................................................................75

Bibliography.......................................................................................................................77
Acknowledgements

I would first like to thank the Policy Studies program for the opportunity to pursue this year-long research and writing project on a topic that I am truly passionate about. To my remarkable advisor, supervisor, and mentor, Professor Edlin—thank you for all of the time and effort you have spent challenging and guiding me throughout this process and for making me realize my full potential. I am also grateful to my family, whom without their continuous love and support, this Honors Thesis would not have been possible. I would especially like to thank my mother, who inspires and motivates me every day to J.K.O.B.Y.
Chapter 1: Introduction

1.1 The issue

Today juvenile justice systems across the United States are “dumping ground[s]” for children with disabilities (NCD (NCD) 2001). The overrepresentation of these youth who are involved in the system is immense. It is estimated that more than 20% of the 100,000 incarcerated juveniles have mental health disorders and disabilities (Aron & Mears, 2003). In only five years, between 1993 and 1997, the number of children with disabilities involved at any stage of the juvenile justice system rose from 12,500 to 16,000, a 28% increase (US Department of Education 2001). Additionally, a recent survey of juvenile and family court judges indicated that 86% believed that “mentally-ill juveniles were being shunted into the delinquent system” and 70% surveyed believed that 15% or more of defendants were “mildly or moderately mentally retarded” (Arrendondo 2003). Children with disabilities who are at risk or already involved with the juvenile justice system are continually overlooked; their mental health needs are either unidentified or unmet by the juvenile justice system and other child-serving agencies.

Statistics and research studies thus far suggest that there is an injustice occurring in our legal system that victimizes children with disabilities. Investigations by the US Department of Justice have called into question the ability of many juvenile justice facilities to respond adequately to the mental health needs of youth in their care (US Department of Justice 2005). The overwhelming overrepresentation of children with disabilities in the juvenile justice system reveals that the unique needs of these children are not adequately being addressed.

This thesis identifies and begins to address some of the underlying injustices of mistreatment and overrepresentation of children with disabilities in the juvenile justice
system. The thesis focuses on children who are solely participants in the juvenile justice system; it does not address juveniles who are transferred to the adult criminal justice system.

Chapter 1 is an introduction to the fundamental concerns surrounding the overrepresentation of children with disabilities involved with the juvenile justice system. Section 1 identifies the issue and delineates the scope of the thesis. Section 2 reviews the origins of the American Juvenile Justice System. Section 3 of the first chapter lays out the philosophical frameworks of the juvenile justice system and describes the evolution of juvenile courts in their transformation from the traditional purpose of *parens patriae* to the modern “tough on crime” trend.

Chapter 2 illustrates the legal gap that contributes to the high incidence of children with disabilities and their mistreatment by the juvenile justice system. Section 1 underlines three federal disability laws that relate to and/or directly refer to children with disabilities who come into contact with the juvenile justice system that result in negative consequences for these children, particularly, Section 504 of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act (IDEA), and the Civil Rights of Institutionalized Persons Act (CRIPA). These provisions require that children with disabilities receive services to address their disability-related needs from the government, including those youth in contact with the juvenile justice system, but fall short in protecting these children. Consequently, children with disabilities are consistently and continuously being shunted in large numbers into the juvenile justice system. Existing federal law is inadequate as the prevalence of children with disabilities in the juvenile justice system is inordinately higher than youth without disabilities who are under the system’s authority (Otto et al. 1992; Wierson, Forehand & Frame, 1992). Sections 2 and 3 of this chapter discuss reasons why non-compliance with existing youth-
related federal disability laws is so widespread. Some reasons noted are the ambiguity in the letter of the law, as well as the issue of a child’s undeclared right to competency throughout the adjudication processes of the juvenile justice system.

Chapter 3 describes the relationship between disability and delinquency. In particular, the chapter discusses three theories previously noted by researchers, professionals, and other practitioners of the juvenile justice system and related areas. The Susceptibility Theory, the Student Risk Theory, and the Differential Processing Theory each link children with disabilities to delinquent behavior and contact with the juvenile justice system. Additionally in Chapter 3, this thesis suggests a fourth theory of Insufficient Knowledge that connects delinquency with disabled children.

Chapter 4 classifies the inadequate representation of children with disabilities as a gap in advocacy within the juvenile justice system. This advocacy gap consists of deficiencies at all levels of a child’s participation in the system (intervention, treatment, and aftercare), as well as insufficient representation, research, and resources among child-serving agencies nationwide. Contributors to the advocacy gap include: public school systems, child welfare programs and juvenile justice systems, as well as families and communities—all lack appropriate information, training, and support, to successfully advocate for children with disabilities (Howell 1995; Loeber and Farrington 2001; Peikin 2001; Smith et al. 2002; Rutherford et al. 2002; Skowyra & Cocozza 2006).

Chapter 5 illustrates the current national trends to resolve the issue of overrepresentation and system deficiencies facing children with disabilities at risk or already in contact with the juvenile justice system. The chapter gives an overview of each solution strategy and recognizes specific state and jurisdictional programs that have implemented
these approaches. The trends highlighted in this chapter include: school based prevention, positive behavioral intervention and support treatment, legal prevention through better implementation of federal disability law, intervention through mental health screening and assessment, enhanced treatment strategies for children with disabilities in contact with the juvenile justice system including mental health training for child-serving professionals, information sharing, aftercare, multi-systematic/wraparound services, and lastly, separate specialized mental health courts.

Chapter 6 summarizes the central issues in the thesis and provides recommendations relevant to each area of deficiency that may contribute to resolving the issues of mistreatment and overrepresentation of children with disabilities in the juvenile justice system.

1.2 Origins of the Juvenile Justice System

In 1899, the state of Illinois established the first U.S. juvenile justice court. By 1904, eleven states across the nation had created juvenile justice courts. Over 20 years later, in 1927, all but two states (Maine and Wyoming) had courts designated for the adjudication of juvenile delinquents. By 1950, every U.S. state had enacted legislation creating juvenile courts (Butts and Mitchell 2000). The creation of juvenile courts in the United States was a response by state governments to several factors that all pointed to one main issue: it had become increasingly apparent that youth offenders were different from, and should be treated differently from adults in the justice system. The most common evidence against the status quo supported a separate judicial intervention approach for juveniles:

- Increasingly frequent scientific and psychological studies showed that children were not only physically less developed than adults but morally and emotionally underdeveloped as well. Children were found less capable of deciphering right from wrong and understanding the consequences of their actions.
- Dissatisfaction among the public as well as court practitioners with the outcomes of cases involving juveniles tried in mainstream adult court. One point of dissatisfaction stemmed from the belief the immature or very young offenders may be viewed sympathetically by jurors and
judges and therefore would not be evaluated based on the facts of their case. Others believed children were being adjudicated too harshly for their age.

- Social science professionals increasingly suggested that alternate methods existed for children in ‘correcting’ various social problems, including crime (Platt 1977; Schlossman 1977; Feld 1999).

1.3 Traditional Philosophy: Parens Patriae

The U.S. juvenile justice system evolved from a judicial system in which children were adjudicated in the same court correspondingly to adults, into a paternalistic system in which the state acted as parens patriae, as the parent of the delinquent child (Schwartz et al. 1999). The government undertook this responsibility to act on the behalf of neglected, abused, or misbehaving children whose parents were not present or could not control or provide for them. The original core ideals of the juvenile justice system were based upon the conceptions that children are dependent upon adults; children are in the midst of developing emotionally, morally and cognitively and, therefore, are psychologically impressionable and behaviorally malleable; children have different levels of understanding and collateral mental functioning than adults; and, accordingly, unlike adults, children should not be held fully accountable for their behavior (Rosenheim et al. 2002).

As a result, juvenile courts traditionally rejected criminal procedures utilized in adult court and instead acted similar to a child welfare system based on the needs and best interests of the child (Feld 1999; Butts & Mitchell 2000). The philosophical framework of juvenile courts surrounded the notion that therapeutic and rehabilitation efforts, rather than a punitive approach, were the most appropriate treatment of children adjudicated delinquent. Emphasis on rehabilitation was derived from English common law, which viewed children as less culpable than adults and less developed morally and emotionally (NCD 2001).

1.4 Modern Philosophy: “Tough on Crime”

Beginning in the 1960s, concern about procedural deficiencies began to arise as a result of the informal decision-making approach historically utilized by juvenile courts (Aron
Many court practitioners as well as society members recognized that the practice of juvenile court operations rarely reflected the best-interest-of-the-child ideals set by the court's founders (Feld 1999). Some argued that this informality led to courts mistreating juvenile offenders, such as secure confinement of children who had committed non-serious offenses. Others noted that children were experiencing leniency as a result of the traditional parens patriae practice of the court (Empey et al. 1999). As a result of the inconsistencies and deficiencies discovered in the juvenile justice system, the general trend of U.S. Supreme Court rulings throughout the 1960s rejected the parens pariae philosophy and began to utilize due process protections afforded to adults in the juvenile system, which in turn constitutionally 'domesticated' the juvenile court (Butts & Mitchell 2000). In *In re Gault*, for example, the U.S. Supreme established that due process rights (including the notice of charge, the right to counsel, the right to confront witnesses, and the right against self-incrimination), previously guaranteed under the Fourteenth Amendment for adults facing legal charges, were also available to juveniles. The opinion in the decision by Justice Fortas concluded with the Court's extension of "fundamental fairness" criteria to juvenile justice proceedings (*In re Gault*, 387 U.S. 1 1967).

As a part of the shift in granting juveniles more substantive legal rights, juveniles also became subject to a higher standard of evidence and truth beyond a reasonable doubt. (*See In re Winship*, 397 U.S. 358 (1970)). In subsequent decades, however, there was concern that the juvenile court was becoming increasingly similar to criminal court, thus losing its justification as a separate system for processing children (Butts and Mitchell 2000). More recently, the concern that there was an increasing focus on the punitive aspects of the system rather than the purpose of rehabilitation for juveniles has become more pronounced (Butts
The goals of the system have shifted: punishment, prevention of recidivism, (i.e., to provide for community safety) and deterrence (of other youth from commuting the same offense), are now the modern pillars of juvenile justice system (Arredondo 2003). Many states have designed and enacted "get tough" laws to increase the punishment options for juvenile offenders (Torbet et al. 1996; Feld 1999). Most have also developed and are continuing to emphasize increasingly punitive sanctioning laws that promote formal processing of youth and minimum terms of incarceration for specific offenses (Feld 1999). Some states currently allow prosecutors to file certain cases directly in adult court depending on a youth's age and/or the type of offense committed. Others have enacted statutes that require certain cases to begin in adult court, placing the burden on defense counsel to justify transferring youth to the juvenile justice system (Butts and Mitchell 2000). The following illustrates the 2003 findings of the NCD pertaining to the near 1.7 million delinquency cases processed in U.S. juvenile courts in 1999:

In that year, 42 percent [of juveniles] were informally processed (i.e., no petition was filed) and 58 percent were formally processed. Regardless of whether they were processed informally or formally, fewer than 1 percent ultimately were transferred to criminal court, 10 percent were placed out of home, 40 percent were placed on probation, 31 percent were given other sanction, and 19 percent were dismissed or released. Of every 1,000 delinquency cases processed in 1999, 581 were formally processed. Of these, 381 (66 percent) were adjudicated and 34 percent were not. In both instances, the vast majority of youth received some type of sanction. Consistent with a trend toward more formal and 'get tough' responses to youth crime, the percentage of cases dismissed or released has declined, from 34 to 19 percent between 1997 and 1999 (39).

Overall, the impacts of the modern "tough on crime" framework of juvenile courts across the nation have created disproportionate focus on punishment rather than rehabilitation, which has formed a conflicting orientation of the U.S. juvenile justice system, especially for children with disabilities (Bernard 1992; Snyder and Sickmund 1999). The current concept of the juvenile justice system as both a child-focused and punishment-oriented institution is flawed for these youth. Neither punishment nor rehabilitation designed
for mainstream delinquents are appropriate treatment methods for this population. Children who have disabilities do not learn, develop socially, or mature at the same rate as children who are not disabled. They have “significantly sub-average intellectual functioning deficits or impairments in adaptive function” (Murphy 2008, 385). In most cases, their disabilities are permanent. Although children and adults can learn to manage the disability to their best ability, it will always inhibit an individual’s capacity to function as highly as an average person in society. Thus, the status quo of the juvenile justice system is inherently unjust for children with disabilities. It is a system aimed at preventing and reducing delinquency by punitive and rehabilitative means that are inappropriate for these youth as they do not address their specific and unique needs. As a result, in the United States, there is currently a disproportionate number of children with disabilities who are in contact with and often mistreated by the juvenile justice system.

Chapter 2: The Legal Gap: Current Law & the Issue of Competency

2.1 Current Law
United States federal law mandates that the civil rights of children and youth with disabilities be protected (42 U.S.C. §12101). Included in the government’s protection is the directive that children with disabilities receive special education and other disability-related services. Under federal law, youth with disabilities are entitled to this government protection in all of their potential environments, including while under the authority of the juvenile justice system (Burrell and Warboys 2000). As a result, a child who has a disability and is under this judicial authority is entitled to protection at all stages of juvenile justice proceedings, including but not exclusive to the intake, disposition, treatment, and aftercare stages of the system.
There is, however, a gap in the government’s legal protection of these children. There are specific federal disability laws that relate to negative and unjust consequences for children who come into contact with the juvenile justice system. For example, the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act (IDEA), and the Civil Rights of Institutionalized Persons Act (CRIPA) all require that children with disabilities receive services to address their disability-related needs from the government, including the juvenile justice system. However well intended, this legislation falls short in protecting these children. According to the NCD, “numerous sources identify legal cases in different court systems (e.g., local, state, federal), cases that collectively help contribute to what the law ‘is’ but such information provides relatively little information about the true extent of compliance with federal law” (120). Consequently, children with disabilities are consistently and continuously being shunted in large numbers into the juvenile justice system. In fact, children with disabilities are disproportionately overrepresented in the juvenile justice system relative to children without disabilities (Otto, Greenstein, Johnson & Friedman, 1992; Wierson, Forehand & Frame, 1992). In this chapter, I will review the federal legislation that relates to government treatment of disabled children and highlight gaps in protection stemming from the language or implementation of the legislation, including the absence of a national competency standard for juveniles in court.

2.1.1 Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973, amended in 1977, provides specific antidiscrimination protections for individuals with disabilities. The new regulations attempted to remove potential barriers and create opportunity and accommodation for people with disabilities. The statute banned recipients of federal funds from discriminating against people with disabilities, including public schools. Section 504 was the first law to state that
the exclusion or segregation of an individual with a disability constituted discrimination. The passing of the amended statute in 1977 also marked the first time that the U.S. government recognized people with disabilities as a protected minority group under the law.

