Addressing Invisible Barriers:
Improving Outcomes for Youth with Disabilities
In the Juvenile Justice System

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The Department of Justice's 1999 National Report on Juvenile Offenders and Victims paints a picture of juvenile justice outcomes (Snyder & Sickmund, 1999). In 1997, the last year for which data are available, approximately 1 in 5 arrests that law enforcement agencies made involved a juvenile. During that year 2,838,000 youths under 18 -- a little over nine percent of the U.S. population ages 10-17 -- were arrested. If current recidivism percentages apply, 46 percent of the males and 27 percent of the females will recidivate.

Many factors affect juvenile justice outcomes. One factor all too infrequently addressed is disability, which can place youth at great risk for contact with the juvenile justice system as well as for poor outcomes, once they have come into contact with the juvenile justice system. National studies show that a minimum of 30% to 50% of youth involved in juvenile crimes have special needs (Rutherford, Bullis, Anderson, & Griller-Clark, this series). Unfortunately, many service providers within the juvenile justice system are not prepared, through their awareness, training or level of resources, to respond appropriately to children and youth with cognitive, emotional, and behavioral disabilities, whose disabilities place them at greater risk than their peers for school suspension, school drop out, substance abuse, arrest, restrictive placement, and recidivism (DeMilio, 1989; Lexcen & Redding, 1999; Prescott, 1998).

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**The Need for Disability-Specific Approaches**

Given the knowledge that many young offenders have disabilities, information about disability characteristics and effective approaches is critical when choosing appropriate settings and determining consequences. In order to make adjudication and placement decisions, a judge, public defender, dispositional advisor, probation officer, and other corrections staff need to consider the following:

- Is there a possibility that, because of a disability, this youth does not understand the charges?
- Has the youth received his or her previous school placement? Is there a current IEP?
- Is an updated or more comprehensive disability or mental health evaluation needed?
• Does the correctional setting being considered for this youth have programs that can accommodate and specifically address his or her disability?

• Are the needs addressed in the youth’s IEP considered and integrated into the consequences determined by the court?

• Does the youth have some understanding about the disability and a plan to address his or her risk-taking or illegal behaviors?

• Do parents (guardians, foster parents, or surrogates), education professionals, correctional program staff, employers, and other involved with the youth understand the youth’s disability needs? What can they do, collaboratively, to provide the youth with supports to successfully transition back into the community, including an aftercare program?

• Are teachers or employers being provided with assistance and knowledge about the range of options they need to address this youth’s disabilities or problematic behaviors?

If there is no documentation of a disability and the youth of family has not indicated a prior diagnosis, the following questions are also pertinent:

• Are there aspects of the youth’s behavior that warrant a screening for a disability evaluation?

• Has the youth experienced a history of behavioral or learning problems?

• How, if at all, have these issues been addressed by the family or the school? (Garfinkel, 1998)

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This volume introduces a series of monographs, the purpose of which is to address the issue of youth with cognitive or behavioral disabilities and their experiences in the juvenile justice system. If strategically positioned staff in the juvenile justice system (e.g., law enforcement personnel, probation officers, judges, and youth guidance counselors) receive support in understanding the cognitive and behavioral problems of youth with disabilities, the system will better serve these children. Appropriate responses by those in the system will lead to better outcomes for the children, for their families, and for society as a whole.

Responding to the disabilities of children and youth is consistent with the logic of the juvenile justice system, which was created a century ago on the belief that there is a fundamental difference between children and adults. Children are still developing, are more amenable to rehabilitation, and therefore need a separate court system to address their concerns.
Responding to the Developmental Needs of Children

Children are developmentally different from adults and therefore children and families need a separate court system to address their legal concerns. They are dependent on adults; they are developing emotionally and cognitively; they are impressionable; they have different levels of understanding than adults. The simple truth that children are not little adults and should not be treated as adults gave rise to the juvenile court almost a century ago and, in more recent times, to the family court. There is a fundamental difference in philosophy between juvenile courts and adult criminal courts. Because young offenders are believed to be particularly malleable and susceptible to moral and social rehabilitation, the juvenile court seeks to rehabilitate juvenile delinquents, thereby preventing future criminal behavior. In contrast, adult criminal courts seek to induce law-abiding behavior by means of punishment for wrongdoing."

Recognizing these developmental difference states gave (in the words of Murray and Adeline Levine) "the juvenile court full responsibility for child guidance and child welfare." (1992, p. 101).

For the juvenile justice system to be effective it must address the needs of children and youth with disabilities, for the differences among youth can be as profound as the differences between juveniles and adults.

A disability-responsive approach to juvenile justice and prevention is also consistent with Federal statutes though which Congress (in terms of children and youth) "attempted to address the longstanding discrimination faced by children with disabilities in the U.S." (National Council on Disability, 2000, p.25). Thee federal statutes are particularly relevant here: The Rehabilitation Act, the Americans with Disabilities Act (ADA), and The Individuals with Disabilities Education Act (IDEA).

Section 504 of the Rehabilitation Act prohibits disability discrimination by any recipient of federal funds ( ). Title II of the ADA prohibits "public entities" from discriminating against a "qualified individual with a disability" on account of that disability. The Supreme Court upheld the
application of the ADA to Prisons in *Pennsylvania Department of Corrections v. Yeskey* (118 S.Ct. 1952 (1998), (see sidebar on the Yeskey case). The IDEA establishes the rights of children with disabilities to a free and appropriate public education which addresses their individual needs and does so in the least restrictive environment appropriate (20 U.S.C. § 1412 (a)(5); 20 U.S.C. § 1401 (29); 34 C.F.R. § 300.26). The IDEA implements rights that were established under two landmark Federal Cases, *Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania* (334 F. Supp. 1257 (E. D. Pa. 1971); 343 F. Supp. 279 (E. D. Pa. 1972), and *Mills v. Board of Education of the District of Columbia*. Placement of a child or youth in a juvenile justice facility does not remove education rights under the IDEA, which covers children and youth until they are 21. Nor does incarceration of a youth in an adult facility remove the protection of the IDEA if any of three circumstances apply:

- The youth is under 18
- The youth is between 18 and 21, but was identified as being a child with a disability and had an Individualized Education Program (IEP) in his or her last education placement before incarceration or before he or she left school; or
- The youth is between 18 and 21 and (while not having an IEP in their last educational setting), had been identified as a "child with a disability" under the IDEA.

Addressing the needs of youth with cognitive and/or behavioral disabilities addresses calls from juvenile justice professionals, educators, and advocates that the needs of children and youth with disabilities be addressed. The Appellate Division, First Judicial Department, Supreme Court of the State of New York, for example, published materials on the representation of children with dyslexia and other learning disabilities in the Family Court (Cohen, Lopatto, & Neely, 1990). Rause (1997) observed that "Individuals with ADHD, who come into the Juvenile Justice System, can go further, faster into the system than children without ADHD" (1997, p. 1). Rause's observations were confirmed and extended to children and youth with learning disabilities, emotional disturbance, and retardation by a July 1999 focus group with correctional educators from across the nation (Osher, 1999). The Office of
Juvenile Justice and Delinquency Prevention identified similar issues in a 1994 Juvenile Justice Bulletin that called for "full compliance with Federal and State" special education law and training correctional staff to "meet the mandates of the American's With Disabilities Act" (Gemignani, 1994).

Disability advocates also have pointed to the importance of addressing the connection between cognitive and/or behavioral disabilities and the juvenile justice system. The Parent Network of Western New York, for example, observed that "people who have brain damage are not able to pay attention or focus their thoughts for any length of time. They may appear cocky, disinterested or defiant," while some persons with cognitive disabilities may "be particularly suceptive to authority figures and will seek approval of those individuals even when it requires giving an incorrect answer" (1993, p. 1). Similarly, the cover page of a special issue on Learning Disabilities and Juvenile Justice by the Learning Disabilities Association of California included handcuffs and the statement: "by the time you find out your child is dyslexic, he could be starting his first sentence." Similarly, in a special issue on Juvenile Justice, the Federation of Families for Children's Mental Health’s Claming Children, families and practitioners identified the need to address the needs of juveniles with mental health needs: family member Jane Adams, Executive Director of Kansas' Keys for Networking (as well as a former correctional educator) described the challenge this way "with mental health, the juvenile justice system is almost 20 years behind most state and community health systems of care." (p. 3)

The failure to address disabilities can have dire consequences. "In some cases," the President of the National Mental Health Association and a colleague observed," abusive treatment of these children results from their being emotionally disturbed. Staffs in juvenile facilities fail to recognize, and in fact punish them for symptoms of their disorders" (Faenza & Siegfried, 1998, p. 3). For more information about the disproportionate representation of children and youth with disabilities in the juvenile justice system see Tulman (this series).
Responding to disabilities also will assist the juvenile justice system to respond to two other pressing matters: substance abuse and the disproportionate arrest and confinement of children and youth of color. Substance abuse often co-occurs with cognitive and/or behavioral disorders. The disorders themselves place children and youth at risk for substance abuse, and the substance abuse, itself, often exacerbates the impact of the disability (Lexcen & Redding, 1999; Prescott, 1998; DeMilio, 1989). Similarly, the failure to respond to disabilities appropriately (Bell & Jenkins, 1991; Benjamin, 1997) contribute to "the disparate treatment of minorities in America's juvenile justice systems" (Hsia & Hamparian, 1998, p.1). This disparate treatment reflects a series of small decisions, the impact of which is amplified (Community Research Associates, 1997) at multiple steps: family support, misbehavior, delinquency, arrest, detention, assessment, adjudication, disposition, probation, revocation, confinement, release, and aftercare in which youth of color may be treated differently. For example, African American children with emotional disturbance are less likely to receive counseling and other supports and are more likely to be placed in restrictive settings than their white peers (U.S. Department of Education, 1998). Similarly, a 1997 study conducted at the Rhode Island Training School (RITS), determined that among Rhode Island youth with comparable symptomatology, youth of color were more like to be confined at the RITS while Caucasian youth were more likely to receive mental health support that enables them to remain in the homes, school, an community (Woodruff, et al., 1999).

