Developments in Mental Health Law

The Institute of Law, Psychiatry & Public Policy — The University of Virginia

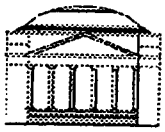
Volume 19, Number 1 January-June 1999

Barriers to Meeting the Mental Health Needs of Juvenile Offenders

*by Richard E. Redding**

Mental illness and substance abuse are significant risk factors for delinquency, and many youth in the juvenile justice system have mental health problems. Studies have consistently found very high prevalence rates of mental illness among detained and incarcerated juveniles, and juvenile offenders generally (see Cocozza, 1992; Policy Design Team, 1994). It is estimated that between 77-93% of juvenile offenders have mental health problems, far higher than the 10-20% prevalence rate found in the non-delinquent adolescent population. Indeed, many juvenile offenders have multiple mental health problems, and about 15-20% have a serious mental illness (Cocozza, 1992; Cocozza, 1997). High rates of substance abuse and learning disabilities also are found in this population.

Also in this issue:



Early screening and intervention for mental health and substance abuse problems is important in preventing some juveniles from entering the juvenile justice system in the first place and in preventing recidivism or offense escalation

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among juvenile offenders. Unfortunately, the mental health problems of juvenile offenders are often undiagnosed or untreated. A statewide needs analysis was conducted to ascertain the systemic, legal, and service delivery barriers to meeting the mental health and rehabilitative needs of juvenile offenders in the Commonwealth of Virginia. This article summarizes the findings of the needs analysis and provides policy and programmatic recommendations based on the needs and problems identified. Although the study was Virginia specific, many of the barriers identified are common problems encountered in many states.

The needs analysis (conducted between September and December 1998) included individual interviews with 32 juvenile justice and mental health professionals from around the Commonwealth, and a review of relevant state documents. The interviewees were selected to represent a cross-section of personnel in Virginia's juvenile justice and public mental health systems, on the state and local levels, and in urban as well as rural Virginia jurisdictions. Since the focus was mental health service delivery to juvenile offenders in the juvenile justice system, many of those interviewed were local juvenile justice (e.g., probation officers, court service unit directors, detention center superintendents) and mental health personnel (e.g., community service board directors and staff).

A summary of the key findings of the needs analysis, along with recommendations based on each set of findings, is presented below. The findings are distilled into ten (10) primary systems problems and needs:

I). LACK OF A GUIDING PHILOSOPHY FOR SERVING JUVENILE OFFENDERS

Many juvenile justice personnel (particularly those working in juvenile correctional facilities) report feeling conflicted about their role in working with juvenile offenders: are they rehabilitating juvenile offenders, punishing them, securing their confinement, or some combination thereof? Some correctional center staff see their role as custodial while others also, to some extent, view themselves as role-model, mentor or counselor. Similarly, some juvenile court probation officers see their role as analogous to that of adult probation officers -- i.e., mainly monitoring probation terms, whereas others see their role as that of obtaining services for, and working with, troubled juveniles and their families.

At the heart of the issue is uncertainty about the extent to which the systems' goal is to punish or rehabilitate juveniles. While there has been some tension between the juvenile justice and mental health systems regarding which aspect of the juvenile's problem behaviors should take priority (i.e., is it primarily a mental health or delinquency problem?), many juvenile justice and mental health professionals are concerned about what they view as the increasingly punitive nature of the juvenile justice system and an insufficient emphasis on treatment and rehabilitation.

Recommendation

Training and mentoring should be provided to juvenile justice personnel on how effectively to integrate their monitoring/custodial roles with any rehabilitative roles that may be appropriate.

II). JUVENILE JUSTICE SYSTEM USED AS A "DUMPING GROUND" FOR JUVENILES WITH MENTAL HEALTH PROBLEMS

The juvenile justice system is seen by some as a "dumping ground" for mentally ill, learning disabled, or behaviorally disordered juveniles. Many juvenile offenders have a history of involvement with the mental health system but migrate to the juvenile justice system because the mental health system has failed to serve their needs.