As a result of Section 504, awareness of people with disabilities rose in American society and people began to recognize discrimination against these individuals as a result of their disability. Section 504 is said to have "contributed to a change in commonly held assumptions that problems faced by people with disabilities—such as unemployment, underemployment, and low educational attainment—were the inevitable result of limitation stemming from the disability itself rather than societal barriers or prejudices" (Aron & Mears 2003, 21). In time, Section 504 became the basis of the Americans with Disabilities Act enacted two decades later in July 1990.

Although the statute has certainly had some positive effects overall for individuals with disabilities, children with disabilities have largely been overlooked by the law. Section 504 applies to children with disabilities because of their participation in public school systems that receive annual federal funds in theoretical compliance with the statute. The statute mandates that all children with disabilities receive a public education comparable to schooling provided for mainstream children who do not have disabilities. Frequent noncompliance or ineffective enforcement of Section 504 by U.S. public schools, however, has created a direct link between children with disabilities who are neglected by inadequate and unspecialized special education programs and youth with disabilities who then find themselves in contact with the juvenile justice system (NCD 2003).

2.1.2 Individuals with Disabilities Education Act (IDEA)

First issued as the Education for All Handicapped Children Act of 1975 to promote and protect the educational rights of children with disabilities, the Individuals with
Disabilities Education Act (IDEA) “established the right of children with disabilities to attend public schools, to receive services designed to meet their needs free of charge, and to learn in regular education classrooms alongside nondisabled children to the greatest extent possible” (NCD 2003, 24). When a child is recognized as disabled by IDEA, and therefore noted in need of special education services provided by the government, a team that includes the child’s parents or guardians and representatives of the public education system develop an IEP (individual education program) or IFSP (individualized family service plan). These plans create a standard by which the law addresses each child’s unique needs. In 1997, Congress revised this provision and amended IDEA so that public schools had to develop and review a child’s individual education program (IEP) to suit better the individual needs of a child with disabilities. The changes also placed greater emphasis on transitional planning for children with disabilities and addressed how the children could be disciplined by schools (Aron & Mears 2003). Amended most recently in 2004, IDEA guarantees:

1. a free appropriate public education [is] available to all children with disabilities residing in the State between the ages of 3 and 21, inclusive, including children with disabilities who have been suspended or expelled from school. 2. Full educational opportunity goal: the State had established a goal of providing full educational opportunity to all children with disabilities and a detailed timetable for accomplishing that goal (20 U.S.C. §1412).

The core substantive rights taken from IDEA are widely known as FAPE: free, appropriate, public education rights in the least restrictive environment (Aron & Mears 2003). Similar to the unintentional consequence of Section 504, however, over the years, public schools’ noncompliance with IDEA has also resulted in an overrepresentation of children with disabilities in the juvenile justice system (NCD 2000). Congress has stated that the rights and protections secured by IDEA do not end when children with disabilities are removed from their school’s environment to be detained or incarcerated under the authority of the juvenile justice system. The provisions of IDEA are
intended to extend to the education of children with disabilities at all state and local juvenile corrections facilities. Alternative education programs in detention and correction facilities and other juvenile justice programs are all legally mandated to provide IEPs to youth with disabilities who need them while they are incarcerated (Robinson & Rapport, 1999; Burrell & Warboys 2000; Aron & Mears 2003).

In addition, IDEA is meant to support children with disabilities at the adjudicatory stage during their contact with the juvenile justice system. The provisions of IDEA intend to ensure that an intellectually disabled juvenile has the right to be “accompanied and advised by counsel and by individuals with special knowledge or training with respect to the problems of children with disabilities” (Ahearn 2001, 1). The reality is, however, that IDEA, already inadequately addressed by the education system, is once again disregarded by governmental authority through the shortcomings of the judicial system. The result is the inappropriate treatment of children with disabilities who come into contact with the juvenile justice system, which in turn bolsters the cycle of the continual rising rate of recidivism of youth with disabilities in the system (Hill & Sprague 1999; Quist et al. 200; Larson & Turner 2002).

2.1.3 Civil Rights of Institutionalized Persons Act (CRIPA) (42 U.S.C. §1997)

Originally enacted in 1980, and most recently amended in 1997, the Civil Rights of Institutionalized Persons Act (CRIPA) authorizes the U.S. Attorney General to investigate conditions of confinement in state or locally operated jails, prisons, pretrial detention centers, juvenile correctional facilities, institutions for people with psychiatric or developmental disabilities, and publicly operated nursing homes. The purpose of CRIPA is to discover, investigate and correct any widespread deficiencies that may seriously jeopardize the health and safety of residents of these public institutions (NCD).
The potential of CRIPA to protect children with disabilities mistreated by the juvenile justice system is immense. The law gives the U.S. Department of Justice the authority to enforce federal disability laws like Section 504 and IDEA and other laws that protect children with disabilities (Aron & Mears 2003). In addition, the law confers power on the Civil Rights Division of the Department of Justice to take legal action against state or local governments for failing to meet previously established constitutional or statutory rights of people institutionalized in publicly operated facilities (Puritz & Scali 1998; Rosenbaum 1999). For incarcerated juveniles with disabilities, findings from the proper utilization of CRIPA would raise government awareness of both the vast overrepresentation of children with disabilities in contact with the juvenile justice system and the inappropriate treatment of those children in the system. Heightened awareness of these issues may then encourage government officials to address the injustices endured by these children. CRIPA is, however, an enormously underused legal tool. By 1999, the Department of Justice had investigated fewer than 100 juvenile detention and corrections facilities in 16 states and territories (Rosenbaum 1999).

2.2 Failure of Compliance with Existing Laws

The application of and compliance with Section 504, IDEA, CRIPA and all other disability and related juvenile laws, impact each of the different stages of a child’s interaction with the system. Reports by the NCD in 2000 and 2002 suggest the continual failure of the U.S. government, school systems, and the Justice Department to implement federal disability law fully and effectively (NCD 2000, 2002). Some barriers noted by experts to proper legal treatment of disabled children in the juvenile justice system include: the lack of sustained and comprehensive commitment among legislators, schools, and juvenile justice systems to implementing IDEA, the lack of reliable and accurate empirical information about the level
and types of implementation of disability laws and programs for juveniles, the lack of cooperation and collaboration between schools, the juvenile justice system and other child-serving agencies in complying with disability and youth related laws, and the lack of awareness and insufficient knowledge about children with disabilities and disability laws for juveniles among education and juvenile justice system practitioners (Aron & Mears 2003, 9, 63-65, 99, 101).

2.2.1 Legal ambiguity

Nonconformity with disability and youth-related law among the education and justice systems is in part due to the ambiguity of the law and legal definitions of key terms relevant to this population. Many definitions have varied so frequently over time that practitioners find it difficult to keep up with the most recent modifications of the law. Researchers observed during the 1980s and 1990s, for example, that the definition and assessment procedures for diagnosing children with conduct disorders had been altered so frequently that, as a result, few reliable instruments existed for making these diagnoses (Mrazek & Haggerty 1994). More recently, in 2002, the NCD noted in its annual review that still “there is no universally accepted definition, and thus measurement, of disability among children and youth” (2002).

Currently, the term “disability” is defined and understood differently in federal legislative acts and by professional organizations, social service and health agencies, schools, and practitioners in the juvenile justice system itself (Murphy 1986; Aron et al. 1996; U.S. Department of Education 2001). Generally, “disability” refers to “how physical or mental limitations are manifested within a specific social or environmental context. Thus, a disability can be thought of as the outcome of an interaction between impairments, or
functional limitations, and behavioral/performance expectation of socially defined roles” (NCD 2003, 49).

Some professionals note that there are at least two distinct approaches in indentifying a disability (Hodges 2005; NCD 2003, Teplin et al. 2006). One approach, used by the National Health Interview Survey, is the “condition-specific or categorical” approach (NCD 2003, 50). One issue with this strategy is that children (with and without disabilities) develop in different cognitive areas and at different rates from one another. Categorizing children with a disability under one broad condition-based definition does not promote individualized treatment proven more successful for these children in the juvenile justice process (Aron et al. 1996). Another problem with the categorical approach of defining a disability is that a child may have more than one disability contributing to her symptoms, behaviors, and limitations and therefore fit into more than one condition-specific category.

The second alternative approach popular among child-serving agencies in defining a disability is known as the “non-categorical or functional” approach (Hodges 2005; NCD 2003). The non-categorical approach defines “disability” with regard to “[children’s] specific condition, children’s functioning in areas such as cognition, communication, motor abilities, social abilities, and patterns of interaction” (NCD 2003, 50). In 1990, the U.S. Supreme Court in Sullivan v. Zebley legally mandated this approach for the Social Security Administration (SSA) when implementing their eligibility determination process. (Sullivan v. Zebley 493 U.S. 521 (1990)). Overall, the use of different terms and approaches to label and assess a disability, defining the same terms differently, and the use of different types of information and approaches to diagnose and classify disabilities, widens the legal gap meant to protect children with disabilities who come into contact with the juvenile justice system.
Definitions of specific disabilities in particular, such as learning disabilities, are also inconsistent across the board. In fact, “learning disability, as a category, has been called a sociological response that attempts to wipe up general education's spills and cleanse its ills” (Colvin & Hefland 1999, 1). Also, the term “has expanded since the advent of EAHCA (IDEA) because it has been able to absorb a diversity of educational, behavioral, and socioemotional problems irrespective of their causes, their responds to good teaching, or their prognosis” (Lyon et al. 2001, 269). It has been noted that the current definition of “emotional disturbance” undermines IDEA as well (O'Neill 2006). In a review of the federal disability law in 2006, it was noted the language excluding youth identified as "socially maladjusted" from the category of “emotional disturbance”:

[E]liminates basic educational opportunities for a major segment of the disabled population. Yet, mental health and special education research do not justify the exclusion. The result of not including 'socially maladjusted' youth from the category of 'emotional disturbance’ especially affects incarcerated youth because of the higher prevalence of special needs within this population. It is also in conflict with the primary goals of the state's intervention with these youths: education, rehabilitation and reduction of recidivism. The special education needs of incarcerated youths with a disability seriously impairing their ability to work, live and function within our society must be addressed for these youths to effectively reintegrate into society upon their release. The goals of the IDEA and rehabilitation within juvenile justice should be in harmony. However, the 'socially maladjusted' exclusionary language in the definition of 'emotional disturbance’ frustrates the rehabilitative goals of juvenile justice (O'Neill 2006, 1189).

Furthermore, in a 1996 Urban Institute review of juvenile justice systems nationwide, researchers note this trend of inconsistency and ambiguity of key terms in the letter of the law:

In practice, no single definitional or classification system has been used by service providers or others in the childhood disability community. Differences in the way children with disabilities are diagnosed and classified remain a continuing problem that affects choices in medical, educational, social, and rehabilitative services. These differences complicate decisions about eligibility, transitioning across programs, program funding, and documentation of program impact. For researchers and policymakers, it also adds to the difficulty of comparing studies and systematically analyzing different policies. This variability reflects conceptual, semantic, and measurement issues (Aron et al. 1996, 13).
Frequently, the ambiguity in disability and youth related laws “[does] not make clear what stage, or part, of the juvenile justice system is responsible for carrying out a given provision of the law, including when and how youth should be screened and assessed for disabilities and related needs” (Aron & Mears 2003, 20). Screening is crucial for youth at the intake stage of the juvenile justice system. Without a proper assessment of a disabled child entering the system, a negative domino effect follows and impacts each stage of that child’s experience with the system. As a result, children with disabilities repeatedly suffer an injustice by the system as they do not receive proper treatment according to their unique needs. Consequently, it is not uncommon for these children to repeat delinquent offenses post-adjudication and return to the system time and time again (Quist et al. 2000; Leone et al. 2002).

2.2.2. Other Barriers

At the education level, in particular, not meeting legal requirements that impact children with disabilities further reinforces the link between disabled students and delinquent children, resulting in the overrepresentation of children with disabilities in the juvenile justice system. Research indicates, “the majority of juveniles who enter correctional facilities have intense educational needs that are often further complicated by mental health needs. The prevalence of special educational needs among incarcerated youth is disproportionately higher than that found in the general population” (O’Neill 2006, 1199). One reason this legal gap exists in schools is a lack of clear guidance about what full compliance with disability law would entail. Other causes may be the lack of sufficient funding or commitment as there are no incentives or motivations to implement the law (Aron & Mears 2003). In one study on federal monitoring and enforcement of IDEA, the NCD discovered that “every state was out of compliance with IDEA requirements and that in some states the lack of compliance has
persisted for many years. The study reviewed 25 years of monitoring reports from the U.S. Department of Education and concluded ‘that federal efforts to enforce the law over several Administrations have been inconsistent, ineffective, and lacking any real teeth’” (Aron & Mears 2003, 24; NCD 2000). Other sources suggest that compliance with IDEA is irregular and unevenly distributed across the nation (Cagungun 2000). With a lack of resources in schools and no real government monitoring of disability related law within the education system, schools find it difficult and feel no incentive to comply with the law, contributing to the legal gap and consequential high prevalence of disabled children in the juvenile justice system.

2.3 Widening the Gap: The Competency Issue

The lack of legal coherence among states in relation to their juvenile justice systems impacts children nationwide who come into contact with the system. In particular, the different approaches among states towards a child’s competency, directly linked to a child’s level of cognitive ability, results in negative consequences for children with disabilities who are involved in the juvenile justice system. In 1987, the U.S. District Court of the Eastern District of Wisconsin in In re T.W. held: “while rehabilitation [in the juvenile justice system] is a priority, the courts are not required to apply the juvenile justice system to a juvenile’s diagnosed intellectual or behavioral problems” (In Re T.W., 652 F.Supp. 1440, 1445 (E.D.Wis.1987)). Additionally, “juvenile justice systems routinely presume that adolescents accused of delinquent or criminal misconduct are competent to stand trial” (Katner 2006, 503). Some research suggests, however, that there is an “issue of large numbers of adjudicated juveniles where competency was not raised, was overlooked, or was not taken seriously[...] For those juveniles for whom competence is never raised or challenged, few procedural remedies may exist (Katner 2006, 518). As a result of this ongoing competency
issue, a 2005 national study of delinquents involved in the juvenile justice system found that among youth who categorically had more severe mental health impairments and associated functional disorders, only 15.4% of those children receive any treatment for their disability (Teplin et al. 2005, 1175).

The U.S. Supreme Court and the United States Congress have never recognized the explicit right of juvenile defendants to be adjudged competent prior to standing trial. Currently, individual states must determine whether a juvenile must be deemed competent to stand trial; and if so, what standards comprise that determination. In adult court, “competency requires that citizens accused of criminal misconduct understand the charges against them, have rudimentary understanding of the court process, be able to understand and answer questions posed to them by their counsel, and be able to make decisions about their trial such as whether to testify, and whether to accept or reject plea bargains (Katner 2006, 503-503; Dusky v. United States, 362 U.S. 402 (1960)). Research suggests that “the absence of this constitutional right in the juvenile justice context has had a significant impact on all children in the system, but a particularly harmful effect on mentally retarded children in the juvenile justice system” (Murphy 2008, 380).