**Background: Federal Efforts Addressing Youth with Disabilities in the Juvenile Justice System**

The Coordinating Council on Juvenile Justice and Delinquency Prevention, an independent body within the Executive branch of the Federal government was established by the Juvenile Justice and Delinquency Prevention Act. The main function of the Coordinating Council is to coordinate all Federal juvenile delinquency prevention programs; all Federal programs and activities that detain or care for unaccompanied juveniles, and all Federal programs relating to missing and exploited children. The Council is chaired by the Attorney General and meets quarterly. See the sidebar titled

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Responsibilities of the Coordinating Council on Juvenile Justice and Delinquency Prevention

- Coordinate all Federal juvenile delinquency programs, programs and activities that detain or care for unaccompanied juveniles, and programs relating to missing and exploited children.
- Examine how programs can be coordinated among Federal, state, and local governments to better serve at-risk youth.
- Make annual recommendations to the Congress with respect to “coordination of overall policy and development of objectives and priorities for all Federal programs and activities that detain or care for unaccompanied juveniles.”
- Review the programs and practices of Federal agencies and report on the degree to which Federal agency funds are used for purposes consistent with the requirements of the Juvenile Justice and Delinquency Prevention Act.
- Review and make recommendations with respect to joint funding proposals undertaken between the Office of Juvenile Justice and Delinquency Prevention and any agency represented on the Council.
- Review the reasons why Federal agencies take juveniles into custody and make recommendations to improve Federal practices and facilities for holding juveniles in custody (OJJDP, 1995).

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In March 1997, The Center for Effective Collaboration and Practice at the American Institutes for Research facilitated a focus group of experts sponsored by the Office of Juvenile Justice and Delinquency Prevention, the National Institute for Literacy, the National Recreation and Park Association, the U.S. Department of Education, Office of Special Education and Rehabilitative Services and the Office of Vocational and Adult Education. The purposes of this meeting were twofold: (1) discuss and analyze the relationship between learning and other disabilities (referred to in this monograph series as children with cognitive and/or behavioral disabilities) and participation in the juvenile justice system, and (2) to make recommendations to the Coordinating Council on Juvenile Justice and Delinquency Prevention concerning the link between these disabilities, juvenile delinquency, and the juvenile justice system. During this meeting, experts from state and local governments, law enforcement, recreation, universities, community and educational groups, juvenile courts, and correctional facilities developed a framework for understanding the relationships between
these disabilities and juvenile justice outcomes: *that the inability of community institutions (including the components of the juvenile justice system) to respond to cognitive and behavioral disabilities contributed to higher arrest rates for youth with disabilities as well as to more restrictive placements, longer placements, and higher recidivism rates.* Specifically, the consensus was that in the case of youth with cognitive and/or behavioral disabilities:

- The juvenile justice system has not responded to nor does it recognize effectively or consistently the[ir] needs;
- Many issues are interconnected, beginning with the lack of early intervention (as with the case of fetal alcohol syndrome) and including early school failure and leaving school, to the inability of the system to respond to these youth as they move toward dangerous behavior. The lack of aftercare is also critical;
- A more restrictive political climate will make treatment of this population more difficult. [These] youth routinely serve their full jail terms due to poor behavior;
- Rates of recidivism are high …when issues contributing to their involvement in the juvenile justice system go unaddressed;
- The connection between [these] youth… and the professionals serving them is often weak. The difficulty these youth have in learning and in controlling impulse, combined with the often inappropriate responses of the professionals interacting with them, frequently leads to dismal results;
- The juvenile justice system must take an active role in intervening on behalf of these youth. For example, youth with conduct disorders who are in custody should not be placed in solitary confinement of left with idle time;
- Both systemic and individual interventions are necessary.
- Both academic and social education is critical;
- Universal access to recreation programs should be the norm; and
- Intervention must be linked to prevention, which begins with preschoolers (Coordinating Council, 1997, pp. 8-11)
The expert focus group concluded that “a revitalized interagency effort, initiated by the Coordinating Council, was urgently needed to reverse the tide of children who are failing in school, engaging in delinquency and violence, and increasingly spending the final years of their youth incarcerated” (Office of Juvenile Justice and Delinquency Prevention, 1997). The group suggested that there should be two major foci for these efforts:

- Prevention of delinquency and subsequent incarceration of youth with disabilities is a priority. These efforts should include early assessment and intervention activities that are coordinated across school, police, court, probationary, and other community-based services.
- Prevention of recidivism also is a priority. These efforts should include appropriate, specially designed instruction services that address the individual needs of youth with disabilities who are incarcerated.

Subsequently, the Coordinating Council on Juvenile Justice met and endorsed the recommendations of the Focus Group.

In October 1998, a policy forum was convened by Project Forum of the National Association of State Directors of Special Education for the U.S. Department of Education’s Office of Special Education Programs in conjunction with the U.S. Department of Justice’s Office of Juvenile Justice and Delinquency Prevention. Similar to the previous meeting, the purpose of this policy forum was to help determine the Federal role in achieving better educational results for youth with disabilities involved with or at risk of involvement in the juvenile justice system. The experts at the policy forum identified eleven issues:

1. There is a lack of compliance with the following legislative mandates in the juvenile justice system: Individuals with Disabilities Education Act (IDEA), the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973.
2. There is a need for increased awareness and training for workers in the juvenile justice system (e.g., judges, probation officers, public defenders), educational system (e.g., teachers and other educators in the public schools and correctional facilities), and mental health system regarding education of youth with disabilities in the juvenile justice system.
3. Research is needed to identify best practices and programs for preventing delinquency, serving youth with disabilities in the juvenile justice programs, and reducing recidivism.
4. There is an over-representation of children and youth of color in the juvenile justice system. This generates concern about differential treatment, the adequacy of information about cultural factors, and the understanding and valuing of differences.

5. We must provide a seamless, consistent, coordinated, and appropriate system of services for children and youth with disabilities across educational, juvenile justice, and other agencies to ensure a smooth transition through the continuum.

6. There is a need to disseminate what is currently known about best practices and programs, as well as what is known about what is not effective, in order to facilitate the implementation of best practices.

7. There is a need for more prevention and early intervention efforts to decrease the numbers of children and youth who become involved in the juvenile justice system.

8. There is a need for early and ongoing parent and family involvement in juvenile justice programs.

9. Within the juvenile justice system, there is inadequate coordination between the educational and residential/institutional programs.

10. There is a need to link educational services for youth with disabilities in juvenile justice programs with the larger issues of educational and institutional reform in order for meaningful change to occur.

11. There is a need for ongoing infrastructure support for teachers and other personnel in the juvenile justice system (Project FORUM, 1999).

Since these two meetings and the Coordinating Council’s action, several initiatives have begun to address the issues identified by the 1997 Focus Group and the 1999 Policy Forum. For example, the U.S. Department of Education’s Office of Special Education Programs, in collaboration with the U.S. Department of Justice’s Office of Juvenile Justice and Delinquency Prevention, has funded The National Center on Education, Juvenile Justice and Disability (EDJJ). EDJJ is a collaborative effort involving faculty and staff from the University of Maryland, the University of Kentucky, Arizona
State University, The Center for Effective Collaboration and Practice at the American Institutes for Research in Washington DC, and the PACER parent advocacy center in Minneapolis, Minnesota.

The research, training and technical assistance activities of EDJJ involve school and community-based prevention activities, education programs in juvenile correctional settings, and transition activities as youth leave juvenile corrections and reenter their communities. Through regional meetings, technical assistance, research and evaluation activities, and publication and dissemination, EDJJ is well positioned to help change the perceptions and understandings about youth with disabilities in communities and in the juvenile justice system. Further, through a network of practitioners, administrators, family members, and policy makers, EDJJ helps shape more effective and appropriate responses and accommodations for youth with disabilities.