Many times the mental health system cannot access needed residential treatment, whereas the juvenile justice system cannot access needed community-based treatments, producing a revolving door of mentally ill juveniles migrating back and forth for services between the juvenile justice and mental health systems. Too often, agencies discontinue services or the services provided are unsuccessful. Perhaps the most significant obstacle to providing mental health services

Developments in Mental Health Law

is published by the Institute of Law, Psychiatry & Public Policy with the support of funds from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. The opinions expressed in this publication do not necessarily represent the official position of either the Institute or the Department.

The publication is distributed free of charge to Virginia residents, and to out of state subscribers at an annual rate of $20. Developments in Mental Health Law is published twice annually, with an occasional publication of a single double-length volume, containing both issues for that year.

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Letters, articles and other materials to be submitted for publication should be directed to the editor.

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ISSN 1063-9977

to juvenile offenders is the fact that, for the most part, funding is not provided to the Community Services Boards (CSBs) under the Comprehensive Services Act for At-Risk Youth and Families (CSA) to serve these youth. (See, IX below, *Inadequate Funding to Localities to Serve Juvenile Offenders*). A juvenile court petition may ultimately be seen as the only way to access needed mental health services: "Court intervention is seen as the only means to access mental health services for clients" (Virginia Commission on Youth, 1996, p. 2).

Many localities feel that it is an abuse of the juvenile justice system to have it serve as a "dumping ground" or general crisis intervention center for troubled juveniles and their families. On the other hand, a few Juvenile and Domestic Relations Court Services Units (CSUs) in some ways welcome the "dumping," viewing their role as that of obtaining needed mental health services for troubled juveniles. But these CSUs generally have substantial resources, many diversionary and alternative programs, ready access to mental health personnel, good working relationships with the mental health system, and inter-agency commitments to serve juvenile offenders.

In many localities, however, the juvenile justice system lacks sufficient resources to serve the needs of mentally ill juveniles. The juvenile court may be insufficiently attentive to mental health issues, with judges and court intake officers lacking knowledge in this area. At detention hearings and reviews, for example, a juvenile's mental health status may be a reason to continue detention, though typically few mental health services are provided in detention. Juvenile detention and correctional centers are not well staffed to serve mentally-ill juveniles. A significant problem is the difficulty experienced by correctional and detention facilities in finding an inpatient facility willing and able to accept seriously mentally ill juveniles from these facilities. Frequently, no bed is available or the waiting time is substantial.

Juvenile justice personnel in most jurisdictions report that schools fail to provide adequate services for the behavioral and learning disabilities of juvenile offenders, and often shift responsibility for them to the juvenile justice or mental health systems. There is a feeling of a lack of accountability for outcomes and a lack of follow-through by schools, and that it is too easy for schools (as well as the mental health system) to discontinue services.

Ultimately, many of these juveniles are referred to the juvenile justice system in the hope that the justice system will be able to monitor the juvenile and provide needed services. More juveniles with mental health problems are being detained, in part, due to a lack of insurance for treatment services, producing a net-widening effect of juveniles who come to detention. This may be producing a "criminalization of the mentally ill" among the juvenile population. Socioeconomic bias may also be operating; lower-SES juveniles may tend to get charged with an offense while higher-SES juveniles may receive treatment services in lieu of a juvenile court petition. *(continued on page 14)*

In the Federal Courts

Private employer not required to provide same benefits for mental and physical disabilities.