In juvenile court, without guidance from the Supreme Court, states have developed and presently employ different approaches to juvenile competency (Johnson 2006, 1074). As of 2002, “thirty-five states and the District of Columbia [had] case law and/or statutory provisions pertaining to adjudicative competence in juvenile court” (Redding & Frost 2001, 353, 368). Florida’s and Virginia’s statutes, for example, prohibit adjudication of a delinquent who is of questionable competence. In a recent 2010 decision by the Supreme Court of Ohio, the Court reversed the delinquency ruling of the lower court on appeal as it
did not recognize that an autistic juvenile was incompetent to stand trial as his special needs
“limitations prevented him from understanding the judicial process and/or communicating
with his counsel to assist in his defense” (*In re T.B.*, 523, 8 Ohio (2010)). Although some
state courts have ruled in favor of juvenile competency, “many state legislatures have not
followed through by passing laws that address the need for juvenile competency hearings or
the implementation of case plans” (Sullivan 1999, 887). A recent study suggested that:

In many court-ordered competency to stand trial evaluations, once the juvenile is found to be
mentally retarded, some evaluators go no further. This is not difficult to understand, especially if
the child’s reading and writing comprehension skills show deficits. Some of the assessment
instruments used to determine MI [Mental Incompetency] will have limited application with
juveniles found to be mentally retarded. This process results in overlooking some of the
complicating factors that give rise to the client's incompetence to stand trial, and it also results in
failing to identify treatable MI suffered by the juvenile (Katner 2006, 518).

Research also shows that:

While most of the states have recognized the right in the juvenile court context, few states have
established restoration services for children that are deemed incompetent. This presents a
particular problem for mentally retarded children because, if determined to be incompetent, it
is unlikely they will be restored because of the permanence of their disability (Murphy 2008,
380).

Even more disabling for these children, fourteen U.S. states have not yet begun to
address the competency issue for juveniles in contact with the system (Johnson 2006, 1075).
And other states, such as Oklahoma, forthrightly disallow juveniles the right to a competency
determination in court proceedings. In *G.J.I. v. Oklahoma*, the Oklahoma Court of Criminal
Appeals stated, “the nature of juvenile proceedings themselves, being specifically not
criminal proceedings and being directed towards rehabilitation of a juvenile, indicates to this
Court the intent of the [Oklahoma] legislature to deal with juveniles regardless of mental
state in an effort to provide rehabilitation and necessary treatment” (*G.J.I. v. Oklahoma*, 778
P.2d 485, 7 (1989)). In this case, the lower court in Oklahoma, “relied on the rehabilitative
nature of the proceedings to conclude that the structure of the system presumed all juveniles incompetent, and therefore the right to competency was not applicable" (Murphy 2008, 383).

Without recognition of a child’s competency prior to adjudication in the juvenile justice system, children with disabilities are misunderstood and inherently mistreated by court proceedings and rehabilitative treatment services provided by the system. One recent study raised the issue of treating juveniles with disabilities the same as mainstream delinquents in this process:

[S]ignificant numbers of juveniles charged with delinquency offenses have diagnosable mental health problems. These conditions require treatment or special placement before some of these juveniles may proceed to trial. Longitudinal studies and other recent literature suggest that significant percentages of this population frequently suffer mental health problems involving multiple diagnosable disorders or conditions. Conventional thinking about juveniles in delinquency systems has yet to consider many of the newly identified mental health problems of these adolescents (Katner 2006, 507).

Furthermore, in an annual report speech to the United States Department of Justice before the National Juvenile Corrections and Detention Forum, Steven H. Rosenbaum, Chief of Special Litigation, noted:

It is clear that a sizeable portion of youths in juvenile facilities has significant mental health needs. An adequate mental health system in a juvenile facility must identify mentally ill youth, provide treatment to them, keep them from harming themselves or others, protect them from abuse, and ensure that they receive necessary accommodations to enable them to benefit from programs offered at the facility (Rosenbaum 1999).

Children’s overlooked disabilities by the courts and by their attorneys result in a system that does not provide them with the appropriate services for their specific needs. One review of the system identified three specific systematic professional educational issues as factors for the systems’ failure to recognize a child’s competency: (1) law schools offer few courses on the representation of children, (2) law schools offer few courses on the representation of mentally ill clients, and (3) state continuing legal education courses are
limited in their ability to properly train attorneys to represent children suffering with mental health problems (Katner 2006, 544). Other studies suggest:

[T]o assert that a juvenile lacks competence to stand trial, the child's attorney must have interacted with the client and determined that the client is either unable to communicate with counsel, unable to understand the legal proceedings, or appears to suffer from a mental condition or illness which prevents the client from participating in the preparation of his defense. This presents an issue for juveniles represented by a public defender, because in that situation the attorney's ability to interact with the client is limited by the attorney's caseload, investigative resources, and knowledge and ability to identify problematic behavior by the client (Katner 2006, 508-9; See also, Chin & Holmes 2002; Grisso 1999).

Consequently, the unaddressed nationwide competency issue by the courts and its practitioners continuously exacerbates the growing overrepresentation of youth with disabilities involved in the system as the recidivism rate for youth with disabilities in the juvenile justice system continues to surpass the rate for children without disabilities. Studies typically suggest, in fact, that around 10% of youth in the general population have a special disability, compared to approximately 30% to 50% of youth involved with the juvenile justice system (Murphy 1989; Brier 1989, Winters 1997; Robinson and Rapport 1999; National Center of Education, Disability and Juvenile Justice 2001; U.S. Department of Education 2001; NCD 2002; Rutherford et al. 2002). One recent study of the lack of a national competency standard concluded:

[M]any juveniles pass through the system without the court recognizing the child's incompetence, especially when the incompetence is due to mental retardation. Possible reasons for under-identification of juvenile incompetency include the traditional role of the juvenile court in treatment and rehabilitation, the ambiguities about the role of counsel in delinquency proceedings, and the limited occasions for review by appellate courts [...] Overall, juvenile courts will best serve the interests of the child by implementing a standard procedure for determining competence with basic factors and standards for each case (Sullivan 1999, 888-9, 896).

The legal gap, defined by the failings of federal legislation that relates to government treatment of disabled children and the gap in their protection as a result of language and implementation of legislation, is to blame only in part for these issues. As Chapters 3 and 4 will discuss, there are additional factors, such as the link between disability and delinquency,
and a gap in advocacy for children with disabilities, which contribute to the disparities in the juvenile justice system for disabled children.

Chapter 3: The Relationship between Disability and Delinquency

Approximately 65% to 70% of children in the juvenile justice system have a diagnosable mental health disorder (Shufelt & Cocozza, 2006; Wasserman et al. 2002, 2004; Teplin et al. 2002) and 26% of youth in the system have severe mental disorders (Cocozza & Skowyra 2006). Nevertheless, despite the strong and apparent correlation, a direct causal relationship between disability and delinquency is difficult to prove. Children who have disabilities do not learn, develop socially, or mature at the same rate as children who are not disabled (Cramer & Ellis 1996). They have “significantly sub-average intellectual functioning deficits or impairments in adaptive function, which presents itself before the age of eighteen” (Murphy 2008, 25). In addition, developmental disabilities are permanent. Although children and adults can learn to manage their disability to their best ability, it will always inhibit an individual’s capacity to function as highly as an average person in society (Wierson & Frame 1992; Cramer & Ellis 1996). Delinquent behavior may be a symptom or an expression of a child’s disability, but delinquency is not always an outcome in children with disabilities.

As discussed in the previous chapter, there is wide variation and general uncertainty nationwide in defining, measuring, and addressing disabilities in children, medically, educationally and legally. As a result, explaining the link between the disability of a child and the best means of recognizing, accommodating and accounting for that disability in the juvenile justice system is not easy.
Another significant contributor to the difficulty in determining the relationship between disability and delinquency is the deficiency in medical and governmental research relevant to the issue of the overrepresentation of children with disabilities in the juvenile justice system (which will be discussed at greater length in Chapter 4) (NCD 2003). In a 2003 Urban Institute Justice Policy Center review addressing types of children involved in the system, Aron and Mears observed: “few studies systematically address the disability-delinquency link by exploring data that could explain whether there is a causal relationship between a child with a disability and their likelihood of partaking in delinquent behavior” (Aron & Mears 2001, 26). Furthermore, there have been very few studies that even attempt to determine the mechanisms through which children with disabilities enter the juvenile justice system (Brier 1989; Aron et al. 2001). Some research questions whether disabled children are more likely to find themselves in the juvenile justice system relative to children without disabilities. Most researchers, however, have developed theories to explain this relationship attributed to the high prevalence of children with disabilities in the juvenile justice system.

3.1 Theories
Most theoretical explanations of the association between delinquency and children with disabilities come from psychologists, education specialists, and social workers. Three theories, in particular, begin to bridge the connection between disability and delinquency: the Susceptibility Theory, the Student Risk Theory, and the Differential Processing Theory. Along with these theories, this thesis proposes a fourth theory based on the lack of awareness and knowledge of children with disabilities in U.S. society as well as the government and the branches and systems within it.
3.1.1 Susceptibility Theory

Up to 80% of youth who come into contact with the juvenile justice system have diagnosable mental health disorders, and at least one out of every five has a serious emotional disturbance (SED) that substantially interferes with daily functioning (Cocozza and Skowyra, 2000). The Susceptibility Theory attempts to link children with disabilities and delinquency by focusing on the physiological and psychological factors that impact a child’s likelihood to engage in delinquent behavior (Larson 1988; Coalition for Juvenile Justice 2001; National Center on Education, Disability, and Juvenile Justice 2002c). On the physiological level, the Susceptibility Theory holds that children with disabilities are more likely to engage in delinquent behavior because of particular biological symptoms associated with a disability (Aron & Mears 2003; Osher et al. 2002). Symptoms such as impulsivity and irritability, for example, may engender delinquent behavior. The commonness of emotional disturbance, for example, is estimated at 50% of incarcerated youth (Rutherford et al. 2002). The physiological link of the theory also suggests that children with disabilities are more susceptible to participating in delinquent behavior, because of a difficulty in understanding the reasons for their actions and behaviors and failure fully to comprehend the cause-and-effect relationship and consequences of those behaviors.

Co-occurring disabilities is a key biological factor that exacerbates this issue; 79% of children in the juvenile justice system who meet the criteria for at least one mental health disorder also meet the criteria for two or more diagnoses (Shufelt & Cocozza 2006). One 2006 study of the juvenile justice facilities in Louisiana, Texas, and Washington (3 previously understudied areas) discovered that 60% of these juveniles were diagnosed with three or more mental health disorders (Shufelt & Cocozza 2006). The study also found that 46.5% of juveniles involved in the system suffer from what they refer to as “disruptive
disorders” such as conduct and behavioral disorders and 46.2% of these children had substance-use disorders such as alcohol abuse, 34.4% had anxiety disorders such as obsessive-compulsive disorder, and 18.3% had mood disorders like depression (Shufelt & Cocozza 2006). Consequently, in comparison to the mainstream youth population who are unaffected by disability, children with disabilities are at a physiological disadvantage in the likelihood that they will become involved in the juvenile justice system at some point in their childhood.

On a psychological level, many children with disabilities are aware of their differences from other children mainly due to situational factors in school, at home and in other social environments, which create a sense of inferiority in these children and may contribute to delinquency. Frequently, children with disabilities are segregated from others and receive differential treatment due to their differences from their peers, family members (such as siblings of a similar age) and community members. Often these children are isolated in special needs classrooms and are not encouraged to partake in similar extracurricular activities as other children their age. Consequently, the severance from what they perceive as “normal” for other children as well as the differential or “special” treatment they receive, demeans children with disabilities and instills in them an overwhelming desire to be treated the same as everybody else. As a result, children with disabilities tend to mimic the poor behavior of other youth to receive a similar kind of attention. Some research suggests that family structure and community ties are among the most critical factors in predicting childhood disability and delinquency-related behavior (Altschuler & Armstrong 2001; Aron & Mears 2003).
3.1.2 Student Risk Theory

The Student Risk Theory identifies a relationship between children with disabilities and persisting juvenile delinquency. Research demonstrates that:

Disabled students have a higher rate of adversarial police interactions and juvenile convictions. A study by the Juvenile Journal for Special Disabilities found that nearly twenty percent of students with emotional disabilities are arrested at least once before they finish school. This compares to an arrest rate of six percent for all students. In addition, a national survey found that individual schools, on average, file police reports for thirty-four percent of their students with disabilities during a school year, compared to only twenty-eight percent of non-disabled students. The same study reported that disabled students were three times more likely than non-disabled students to face serious disciplinary actions [...] Students with attention deficit hyperactive disorder are seven times more likely to be suspended from school and eight times more likely to have adversarial encounters with the law than non-affected peers (Soliz & Cuttler 2001, 267-8; See also, Burrell & Warboys 2001; Holden 2000).

The Student Risk Theory, also referred to as the School Failure Theory (Aron et al. 2001), suggests that a child's disability could contribute to difficulties, frustration, and failure in school. The theory indicates that accumulation of stress and frustration from both social and academic difficulties in school may be a key contributor to delinquency for students with disabilities. The Student Risk Theory explains the high incidence of youth with disabilities involved in the juvenile justice system by establishing a link between children with undetected or poorly managed disabilities and resulting delinquent behavior that triggers the juvenile justice system (Keilitz & Dunivant 1986; Norman 1989; Waldie & Spren. 1993; Winters 1997; Crawford 1996; Malmgren et al. 1999; Burrell & Warboys, 2000; Coalition for Juvenile Justice 2001a; Finn et al. 2001; American Youth Policy Forum and Center for Education Policy Brief 2002). In 2000, the Office of Special Education Programs reported the prevalence of disabilities among school-age children in the United States as 9%, compared with an estimate of 32% within the juvenile justice system (Quinn et al. 2001). Other studies find that the prevalence of attention deficit hyperactivity disorder (ADHD) is four to five times greater in the juvenile justice system than in schools; an astonishing 20% to
50% of juveniles in the system are affected by it (Rutherford et al. 2002). Another study provides alternative data to support the Student Risk Theory by highlighting two central demonstrations of the education system's lack of commitment to children with disabilities: the high costs of addressing the specific needs of some students with disabilities, and the school's exclusion of students with disabilities from adequate and appropriate education as a result of the government's financial incentive for schools to enhance their students' test performances (Finn et al. 2001).