A second example of the Federal government’s efforts to address the issues raised during the expert meeting is the National Survey to Determine Special Education Services for Juvenile Offenders with Disabilities, funded by the U.S. Department of Education’s Office of Correctional Education. This project, spearheaded by the American Institutes for Research, and supported by efforts from the National Center on Education, Disability, and Juvenile Justice, will determine and verify the extent to which special education services are provided to incarcerated youth with disabilities.

In 1985, Rutherford, Nelson, and Wolford conducted a national survey of the state departments of special education and correctional education to determine the need for, and provision of, special education services to offenders with disabilities. The results of that survey suggested that, although services offered in most states varied widely, not all offenders with disabilities were receiving the special education due to them. In the years since the first national survey was conducted, the number of juvenile and youthful offenders who are incarcerated has increased markedly. In many states that provide special education services to these youth, the percentage of offenders with disabilities has increased as well. The new survey will poll the heads of state juvenile and adult corrections systems and the state directors of special education, as well as directors of secure juvenile detention facilities. By collecting these data from a variety of sources, the survey will yield much needed information to
determine and verify the extent to which special education services are provided to incarcerated youth with disabilities.

This monograph series, which is described below, provides a third example. It was conceptualized by the Office of Juvenile Justice and Delinquency Prevention, the National Institute for Literacy, the National Recreation and Park Association, the U.S. Department of Education, Office of Special Education and Rehabilitative Services and the Office of Vocational and Adult Education, and it addresses issues that the 1997 focus group identified.

**About This Monograph Series**

This monograph series represents another Federal effort to address issues around youth with disabilities in the juvenile justice system. This introductory volume is divided into four major sections. The first section provides a discussion of the importance of prevention and early intervention as a means of diverting youth with disabilities from entering the justice system. Second, we discuss the various cognitive, behavioral, and emotional disabilities that put youth at greater risk for becoming involved in the juvenile justice system and make their experiences there more complex. Third, we present a discussion of how disabilities might be address as a youth makes his or her way through the juvenile justice system. The last section provides a brief description of the contents of each of the other seven monographs in this series. We hope that this series will help to raise awareness of the important issues surrounding the relationship between youth with disabilities who are involved or at-risk for involvement in the justice system and will serve as a springboard for improved practices.

**Prevention as a Means of Diverting Youth with Disabilities from Entering the Justice System**

In 1997, the most recent year for which complete statistics are available, over 2.8 million juvenile arrests occurred. The majority of these cases do not reflect chronic problems with violations of the law. However, with every arrest, there is increased likelihood that a youth will get into trouble again. A small minority of persistently offending youths account for the majority of juvenile arrests, and many of these individuals will later become adult criminals. The cost to society (victims, police,
courts, and corrections) of a single delinquent career has been estimated by a Vanderbilt University economist at $1.0 to 1.3 million (Cohen, 1998). Regarding only the four percent of youths who are considered to be both chronic and violent offenders (Snyder, 1998), and assuming an overall re-arrest rate of 50% within the year, the cost of today’s juvenile delinquents is between $76 and 98 billion. A more balanced approach to youth interventions, one that focuses on prevention and rehabilitation over repeated sanctions, can maximize the safety and well-being of the public while also minimizing the high costs of punishment (Eddy & Gribskov, 1998).

To be most effective, prevention efforts must focus on several different levels of need. Researchers have applied the traditional three stage public health model of prevention (universal, selective, and indicated) into approaches for youth with disabilities who are at-risk for involvement in the juvenile justice system (Quinn et al., 1998; Walker et al., 1996). They describe a three-tiered approach to the prevention of problem behavior.

The first tier includes “universal prevention” efforts directed at everyone in a school or community. These efforts include primary interventions such as providing a structured environment with clear behavioral expectations and positive consequences for appropriate behavior. The goal of primary prevention is avert the initial acquisition of problem behaviors. Universal Prevention can reduce the behaviors that place children and youth at risk for involvement in the Juvenile Justice System. For example, it is estimated that school wide interventions can usually reduce problem behavior for 80 percent of students (Dwyer & Osher, in press). Similarly community interventions which target those factors that place youth at risk and strengthen those factors that protect youth can strengthen the youth’s bond to their community, develop clear and consistent standards for behavior, and teach children and youth the skills they need to be able to live up to those standards. This approach has shown to lower costs for intervention and treatment (Catalano, Arthur, Hawkins, Berglund, & Olson, 1998).

At next level are “selective prevention” efforts. These efforts are directed at youth who are considered at-risk for involvement in the juvenile justice system because of factors such as poverty, high neighborhood violence, family disruption, disability, substance abuse, or poor school
performance. Some of these interventions are carried out in small groups. Programs that teach youth social problem solving skills and conflict resolution or after school therapeutic recreation programs are examples of these selected, early interventions. Others are individualized, for example, effective special education programs can reduce the drop out rate of youth with emotional disturbance, which is over 55 percent (U.S. Department of Education, 1994). This, in turn, is likely to reduce the arrest rate of these youth (73% of youth with emotional disturbance who drop out of school are arrested within three to five years of leaving school (U.S. Department of Education, 1994). The goal of secondary prevention is to quickly remediate problems while they are still emerging and to strengthen the impact of protective factors (close relationships with prosocial adults, school achievement, etc.) that might avert subsequent juvenile delinquency.

At the third or “indicated prevention” level, efforts can be individualized and intensive. The goal at this level is to prevent youth who are beginning to experience behavior problems from becoming more severely involved or from recidivating. Services at this level must be collaborative and provide intensive individualized services and supports to meet the needs of the youth and in many cases their families as well. Wraparound Milwaukee, a collaboration between The County Mental Health Division, Child Welfare, and Juvenile Justice, funded by the Center for Mental Health Services Comprehensive Services for Children and Their Families Program, provides an example. This program employed strengths-based, coordinated individualized planning and services to reduce out-of-home placement, costs of services (from $6,000 per month to a little over $3,200 per month), and recidivism, while improving clinical outcomes for almost 700 youth, 65 percent of whom had committed a delinquent act and were referred to the program by the Milwaukee County Juvenile Court (Kamradt & Meyers, 1999). Wraparound Milwaukee employed such services as care coordination, a mobile crisis team, in-home therapy, family therapy, alcohol and substance abuse counseling, mentoring, respite care, specialized camps, and independent living support to address the needs of these children and youth (Kamradt & Meyers, 1999).

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Wraparound in Action: Example
Mark is a 15-year-old referred to Wraparound Milwaukee in March of 1999 for 1st degree sexual assault of a child. Mark had been originally recommended for transfer to the Department of Corrections for placement in a State juvenile corrections facility. That order was “stayed” and he was ordered by Children’s Court into Wraparound. Mark and his family had strengths including good motivation to accept help, an interest in school and sports, a good sense of humor and an ability to make friends.

The comprehensive range of services Mark received covered many aspects of his life domains. He was enrolled in and successfully completed a special outpatient treatment program for sexual offenders. He was matched with a mentor who got him involved in an after school recreation program and doubled as a tutor to help him with schoolwork. He and his family were involved in family counseling which has made them a stronger family unit.

Mark has committed no new delinquencies and is doing well at home and in the community.

Joseph, age 16, was referred to Wraparound after multiple delinquencies such as assault, theft, breaking and entering homes, and was a frequent runaway from home. He had been abandoned as a child and therefore demonstrated poor attachment to adults. At the time of referral to Wraparound he was living on the streets of Milwaukee, finding places to sleep where and when he could.

But Joseph was a quiet, creative child, with a good sense of humor. He was courteous, bright and had good communication skills. After a short 60-day residential treatment placement, he was moved into a group home. He too benefited from being matched with a mentor and a job coach. The job coach worked on skills to help him find a job. His Child and Family Team including the mentor, his brothers, group home staff, and the job coach from the employment agency.

Joseph has not committed another delinquent act in a year and is slated to transition from Wraparound Milwaukee next month. He now has a job working for the City’s largest newspaper.

Latasha, 17, had a history of runaways and was very street wise at time of referral. Her delinquencies included party to a crime, a serious assault of another child and several counts of criminal damage to property.

At time of enrollment in Wraparound, Latasha was languishing in a residential treatment center. She was bonded with her mother and sister but neither could care for her. Her mother has a serious drug problem and her sister was unemployed with no way to support Latasha. The Wraparound Care Coordinator and her family addressed the mother’s needs by involving her in a drug rehab facility called META House. Her sister was referred to an employment agency that helped her find a job so she could be a placement resource for Latasha. Additionally, Wraparound secured some in-home therapy for Latasha and a job coach.

Latasha now is attending school regularly and has an after school job at a restaurant. She too has had no new delinquencies in over 1 year in Wraparound.

In all three of these examples, the care coordinator identified and utilized the child’s strengths and those of the family in developing a plan. The Child and Family Team guided the planning process rather than a professional. Services were determined based on the needs and strengths identified by the child and family.