Harold Lewis, Plaintiff-Appellee, v. KMart Corporation, Defendant-Appellant, and Aetna Insurance Company; Aetna Life Insurance Company, Defendants. National Retail Federation; Chamber of Commerce; Equal Employment Advisory Council; American Council of Life Insurance; The Health Insurance Association of America; The National Alliance for the Mentally Ill; Employment Law Center; American Psychiatric Association; Disability Rights Advocates; Disability Rights Education and Defense Fund; National Association of Protection and Advocacy Systems; National Depressive and Manic Depressive Association; World Institute of Disability; Equal Employment Opportunity Commission, Amici Curiae, 1999 WL 394280 (4th Cir. (Va.) 1999)

In 1995, Harold Lewis became unable to work, due to depression. Lewis had suffered from severe depression since 1979 and had been receiving treatment. Until 1995, he had not had significant work impairment. Under the disability plan of Lewis' employer, KMart Corporation, his long-term disability insurance was subject to a two-year cap for mental disability, although those disabled by a physical disability were covered until age 65. The trial court held that this was impermissible under the Americans with Disabilities Act (see DMHL v.18 for a note on this lower court case).

The Court of Appeals, overturned the lower court's decision and held that KMart was not required by Title I of the Americans with Disabilities Act (ADA) to provide the same level of coverage for both mental and physical disabilities. The Court had addressed a similar issue under Title II of the ADA, which applies to public entities. The court in that case looked at the legislative history of the ADA, its "safe harbor" provision, and decisions around a sister act, the Rehabilitation Act. Without going into detail, the Court held the same reasoning applied and thus, KMart did not discriminate by providing differential coverage.

Court Must Look At Actual Conditions of Confinement in SVP Determination

Andre Brigham Young, Petitioner-Appellant, v. David Weston, Superintendent of the Special Commitment Center, Respondent-Appellee, 176 F.3d 1196 (9th Cir. (Wash.) 1999)

Young was committed under Washington's Sexually Violent Predator Act in 1990. Young filed suit in 1994, seeking his release under a variety of legal theories. While the court on the initial appeal

found the SVP Act unconstitutional, the U.S. Supreme Court ruled that SVP Acts were constitutional in *Kansas v. Hendricks*, during the subsequent various appeals of Young's case. Here, the Federal Court of Appeals held that in considering SVP Act challenges, courts must look to whether the statute is punitive in fact, and thus subject to the ex post facto and double jeopardy clauses of the U.S. Constitution. The ex post facto clause forbids punishment of individuals for crimes committed prior to a statute's enactment; while the double jeopardy clause forbids a court from punishing a person twice for the same offense.

To make this determination, the court held that the correct inquiry is to look at Mr. Young's actual conditions of confinement under the SVP program. The court found that the lower trial court had not allowed for a full hearing on the actual conditions under which Mr. Young was confined as a result of his civil commitment under the SVP Act. Thus, the case was remanded to federal district court for a rehearing on this matter. Young's various other challenges on this appeal were rejected.

The key to understanding Mr. Young's situation is that the U.S. Supreme Court upheld SVP Acts as constitutional because they are a form of civil commitment, and not a criminal proceeding. As a civil proceeding, the Ex Post Facto and double jeopardy clauses do not apply.

Merely labeling a proceeding "civil", however, doesn't automatically render it so. The court in this circumstance must look at the actual conditions of confinement and treatment of the committees to see if the state's actions constitute punishment, which would possibly violate both the *Ex Post Facto* and Double Jeopardy protections. If the district court finds that they do, then Mr. Young would be entitled to an appropriate remedy for being wrongfully held.

Burden of Proving Condition Changed is Acceptable

David L. Nagel, Petitioner-Appellant, v. Douglas Osborne, Acting Superintendent of Central State Hospital; James W. Mimbs, M.D., Chief Medical Officer and Clinical Director of Central State Hospital, Respondents-Appellees, ,164 F. 3d 582 (11th Cir. (Ga.) 1999)

Nagel was acquitted of the murders of his grandparents and was civilly committed to a Georgia State institution. Some ten years subsequent, Nagel filed a petition for release in state court. The psychologist and psychiatrist who testified stated that Nagel was not mentally ill, nor imminently dangerous, nor in their opinion, had he ever been mentally ill. Additionally, the doctors' testimony was that Nagel did not meet criteria for civil commitment.