3.1.3 Differential Processing Theory

The Differential Processing Theory holds that children with disabilities are not in fact more likely than children without disabilities to participate in delinquent behavior because of physiological, psychological or school-failure-related factors. The theory suggests that they are, however, more likely to be processed differently by the systems with which they come into contact, therefore creating a correlation rather than a causal link between children with disabilities and delinquent behavior. The Differential Processing Theory notes that school officials and administrators, law enforcement officers, court professionals and legal practitioners are all essential contributors in further disabling these youth. In relation to a child’s participation in the juvenile justice system specifically, researchers and advocates of this theory distinguish three fundamental stages at which children with disabilities are processed differently from mainstream delinquent offenders:

1. **Arrest and referral:** Children with disabilities may be less likely to hide their delinquent behavior and therefore more easily accused of delinquency.

2. **Adjudication:** Children with disabilities may be more likely to be adjudicated delinquent due to their inability to understand fully the system's judicial proceedings and general system practices. In addition, it is more likely that youth with disabilities are misinterpreted by legal practitioners of the system who are not aware of a child's disability or the implications of an identified disability in a juvenile.

3. **Sentencing and treatment:** Due to a misunderstanding or neglectful recognition of a child’s disability, a child’s disability may not be considered with respect to their delinquent behavior. Therefore, the disposition by the court may be more severe and the treatment services
According to a 1997 study by SRI International, youths with learning disabilities or emotional disturbances are arrested at higher rates than their non-disabled peers (Young 2001). In J.D.B. v. North Carolina, for example, a thirteen-year-old special needs student was questioned in his school by a police officer (in a confined conference room with no parent or legal guardian present) about a series of break-ins that did not occur on school grounds nor during school hours. Although the juvenile confessed to the police of his participation of the alleged break-ins, the Court found the child not responsible as he was clearly taken advantage of and not properly Mirandized by the police as a result of his disability. (See J.D.B. v. North Carolina 131 S. Ct. 502 (2010)).

The cycle that the Differential Processing Theory exposes in the juvenile justice system is reflected in the high recidivism rate of children with disabilities involved in the system. In their 2003 review of the juvenile justice system, Aron and Mears noted specifically that

[O]verrepresentation [of children with disabilities] may result from differential school and law enforcement targeting of youth with disabilities and then differential processing once they have entered the juvenile justice system. Such differences can become self-reinforcing with youth disabilities who are formally processed are more likely than other youth to recidivate or to be further targeted by schools and law enforcement agencies (2003, 7).

These three theories are not mutually exclusive and they all help to explain the overrepresentation of disabled children in the juvenile justice system. Of the three, the Differential Processing Theory, which incorporates the underlying notion of a lack of knowledge of youth with disabilities, is most widely known (Brier 1989; Waldie & Spreen 1993; Malmgren et al. 1999; National Center on Education, Disability and Delinquency 2001; US Department of Education 2001). Unfortunately, despite its prevalence, the
Differential Processing Theory is not always recognized as a separate and independently viable explanation for the presence of disabled children in the juvenile justice system.

3.1.4 Insufficient Knowledge: A Fourth Theory

Although inconsistent medical and legal definitions and these three theories help to explain the overrepresentation of children with disabilities in the juvenile justice system, the most noteworthy overarching factor that fosters this relationship is the lack of awareness and limited knowledge about youth with disabilities. Most research suggests that "practitioners have a marginal understanding of federal disability law, the special needs of youth with disabilities, or effective ways to provide services" (Smith et al. 2002, 5). Inadequate understanding of the complex array of issues presented by and for children with disabilities at all levels of the education, social service, and juvenile justice systems, means that, at each stage of their participation, the juvenile justice system becomes punitive, even detrimental, rather than rehabilitative for them.

The widely misunderstood multidimensional nature of disabled youth, the psychological, social and moral development of these children, and the range of specialized needs of each disabled child, results in a greater likelihood that a child with disabilities will come into contact with the juvenile justice system (Loeber & Farrington 2001). At the prevention level, this occurs if a child's disability goes undetected or is poorly managed by her school or child welfare provider and also at the intake stage of the juvenile justice system (an area of deficiency that this thesis will later discuss in greater depth in Chapter 4) (Rutherford et al. 2002).

At the adjudication level as well, the inadequate representation of children with disabilities is a result of insufficient knowledge, known as "rolelessness" (Costello 1999). Rolelessness refers to "the confusion experienced by many lawyers/advocates who are
unsure about how to carry out their professional obligations to a client who is mentally
disabled or who is a child” (Costello 1999, 107). Many juvenile law practitioners including
judges, prosecutors, defense counsel, probation officers, detention and correctional staff, and
jurists do not always fully comprehend the special circumstances and specific needs of
children who have cognitive disabilities. For example, many attorneys who represent
children with disabilities fail to take into account the specific needs and potential
vulnerabilities of the child who is being represented (Peikin 2001). Experts note that “an
attorney representing a juvenile client should be aware not only of developmental immaturity
and its potential impact on client competency, but also of the potential impact of mental
illness or mental retardation combined with a client's developmental immaturity and how
these combined factors affect the competency of the juvenile” (Katner 2006, 508; Costello
1999). Other research demonstrates a serious practical problem with increasing attorneys’
training concerning children with disabilities: the attorneys who represent this youth
population are most frequently public defenders with large caseloads and limited time and
resources to dedicate to their clients (Katner 2006). In 1995, a joint project by the ABA
Juvenile Justice Center, the Youth Law Center, and the Juvenile Law Center funded by the
U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention found
“high caseloads to be the single most important barrier to effective representation” (Puritz et
al. 1995, 7). A concurring study concluded that:

High caseloads plagued public defenders everywhere. Almost none of the public
defenders surveyed have a cap on the number of juvenile cases they may handle. More
than two-thirds of public defenders feel that caseload pressures limit their ability to
represent juvenile clients effectively. More than a third of those responding said that
the time available to meet with and prepare clients before their cases are called is
inadequate (Katner 2006, 537-8; See, Puritz et al. 1995, 7-8).
Therefore, the system is inherently disadvantageous to a child with disabilities, because many times the child’s own counsel does not understand the child’s specific needs and circumstances (Peikin 2001).

In addition, due to the ignorance of the juvenile justice system itself regarding children with disabilities, many states in attempting to address the overrepresentation of these youth in the system, have implemented “unrealistic expectations for interventions, focusing primarily on reducing recidivism” rather than first addressing the cause and effect relationship of the issue at hand (Howell 1995, 156). These treatment programs tend to adopt strategies already employed in an effort to deter mainstream delinquents from re-offending. These efforts do not recognize that there is a fundamental link between disability and delinquency and therefore are not tailored to address the unique circumstances of children with disabilities. In an example from 2004, the U.S. Court of Appeals for the third circuit found the Luzerne County Juvenile Detention Center of Pennsylvania in violation of the substantive due process rights of a 13-year-old child with severe developmental disabilities upon instituting, “deficient hiring and staffing policies and practices; [a] lack of established protocols to ensure youth safety; and [a] lack of established policies to address the mental and physical health needs of youth residents” (Juvenile Law Center 2001; See A.M. ex rel. J.M.K. v. Luzerne County Juvenile Det. Ctr., 372 F.3d 572, 586 (3d Cir. 2004)).

As previously discussed, part of this issue is a result of the minimal education and lack of training that most law practitioners and other staff have regarding disabilities at all phases of the juvenile justice process, including the intake stage, adjudication, treatment programs, and aftercare services provided by these professionals. Organizations such as the National Association of Counsel for Children and the American Bar Association’s Center on
Children and the Law, recommend conferences and other training programs for attorneys, but these programs are attended by a minority of the attorneys practicing in this field (Katner 2006). Although this may be a consequence of the scarce time the court’s already overburdened personnel have to learn about the thoughts, behaviors, symptoms, and emotions of these children, as well as insufficient funding and research on the issue, without the court’s full understanding of children with disabilities, many juveniles are misunderstood, misrepresented, and mistreated by the system.

Children with disabilities are often unidentified or misunderstood in the justice system because their disabilities manifest in a variety of forms: age, gender, education, home and social life may each play a role (Murphy 2008). It is easy for juvenile justice system personnel unknowingly to group certain behaviors and attitudes of delinquents together with symptoms of intellectual disabilities, but there is no formula to decipher the behavior or thoughts of these children (Malmgren et al. 1999, 194-200). Youth who are developmentally delayed commonly appear uncooperative, disrespectful, angry, harmful, and irritable; this is especially true in circumstances in which a juvenile is uncomfortable and uncertain of his surroundings, such as a court proceeding:

Leading questions also make these individuals vulnerable to giving inaccurate answers. During interrogations or cross examinations, police and prosecutors often take for granted a mentally retarded child’s inability to respond to questions quickly and accurately. Further complicating the situation is the fact that mentally retarded children are usually ignorant to the roles that police and attorneys play in the justice system because the curriculum in special education classes is more limited than general education classes, and therefore disabled children do not develop the same general body of knowledge (Murphy 2008, 387; See also, Ellis & Luckasson 1985; Leone et al. 2002).

Additionally, children with disabilities often give deceptive “normal” answers in response to law practitioners (Keilitz et al. 1986, 18-26). Because developmentally delayed children have a motivation to please authority figures, they will often answer questions about acceptable
social behavior in the affirmative and inappropriate behavior in the negative because they believe it is the authority figure’s desired answer (Murphy 2008). These limited communication skills inhibit the attorney-client relationship and judges’ interactions with juveniles with disabilities because they are not apt to provide the proper information. The behavioral symptoms of juveniles with disabilities, as well as their attitudes, which express negative self-images or irrational fears, are a result of poor judgment skills, lack of impulse control, poor social skills, and short attention span, all symptoms of a cognitive delay (Murphy 2008). As a result, children with disabilities are frequently mistaken as dangerous and a flight risk and they are falsely associated with failure in academics, truancy, and delinquency (Waldie & Spreen 1993, 417-423).

In a National Center for Mental Health and Juvenile Justice study, researchers found that “[a] lack of understanding about the manifestation of mental health problems among youth in the juvenile justice system can lead to inappropriate and ineffective responses to these manifestations, and, consequentially, further exacerbation of a youth’s symptoms” (Skowyra & Cocozza 2006, 10). Additionally, research suggests that “practitioners have a marginal understanding of federal disability law, the special needs of youth with disabilities, or effective ways to provide services” (Mooney & Silver-Pacuilla 2010, 9). Due to the limited knowledge of children with disabilities, the juvenile justice system acts in ways it believes to be the correct manner by upholding its goals and acting as parens patriae to protect the health, safety, and welfare of the child. However, a failure to identify and understand children with disabilities leads juvenile justice practitioners to enforce inappropriate treatment and case management strategies for these youth. As these programs were designed for mainstream children, they are not successful in teaching disabled children...
comprehension of their delinquent behavior, nor are they successful in rehabilitating children with disabilities (Leon et al. 2002). Consequently, these strategies of the juvenile justice system in addressing disabled children may in fact be punitive and do a disservice to them.

Chapter 4: The Advocacy Gap: Inadequate Representation of Children with Disabilities at all Levels of the Juvenile Justice System and among Child-Serving Agencies

4.1 Opportunities at the Different Stages of the Juvenile Justice System

As previously noted in Chapter 3.1.4, there is a deficiency in child-serving agencies in the United States. This legal gap, and unclear relationship between disability and delinquency, have created areas of deficiency and fragmented services at each stage of a child’s participation in the system. At all levels of the juvenile justice system, the best interests of youth with disabilities are not being advocated for by the programs in place nor by the professionals involved in each child’s case.

In 2002, Stephen Rosenbaum, the Chief of Special Litigation of the Civil Rights Division within the U.S. Department of Justice, identified five areas of deficiency in regard to youth with disabilities in the juvenile justice system: identifying children with disabilities, providing treatment for them, keeping them from harming themselves or others, protecting them from abuse, and ensuring that they receive necessary accommodations to enable them to benefit from programs offered at the facility (Rosenbaum 2002, 6). One recent study also noted that “[i]nconsistent intake procedures, unqualified staff, and inadequate interim monitoring contribute to the failure to identify disabled youths in correctional facilities” (Soliz & Cuttler 2001, 267). Not only is the overrepresentation of children with disabilities in the system a consequence of these deficiencies, but so is the misrepresentation and mistreatment of these children at two
particular stages of the system: the intervention (pre-adjudication), and treatment and aftercare (post-adjudication) stages.

As a result of the system’s limited recognition of a child’s disability due to scarce screening and assessment tools, as well as poor general awareness among practitioners of the special needs of children with disabilities and their link to delinquent behavior due to inadequate professional training, the unique needs of children with disabilities in the juvenile justice system are not being met (Howell 1995; Loeber & Farrington 2001; Peikin 2001; Smith et al. 2002; Rutherford et al. 2002; Skowyra & Cocozza 2006). Treatment and educational services (as discussed in Chapter 2.2.2), intended to provide rehabilitative support for mainstream delinquents, do not appropriately approach children with disabilities according to their specific needs and in turn may be punitive for them. As argued in the previous chapter, some children’s disabilities predispose them to aggressive and obstinate behavioral patterns. With unknowledgeable practitioners managing and treating children with these symptoms, the system provides inappropriate and ineffective responses and treatment strategies that are further disabling for this population. Although effective services for children with and without disabilities involved in the juvenile justice system are required by federal law (also discussed in Chapter 2), the overrepresentation of children with disabilities demonstrates that the intervention and treatment strategies of the juvenile justice system are its major areas of deficiency.

4.1.1 Inadequate Intervention

Children with disabilities are at a further disadvantage due to a juvenile justice system that is unable to intervene appropriately at the pre-adjudicatory stage because the system was “not designed to adequately identify or provide services for youth with disabilities that need specialized educational or mental health treatment and services” (Smith et al. 2002, 4). Most
commonly, “their symptoms serve as a basis for intervention rather than a basis for identification of the cause of this behavior” (OJJDP 1993, 103). As a consequence, the central downfall of the intervention phase is the inadequate screening and assessment of children with disabilities at the system’s intake stage, which is one result of the absence of competency determinations discussed in Chapter 2.3. In the interest of Holifield (1975), for example, was one of the first instances in which an appellate court recognized that a juvenile’s competency was not properly assessed during the intake process and thus reversed the lower court’s ruling as a result of the child’s incompetence caused by his disability. More recently, in 2005, the Supreme Court of Pennsylvania reversed a lower court’s delinquency ruling in the case of an eleven-year-old child with Asperger’s Syndrome (a neurological disability on the Autism spectrum) as the juvenile court did not admit or consider the child’s disability in the intake process prior to his adjudication. (See In the Interest of D.A.S., No. 668 MDA 2005 (Pa. Super. Apr. 4, 2006)).