A comprehensive array of services was provided to each child to address multiple life domains (e.g., psychological needs, living situation, education, vocational, legal, etc.) Services were highly individualized to that child’s needs. Finally, services were provided mainly in the community rather than in institutional settings. (Kamradt & Meyers, 1999).
Another successful program, which has employed strengths-based individualized planning and care to reduce recidivism, is the Safety Surveillance Network, which is run by the Georgia Parent Support Network. This program provides a "holistic, family-focused, empowerment-based program" that helps adjudicated juvenile sexual offenders to participate in outpatient treatment and to live at home with community safeguards. The Network employs individualized planning that involves all stakeholders and develops a support plan which provides for appropriate treatment and therapy, continuous supervision, crisis intervention, and progression toward independence. While 24-hour-a-day monitoring is an essential component, the "most important of these safeguards is a 'network' of family members, friends, teachers, coaches, and other community members or professionals who are committed to the success of the child." (Smith & Huckeba, 1999, p. 34).

Along with the severity of crime, age of onset is a powerful predictor of adult criminality. Early intervention, therefore, is crucial in effectively changing the life pattern of youth involved in the justice system. Thirty percent of juvenile arrests for violent crimes (murder, rape, robbery, and assault) in 1996 involved children aged 14 or younger (Snyder, 1997). Every one of these arrests is an opportunity to respond in a way that will reduce the likelihood of later, repeated problems. Problems with older youth tend to result in interventions that are more restrictive (Howell, 1998), more expensive, and in general, ineffective (Lipsey, 1995). There are promising interventions, which, particularly when implemented early, can markedly improve outcomes for many of these youth.

The Office of Juvenile Justice and Delinquency Prevention has developed a Comprehensive Strategy to address juvenile justice and delinquency prevention. There are two principal components to this strategy. The first of these is “preventing youth from becoming delinquent by focusing prevention programs on at-risk youth.” This focus on prevention is justified because the promise of prevention is real (see sidebar: High/Scope Perry Preschool Prevention Program). A scientifically

“In most jurisdictions, the juvenile system has little to offer an 11- or 12-year old delinquent youth because they are not yet seen as dangerous... but these delinquents disproportionately include the future violent criminals of their cohort.”

A rigorous study conducted by the Rand Corporation (Karoly, 1998) reviewed the social and economic effectiveness of a variety of early intervention programs. Programs providing high-quality day care or preschool-plus-family support significantly reduced criminal activity on the part of participating children in the years following intervention. A program offering home visits by nurses over the first two years of a child’s life to high-risk families was found to significantly reduce mothers’ crime. Savings to the government alone (not the broader societal savings) of early intervention programs were estimated to outpace costs at a rate of 2 to 1 for a preschool intervention, and 4 to 1 for a home visitation program. In general, higher-risk children tend to realize the greatest benefits from early intervention efforts.

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High/Scope Perry Preschool Prevention Program

In 1962, the Perry Elementary School in Ypsilanti, Michigan (a suburb of Chicago) began working with poverty-stricken 2-5 year olds considered at high risk for school failure. The program actively involves the children in 10 developmental experiences: creative representation, language and literacy, social relations and personal initiative, movement, music, classification, sequencing, numbers, space, and time. The children are asked questions such as “What happened? Can you show me?” and “How did you make that?” rather than merely being drilled rote academic skills. In addition to the classroom work, the teacher visits each child’s home for 90 minutes a week.

This intensive program is cost effective. It is estimated that for every dollar that is spent on the program, $7.16 is returned. In a well-designed and rigorous longitudinal study of the High/Scope program participants and a control group of non-program participants, researchers found significant differences in the outcomes of participants at age 27. These differences include:

- Arrest rates: 35% of the control group was arrested at least 5 times and 25% of the control group was arrested at least once for dealing drugs. This is compared to a 7% arrest rate for the High/Scope group in each of these two categories.
- Education: 54% of the control group completed at least 12 years of school, compared to 71% of the High/Scope group.
• Earnings: Only 7% of the control group earned at least $2,000 per month, but 29% of the High/Scope group earned at least this much.

• Welfare Participation: 80% of the control group received welfare as an adult, compared to 59% of the High/Scope sample.

(Henderson & Berla, 1994; Schweinhart, Barnes, & Weikart, 1993; Schweinhart & Weikart, 1993).

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There are promising interventions for at-risk older children as well. Larson and Turner (this series) report these in detail. An economic analysis conducted by Greenwood et al. (1996) compared the costs of various proactive interventions with the costs of California’s reactive three-strikes law. The proactive interventions studied included: home visits (birth through age 2) by child care professionals and provision of four years of day care; parent training; graduation incentives for poor, minority youth; and monitoring and supervision of delinquent high school students. Home visits and day care cost about $23,400 per year; parent training cost $3,000 per family; graduation incentives cost $3,130 per youth per year (for 4 years); and monitoring and supervision was estimated to cost $10,000 per youth. The three-strikes law was estimated to cost $16,000 per serious crime prevented, or $5.5 billion per year if fully implemented (however, due to budgetary constraints and District Attorney discretion in implementation of this law, it has never been fully implemented).

Effectiveness rates were reported as follows: Home visits reduced crime by 24% (and reduced child abuse by 50%), parent training was reported to reduce crime by 29%, graduation incentives were estimated to reduce juvenile crime by 56%, and the intensive supervision program for delinquents was found to reduce juvenile crime by 8%. It was estimated that if the California three-strikes law were fully implemented it would only reduce serious adult crimes by 28%. Although the three-strikes law does prevent future crime, it is very expensive, and graduation incentives produce almost the same benefit at about 10% of the cost.
The Importance of Family Involvement

One challenge all prevention programs face is gaining the trust and cooperation of the families involved. In most truly preventive interventions, the children are not yet in trouble, and the family is not necessarily asking for help. They may not want “the man” getting into their business. This may be particularly the case for families of color who have historically been treated unfairly by government or bureaucratic systems and who may be wary of diagnostic labels or of participating in the next “program” with uncertain benefits. It is incumbent upon those practicing prevention to use culturally competent, family friendly, and community-based initiatives in order to help families accept the best services available.

One issue in reaching families is timing. When are families most open to intervention? Research shows that points of transition are the most opportune times to reach out to families. Transition points include such events as the birth of a child, a child starting or changing schools, divorce or other family changes, or a child’s initial contact with the juvenile justice system. At any and every opportunity, people in helping roles can act to improve the life outcomes of that child and their family, and decrease the likelihood of arrest, adjudication, or recidivism.

Another issue in reaching families is stigma. One way to make preventive services less stigmatizing for families is by focusing on strengths and on building resilience rather than on problems, "dysfunction," or deficits. Imagine your son has been arrested and charged with drug possession. What would you rather hear, “Your son is in big trouble – he’s probably going to become an addict if you don’t do something now,” or “Your son is in trouble now, but we would like to support him in choosing a more positive path”?

Assessment and Evaluation

Traditionally, agencies assess children with cognitive and/or behavioral disabilities by using only deficit-oriented assessment tools to identify the child’s problems and weaknesses. Researchers argue that this does not give the evaluators and program developers a complete picture of the child and does not provide enough information to develop, implement, and monitor comprehensive intervention plans (Harniss, Epstein, Ryser, & Pearson, 1999). Families and service providers need
to know more than just what is wrong with the child, they need to know what is right with them as well. This information is believed to be key to developing better Individualized Education Programs and individual service plans (Epstein, in press).

Recently, the use of only deficit-oriented assessment tools also has been called into question by a number of social service and education initiatives such as the U.S. Department of Education’s National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance (1994), Wraparound approaches (VanDenBerg & Grealish, 1996), and the Child and Adolescent Service System Program (Stroul & Friedman, 1994). These initiatives call for the use of strength-based assessments that will view each child as an “individual who possesses unique strengths and weaknesses” (Harniss, et al., 1999, p. 12). Strength-based assessment has been defined as “measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one’s ability to deal with adversity and stress; and promote one’s personal, social, and academic development” (Epstein & Sharam, 1998, p.3). It is argued that strength-based assessments in conjunction with the traditional deficit-oriented assessments will yield a more complete picture of the child and will ultimately lead to more accurate, effective, and comprehensive intervention plans.

Strength-based assessments exist (Epstein & Sharma, 1998) that can highlight what resources, supports, competencies, and preferences a child has upon which interventions may be built (see sidebar: A Strength-based Approach to Evaluation).

Insert as a sidebar

**A Strength-based Approach to Evaluation**

The Behavioral and Emotional Rating Scale (BERS; Epstein, & Sharma, 1998) is a 52-item scale assessing various strengths of children ages 5-18. It is divided into 5 subscales (Interpersonal Strengths, Family Involvement, Intrapersonal Strengths, School Functioning, and Affective Strengths) and can be completed by teachers, psychologists, social workers, or parents in as little as 10 minutes. Sample items include:
• Is self-confident.
• Demonstrates a sense of humor.
• Enjoys a hobby.
• Participates in family activities.
• Talks about the positive aspect of life.
• Uses appropriate language.
• Uses note-taking and listening skills in school.