The State Court denied the application for release, despite there being no other mental health testimony. Nagel's appeal to the Georgia Supreme Court resulted in the case being remanded for specific findings of fact and conclusions of law. Again, the lower court denied Nagel release, finding that his violent history, along with the likelihood that Nagel's stabilized condition may be temporary, outweighed the doctors' testimony. The Georgia Supreme Court upheld the lower courts decision. Nagel then filed a petition for release in federal district court, better known as a "habeas corpus" petition.

Nagel's challenge to his continuing commitment is built on Georgia's presumption of continuing insanity. Georgia requires the person found not guilty by reason of insanity, who is subsequently committed, to prove a change in mental condition. Nagel argued that the experts' testimony regarding his mental health served to rebut the presumption of continuing insanity. The federal district court denied Nagel, holding that the state court acted reasonably in questioning the expert testimony in light of all the evidence. Nagel then appealed the federal district court's decision to the Federal Court of Appeals for the 11th Circuit.

The appellate federal court upheld the lower court's decision, finding that Nagel did not meet his burden of proving his sanity. The court discounted the experts' testimony, stating that Nagel had a condition sufficient to afford a defense to murder. The court continued by stating that since the experts testified that "Nagel is not now mentally ill and was never mentally ill, the experts testified his condition remains unchanged. Therefore, Nagel has failed to carry his burden of showing that his condition had changed."

Georgia requires the person found not guilty by reason of insanity, who is subsequently committed, to prove a change in mental condition.

A strong dissent by Senior Circuit Judge Clark argued that the majority's position creates an irrebutable presumption of continuing insanity. Clark found that the law mandated Nagel's release, although that action may cause "much anxiety and apprehension." Clark's argument turns on the present-focused inquiry the court must make for civil commitment and thus would give no current weight to the testimony regarding Nagel's sanity at time of offense. Judge Clark also would have looked to the U.S. Supreme Court's ruling in *Foucha v. Louisiana* for controlling authority. *Foucha* held that states cannot continue to confine someone through civil commitment once the person either is not mentally ill or is not dangerous. As Nagel presented evidence that he was not mentally

ill, Clark would have found that *Foucha* compelled the release of Nagel.

Court Limits Expert Testimony on Compulsive Gambling

United States of America, Plaintiff-Appellee, v. William L. Scholl, Defendant-Appellant. United States of America, Plaintiff-Appellant, v. William L. Scholl, Defendant-Appellee, 166 F.3d 964 (9th Cir. 1999)

According to the Ninth Circuit Court of Appeals, a trial court may limit proffered expert testimony on compulsive gambling where such testimony would be misleading to the jury.

William L. Scholl, a compulsive gambler, was convicted on four counts of filing false tax returns and three counts of structuring currency transactions arising from his failure to report gambling winnings. On appeal, Scholl argued that his defense was hampered by the trial court's limitation on the testimony of his compulsive gambling psychological expert and the exclusion of evidence that would have laid the foundation for this expert's testimony.

Scholl's expert would have testified that compulsive gamblers have distortions in thinking and experience denial, which impact their ability to maintain records of gambling wins and losses. Applying the analysis of scientific evidence set forth in *Daubert*, the trial court ruled that the diagnosis of compulsive gambling disorder was valid. However, the trial court limited the expert's testimony to the ten diagnostic criteria for compulsive gambling set forth in the DSM-IV, and excluded proffered evidence on the associated descriptive features of distortion in thinking and denial. The trial court also found that the expert's opinion on Scholl's denial was not relevant and could be confusing, inconsistent and misleading to the jury under Federal Rules of Evidence 402 and 403.

> [E]xpert would have testified that compulsive gamblers have distortions in thinking...

In affirming the trial court, the Ninth Circuit held that the expert's proffered testimony had essentially no probative value but substantial role of prejudicial effect. At best, the Court concluded, the expert's opinion would have been that compulsive gambling makes the gambler believe that he has lost more money than he has won, not that it renders him unable to report winnings and losses on his tax return. Because the expert's testimony on denial may have been mistaken to mean that Scholl lacked intent to report gambling wins and losses, a conclusion without support on the scientific community of the expert's own experience, it was properly excluded by the trial court.