A noteworthy approach to intervention for children with disabilities who come into contact with the juvenile justice system is a positivist understanding of their delinquent behavior. Positivist criminology for disabled children “advocate[s] a system of ‘individualized justice’ in which background and personality traits of each offender could be considered and in which punishment and deterrence would have little relevance” (Manfredi 1998, 26). This notion of individualized justice through a positivist understanding of each disabled child may be most practicable and beneficial through mental health screening and clinical assessment strategies for children in the juvenile justice system. Although infrequent in today’s juvenile courts, the benefits of screening and assessment tools for children who come into contact with the juvenile justice system have been recognized by the courts for
decades. In 1980, for example, the Supreme Court of Appeals of West Virginia held that “the court has a duty to insure that the child’s social history is reviewed intelligently so that an individualized treatment plan may be designed when appropriate. This information also insures that the disposition decision is not made simply by reference to the very misbehavior which is the ground for the juvenile proceeding” (State Ex Rel. D. D. H. v. Doster 165, 414 W.Va. (1980)).

Mental health screening is a standardized tool used by non-clinical staff to identify children with disabilities who come into contact with the juvenile justice system. A Clinical Assessment (CA) occurs after a mental health screening if a child’s score from the screening process is suggestive that the child may have an emotional or cognitive disability. CAs are performed by trained clinicians and offer more comprehensive, individualized evaluation of children. The assessment process may include psychological testing, clinical interviewing, and reviewing any past documentation of a child’s disability—from school, health care provider, social service agency, etc. (Williams 2006). Experts suggest that information about a child’s disability through mental health screening or a CA:

May help to determine whether formal delinquency proceedings should proceed or suggest important directions for investigation and case strategy. Information about the disability often helps to explain behavior in a way that facilitates constructive intervention, and it is essential to arriving at a disposition that will both meet the youth’s rehabilitative (Burrell & Warboys 2000, 1).

Evidence suggests, however, that few juvenile justice systems employ adequate screening and assessment tools at the intake stage (Towberman 1992; Mears & Kelly 1999; Aron & Mears 2001). Most frequently, decisions regarding a child’s disposition and treatment strategies are based upon preexisting mental health diagnoses (if available) and a child’s history of aggressive or violent behavior (Lyons et al. 2001). Other studies reveal that there are few intake units that even have the capacity or training to identify youth with
disabilities, interpret their behaviors correctly, or link them to needed services (Mears & Kelly 1999; Leone et al. 2002). A recent publication by the U.S. Justice Department's Office of Juvenile Justice and Delinquency Prevention has criticized current practices and concluded that:

Although great advances have been made in reliable mental health assessment of children and adolescents assessment practices in juvenile justice settings remain highly variable and generally have not used evidence-based, scientifically sound instruments. A common practice has been to rely on a youth's history of using mental health services as an indicator of whether the youth currently needs services. However, research suggests that the juvenile justice system cannot rely on other systems to provide information on the previous use of mental health services for all youth at entry. For example, Novins and colleagues (1999) found that only 34% of a sample of juvenile detainees with a documented anxiety, affective (mood), or disruptive behavior disorder had previously received services for those disorders. Similarly approximately 50% of the juvenile detainees in Virginia showed mental health problems of moderate severity or higher and that 8.5% showed ‘severe’ problems, but that only 15% were receiving mental health services (Katner 2006, 580).

Currently, juvenile courts are not required to perform mental health screening or CAs. Some states do incorporate a screening process as a part of their intake assessment of each child who comes into contact with the system. However, many of the mental health screening tools being used across the country are only capable of identifying emotional mental health issues. Therefore, the needs of children with other disabilities, such as learning, developmental or cognitive disabilities, are not addressed through the use of these screening assessments. In addition, federal laws are unclear as to what stage of the process and whose responsibility it should be to screen and assess each child with a disability; and generally, many states do not have the financial or staffing resources to administer and evaluate juveniles using these tools. Moreover, as a result of the lack of research that identifies the issue of the overrepresentation of children with disabilities and their mistreatment by the juvenile justice system (which will be discussed at greater length in Section 2.2 of this chapter), there is minimal incentive and motivation to address the issues affecting children with disabilities involved in the system.
The information learned about each child’s disability through the screening and assessment process is necessary to understand the behavior of the child and consequently the appropriate individualized treatment, management, and aftercare strategies that occur later in the child’s experience with the system. Specialists on mental health screening and assessment in juvenile justice note:

The juvenile justice system must be able to identify youths with mental health needs as they enter and reenter the system. Diversion, emergency responses, and long-range treatment planning can occur only if we have reliable ways to identify which youths have serious mental health needs, what those needs really are, and how they can be described in ways that promote rational responses to the youths’ clinical conditions (Grisso et al. 2005, 4)

4.1.2 Trouble with Treatment
Without an appropriate identification of a child with disabilities and the specifications of a child’s disability through proper screening and adequate assessment tools at the intake stage, system professionals and treatment providers unknowingly manage treatment and aftercare programs detrimental to the health, safety and welfare of these children:

[R]ates of recidivism can be reduced by providing these children with professional assistance, medication, and therapy. Alternatives to incarceration or providing competent mental health services to juveniles during periods of incarceration ensures that this population receives the professional services to which they are legally entitled, and it also helps ensure that the community does not view these juveniles as creating unnecessary risks once they are released from delinquency systems. Presently, the mental health needs of this population are something of an afterthought rather than a defining issue around which the delinquency system is built. Currently, although mental health treatment services for detained juveniles are in great demand, it has been asserted that these programs are woefully inadequate, uncoordinated and fragmented. It also has been suggested that they fail to respond to the individual needs of juvenile offenders and in some cases are actually counterproductive (Katner 2006, 581-2; See Josi et al. 1999; Cottle 2001; Armstrong 2003; Marczyk 2003).

According to Burrell and Warboys, children with disabilities “may be unable to succeed in programs geared toward the minor offender, resulting in longer-than-anticipated stay, which decreases his or her chance to success upon release” (200). Others confirm that length of stay in treatment facilities for children with disabilities is significantly longer than mainstream juveniles (Lyons et al. 2001; Hussey & Guo 2005). Investigation of the
conditions of confinement in juvenile detention and correctional facilities throughout the country by the Department of Justice over the last few decades (most recently in 2005) have repeatedly found a failure on the part of the facilities to address adequately the mental health needs of youth in their care (US Department of Justice 2005). In 2003, Chief Justice Lavery of the Supreme Court of Connecticut, in his opinion in *In re Steven M.*, also noted this failure of the juvenile justice system to offer “adequate treatment programs corresponding to the individual needs [of disabled juveniles.]” Justice Lavery concludes that his ruling and concurring opinion in the case was an effort to promote a nationwide goal that “no mentally handicapped child will ever have to suffer the debilitating treatment suffered by the respondent [in his case]” (*In re Steven M.* 264: Conn. 747 (2003)).

At the adjudication phases, children with unrecognized disabilities cannot understand the proceedings or the roles of practitioners. Consequently, children with disabilities may confess to charges they did not commit and may have difficulty communicating with lawyers and court personnel (Leone et al. 1991). Children with unrecognized disabilities in juvenile detention centers and institutions are placed among mainstream delinquents. These children are frequently reported has having difficulty complying with and responding to the rules and procedures in the system (Leone et al. 2002). In these facilities, juveniles with disabilities tend to mimic other adjudicated delinquents (Leone et al. 2002; Murphy 2008). As a result, a juvenile with a disability may appear to be a continuous threat to himself and society, and therefore, persuade the uninformed court to lengthen the duration of his stay in a facility or placement (Sims & Preston 2006, 355). Furthering this theory, other experts suggest that:

> Juvenile detention homes do not provide proper rehabilitative services for mentally retarded children, and while detained, these disabled children learn to mimic the destructive behavior of other detainees. Once inside the detention facility, juveniles are not properly rehabilitated because the facilities are not conducive to that type of treatment. Additionally, as the Supreme Court correctly stated in *Roper v. Simmons*, juveniles are more susceptible to negative outside
influences. Mentally retarded juveniles are even more vulnerable to these influences, and inside a juvenile detention facility, their exposure to such negativity is constant. This results in the unwarranted detention of the child in a home where his level of dangerousness seems to increase because he mimics the violent behavior of his peers. As a consequence, juveniles appear to remain dangerous to themselves or others, lengthening the duration of their stay, particularly if detention is conditioned upon a finding of competency or no longer dangerous. (Murphy 2008, 390-1; See also, Ellis & Luckasson 1985; Lubow & Tulman 1995; Roper v. Simmons 2005).

Juvenile delinquent facilities are not the only inappropriate treatment factors for children with disabilities; rehabilitation and other treatment programs are also inherently punitive as they are designed for mainstream juvenile delinquents and are unequipped to care and provide treatment for these children. A disability is a lifelong circumstance, and many times, disabled juveniles do not and will never have full understanding of their actions and their consequences. Without recognition of this, however, most juvenile justice systems offer inappropriate treatment methods for these youth at the treatment and aftercare levels, which cause them to return to delinquent behavior and eventually return back to the system in the future (Murphy 2008, 388 citing Ellis & Luckasson 1985).

Educational programs in juvenile facilities that employ traditional teaching strategies for mainstream youth, for example, are inappropriate and unsuccessful for children with disabilities. It has been reported that between 30% to 50% of incarcerated juveniles require special education services compared to one in ten of the general youth population (Heilbrun et al. 2005, 99). For children with disabilities, “learning is largely dependent upon the development of significant interpersonal relationships between teacher and students, which requires specialized teacher training and low teacher-student ratios,” which current juvenile facilities lack (Fagan & Zimring 200, 241). Additionally, case studies of state departments of juvenile services found “undue delays within the system providing special education and related services” and the absence of “a procedure for referral for children who needed to be evaluated for a disability, and no effective mechanism and/or protocol for retrieving the
school records of those youth placed in the system” (Morris 2006, 149). The NCD also notes that “without commensurate increase in special education programming resources in correctional facilities, such efforts may result in a decreased ability to identify youth with disabilities or meet the needs of identified youth with disabilities” (2003, 74). In response to this position, some argue that the education issue for children with disabilities in the juvenile justice system is already being addressed:

The inability of juvenile correctional facilities to enact proper educational measures for disabled students in prison has motivated over twenty class action lawsuits since 1975. These cases demanded the establishment of special education services in correctional facilities which would be overseen by the states’ department of education, and which would focus on the rehabilitation of juvenile corrections. Since 1990, over a dozen cases have addressed identification and assessment problems in correctional facilities. These cases have had significant effects on laws affecting disabled youth by defining the IDEA statute (Soliz & Cuttler 2001, 272-3; See also, Puritz & Scali 1998).

In regard to other treatment services, juvenile and family court judges have also recognized the deficiencies within the system. A 2002 survey of such judges found that 77% of those surveyed believed they could reduce detention rates for offenders with better treatment options [for children with disabilities] (Arredondo 2002). Generally, improved treatment options for this population are those designed specifically for children with disabilities. Research has shown that “when a state system of juvenile justice uses a one-size-fits-all approach to rehabilitation, it may be denying the benefits of rehabilitation to its mentally disabled wards” (Calhoun 2004, 201). Positive behavioral support treatment (which will be further discussed in Chapter 5.1.1), or restorative justice techniques that focus less on establishing proof of crime in the legal system and more how to address the consequences of crime most effectively, are other examples of appropriate treatment strategies for children with disabilities (NCD 2003, 78-86). Some experts suggest that enhanced treatment services for these children include “a continuum of services, with up-front investment in a
developmental, preventative approach that minimize the number [of disabled children] who fall by the wayside” (Rosenheim et al. 2002, 333).

An advantageous juvenile justice system for these children may maintain separate facilities, treatment services, educational program, and have an overall approach to treatment that encompasses supportive learning and rehabilitative strategies rather than today’s “get tough on crime” approach employed in many states through “increasingly punitive sanctioning laws that promote formal processing of youth and minimum terms of incarceration of specific offenses” (NCD 2003, 74 quoting Feld 1999). Additionally, the NCD has compiled a list of essential dimensions of appropriate treatment programs for children with disabilities in the juvenile justice system, which includes: physical and psychological safety (e.g., limit-setting, clear rules, predictable expectation about program functioning), supportive relationships (e.g., warm and close relationships with adults and peers), opportunities to belong, including meaningful inclusion in social activities, positive social norms (e.g., modeling of appropriate and positive attitudes and behaviors), support for efficacy (e.g., learning about social, communication skills), and integration with family, school, and especially community efforts (2003, 112).

Aftercare in the juvenile justice system refers to the final stage and continuity of treatment services for juvenile delinquents during their transition back into the community. For children with disabilities, the status quo of many systems’ aftercare phases is a serious area of deficiency in the juvenile justice system. Children with disabilities have “greater social, emotional, and learning needs than their peers without disabilities, resulting in an increased demand for transition services with the community” (Morris 2006, 151). Studies continually support the notion that the aftercare phase is “a critical yet understudied area of
opportunity to reinforce the impacts of the systems programs and to ensure the effective continuity of care and service for these children [with disabilities]” (Altschuler & Armstrong 2001, 88; See also Altschuler et al. 1999). Aftercare for these youth “requires increased collaboration, continuity of care, and the ability to recruit and retain providers with the ability to treat multiple needs” (Shufelt & Cocozza 2006, 3).

Many aftercare programs, however, fail to monitor the progress of their youth, and frequently, there is little communication and coordination between the primary agents who advocate for and support a child after she is released from the system (including schools, social service agencies, the child’s family, as well as aftercare providers of the juvenile justice system) (NCD 2003). For children with disabilities, these areas of deficiency at all stages of the juvenile justice system may increase the rate of children with disabilities in the juvenile justice system, which is higher than that of children without disabilities (Quist et al. 2000; Leone et al. 2002).

4.2 Other Opportunities

The noted gap in advocating for children with disabilities involved in the juvenile justice system is also evident through a nationwide lack of commitment to these children across child-serving agencies. According to the NCD:

The juvenile justice system is but one part of a broader set of systems focused on children and youth. Other systems include education, child welfare, social services, and a panoply of local, state, and national programs and laws that provide a range of rights and services. From this perspective, any failings of the juvenile justice system might more appropriately be viewed as a lack of societal commitment to serving youth with disabilities, especially those who are delinquent and involved in the juvenile justice system. The result of this lack of commitment can be seen, many reviews and commentators have suggested (e.g., Smith et al. 2002), in the lack of communication, cooperation, and collaboration across the different systems. It also can be seen in the lack of sufficient funding to support appropriate programs and services for disability-related needs among youth in schools and the juvenile justice system (2003, 125).

Although the growing issue of the overrepresentation of these children and their mistreatment by the juvenile justice system has been perceived by the government and legal professionals
in many states and local jurisdictions over the last few decades, there is still no existing federal organization or agency that addresses the specific issue of youth with disabilities who are involved in the juvenile justice system (Coalition of Juvenile Justice, 2001; National Center for Mental Health and Juvenile Justice, 2006). Nor is there an "organized constituency for youthful offenders who have disability-related issues and few agencies provide direct services to these young people" (Smith et al. 2002, 3).