End Sidebar

A strength-based approach to assessment is one way to enhance protective factors, and it is the cornerstone of competent practice. The goal of enhancing protective factors is to moderate the risk factors that are responsible for causing or increasing the likelihood that problems will occur (e.g., poverty, disability, disorganized communities). Protective factors do not remove risk factors, but can help increase the child’s resistance to them. For example, protective factors cannot remove children’s learning disabilities, but will provide them the supports necessary to be successful in school in spite of their disabilities, and prevent the onset or growth of delinquent behavior.

**Protective Factors to Enhance Prevention**

Researchers have identified three categories of protective factors: (1) individual, (2) social bonding, and (3) beliefs and standards for behavior (Hawkins, Catallano, & Miller, 1992). Individual protective factors include being a female, being intelligent, and having a positive social orientation and a resilient temperament (Rutter, 1985; Werner & Smith, 1982). Social bonding includes having a strong, supportive, and loving relationship or attachment with your family or other adults (Garmezy, 1985). Finally, healthy beliefs and clear standards include a family and community that value academic achievement and healthy development and object to violence and crime (Brewer, Hawking, Catalano, & Neckerman, 1995). For a discussion on risk and protective factors see Leone, Quinn, & Osher (this series).

Prevention works best when it revolves around an ongoing commitment to positive outcomes that involves the youth and the family. School involvement is crucial when children are of
school age. Community norms against delinquent behavior need to be built and reinforced. Most of all, any and all prevention programming must be appropriate to the developmental level of the child involved (preschooler, elementary school-age child, or teen, for example) and must be culturally competent. Prevention works when it is implemented in a sensitive, positive way, and everyone realizes the benefits.

One theory-based approach to prevention asserts that every individual functions in and must adapt to different “social fields,” such as home, school, and the peer group (Kellam, Branch, Agrawal, & Ensminger, 1975; Kellam & Rebok, 1992). Each social field has one or more “natural raters” who make the rules and who can determine whether an individual is adapting well or poorly (parents, teachers, peers, intimate partners, and bosses are examples of natural raters). Over the course of our lives, these social fields change in terms of their salience, becoming more or less important in our overall lives. The heart of the theory is that when we succeed, we are happy, but when we fail to adapt, our psychological well being suffers. Failure in one social field puts us at risk for failure in other domains, and early failure is a risk factor for later failure. Prevention must be specific to a given social field, and any assessment of the effectiveness of that preventive intervention must include that social field’s natural raters. Life course social field theory is illustrated in the following diagram.
Disabilities of youth in the juvenile justice system.

Once a youth has entered the juvenile justice system, in order to produce the best outcomes for that individual and for the public, the needs of that youth must be responded to effectively. One set of needs that have not received adequate attention is the emotional, behavioral, and learning disabilities of youth involved in the system. Rutherford, Bullis, Anderson, and Griller-Clark (this series) review prevalence rates in detail. In short, children with cognitive and other disabilities are overrepresented in the juvenile justice system with estimates between 17% and 53% having some identified learning disability, up to 46% having Attention Deficit Hyperactivity Disorder, up to 78% having an anxiety or depressive disorder (Edens & Otto, 1997) and up to 12.6 % having mental retardation (Casey & Keilitz, 1990).

Learning Disabilities and ADD/ADHD

The definition of “learning disability” is controversial. Since the term was coined, a battle has waged over a proper definition. Part of the problem with defining “learning disability” is that no two individuals with learning disabilities necessarily “look” alike. One child with a learning disability
may have difficulty in spelling, while another may have difficulty in math. Furthermore, youth with learning disabilities do not necessarily struggle in all academic areas. Having a learning disability is not equivalent to having mental retardation. Children with learning disabilities generally perform in the “normal” range of intelligence, and although they may struggle in one academic area, they may perform as well as any nondisabled youth or even excel in other academic areas. A child with a reading disability may perform two grade levels below his peers’ reading level, but at the same time perform two grade levels above his peers in math.

Although a child with a learning disability may not, on the surface, appear to experience as many or as significant problems in school as other students, she or he does struggle. No one who has a learning disability “outgrows” it. Having a learning disability is life long, and a successful adult who has a learning disability has learned to cope with his or her condition, has discovered and built upon his or her strengths, and has shown great perseverance.

Learning disabilities are commonly associated with reading problems; however, they also can be manifested in other difficulties including but not limited to spelling, written expression, and math. Reading problems may relate to understanding the rules involved in putting sounds together to make up words (phonological skills) and visually processing information from letters. Dyslexia is a specific kind of learning disability related to severe reading difficulties. Youth with learning disabilities involving writing may experience great difficulty with spelling, handwriting, and/or composition (writing fluency and strategies – planning, organizing, drafting, and editing). A youth with a learning disability also may have great difficulty holding a conversation. She or he may struggle with the mechanics of spoken language (such as grammar), as well as with meeting social expectations of what one would call comfortable, “normal” discourse. In math, a child with a learning disability may have difficulty with computation and/or problem-solving (choosing the correct strategy). A child with a learning disability may experience visual perceptual problems (e.g. reversing letters, seeing and remembering shapes – putting together a jigsaw puzzle may be particularly difficult for him or her to do), as well as what one would call “coordination” problems (i.e., problems with fine and gross motor skills). Youth with learning disabilities also may have problems with memory. It is not uncommon
for a child with a learning disability to forget something she or he just heard or saw, and/or to remember one thing as she or he is attending to something else. Children with learning disabilities often do not use strategies to obtain or retain information the way nondisabled youth do. In many instances, learning disabled youth have great difficulty making plans, organizing their thoughts, and utilizing problem-solving techniques (e.g., improving reading comprehension, what to do if placed in a problematic situation).

In addition to the academic problems described above, children with learning disabilities may also display social and emotional problems. This may be due to their misunderstanding of social cues and misinterpretation of feelings of others. Learning disabled youth may experience motivational problems, due to their feelings of lacking control over situations. Often, children with learning disabilities feel controlled by others and have little if any sense of control over their own lives. Further, these children are often insecure about acting positively and making correct choices, and do not believe that they adequately solve problems. It is not surprising, then, that youth with learning disabilities often have low self-esteem.

How is it that we can help youth with learning disabilities? From an educational standpoint, children with learning disabilities can benefit from developing and fine-tuning learning and problem-solving strategies, developing self-determination skills, and through Direct Instruction (i.e., a rehearsed, highly structured instructional model that focuses on repeated and intense drill, practice, and immediate feedback). Some examples of effective instruction models include (but are not limited to) the following:

- Self-instruction – where children talk themselves through problem solving, asking such questions as, “What is the problem?” “What do I need to do to solve this problem?” and follow a series of steps to accomplish a goal, including monitoring progress and ending with the children giving themselves a “pat on the back”;
- Scaffold instruction – a master-to-apprentice form of instruction that begins with observing the teacher go through the steps of problem-solving, then having the youth
go through the steps under the guidance of the teacher, then having the teacher taper off guidance until the youth can perform the task on his/her own;

- Using mnemonic devices – converting abstract information into more concrete representations (e.g., remembering the word HOMES to help recall the names of the great lakes: Huron, Ontario, Michigan, Erie, and Superior). This is particularly effective when youth are attempting to learn new vocabulary words or concepts with which they are not familiar.

**Emotional/Behavioral Disorders**

Most people have long regarded problems like anxiety and depression as “emotional” disorders. What researchers are increasingly coming to see is that conduct problems, the kinds of behaviors that can get children into trouble, are also emotional disorders. The root of these disorders lies in an individual’s emotion regulation system. These children find it very difficult to control their emotions and consequently, often have difficulty controlling their behavior.

Conduct problems reflect improper regulation of the anger and anxiety systems. Children with these problems feel anger much too readily (e.g., they may become physically aggressive if someone brushes against them in a hallway) and have learned to suppress anxiety about punishment. Most children in trouble who do not express fear, still experience it. Oddly enough, the experience of fear or anxiety has been found to predict better adult outcomes. One study (Raine, Venables, & Williams, 1995) for example, found that the experience of anxiety (i.e., increased heart rate and palm sweating) in youths, whether or not that anxiety was expressed, was associated with decreased criminality as an adult.

Anxiety by itself can be a debilitating condition. Youth with anxiety problems are so afraid, uneasy, or worried that they are not able to carry out their lives in a normal way. There are several distinct disorders of anxiety. *Specific phobias* are unrealistic and excessive fears of some situation or object. Some truancy may be related to school phobia, which is an irrational fear of going to school (school refusal because of fear of bullies is not strictly irrational, but may also be related to truancy). Youth presenting with *Generalized anxiety disorder* may seem tense, fatigued, self-conscious, and
may seek reassurance continually. These children may also have stomachaches, headaches, or other physical problems related to their uncontrollable, excessive worrying. Panic disorder refers to the persistent concern about, or extensive avoidance of, situations that might bring on panic attacks. Panic attacks are sudden, intense, but usually relatively brief experiences of great fear in which the individual often fears he or she is dying.