In the Virginia Courts

Evidence of Planning Does Not Preclude M'Naghten

Eugene Allen Bennett v. Commonwealth of Virginia, 29 Va.App. 261, 511 S.E.2d 439 (Va. App. 1999)

In 1996, Eugene A. Bennett broke into his wife's church, abducted the church's minister and threatened to harm the minister's children unless the minister lured Bennett's wife to the church. Bennett's wife appeared at the church and was confronted by Bennett at gunpoint. After spraying Bennett with pepper spray, the wife summoned police.

Bennett was convicted by jury trial of kidnaping, burglary and other offenses. At trial, Bennett presented a M'Naghten insanity defense and called two expert witnesses regarding his mental state at the time of the offenses. Bennett's expert psychiatric testified that Bennett suffered from a dissociative disorder and did not appreciate the nature of his acts. The expert did not testify that Bennett acted under and irresistible impulse, the second test recognized under Virginia law for criminal insanity.

The Commonwealth's expert testified in rebuttal that Bennett was malingering and concluded that he was legally sane at the time of the offenses. The Commonwealth also introduced the testimony of Bennett's wife regarding a previous, unrelated abduction by Bennett in 1993. The wife testified that she had taken a polygraph exam about the prior abduction in connection with her cooperation with the Department of Justice. Bennett's counsel immediately objected to the polygraph reference, and the trial court instructed the jury at the close of evidence that the results of the polygraph were not admissible.

On appeal, Bennett argued that his wife's reference to the polygraph exam irreparably damaged his defense. The Court of Appeals of Virginia agreed that the wife's testimony was probative as to Bennett's insanity defense, and that the Commonwealth had improperly elicited testimony about the polygraph exam. However, the Court of Appeals affirmed the trial court's decision to deny Bennett's motion for a mistrial.

> Specifically, the Commonwealth argued that if Manson, Speck and Dahmer were legally sane, then so was Bennett.

The Commonwealth used the wife's testimony about the previous abduction to argue that Bennett planned the 1996 offenses. Evidence that a defendant planned his criminal act precludes any finding

that a defendant acted under an irresistible impulse under Virginia law. However, evidence of planning does not preclude a M'Naghten defense.

Noting that Bennett only presented evidence of his insanity under the M'Naghten Rule, the Court of Appeals concluded that the improper polygraph evidence did not prejudice Bennett in establishing a defense for which he presented no evidence.

Bennett's second appellate issue concerned the Commonwealth's reference to Charles Manson, Richard Speck and Jeffrey Dahmer during closing arguments. Specifically, the Commonwealth argued that if Manson, Speck and Dahmer were legally sane, then so was Bennett. Bennett's counsel objected and moved for a mistrial at the close of the Commonwealth's argument. The Court of Appeals held that by withholding his motion for mistrial until after the Commonwealth completed its closing argument, Bennett had failed to preserve his objection for appeal.

Court finds no automatic right to second expert.

James Carl McCulloch v. Commonwealth of Virginia, 29 Va. App 769; 514 S.E.2d 797 (Va. App. 1999)

McCulloch was charged with first degree murder. McCulloch moved for an evaluation to be performed regarding his competency to stand trial and his mental status at the time of offense, or sanity. The expert, Dr. Nichols, found McCulloch competent to stand trial and sane at the time of offense.

While in jail, McCulloch attempted suicide and Dr. Nichols subsequently found him incompetent to stand trial. Upon restoration to competency, McCulloch filed notice of his intent to mount an insanity defense. The prosecution requested, and got, an evaluator appointed for a secondary determination. The evaluator requested by the prosecution found McCulloch to be sane.

> [T]he Court of Appeals reiterated the long-standing rule in Virginia that insanity cannot be proved by lay witnesses alone, but requires expert testimony as to the "existence of a particular mental disease or condition."

On the day prior to trial, McCulloch sought the appointment of yet another evaluator for sanity determination. This was denied. Additionally, at this pre-trial hearing, the court ruled that McCulloch could not present an insanity defense unless he presented expert testimony regarding the presence of a mental disease or defect. McCulloch appealed these

issues to the Court of Appeals.