Also contributing to this advocacy gap is the limited research on the prevalence of children with disabilities within the system and the inconsistencies in their identification and treatment: "prevalence estimates vary considerably because of differences in how disability is defined and measured, poor screening and assessment processes both in schools and in the juvenile justice system, and inconsistent to nominal transfer of school records to juvenile court and correctional facilities" (Rutherford et al. 2002, 7). Furthermore, as a result of narrow research and empirical data supporting the issue of high prevalence and mistreatment of disabled children in the juvenile justice system, there is scarce government and private funding to aid appropriate programs and services for disability-related needs among children with disabilities in both schools and the juvenile justice system (Aron & Mears 2003). Consequently, the advocacy gap in both research and resources contributes to the inappropriate treatment and overrepresentation of children with disabilities who are in contact with the juvenile justice system.

4.2.1 Representation

Although juvenile justice systems differ from state to state, the negative implications for children with disabilities involved in the system are symptomatic across the nation and have been escalating since the modern "get tough on crime" framework of the late eighties and early nineties was established (Torbet et al. 1996; Feld 1999; Butts & Mitchell 2000).
Sustained federal initiatives by agencies such as the U.S. Department of Education, the Office of Juvenile Justice Delinquency Prevention, or the National Center for Mental Health and Juvenile Justice, for example, seemingly demonstrate a nationwide commitment to resolving the advocacy gap for children with disabilities involved in the juvenile justice system.

For individuals with disabilities, federally-mandated Protection and Advocacy Systems (P&As) are required of each state, the District of Columbia, and U.S. territories, which provide protection of the rights of persons with disabilities through legally-based advocacy. In support of P&A systems, PADD (Protection and Advocacy for Persons with Developmental Disabilities), created by the Developmental Disabilities Assistance and Bill of Rights Act of 1975 and amended in 2000, requires P&A systems in each state to pursue legal, administrative, and other appropriate remedies under all applicable federal and state laws to protect and advocate for the rights of individuals with developmental disabilities (29 U.S.C. § 794). CAPs (Client Assistance Programs), established by the 1984 Amendments to the Rehabilitation Act of 1973, are required to provide information and assistance to individuals seeking or receiving services under the Rehabilitation Act, including assistance in pursuing administrative, legal, and other appropriate remedies to ensure the protection of their rights (29 U.S.C. § 732). Currently, only eight states have functioning P&As and CAPs, none of which addresses the issue of the disproportionate number of children with disabilities in contact with the juvenile justice system or the punitive treatment these children experience as a result of the ignorance of system practitioners in advocating for and treating these children (National Disability Rights Network).
4.2.2 Research

In existing research, only certain aspects of children with disabilities and their relationship with the juvenile justice system have been studied. National studies of the general population of children in the United States do not systematically examine disabilities and delinquency in the same study. The result is a lack of direct assessment of the issue of overrepresentation; there are no hard data on children with disabilities in the juvenile justice system (Aron & Mears 2001). The varying definitions and measurements of disabilities in children among studies and juvenile justice systems state-by-state also contributes to the inconsistent and inconclusive research data. Consequently, “without a clear idea of the number of youth with disabilities in the correctional system, it may be impossible to plan administratively for ways in which special education and other social services should be structured to address the needs of these youth” (Rutherford et al. 2002, 19).

Furthermore, some disabilities are given more attention in research initiatives than others. This results in an inadequate overall assessment of the prevalence of children with all types of disabilities in the system: “The two most common disabilities found in the juvenile justice system are special learning disability and emotional disturbance” (Burrell and Warboys 2000, 2). However, few studies have focused on other disabilities, such as those linked to speech and language, as well as autism, Down syndrome, and mental retardation. A study performed by the Department of Education in 2001, for example, limited its research to the prevalence of emotional disorders (ED) and learning disabilities in the juvenile justice system. Additionally, studies frequently suggest that although only around 10% of all school-aged children have a learning disability, the prevalence of incarcerated children with learning disabilities is between 30% to 50% depending on the study (Murphy 1986; Brier 1989; Winters 1997; Robinson & Rapport 1999; National Center on Education, Disability and

Researcher bias is a contributing factor to this inadequacy. In fact, few studies “employ random samples of youth populations or a range of disabilities and types of delinquency” (NCD 2003, 54 citing Malmgren et al. 1999). Researchers often manipulate their findings to downplay or overemphasize the prevalence of disabled juveniles involved in the system to support the hypothesis of the agency or organization by which they are employed (Larson 1988; Crawford 1996; Butts & Buck 2000). Many times researchers use different age groupings depending on their theoretical perspective or restrictions imposed by their data (Aron et al. 1996) and there is also a larger focus on children incarcerated in long-term secure confinement facilities, where there are fewer juveniles, than on short-term detention, probation or parole, or in residential treatment facilities. This narrow focus on a minority of juvenile delinquents results in more extreme findings and does not adequately represent the population of children with disabilities in the juvenile justice system.

Some researchers believe there is a problem with research on the theories that link disability with delinquency as many studies presuppose rather than prove a causal relationship between the two. Rather than considering external factors such as the Student Risk Theory and the Differential Processing Theory, which may link disability to delinquency (see Chapter 3, Sections 1.2-1.3), many studies assume that a child’s physical disability, his biological and neurological differences from mainstream children, causes his delinquent behavior (Waldie & Spreen 1993; Malmgren et al. 1999). In ignoring other possible explanations for the strong correlation between disability and delinquency, some researchers have noted that recent meta-analyses and reviews of delinquency interventions
have focused on the need for science-based programming that involves clear medical criteria for assessing effectiveness. As a result, within the juvenile justice system, many states implement interventions that are too heavily reliant upon general scientific data on a wide range of disabilities rather than individual behavioral and personality traits and other unique symptoms of these children (Mears 2000; Cullen & Gendreau 2000).

Others note a gap in advocacy that stems from the scarce research concerning U.S. school systems and their compliance with federal disability law for children. In their 2003 review of the system and its policies, Aron and Mears noted:

[T]he failure of many schools to fully comply with IDEA—as it has been interpreted by the courts—suggests the possibility that the law as written or as funded cannot be fully implemented[...] studies are needed to examine the extent to which IDEA can be implemented by juvenile justice systems in local jurisdictions and among states. Coinciding with such studies should be one that examines the full range of strategies for improving implementation, including supplementary federal funding, professional training, technical assistance, sanction, and public awareness campaigns. Additional studies should examine if the goals of IDEA can be met more readily and effectively through other policies or approaches (63).

As a result of inadequate compliance with IDEA, as well research performed under a limited or narrow scope, cases of children with disabilities in contact with the juvenile justice system are not appropriately addressed. This gap in research advocacy further aggravates issues such as inadequate assessment and inappropriate management strategies for children with disabilities in the juvenile justice system previously discussed in the chapter.

4.2.3 Resources
The issue of the lack of reliable, accurate, empirical data on all dimensions relevant to increasing and improving services for youth with disabilities at risk or already in contact with the juvenile justice system has been widely observed and criticized; yet this gap in research remains unaddressed (Cramer and Ellis 1996; Robin and Rapport 1999; U.S. Department of Education 2001; Aron and Mears 2003). Without data and sufficient knowledge from
research, there is no way for policy makers and reformers to identify the specific needs and the areas of inefficiency of the system, as well as where specific resources are needed.

It is no surprise, then, that an already understaffed and underfunded juvenile justice system, overburdened enough with mainstream children, tends to avoid addressing the issues disabled youth face: "the juvenile justice system in particular has far less funding for and experience with the disability law and the needs of youth with disabilities" and that funding is scarce at the educational and judicial levels to develop programs and create incentives for compliance with disability law (Aron & Mears 2001, 57). Despite the origins of these funding problems, research shows that economics play a decisive role in whether a youth gets timely and significant mental health support (Coalition for Juvenile Justice, 2000). As a result, the nearly absent resources that support children with disabilities in the juvenile justice system further widens the gap of advocacy for these children.

4.3 Conclusion

Thus far this thesis has considered and examined three fundamental discrepancies of the juvenile justice system that contribute to the mistreatment and overrepresentation of children with disabilities in the system: 1) The legal gap (discussed in Chapter 2), characterized by federal legislation and a lack of a competency standard; 2) the relationship between disability and delinquency (discussed in Chapter 3), which encompasses the theories that link the two together; and 3) the advocacy gap (discussed in this chapter), defined by inadequate representation of children with disabilities at all levels of the juvenile justice system and among child-serving agencies nationwide. The following chapter will identify current programs and policy trends that attempt to resolve these issues for children with disabilities. It will also consider the advantages and disadvantages of each of these solutions to construct the most appropriate recommendations presented in Chapter 6.
Chapter 5: Current Solutions

The overrepresentation and mistreatment of juveniles with disabilities involved in the juvenile justice system are issues that some states and local jurisdictions have attempted to resolve. Program and policy initiatives to address these issues for children with disabilities have become more widespread and diverse in the past decade; yet these children still suffer from mistreatment by a system intended to help them. At the prevention, intervention, and treatment levels of a child’s contact with the juvenile justice system, a variety of solutions have been proposed and adopted in some states and jurisdictions: school-based prevention, positive behavioral support treatment, legal clarification, screening and assessment intervention, professional training for treatment providers, information sharing, aftercare, multisystem wraparound services, and separate specialized youth mental health courts are the current trends in the U.S. for resolving these issues.

5.1 School-based prevention

On the whole, there is a merited nationwide trend of fundamentally rethinking the U.S. special education system to benefit students and to lessen their likelihood of contact with the juvenile justice system (Finn et al. 2001; American Youth Policy Forum and Center for Education Policy 2002; President’s Commission on Excellence in Special Education 2002). Studies have identified three prevention strategies as central to this school-based initiative. Effective practices should 1) be applicable to students at risk for antisocial behavior and/or failure in the traditional classes, 2) be sufficiently practical to be implemented in public schools, and 3) show convincing evidence of positive outcomes (Tobin & Sprague 2000). Preventative school-based approaches incorporate a number of factors: a low ratio of students to teachers, highly structured classrooms that employ behavioral classroom management techniques, a positive rather than a punitive approach to
behavior management, adult mentors in the school atmosphere, individualized behavioral interventions based on functional behavioral assessments, social skills instruction, academic instruction, and greater parental and family involvement (Tobin & Sprague 2000; Coalition for Juvenile Justice 2001; Chester et al. 2001; American Youth Policy Forum and Center for Education Policy 2002). If implemented with these elements, preventative school-based approaches could have a great impact in preventing at-risk children with disabilities from coming in contact with the juvenile justice system.

Although these strategies have been widely identified for the improvement of school-based prevention for children with disabilities, few school systems have implemented any reforms. One example of attempted improvement, however, is the ALAS (Achievement and Learning for All Students) program adopted by the Los Angeles Unified School District and funded by the U.S. Department of Education. ALAS is one of three national prevention programs that target learning disabled and youth with severe emotional disorders at the educational level. By focusing on incorporating and validating the racial/ethnic and cultural perspectives of youth and their parents, the goal of the program is to develop individualized intervention strategies and the collaboration of school-based counselors with community agencies (Larson & Turner 2002; Aron & Mears 2003). The success of ALAS can be seen through immense student improvement and a decline in the number of children with disabilities dropping out of school, failing classes, and coming into contact with the juvenile justice system from the Los Angeles Unified School District (Larson & Turner 2002; Aron & Mears 2003). On the whole, the program has proved itself a viable school-based preventative strategy for children with disabilities.
5.1.1 Positive Behavioral Intervention and Support Treatment

Positive behavioral interventions and support (PBIS) treatment is the application of behavior analysis to achieve socially important behavior changes (Sugai et al. 1999). PBIS treatment maintains a long-term problem-solving approach designed to reduce inappropriate behavior, teach more appropriate behavior, and provide the supports necessary for successful outcomes (Warger 1999). PBIS surfaced in the late 1980s and became increasingly popular throughout the 1990s. Most often PBIS is based on functional behavioral assessments (FBA), which can be used at the intake stage of the juvenile justice system. These treatments tools were first used as an alternative approach to traditional behavior-changing strategies for student with severe disabilities who engaged in extreme forms of self-injury and aggression. In addition, PBIS was thought to aid in implementations mandated by federal law such as IDEA and the ADA. In 1999, PBIS and FBA were included in amendments to IDEA and, since then, PBIS has been used to address a wide range of needs of children with disabilities in the U.S. school systems and has been successful in doing so (US Department of Education 2002).

In the mid 1990s, the most noteworthy PBIS program strategies were implemented in pilot programs in Columbia, Missouri and Simpsonville, South Carolina. These treatment initiatives for children with disabilities combined positive behavioral intervention strategies with Multisystemic Therapy (MST) treatment sponsored by the Office of Juvenile Justice and Delinquency Prevention and by other public and private funds. MST, targeted to at-risk juvenile delinquents, is based upon school, family and community based treatment, and focuses on changing how children with disabilities function in their natural home and school environments. The treatment encourages positive behavior while decreasing antisocial behavior by using the family preservation model of service delivery and a teacher-mentor
model in educational and familial settings (Henggeler et al. 1998; Larson & Turner 2002). As a result, MST treatment programs have succeeded in a number of ways: improving caretaker discipline skills, enhancing family relationships, increasing youth association with pro-social peers, decreasing youth association with deviant peers, engaging youth in pro-social recreational activities, improving school/vocational skills, and providing long-term and ongoing aftercare (Henggeler et al. 1998; Larson & Turner 2002).

5.2 Legal Prevention
In Chapter 2, this study examined current federal disability law that relates to children with disabilities who are at risk or already involved in the juvenile justice system. Section 2.2 of the chapter highlights the issue of nationwide non-compliance with existing laws and illustrates the reasons why state and local jurisdictions either ignore or are not in full compliance with these laws. In an attempt to resolve the legal gap for children with disabilities in contact with the system, there have been recent nationwide calls for support in both government and society based implementation strategies to aid the prevention of these youth in contact with the system (Burrell & Warboys 2000; NCD 2000, 2002; Smith et al. 2002; Aron & Mears 2003). The call for improvement, however, has yet to be answered by the parties involved.

One valuable legal preventative strategy is for Congress to review the relevant federal disability law. Legislative review may result in the identification of the ambiguities in the law that in turn cause this "legal gap" for children with disabilities. The legal ambiguity most frequently observed in child-related disability law include unclear legal definitions of key terms for understanding the legislation, such as "disability," as well as references to the juvenile justice system without identification of the specific system stages and professionals responsible for upholding the law, such as the role of probation officers in the aftercare phase.
of the system. As a result of these legal ambiguities, legislators place accountability upon educational and juvenile justice practitioners who have limited understanding of the meaning of the law and their role in its implementation. The value of Congressional review of child-related federal disability law would be clarification among child-serving agencies and professionals to better serve children with disabilities who are at risk or are already in contact with the juvenile justice system.