Some people have persistent ideas, impulses, or images (obsessions) that are unpleasant and cause anxiety. Those individuals may then engage in repetitive acts (compulsions) which relieve that anxiety but take up so much time or cause such severe distress that Obsessive-compulsive disorder is diagnosed. Youth with odd habits or rituals, especially if they involve checking, washing, or putting things in a certain order, may have this condition. Finally, youth from violent homes or violent communities may have symptoms of Post-traumatic stress disorder (PTSD). This disorder involves persistent re-experiencing of some trauma, often with feelings of guilt about surviving or what had to be done to survive, avoidance of things associated with the event, feeling “numb,” and a sense of hyper-alertness. PTSD may be associated with a loss of previously held sustained beliefs, self-destructive or impulsive behavior, hostility, feeling damaged, or social withdrawal.

Mood disorders are also common among youth. Depression is a period of at least two weeks when for most of the time, a person is sad, irritable, or has lost interest in things that used to be enjoyed. Not caring about things, feeling worthless, or feeling guilty may be signs of depression, especially when combined with changes in appetite, sleep, physical activity, or sexual interest. Suicide is a complication of depression that cannot be accurately predicted. Therefore, close supervision of depressed youth is always indicated.

Another type of mood disturbance is called mania. Mania involves excessively euphoric, enthusiastic, or irritable mood. It is not uncommon for actively manic individuals to come to the attention of law enforcement authorities, as they may engage in risky, illegal, antisocial, and/or unethical acts in flamboyant ways. Youth with mania often sleep much less without feeling tired, speak or think rapidly, and be distractible. Some people alternate between depressed and manic
moods in a cycle that is referred to as “bipolar,” or “manic-depressive.” Treatment of mood disorders typically involves education, psychotherapy, and usually medication.

The role of irritability in both anxiety and depressive disorders is especially important to highlight for youth in juvenile justice contexts. Not all outbursts of anger are signs of “rotten” behavior, and not all behavior is a youth’s choice. When people have an emotional disorder such as those described here, they may be confused and upset by their own behavior, and feel helpless to change the way they are acting. This does not mean that they do not seem obnoxious to others – poor social functioning is a diagnostic criterion for emotional disorders. It simply means that many youth who are in trouble could benefit from assessment and appropriate treatment of their emotional problems.

Attention Deficit Hyperactivity Disorder (ADHD) is the behavioral disorder most often co-occurring with delinquency (other than Conduct Disorder, which has significant definitional overlap with delinquency). Children with ADHD present as extremely physically active and fidgety (much more than that individual’s cultural norm), impulsive, and inattentive. While conduct problems reflect underlying problems in emotion regulation (as described above), ADHD is currently regarded as a genetically influenced disorder of the brain’s behavioral inhibition system. Inhibition is the ability to stop oneself from doing something, and it has important roles in memory, emotion, and speech. Studies over time have demonstrated that children with ADHD are at increased risk for academic problems, antisocial behavior, drug use/abuse, academic dropout, and depression. Whether alone or in combination with other problems, the treatment of choice for ADHD is the combination of accurate diagnosis, counseling about the disorder, medication, and accommodation using behavioral methods, environmental changes, and curriculum adjustments.

“From a prevention framework, ADHD can be conceptualized as a vulnerability factor for the development of more severe and chronic psychopathology. Similar to interventions used to treat individuals with chronic diseases such as hypertension and diabetes, intervention efforts with ADHD children should focus on preventing development of debilitating complications.” -- Gerald August, 1997
One factor complicating assessment and treatment of youth in trouble is the fact that emotional, behavioral, attention, and cognitive problems do not always occur one-at-a-time. Particularly during childhood and adolescence, comorbidity (the presence of multiple diagnoses) is strikingly common. For example, in a recent review of general population studies, Zoccolillo (1992) indicated that up to 50% of children with conduct problems also had anxiety or mood disorders. For youth with conduct problems, withdrawn behavior tends to be related to physical aggression and problems like stealing or lying, and depressed mood tends to be related to delinquency and substance use (Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998). Early onset delinquency is especially likely to be associated with depression. Learning disabilities also occur in about 38% of youth with emotional or behavioral problems (Fessler, Rosenberg, & Rosenberg, 1991).

The reality of comorbidity is especially troubling for those who prefer to compartmentalize youth into specific service programs based upon some diagnostic label. The effort to determine which type of intervention is most appropriate for which kinds of youth may be noble, but it may also be problematic if “typing” is carried too far. The best outcomes are realized when youth receive individualized, culturally competent assessment, and coordinated, family- and community-based services.

**Addressing the Invisible Barriers of Children with Disabilities in the Juvenile Justice System**

Behavioral characteristics associated with cognitive and other disabilities create problems that are seen in the home as well as in school. When a child or youth later comes in contact with the justice system, these problems become magnified. These children and youth have difficulty behaving appropriately toward law enforcement and other authority figures, and are often unable to understand the consequences of their behavior. Therefore, they are more likely than other children to be taken into custody. Adding to this problem, the behavioral characteristics of a child or youth with learning disabilities can lead to inappropriate interactions with officers and others in the system. Once in the system, inappropriate testing and assessment of a child’s disabilities and needs can occur due to inadequate materials or initial perceptions of problematic behavior. Learning disabilities may be
considered irrelevant to the adjudication process once a crime has been committed. Law enforcement officers, lawyers, judges, teachers, and others in the correctional system need higher levels of support in order to understand the specific problems and needs faced by children with learning and behavioral disabilities and to learn effective strategies for intervention.

In order to begin addressing the barriers to effectively meeting the needs of children and youth with cognitive and other disabilities, this section walks though the various stages of a youth’s involvement in the justice system, and discusses ways that disabilities could be addressed and accommodated, so that the law is followed and outcomes can be improved.

*Custody/Detention.* In each state, there is a legal process for deciding when a juvenile should be detained. If it is for a criminal violation, the law enforcement officer who has contact with the youth generally makes the initial decision to detain or release the youth. In making this decision, the officer considers several factors, but the two most important should be the protection of society and the best interests of the youth. If the youth is violent and is not likely to appear for further proceedings, then he or she should be detained. However, if there is no danger to society and there is no reason to believe the youth will not appear for subsequent proceedings, then the youth needs to be released to a parent, guardian, custodian or other responsible adult (and may have conditions placed on his or her freedom). If the youth is detained, then immediate notice must be given to parents, guardian, or custodian of the youth. Youth with disabilities such as Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Oppositional Defiant Disorder, and/or Learning Disabilities would be at risk to be held rather then released. Because of the nature of these types of disabilities, the youth may say the wrong things, fail to process information appropriately, or make decisions quickly without thinking. A youth with a learning disability may not understand what the officer is saying, and may not understand written materials given to him or her to sign.

The assessment process for youth detained by authorities should require that the parent, custodian, or guardian of the youth be questioned regarding any special needs, medications, or other information that would affect a youth in detention. Staff at all facilities should ask questions regarding whether the youth is taking any medications, and whether the youth has any diagnosis that
qualifies as a disability under either IDEA or the ADA. When staff become aware that a youth may have a valid disability, then accommodations must be made for participation in any programs, explanation of detention policy and detention rules. A staff person may need to go over a written set of rules with the youth to make sure the youth is able to comprehend and participate in any programs. Some short-term detention facilities provide for continuation of the youth’s educational needs. A written policy requiring contact with the youth’s school to obtain his educational plan (IEP) should also be in place so that those youth who qualify under IDEA may continue with their educational programs.

*Initial Appearances.* The initial appearance takes place shortly after the youth enters detention. It may be only for a further detention hearing, it may be after the petition/charge is formally brought or for both these reasons. It is recommended that the child have a non-waivable right to effective counsel in all juvenile court cases. The juvenile court will, if the formal petition is on file, explain the constitutional/statutory rights to the juvenile and the juvenile’s parent, custodian or guardian. Accommodations for those juveniles who have a recognized disability would be required. This may mean allocating more time for the explanations of rights, requiring a quiet atmosphere, cutting down on possible distractions in the court room, and possibly providing written explanations of juvenile rights which the youth may take with him for later reference. Once the juvenile judge has explained the youth’s rights and made a determination regarding legal counsel, a date is scheduled for the juvenile to plead or admit/deny the petition. At the detention hearing, the juvenile court considers whether further detention is necessary. At this time, legal counsel for the juvenile should present any relevant information that would affect a decision for further detention. If the parent is able to testify that the juvenile does, in fact, have a recognized disability, then the court is alerted that accommodations will need to be made for the juvenile at other hearings. If the child benefits from medications, and the detention center did not have access to those medications, then the court should enter an order providing for the administration of the medications. The court may be petitioned to place the juvenile with a parent or responsible adult who will make sure the juvenile takes the medications as prescribed.
Prosecution Filing Decisions/Diversion. There are may different types of programs across the country through which a youth can voluntarily enter a diversion program and avoid having to go through the formal processes of juvenile proceedings. In some states, the prosecution makes that decision. In other states, an arm of the court may make that decision. All such programs provide that, if the youth meets the requirements of the diversion contract, the charges/petition will not be processed against the juvenile and will not go on the youth’s record. The law clearly requires the entity making a decision to divert a youth to make accommodations for any disability in deciding whether the youth should be diverted or not.