The Court of Appeals upheld the lower court's decisions, and expanded on the reasoning underlying them. As regarded the appointment of a second expert for the defense, the court noted that the court is only required to appoint an evaluator once the defendant has demonstrated that sanity will be a significant factor at trial. The Court of Appeals seemed to indicate that had McCulloch shown more than a mere possibility, that is, if he had reasonably shown that a psychiatrist's evaluation might have turned out differently (due to the different expertise), then potentially a second expert may have been appointed.

McCulloch had also argued that under the U.S. Supreme Court's decision in *Ake v. Oklahoma*, he was to be appointed a psychiatrist, not a psychologist. The Court of Appeals relied on the ruling in Virginia that the U.S. Supreme Court did not mean to limit sanity evaluations to the purview of psychiatrists alone. Thus, under the statutes of Virginia, a clinical psychologist can perform sanity evaluations.

Regarding the requirement of expert testimony in insanity defense presentation, the Court of Appeals reiterated the long-standing rule in Virginia that insanity cannot be proved by lay witnesses alone, but requires expert testimony as to the "existence of a particular mental disease or condition."

In Other State Courts

Continuing Commitment Does Not Require Same Diagnosis

State of Montana, Plaintiff and Respondent, v. Ronald C. Wooster, Defendant and Appellant, 974 P.2d 640, 1999 MT 22 (1999)

Wooster was committed to the Montana State Hospital after being found incompetent to stand trial for two courts of deliberate homicide. At the time of commitment, Wooster had been diagnosed with Schizophrenia, chronic undifferentiated type. Subsequently, the court determined that Wooster was incapable of "appreciating the criminality of his conduct" or "conforming his conduct to the requirements of the law." He was acquitted of the charges, and committed to the custody of Montana State Hospital.

In 1990, twelve years after commitment, Wooster petitioned for release. The court appointed a psychiatrist and a psychologist to evaluate Wooster, who was currently with antisocial personality disorder, alcohol dependency in remission, and psychoactive substance abuse not otherwise specified. Both evaluators concurred with the current diagnosis , and both believed Wooster posed a substantial threat or risk to others. Wooster was not released.

In 1994, Wooster sought release again. This time are evaluators "urged that Wooster not be released", while the other recommended conditional release following sex offender and chemical dependency treatment. A five-year conditional release plan was developed at the courts request. In 1997, the District Court, after multiple hearings, found that Wooster still had substantially the same mental disease or defect as at initial commitment. This finding prevented the court from releasing him from the hospital. The court held that Wooster posed an unreasonable threat. Wooster subsequently appealed, resulting in the present case, with a challenge that the District Court clearly erred in finding that he currently had a mental disease or defect that causes him to be dangerous.

The Supreme Court at Montana reviewed most of the U.S. Supreme Court cases in the area of commitment following acquittal due to mental disease or defect, and held that Wooster may continue to be committed even if he now suffers from a disease or defect which is different than the one he had initially. There is no requirement for release if the mental illness is "not the same mental illness as that from which he suffered at the time of original commitment. The question is whether there is a present mental disease or defect.

Also, the court noted that the Montana statute does not define mental disease or defect, and they need not adopt a medical definition of that term. Instead the court utilized a workable legal definition of "an affliction with a mental disease or mental condition that is manifested by a disorder or disturbance in behavior, feeling, thinking or judgment to such an extent that the person afflicted requires care, treatment, and rehabilitation."

The Court remanded the case back to the trial court to determine if Wooster's condition fell within the definition of mental disease or defect as elaborated by the court above.

Court Finds No Duty to Non-patient Third Parties

Renu K. Thapar, M.D., Petitioner, v. Lyndall Zezulka, Respondent, 42 Tex. Sup. Ct. J.824 (1999)

Following the murder of a man by his stepson, a suit was brought by the victim's wife (who is also the mother of the murderer) against the psychiatrist who was treating the murderer. The lawsuit alleged negligence in treatment and failure to warn resulting in wrongful death of the victim. The court held the psychiatrist was not liable for failing to warn the Zezulkas of the murderer's previous statements.