Although limited, there are some studies that have observed court action advocating for children with disabilities. These researchers note:

Although not yet addressed by the United States Supreme Court, many lower courts have identified the Fourteenth Amendment as the basis for entitling incarcerated youth to adequate mental health care. Further, the more generalized notion of the state's duty and obligation to provide adequate medical care for incarcerated adults based on the Eighth Amendment's prohibition against cruel and unusual punishment was established by the Supreme Court in *Estelle v. Gamble*. Subsequent federal circuit court decisions have focused on the Eighth Amendment as the basis for establishing the right of adult inmates to adequate mental health care while they are incarcerated. The 8th Circuit's decision in *A.J. v. Kierst*, relied on the due process clause and found that the juvenile system is designed to rehabilitate, not punish, offenders. [...] Other courts have cited the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973, as the compelling legal basis for juvenile detention facilities to make their programs, services, and activities readily accessible to juveniles suffering disabilities (Katner 2006, 570-1, 572; See also, *Estelle v. Gamble* 1976; *Youngberg v. Romeo* 1982; Mayar 1989; *A.J. v. Kierst* 1995; Stark 2000; Parks 2003; Weber 2004).

Court action in lower courts has yet to make a significant impact on the nationwide competency issue for children who come into contact with the juvenile justice system. The most notable solution for legal prevention for disabled children is to address the competency issue discussed in Chapter 2.2.2 by establishing a national competency standard for youth who come into contact with the juvenile justice system. The federal judiciary could implement a standard similar to adult court. Another option is to adopt a current state's policy that is tailored specifically to protect children with disabilities who are incompetent to stand trial. One study suggests instituting a broader standard for
juveniles and another solution specific for children with disabilities determined incompetent:

[T]he remedy to this problem [the absence of a juvenile’s right to competency] involves establishing a right to be competent in delinquency proceedings established by either the Supreme Court or Congress. The established standard should account for not only the presence of mental retardation, but also for the age and immaturity of the defendant. Children that are determined to suffer from mental retardation should be either returned home with services or should be placed in foster care [...]. Implementation of these procedures should hopefully protect the rights of mentally retarded children and assist in their rehabilitation to become contributing members of society (Murphey 2008, 395-6).

5.3 Intervention through Mental Health Screening and Assessment

Intervention for children with disabilities who come into contact with the juvenile justice system is most common through the use of mental health screening and assessment strategies. Some experts note that when juveniles are properly assessed and treated by the judicial system, it may well reduce the probability that their behavioral problems will persist and lessen the recidivism rate for these juveniles (Wolber & Banze 1998; Katner 2008). A few states, such as Massachusetts, have adopted their own screening tests to identify these youth and provide the most appropriate treatment for each individual child’s needs. The Massachusetts Youth Screening Instrument-Second Version (MAYSI02) is a 52 item self-report instrument that identifies potential mental health and substance use problems among youth who come into contact with the juvenile justice system (Scowyra & Cocozza 2006). The issue with Massachusetts’ assessment strategy, however, is that it does not consider children’s disabilities that have been diagnosed prior to their participation in the juvenile justice system. Other states, such as New York and Maine, have adopted assessment tools that measure the level or severity of disabilities that have already been diagnosed or identified. The Child and Adolescent Functional Assessment Scale (CAFAS), for example, which has been implemented in over 20 states, is an assessment tool used to identify the degree of impairment in youth with emotional, behavioral, or substance use symptoms or
disorders (Hodges 2005). The success of CAFAS is evident as it has proven to be a high predictor of recidivism among children with disabilities who enter the juvenile justice system (Quist et al. 2000).

Juvenile Assessment Centers (JACs) are another alternative intervention strategy with proven success in screening juveniles who enter the system. JACs were first established in 1993 by the state of Florida to provide well-coordinated screening and assessment, and collaboration with child welfare and other social service agencies (Mears & Kelly 1999). The most common goals of JACs include: “providing comprehensive assessment of juvenile needs, improving case management and treatment, making efficient use of law enforcement, juvenile justice, and treatment resources, avoiding unnecessary detentions, enhancing information sharing across agencies, and improving monitoring of system performance” (Institute on Criminal Justice 1999, 8). Since its first appearance in 1993, a few jurisdictions, such as Bernalillo County, New Mexico, have incorporated JACs into their juvenile justice systems and now employ systematic screening and assessment approaches that collect information from diverse sources promoted by JACs (Aron & Mears 2003). The Bernalillo County, NM Juvenile Detention Center uses JAC methods as a part of its intake process to identify children with mental health needs, and instead of moving forward in the adjudication process, redirects these children to the Children’s Community Mental Health Clinic, a community mental health clinic in Bernalillo County, which then performs a more comprehensive assessment of the child. Once the child’s individual needs are identified, the adjudication process moves forward and collaboration between the clinic and the juvenile justice system occurs as services are provided to youth while they are in detention as well as in their aftercare (Cocozza & Skowyra 2006). Other states that have adopted similar JAC
facilities include Texas, Utah, Colorado, Kansas, North Carolina and Minnesota (Spring et al. 1999; Silverthorn 2003). The drawbacks of JACs, however, include its expensive facility and professional health care costs as well as its lengthened adjudication process.

5.4 Treatment Strategies
5.4.1 Professional Mental Health Training

In Chapter 3, one link between children with disabilities and their overrepresentation and mistreatment in the juvenile justice system is explained by inadequate understanding of these children and their unique needs. In a 2006 Annual Report of the Juvenile Justice System by the Federal Advisory Committee on Juvenile Justice, nationwide research found that “Juvenile Justice Agencies report a lack of expertise, staffing, and training to care adequately for emotionally challenged youth” (Annual Report 2006, 4). Some proponents of this argument have shown in their research that:

[B]y improving the educational institutions and programs that train children's lawyers to better identify and understand the needs of this population, the legal system aspires to achieve a more humane result in the treatment and handling of its most vulnerable and sometimes fragile clientele, children with mental health problems. By redesigning the juvenile delinquency system with full recognition of the major role played by mental health disorders and co-morbid disorders, judges will have at their disposal working alternatives to incarceration of children with serious mental health problems. It may be that recognition of the mental health paradigm in the delinquency system might contribute to the reduction of rates of recidivism. At the very least, this approach should help ensure that children lacking competence to stand trial no longer "waive" their rights without benefit of counsel, or without recognition by the court system of the mental health issues these juveniles present (Katner 2006, 582; See also, Pattison 1998; Lourie & Hernandez 2003).

Examples of states that have attempted to correct this area of deficiency in the system include: Connecticut, Ohio, Illinois, Texas and Washington. These states have all recently mandated a program for its juvenile justice professional practitioners called Mental Health Training Curriculum for Juvenile Justice (MHTC-JJ). MHTC-JJ is a 1.5 day (10.5 hour) training for juvenile justice staff including probation, detention, and correction personnel who manage and provide treatment services for children with disabilities. The MHTC-JJ program incorporates all stages of the juvenile justice system and includes modules
focusing on: mental disorders in youth and important adolescent development concepts, how mental disorders are identified in juvenile justice youth (including the use of screening and assessment instructions), common treatment strategies used with this population, the role of the youth’s family in their treatment, and practical strategies for interacting with and responding to youth with mental health needs (Models for Change 2011). MHTC-JJ is an example of professional mental health training for juvenile justice practitioners that could reverse the currently inhibitive treatment of children with disabilities at all stages of the juvenile justice system from screening/assessment in the intake phase to aftercare treatment.

The Cook County, Illinois Juvenile Court Clinic is another example that promotes education for professionals about children with disabilities in the juvenile justice system. This program, however, focuses on providing a variety of professional training services to practitioners specifically at the adjudication stage of the system. The Clinic, composed of a multidisciplinary staff of psychologists, psychiatrists, social workers and lawyers, informs judges and court personnel using clinical information, forensic clinical assessments and information regarding community-based mental health resources relevant to youth with disabilities in juvenile court proceedings (Skowyra & Cocozza 2006). The Clinic also provides a clinical coordinator to be present in court proceedings on behalf of the juvenile and is also available at this stage in the process to provide guidance to judges and probation staff regarding the child and his or her unique disability and the services the County’s system is prepared to provide (Skowyra & Cocozza 2006). Although a program like Cook County’s has its merits, such programs, in ignoring the other stages a child experiences in the system,
do not sufficiently address the broader issues these children face, such as the treatment programs designed for mainstream juvenile delinquents.

Overall, the best professional mental health training allows practitioners to support children with disabilities at all stages and levels of the juvenile justice system. Knowledge of these youth and the issues they face as participants in the system, such as a lack of detecting a disability, misinterpretation by court personnel, and inappropriate treatment programs, allows for proper screening and assessment, planning and treatment management, monitoring, and aftercare and may in turn reduce the high prevalence of these children who come into contact with the system. Some research suggests that:

Perhaps most important, the lawyer must be educated in the effect of mental disability on the client. To effectively represent any child client, the lawyer needs to be trained in child development and its possible effects on the child's ability to understand and participate in decision-making as well as the effects of different mental disabilities. This knowledge can assist the lawyer in determining the client's capacity and working to maximize the child client's participation in the lawyer-client relationship (Costello 1999, 101).

Other studies suggest, however, that the most important element to professional training is that it be beyond a classroom experience. Even if attorneys have had some classroom training, unless counsel have participated in clinical programs which provide experientially-based education and exposure to various mental health issues, it seems unlikely that lawyers will easily recognize many of the mental health problems exhibited by this population (Katner 2006, 546; See also, Engler 2003).

5.4.2 Information Sharing

Proponents argue that information sharing is an essential way to gain greater knowledge of these youth in the system. Supporters of this method suggest that information sharing promotes successful collaborative efforts between juvenile justice and mental health systems, schools, child welfare and social service agencies, as well as
families and caregivers. Evidence has shown these collaborative efforts to increase efficiency and enhance treatment services at the prevention, intervention (screening and assessment) and treatment/aftercare phases of the system (Aron & Mears 2003). In addition, communicating the specific needs of each child to all members of his treatment team increases the likelihood of children with disabilities succeeding in treatment, thus reducing the population's recidivism rate in the juvenile justice system. Some studies have found that:

Cross-system collaborations—using professionals representing juvenile justice, mental health, education, and substance abuse delivery systems offer potential solutions for juveniles with mental health and substance abuse disorders. However, many communities lack the resources and programs currently necessary to provide effective treatment programs and intervention services (Katner 2006, 568; See also, Jenson and Potter 2003).

Opponents of the information sharing technique among juvenile justice practitioners and other child-serving agencies emphasize the denial of a child’s right to privacy. These critics reference FERPA (Family Educational Rights and Privacy Act) and argue that the shared information about the juvenile may be misused, misinterpreted or misrepresented by the system and in turn be disruptive to the child’s success during her experience with the juvenile justice system (Mears & Kelly 1999). FERPA, however, need not be a barrier to appropriate and helpful information sharing as the law limits rather than prohibits sharing information about children (with and without disabilities). In 1997, the Office of Juvenile Justice and Delinquency Prevention specifically addressed this issue:

FERPA allows schools to play a vital role in a community’s efforts to identify children who are at risk of delinquency and provide service prior to a child’s becoming involved in the juvenile justice system [...] Educators [can] share information with juvenile justice system agency officials on children who are at risk of involvement or have become involved in the juvenile justice system, prior to adjudication [...] As more and more states establish information sharing programs to serve students though cooperation with the juvenile justice system the emphasis on neighborhood school
participation in interagency information sharing agreements will increase. FERPA need not be a barrier to this process toward proactive information sharing networks (Medaris et al. 1997, 8-9)

Although information sharing cannot address all of the deficiencies of the juvenile justice system for children with disabilities, such as the previously noted legal gap in advocacy for these children, information sharing is still a viable, inexpensive, and easy to execute strategy to resolve some areas of the gap in advocacy, such as specific knowledge of a child’s unique individual needs.

5.4.3 Aftercare

As previously noted in Chapter 4.1.2 juvenile aftercare is an essential yet overlooked treatment phase of the juvenile justice system for children with disabilities. Adequate follow-up services and continued support for these youth in their transition back to the community and their families are central to the likelihood of their return to the system. Insufficient aftercare impacts the current overrepresentation of this population in juvenile justice systems nationwide. Some programs have identified the importance of aftercare for children with disabilities and have begun to resolve the issues these youth face as a result of their contact with the juvenile justice system.

Project Hope, an aftercare program from the Rhode Island Training Schools (RITS), is available to all youth with mental health diagnoses who come into contact with the juvenile justice system. Through Project Hope, children undergo a secondary mental health assessment to provide appropriate and adequate treatment for each child in the aftercare phase of the juvenile justice system rather than prior to their adjudication. As a result, the programs’ greatest influence is the collaboration of family service coordinators with clinical social workers and the child’s probation officer in the aftercare stage. Consequently, Project Hope provides individualized treatment and management plans for
each individual child that is many times absent in the system. In addition, Project Hope’s prolonged aftercare strategy is merited for its monitoring approach of these children that lasts 9 to 12 months post-detention to ensure implementation of the program’s treatment plan.

The Oregon Transition Support Initiative at the Farrell School takes an alternate approach to aftercare. The Oregon Transition Support Initiative was a result of collaboration between the Juvenile Corrections Education Program (JCE) in the Oregon Department of Education, local school districts, and state corrections personnel. The aftercare transition model was initiated in the Farrell School and it has since expanded throughout the state of Oregon. Through a process of transitioning a juvenile with disabilities back into the community through a separate education program with its own curriculum and academic structure, the Farrell School and others like it focus on academic, social and workplace skills geared towards reintegrating adjudicated youth with disabilities into the community and school system (Larson and Turner 2002).

5.4.4 Multi-systematic Wraparound Services
Multi-systematic wraparound treatment strategies implement solutions that address the issues these youth face at each stage of their participation in the system. The wraparound treatment approach addresses risk factors, elements that increase the likelihood of delinquency, treatment factors, as well as future protective factors, and provides support through “community-based, family-focused, and prevention-oriented collaboration, rather than incarcerating youth for longer periods of time” (Stenhjem 2005, 2). In most cases, programs that adopt the multi-systematic approach emphasize improved screening and assessment techniques of children with disabilities, promote diversion to appropriate treatment services during contact with the system and in aftercare, advocate for
the linking of agents/agencies who act on behalf of the best interest of each child—such as schools, families, doctors, and social service agencies, and encourage the development and implementation of individualized approaches to address each child’s unique needs (Henggeler et al. 1998, Osher et al. 2002). Overall, the merits of multi-systematic wraparound treatment services are highlighted by the approach’s basis in “the importance of collaborative and well-coordinated networks of services to ensure that all of a youth’s particular needs are addressed” (Aron & Mears 2003, 74). One recent study noted that this approach may be a solution to the competency issue as well: “juveniles diagnosed with conduct disorders and exhibiting competency problems stand to benefit greatly from court ordered MST [Multi-systematic treatment] either in conjunction with competency restoration services, or as an alternative dispositional service if the juvenile is found not likely to have competency restored” (Katner 2006, 531).