Cognitive and Behavioral Disabilities and Trial Issues. Youth have the right to pretrial motions raising issues about the detention and voluntariness of their confessions (People ex rel. Guggenheim v. Mucci, 1974; Rhodes v. State, 1975). The United States Supreme Court, in criminal cases, has held that a defendant is denied their 6th and 14th Amendment rights to present a defense if prohibited from presenting evidence “about the physical and psychological environment in which the confession was obtained” (Crane v. Kentucky, 1986). Recently, the Nebraska Supreme Court reversed a first degree murder case on the grounds that the defendant had been prohibited from presenting evidence from a clinical psychologist who had conducted a mental health evaluation of the defendant and who had also reviewed the defendant’s confession to the murder. The psychologist was prepared to testify that the defendant suffered from major depression, attention deficit disorder, anxiety disorder, and paranoid personality disorder. The psychologist was also prepared to testify that the defendant, prior to his confession, was incarcerated and was in the throes of methamphetamine withdrawal. The psychologist would have testified that the effects of the withdrawal include severe depression, extreme feelings of hopelessness, difficulty concentrating and high levels of distress and suggestibility. As a result, the defendant would have been very suggestible, would waiver in his attitudes and beliefs, would process information haphazardly and would often reach faulty conclusions. The State Supreme Court held that the trial court, in excluding the proffered testimony, did not make a harmless error and reversed the decision (State v. Buechler,
This ruling could be applied to a juvenile court in considering the confession or other defense of a juvenile with a disorder or combination of disorders. Some disorders such as Attention Deficit Hyperactive Disorder may have an effect not only on confessions but also on premeditation as an element of a crime.

**Adjudication Hearing/Trial.** Should the juvenile not wish to plead/admit the facts in a petition, then a trial must be held. Should the juvenile admit/plead to the allegations, then the court must be careful to go through a question and answer process to make sure the juvenile knows what he is doing and is voluntarily admitting/pleading to the allegations.

When trial is held, the Court must ensure that all procedures necessary to protect the juvenile’s rights are followed and that a record is made of the proceedings in case there is an appeal later. During the trial, the court, if so informed, must make accommodations for juveniles with a demonstrated disability. This could be as simple as providing an interpreter for a deaf juvenile or making more subtle accommodations for a juvenile diagnosed with ADHD. Because the Federal government considers ADHD a disability, if the disorder limits a major life activity, then individual’s appropriately diagnosed with ADHD are entitled to reasonable accommodations in the courtroom, just as they are in the classroom or workplace (*Aviles v. Bowen*, 1989). Courtroom accommodations might include careful repetition of important information, additional time to think in response to questions and non-confrontational communication. When ADHD is coupled with a learning disorder, which occurs in approximately 30% of all cases, the court also must accommodate the particular learning disability.

**Post Adjudication Evaluations.** Every state has an assessment process after adjudication in which an entity examines various aspects of the juvenile’s actions, his past, influences to which the juvenile may have been subject, restitution to any victims and safety of the public in formulating an appropriate disposition/sentence. Since a juvenile court will have an array of dispositions, which may range from leaving a juvenile in the home to commitment to a locked facility. The modern juvenile court is interested in protecting society, restitution to the victim, and individual rehabilitation. The evaluation, then, should look not only at the concerns of the public security and restitution to the
victim and society, but also to determine what program or programs will work best to make the juvenile a productive part of society.

The juvenile court’s probation department is generally the first place where the evaluation/pre-disposition report begins. Again, as in the detention portion of the system, an assessment occurs to examine the juveniles past, present situation and to make future predictions for the juvenile. When the evaluator is gathering information, parents/custodians should be asked if the juvenile is under any treatment for mental and emotional problems, taking any medications, or has an IEP in school. If the probation department is large enough to have expertise in the areas of learning disabilities and childhood or adolescent disorders, then some prescreening should be available for determining the need for more in-depth evaluations. For less specialized offices, training in preliminary screening should be required with a final determination to be made by medical or mental health professionals. The court should, either by statute or by court order, have the authority to conduct medical and psychological testing either at parental or government expense. Since some disorders such as ADHD are highly responsive to drugs, it is imperative to use trained physicians in the local or nearby communities for some of the diagnosis and treatment processes.

*Dispositions/Sentences.* The juvenile courts should use a continuum of program options in the provision of services for delinquent children and their families. Priority should be given to providing sanctions and services for potentially or already serious, violent, and chronic juvenile offenders as early as possible in the youth’s life. However, services for mentally ill, mentally retarded, and youths with disabilities are severely lacking in most juvenile justice and mental health systems. It would be beneficial to both the juvenile system and the juveniles if disposition orders required that juveniles be given information in understanding their disability and in strategies to manage their disability.

Where appropriate, medications can help a juvenile manage their disability. Medications should be prescribed and monitored by physicians familiar with the comprehensive treatment of children and youth. A program that does drug screening could be modified to screen not only for illegal drugs, but also to ensure the proper medications are being taken.
The juvenile justice system should work hand in hand with the various schools in which their juveniles are placed. A checklist for the probation officer should consider whether the child is a special education student and, if so, whether there is an Individualized Education Plan (IEP) for the juvenile. In those areas where the probation department or court services are able to have that information from the school for the disposition report, the officer should look at how the court disposition can enhance the IEP by appropriate programs that allow the juvenile to do well in their program at school. Court ordered tutoring and study halls may be helpful to juveniles who are having problems in school and need the extra incentive and support.

In some cases, the court will have no choice but to remove a juvenile from his home and possibly the community, either for the welfare of the juvenile, the safety of the community, or both. When this choice has to be made, a judge must require that the court have options for appropriate placement of the juvenile with a disability. When aware of a juvenile with a disability, the juvenile system ought to look for a placement that can facilitate the rehabilitation of the juvenile. This should include, for some disabled juveniles, facilities that give medications when appropriate and provide training programs to enable their staff to develop a clear understanding of the symptomatology of disorders such as ADHD, depression, and anxiety disorders. Courts can be of great assistance by letting it be known that they expect the facilities in which they place juveniles to be qualified and able to handle special education problems and juveniles with these types of disabilities.

Revocations/Further Dispositions. It is a truism that there is not a single juvenile judge or probation officer who hasn’t had a juvenile, despite the very best plan, do things that are in violation of their probation and/or court order. Whether it is committing another law violation, failing to complete community service work, violating curfew, associating with persons he/she is not supposed to, or skipping or flunking school, juveniles test the juvenile justice system. When a probation officer or institutional worker finds that juveniles are not living up to their part of the plan, they must decide if it is serious enough to warrant further juvenile court intervention.
Personnel trained to understand behavioral and cognitive disabilities may examine whether a
disability played a role in the transgression. If so, was it because a juvenile quit taking his medications,
or was the supervision that was to be provided by the family or others missing? If the juvenile is in an
institution, has the institution made accommodations in its programs for the disabled child? If the
institution does not make accommodations, then it may be prohibited from taking action against the
juvenile, if the juvenile’s actions were the result of the disability.

If there is a violation, then the probation department or the institution, if the juvenile has
been placed, should act in a timely matter, because sanctions occurring closer to the time of the
action can have a more powerful (and beneficial) effect on the youth. Such sanctions as less free
time, loss of a privilege or not being allowed to associate with individuals who facilitate inappropriate
decisions are needed.

Training of Judges, Lawyers, and Others. Juvenile court judges, family court judges, and judges
exercising juvenile court jurisdiction need training in more than the traditional aspects of the law. It
continues to be important for the judge to know due process and the rules of evidence, as in any
court. However, judges who fail to understand the developmental and psychological needs of youth
who have disabilities and how that affects their actions and reactions in the system are not failing not
only the law but the youth they are charged with helping.

The judge needs to set the standard by making time for education in the needs of juveniles
and requiring staff to engage in continuing education regarding the needs of juveniles with disabilities
and the latest techniques for accommodating the various disabilities affecting youth. Juvenile courts
can and should require training of guardians ad litem and legal counsel who represent them and the
juvenile. The judge of a juvenile court should never consider appointing legal counsel who have not
been trained in representing juveniles, including juveniles with disabilities.

The Monograph Series

The monographs that follow in this series address the key issues surrounding the topic of
youth with disabilities who encounter the juvenile justice system, or are at risk of coming into
contact with the juvenile justice system. These monographs have been written with the goal of
improving services to these children. It is our hope that the information in these bulletins will be useful in achieving the long-term goal of creating a comprehensive system that is sensitive to the unique needs of youth with disabilities who enter the juvenile justice system.

In their essay, *Youth with Disabilities in the Correctional System: Prevalence Rates and Identification Issues*, Robert Rutherford, Jr., Michael Bullis, Cindy Wheeler Anderson, and Heather Griller-Clark review current data on disabilities requiring special education and related supports. The authors find that youth with cognitive, behavioral, and emotional disabilities are entering the correctional system at rates four to fives time greater than their representation in the general population. Analyzing disability rates also is discussed as a complex task due to inconsistencies in identifying and defining disabilities. For example, individuals identified as having a disability by one agency (e.g., children’s mental health agencies) may not be recognized as disabled by the correctional facility. Moreover, research on prevalence rates may use different definitions, making it difficult to compare findings across studies.

Rutherford et al. (this series) emphasize that awareness of issues surrounding disability identification are insufficient for establishing an infrastructure for consistent provision of necessary services. Knowledge of prevalence rates and identification issues is viewed as a starting point for effective services and support. The information provided in this monograph is useful for practitioners involved in system-level administrative planning, personnel recruitment, and the development of intervention programs for children and youth with disabilities in the correctional system.

The crucial issue of disproportionate representation is discussed in Joseph B. Tulman’s work, *Disability and Delinquency: How Failures to Identify, Accommodate, and Serve Youth with Education-Related Disabilities Leads to Their Disproportionate Representation in the Delinquency System*. This monograph discusses the laws that entitle people with disabilities to specialized services and accommodations, and the points along the system in which faulty decisions can be made that result in the disproportionate representation of children with education-related disabilities in the juvenile justice system. Three laws are discussed. First, the Individuals with Disabilities Education Act
(IDEA) is examined. IDEA guarantees a free and appropriate public education to a child with a disability enumerated in the Act, and who requires special education because of that disability. Next, Section 504 of the Rehabilitation Act is reviewed. This Act prohibits discrimination on the basis of a disability within any program that receives federal funding. In order to qualify for protection under this Act, 1) an individual must have a disability, 2) the individual must be otherwise qualified for the program, 3) the individual must be excluded solely on the basis of his or her disability, and 4) the program must be funded at least in part by Federal dollars. Finally, Tulman reviews the Americans with Disabilities Act (ADA). This Act is a comprehensive anti-discrimination package that serves as a national mandate to eliminate discrimination against individuals with disabilities. This Act governs entities who receive Federal funds as well as those that do not.

Tulman’s monograph calls attention to the many points at which failures to appropriately recognize and respond to the educational needs of children with disabilities can lead to poor outcomes for these children. The roles and responsibilities of the education system, defense attorneys, prosecuting attorneys, intake probation officers, police officers who process the child, and juvenile court judges are examined. The questions of how laws affect adults’ treatment of children with disabilities, and what outcomes are required, are raised.

Katherine A. Larson and K. David Turner identify and describe best practices for reducing delinquency and preventing recidivism in their essay, *Best Practices for Serving Court Involved Youth with Cognitive and other Disabilities*. Larson and Turner also describe a small number of model programs directed toward court-involved juveniles with disabilities. Because of the connection between disability and delinquency, it is likely that a significant proportion of court-involved, disabled youth can be expected to manifest social skill deficits and as a consequence be difficult to manage. However, interventions that are skill-based, use positive discipline, teach self-control and social cognitive skills and problem solving, and which involves the youth’s family are shown to reduce recidivism as well as increase a youth’s prosocial behavior, commitment to school, and trust in working with systems. Approaches that address the needs of youth in all of his or her environments
have a greater chance for success than those directed exclusively at a youth’s behavior in school settings.

Larson and Turner describe eight types of effective practices for working with court involved youth. These research-based practices, used in combination, can help reduce delinquency and recidivism. These practices include: individual juvenile planning; skill-based interventions (including counseling, social skills training, academic and vocational interventions, and life skills/multimodal approaches); medical interventions (including medication and substance abuse treatment); behavioral systems; family involvement; the use of individualized transition planning (including a transition plan and a system of care and wrap around planning and supports); effective staffing; and the ongoing assessment of program effectiveness.

*Current Education Practice for Youth with Learning and Other Disabilities*, by Ken Howell and Bruce Wolford, describes children and youth currently placed in the juvenile justice system, the educational services provided to them, and the quality of those services. In addition, the authors provide specific recommendations on how services to children and youth with disabilities might be improved. To provide a complete overview of current conditions and practices, the authors examine correctional system monitoring reports, materials from enforcement actions taken against correctional agencies, and reports from interviews conducted with correctional educators, administrators, and security staff. The authors found that there was a frequent lack of understanding by correctional system practitioners of appropriate educational materials and supports for children and youth with disabilities. This finding is underscored by the many violations found in Individual Education Programs (IEPs) prepared for children and youth placed in correctional settings. Howell and Wolford recommend better assessment, instructional, and evaluation practices in support of children and youth with disabilities, and also identify five major barriers to providing effective special education services in correctional settings. Improvements to system leadership and financial support at the state level are emphasized as necessary for overcoming existing barriers.

Building strengths and protective factors are the issues raised in Lorraine Peniston and David Howard’s *The Role of Recreation in Preventing Juvenile Delinquency and Recidivism Among Youth*
with Disabilities. Research suggests that youth with disabilities involved in or at risk for involvement in the juvenile justice system benefit from community parks and recreation programs. Research also shows that individuals with and without disabilities can profit in various ways from taking part in recreation activities, and that integrating people with and without disabilities in recreation settings has benefits for both groups. Parks and recreation programs have the potential to prevent children from getting into trouble, while providing them with enriching activities that contribute to their development. Peniston and Howard examine community efforts to provide recreation services to at-risk youth. Quantitative and qualitative data from these programs show improvement in academic performance, decreases in involvement with the juvenile justice system, better communication with families, a more positive outlook on life, and greater self-confidence. In addition to recreation programs for at-risk youth, the authors describe therapeutic recreation programs specifically designed to address the more intensive needs of youth with disabilities. The combination of structured and unstructured recreation activities that are used in therapeutic recreation appear to be a viable treatment intervention for children with disabilities.

The crucial role of advocacy for youth with disabilities is discussed by Carl Smith, Joan Esposito, and Soleil Gregg in Advocating For Children with Cognitive Disabilities in the Juvenile Justice System. Smith et al. discuss the challenges involved in helping professionals, family members, and the youth themselves understand the connection between disabilities and problematic behavior. This monograph describes the multiple barriers that often hamper youth with cognitive and other disabilities from receiving appropriate interventions that might help them avoid contact with the justice system or teach them new patterns of behavior after they have been incarcerated.

Smith et al. suggest eight principles to guide advocacy for this group of youth. These principles are designed to help reduce the risk of initial entry into the juvenile justice system, and to increase and improve services for those youth who are already incarcerated, in order to reduce the risk of recidivism. These strategies include advocating for improvements in research, public education and working with the media, individual case advocacy for youth and their families, coalition building among concerned families, advocates, and professionals, legislative or administrative advocacy, and
litigation. Smith et al. conclude with a description of a model program that provides individual case advocacy to youth in the juvenile justice system that have undiagnosed cognitive or emotional disorders.

Peter Leone, Mary Magee Quinn, and David Osher explain the role of collaboration among education, mental health, child welfare, recreation and youth development, law enforcement, disability organizations, and juvenile justice in improving practices and services for youth in the juvenile justice system. Their monograph, *Collaboration with the Juvenile Justice System and Youth Serving Agencies: Improving Prevention, Providing More Efficient Services, and Reducing Recidivism for Youth with Disabilities* begins with a discussion of the current categorical, fragmented, and uncoordinated services that currently exist, and describes collaboration as a viable option for improving these services. The authors suggest strategies for implementing positive and proactive collaborative approaches to preventing delinquency through a three-tiered approach that includes primary, secondary and tertiary prevention activities. These activities serve to decrease the risk factors and increase the protective factors that can “predetermine” negative outcomes for many youth at-risk for involvement in the juvenile justice system. Each level of prevention is described and examples are given on actual research-based programs that have data that show their effectiveness. Leone et al. conclude with a discussion of the costs of developing collaborative programs and compares this to the exorbitant cost of delinquency to our society.

This monograph series is a resource that can increase awareness of the issues related to youth with disabilities in the juvenile justice system. Awareness is the first step toward systemic change and toward improved outcomes for youth. Although reactive and punitive approaches to juvenile delinquency may present a quick fix; in the long run such approaches can make the problem worse rather than better. The mission of the juvenile justice system is to protect and rehabilitate youth in trouble, not merely to punish them. Punishment-based approaches are costly not only economically, but also in terms of the lives of the youth involved. When preventive interventions have been implemented and some youth still get into trouble, a more humane and more effective approach is to use the considerable resources of the juvenile justice system to build on the strengths of youth and
their families, and provide acceptable and prosocial alternatives to destructive behavior. Positive and proactive approaches can help not only youth, but also whole communities, flourish.
References