The MH/JJ Action Network, established in 2007 to serve as a driving force for innovation and reform around how the juvenile justice system responds to youth with mental health needs, is an example of a program that attempts to develop and implement a multi-systematic approach to support children with disabilities who are risk or already involved with the system. The MH/JJ Action Network represents a collaboration of eight states: Pennsylvania, Illinois, Louisiana, Washington, Colorado, Connecticut, Ohio, and Texas. The program is aimed to: develop, implement, and evaluate new models and strategies for addressing common problems that can be sustained, expanded, and replicated in other jurisdictions; foster the continued development and exchange of ideas and information within the Action Network states; and provide national leadership on issues pertaining to mental health and juvenile justice (MH/JJ Action Network). To achieve these
goals, the Action Network identified three fundamental strategies at each level of the adjudicatory process to address the issues facing these children:

1) Front-End Diversion Initiative (DEDI) at the pre-adjudicatory stage to establish diversion options and screening techniques for youth with mental health needs at three points of contact—schools, law enforcement, and probation intake; 2) Workforce development throughout the system for mental health training and education for all staff working in a variety of juvenile justice settings; 3) Family and youth relationship building during the treatment and aftercare processes of the juvenile justice system to engage families of these youth effectively and meaningfully, and encourage positive, supportive relationships between previously adjudicated delinquents and their families (MH/JJ Action Network).

Although viable in theory, the success of the MH/JJ Action Network has not been measured since its implementation in 2007; therefore, the program remains practical in theory yet unreliable in practice.

The Wraparound Milwaukee model, organized in 1994 under the Milwaukee County Mental Health Division, exemplifies the successful implementation of the multi-systematic wraparound treatment solution for children with disabilities involved with the juvenile justice system. The program “relies heavily on the involvement of schools and child welfare, social service, and juvenile justice system representatives to develop and implement treatment plans and to eliminate redundant efforts” (Aron & Mears 2003, 74). Wraparound Milwaukee incorporates these various child-serving agencies and systems by using a case management model. The model include: an individually developed treatment plan, a care coordination management system to ensure services are strength-based, coordinated, monitored and evaluated, a provider network that furnishes an array of over 80 mental health, child welfare and supportive services, a mobile urgent treatment team to provide crisis intervention services, strong and active family involvement in implementing plans, and a managed care approach to monitor service utilization, quality and cost (Kamradt 2000; Aron and Mears 2003). Unique to the Milwaukee model’s wraparound
services is the emphasis on monitoring the performance and progress of each child and treatment program. The successes and failures of each child within each program are essential to the progress of the Milwaukee model as the collected data is used to make adjustments and improvements to the programs current and future wraparound services.

In its first two years (1994–1995), Wraparound Milwaukee served 175 children. That number grew to a total of 869 youth and their families in 2001. The program has been described as a best practice by the Office of Juvenile Justice Delinquency Prevention (OJJDP) for working with youth with serious mental health needs in the juvenile justice system and as a promising practice in children’s mental health by the Center for Mental Health Services (Milwaukee County Mental Health Division 2001). The success of Wraparound Milwaukee can also be measured through its 60% reduction in recidivism rates for delinquent youth from a year prior to enrollment to one year post disenrollment (Kamradt 2000).

5.5 Separate Specialized Mental Health Court
Specialized courts as an alternative to traditional juvenile courts are generally aimed towards the common deficiencies of the juvenile justice system: lengthy delays in processing cases, the lack of individualized and appropriate treatment and sanctioning, and the lack of sustained and consistent monitoring of the progress youth make while under court supervision (NCD 2001; Aron & Mears 2002). Separate specialized courts—including teenage courts, drug, mental health, and gun courts—for juvenile justice proceedings have become increasingly popular across the nation as more and more legal practitioners involved in the system became dissatisfied with inefficient traditional juvenile court proceedings (Butts and Harrell 1998; Mears 2001). Some refer to specialized juvenile courts as “problem-solving courts.” Advocates of these courts suggest:
Specialized juvenile courts are designed to intervene aggressively and immediately in the lives of troubled youth. Through early intervention and comprehensive treatment plans, ‘problem-solving’ courts empower judges to consider the needs of individual offenders and creatively tailor dispositions [...] ‘Problem-solving’ juvenile courts universally strive to use both consequences and incentives in treatment and recovery plans and focus on “the role and functioning of the youth's family in terms of rehabilitating the youth.” These common goals can best be clarified through an examination of juvenile "problem-solving" courts in existence today, with a focus on the more established juvenile drug courts and the nascent juvenile mental health court movement (Geary 2005, 686-7; See also, Arredondo et al. 2001).

Specialized mental health courts for juveniles separate mainstream youth from children with disabilities who come into contact with the judicial system. These courts use a separate docket, along with a team approach and regular judicial supervision, to respond to individuals with mental illnesses who come into contact with the justice system (Council of State Governments 2005, Shufelt & Cocozza 2006). The trend towards juvenile mental health court first began in 2001 in Santa Clara County, CA. Since then, nine other jurisdictions have implemented full functioning separate specialized juvenile health courts (Arredondo et al, 2001; Cocozza & Shufelt 2006). Comparatively, there are over 100 adult mental health courts nationwide (National GAINS Center, 2004). Several of these courts operate at the pre-adjudication stage and some function as an aftercare program for disabled youth who come into contact with the juvenile justice system. Many of the separate specialized mental health courts for juveniles, however, have adopted a similar multidisciplinary team approach to develop plans, provide treatment, and monitor the progress of each child. Team members often include the district attorney, the child’s attorney, mental health providers, case managers, juvenile program coordinators and probation officers. With this system, the average length of court involvement for youth with disabilities is 10 to 18 months; some are as few as three months and others as many as two years.

The difference between the specialized mental health court for juveniles and the traditional juvenile justice system is a greater assessment and attention towards each
individual child and his specific needs. The goal of specialized mental health courts for juveniles beyond adjudication and determination of guilt is to provide better, more individualized treatment for each child, which in turn can result in a reduction of the recidivism rate of children with disabilities in the juvenile justice system and impact the overall overrepresentation of children with disabilities in the system. These courts utilize improved and in-depth identification tools (screening and assessments) to increase the likelihood of appropriate and successful treatment services provided to the child. Treatment techniques and program management are unique to each child, and their progress, even in aftercare, is more highly monitored than those of mainstream juvenile delinquents (Cocozza & Shufelt 2006).

According to Mental Health of America (MHA), "mental health courts [can] play a role in convening criminal justice, mental health, substance abuse and other relevant social service agencies to facilitate diversion from the criminal justice system.” MHA and other supporters of juvenile mental health courts also note that “acceptable mental health court models should neither coerce nor compel treatment,” but rather work to "effectively determine individual needs and advocate for good individual treatment" (Geary 2005, 685; See also, MHA). These advocates also argue:

Individualized treatment should focus on recovery and choice, and include mental and physical health care, case management, housing, supportive education, substance abuse treatment, and psychosocial services in the least restrictive environment possible. Finally, in order for mental health courts to benefit the offender and community alike, court systems must avoid simply straining already insufficient local resources; they must promise to bring additional treatment resources into the communities where they operate (Geary 2005, 686).

Other proponents of specialized youth mental health courts emphasize ways in which juvenile courts have become increasingly like criminal courts as a result of the modern "tough on crime philosophy and note the potential effectiveness of alternative courts that can
better achieve the goals set by the founders of the juvenile court (NCD 2000). Advocates of this theory often refer to juvenile mental health courts as “therapeutic jurisprudence” that will “help deal with root causes of juvenile offenders’ behavior, and to lower recidivism rates” (Nicholls 2009, 558). These supporters note in their defense:

While some have criticized the coercive and paternalistic potential inherent in specialized therapeutic courts, advocates of these courts tout as benefits the reduced recidivism rates and the greater likelihood that defendants will return to their communities as productive individuals [...] Despite frequent concerns about the resources required to establish and maintain therapeutic courts, the size, number, and diversity of these courts continues to grow. While the oldest and most prominent specialized therapeutic treatment courts were developed primarily to handle the problems of substance abuse, a much younger mental health court movement has now emerged and expanded in step with the growing understanding of therapeutic jurisprudence and the mental health needs of offenders (Geary 2005, 681-2; See also Finlay 2002).

Other skeptics note, however, that, in practice, therapeutic jurisprudence and separate specialized mental health courts for juveniles are rarely implemented as designed as establishing a separate court system such as this is complex and costly (Goldkamp & Irons-Guynn 2000; National Mental Health Association 2001; Nicholls 2009).

5.6 Conclusion

As discussed throughout this chapter, current trends in resolving the deficiencies within the juvenile justice system that have a negative impact on children with disabilities range from preventative, intervention and aftercare strategies, as well as holistic approaches, as alternatives to the current juvenile justice system. A few strategies, such as positive behavioral intervention and support treatment, increased and improved professional mental health training, and multi-systematic wraparound services, have been successfully adopted and implemented in jurisdictions across the nation. Consequently, these approaches have been studied, reviewed, and awarded both local and national merit based upon their success. Other methods and programs, however, such as juvenile assessment centers (JACs), the Oregon Transition Support Initiative, the MH/JJ Action Network, and specialized mental
health courts, require additional time, money and personnel resources and many fail to monitor and measure the results of their new strategies. As a result, it is difficult to draw valid conclusions of the success of such initiatives and whether to maintain, alter or discontinue them. Prior to the implementation of the thus far successful strategies, however, a full and broad based commitment for implementation amongst all juvenile justice practitioners and child-serving agencies is necessary to address properly and begin to resolve the overrepresentation of youth with disabilities in the juvenile justice system and the injustices endured by these children as a result of their experience in the system.

Chapter 6: Conclusions and Recommendations

In an attempt to address adequately the unique needs of children with disabilities at risk or already involved in the nation’s juvenile justice systems and their widespread overrepresentation in that system, first and foremost, an intentional and forthright commitment by schools, social service and other child-serving agencies, families and caretakers of children with disabilities, and practitioners at all levels and stages of the juvenile justice system, is essential. There is no single solution, however, that will adequately address all the issues facing youth with disabilities in the juvenile justice system. A multifaceted approach, promoting and reaffirming programs, policies, and initiatives aimed to protect and promote the rights of children with disabilities who come into contact with the system as well as tackling the areas of deficiency within the system and the issue of their high prevalence is highly recommended. Addressing the legal and advocacy gap as well as intervention and treatment strategies in particular should be done in a realistic and comprehensive manner.
6.1 Legal Gap Recommendations
- Federal policy reform of current disability and youth related laws by legal terms and
disability clarification and compliance reinforcement
- National competency standard for juveniles

6.2 Advocacy Gap Recommendations
- Educational/training programs for juvenile justice practitioners and facility staff members
  on how to recognize and treat children with disabilities who come into contact with the
  system
- A single well-funded and well-coordinated federal agency or advocacy organization that:
  a) demonstrates a high level of commitment to the issue and is solely dedicated to
     ensuring the rights and needs of children with disabilities who come into contact with the
     juvenile justice system; b) provides information, guidance, and connections with
     appropriate resources to families and practitioners who support children with disabilities
     in contact with the juvenile justice system; c) emphasizes all areas of deficiencies for
     children with disabilities in contact with the juvenile justice system and also encourages
     government and private research and funding; d) provides a standard definition for
     identifying and measuring key terms relevant to this issue (i.e. disability)
- Research initiatives that: a) focus on the relationship between disability and delinquency;
  b) calculate the prevalence of children with disabilities in the juvenile justice system
  without centralized attention to only a few types of disabilities; c) locate where there are
  needs and gaps for these youth in the system; d) identify what works and what is failing
  in current solution trends in states and local jurisdictions across the nation

6.3 Intervention Recommendations
- School and community-based programs that appropriately and adequately provide for the
  specific, individualized needs of children with disabilities by: a) teaching preventative
  strategies to break the link between delinquency and disability; b) encourage healthy
  coping mechanisms and risk management strategies for these youth
- Systematic screening and assessment process that occurs immediately and is conducive to
  non-clinical professions to identify children with disabilities and assess the needs for
  specific treatment to each child

6.4 Treatment Recommendations
- A “team” of key players (i.e. family members, judges, lawyers, guardians ad litem,
  probation officers, treatment coordinators and caregivers, therapists, doctors, teachers)
  for each child that: a) is committed and held accountable to advocating for the specific
  individualized needs of each child at all levels of the system and in aftercare; b)
  effectively coordinates, collaborates, monitors, and communicates through information
  sharing to advocate for and support each child during and after his contact with the
  juvenile justice system; c) creates cohesion among fragmented and disconnected services
  to address the unique, individualized needs of children with disabilities during and after
  their contact with the system
The above recommendations may contribute to addressing the overrepresentation and
mistreatment of children with disabilities who come into contact with the juvenile justice
system. Although there are currently other strategies in place in states and jurisdictions across
the nation that attempt to resolve these issues as well, the findings of this thesis strongly
reinforce the approaches above.

These recommendations recognize the particular gaps and deficiencies contributing to
the issues for children with disabilities at risk or already in contact with the juvenile justice
system. Compliance with these recommendations may allow practitioners involved at all
levels and in all systems (i.e. educational, legislative, judicial, social services) the ability to
pinpoint initiatives that will allow them to work in collaboration with the other key players to
identify the unique needs of each child with a disability, implement federal disability law,
create and employ effective programs and strategies, and provide continual, effective
aftercare for children with disabilities at risk or involved with the juvenile justice system. In
addition, the recommendations encourage research and further awareness of these youth and
the unwarranted issues they face as a result of their disability. With enhanced screening and
assessment techniques, children with disabilities will be more accurately identified and
therefore receive appropriate individualized treatment specific to their unique needs. As a
result, the recidivism rate of these youth may decline and the overrepresentation of children
with disabilities involved with the juvenile justice system will likely dwindle. Ultimately,
compliance with the recommendations set forth by this thesis will allow practitioners of
disability and child-related services the ability to work towards a fundamental goal of the
juvenile justice system, in the best interest of each child.
Bibliography


*In re Steven M.* 264: Conn. 747 (2003).


In the interest of Holifield, 319 So.2d 471, 473 (La. App. 4th Cir. 1975).


Kamradt, Bruce. 2002. Funding Mental Health Services for Youth in the Juvenile Justice System: Challenges and Opportunities. National Center for Mental Health and Juvenile Justice.


NCD. *NCD Calls for Changes in Juvenile Justice and Education of Youth with Disabilities*. Washington, DC.


Office of Juvenile Justice and Delinquency Prevention, U.S. Office of Special Programs.


Shufelt, J.L., and J. Cocozza. 2006. *Youth With Mental Health Disorders in the Juvenile Justice System: Results From a Multi-State Prevalence Study*. New York, NY:


The Individuals with Disabilities Education Act, 20 U.S.C. §1412 IDEA.


Tate v. State of Florida, 864 So. 2d. 44, 54 (Fla. 4th DCA 2003).