The treatment records revealed that the murderer had made statements about wanting to kill the victim, but also that the statements were about feelings and not about a plan of action. The psychiatrist never warned anyone about these statements.

The court was in the position of determining the duties a "mental-health professional owes to a non-patient third party", and specifically whether there is: 1) a duty to not negligently treat someone that runs from the psychiatrist to a non-patient third party, and 2) a duty to warn non-patient third parties.

First, the court found no duty for mental-health professionals to non-patient third parties to not negligently treat or diagnose a patient. While a psychiatrist has this duty to the patient, there is no such duty to non-patients.

Second, the court considered the duty to warn third parties, or the "Tarasoff" rule. Texas, however, has never recognized a duty to warn, and declined to do so now, citing the mental health confidentiality statute. The statute provides no exceptions for "Tarasoff-like" situations. [While there is an exception for disclosing to law enforcement personnel, it is permitted but not required. In addition, the exception is only for risk of imminent physical injury.] In light of the statute, which shows the intent of the legislature, the court refused to impose a common law duty to warn. The court granted judgment for the psychiatrist.

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Recommendations

Inter-agency responsibilities for serving mentally ill juvenile offenders need to be clearly defined.

Funding sources, particularly funding under the Comprehensive Services Act, should be re-examined to determine how to structure services and funding streams so that localities (particularly the community service boards) can adequately serve juvenile offender populations.

Juvenile justice personnel need more training on the mental health needs of juvenile offenders and court services unit programs need to be developed to serve those needs, including the development of systematic intake procedures to screen for mental health needs.

There is a need for more systematic detention hearings and screening measures that consider juveniles' mental health needs.

Localities should consider establishing community assessment centers, to provide a centralized and integrated point for mental health screening and service referral for juvenile offenders and at-risk youth. Referrals to the community assessment center could be made by schools, parents, social service agencies, and juvenile justice agencies. Such centers are currently operating in several Virginia localities, and several community assessment centers demonstration projects are currently being evaluated by the Office of Juvenile Justice and Delinquency Prevention.

III). MANY JUVENILE OFFENDERS HAVE LEARNING DISABILITIES UNDIAGNOSED OR UNTREATED IN THE SCHOOL SYSTEM

A significant number of juvenile offenders have a learning disability (LD). However, these LD problems may not be properly diagnosed and/or treated in the school. (For example, some juvenile offenders are diagnosed by schools as having oppositional-defiant disorder though the true underlying problem may be attention-deficit or attention-deficit-hyperactivity disorder.)

A related problem is the relatively poor working relationship between schools and the juvenile justice/mental health systems, with juvenile justice and mental health personnel often feeling that schools are not receptive to their input or requests regarding diagnosis, treatment, and programming for this special population of juveniles. There is insufficient programming or treatment services for these learning-disabled juveniles in the schools (and also in the juvenile justice system), which may contribute to their entry or further penetration into

the juvenile justice system.

Recommendations

Statewide data are needed on the prevalence of various learning disabilities in the juvenile offender population generally and in various sub-populations. This would help guide the development of, and funding for, special educational programs for these juveniles.

A study should be undertaken to examine the reasons for the poor working relationships between schools and the juvenile justice/mental health systems, with the goal of developing policy and practice recommendations for improving those relationships (and possibly also to make proposals for legislation), particularly regarding treatment and programming for learning disabled juveniles.

There should be a review of existing juvenile justice system programming for learning disabled juvenile offenders and recommendations made for program enhancements.

IV). LACK OF EARLY INTERVENTION ON THE COMMUNITY LEVEL, LEADING TO ESCALATION OF DELINQUENT BEHAVIORS

There are not enough community-based prevention and early intervention programs to intervene when a juvenile's aggressive or delinquent behavior, truancy, or substance abuse first appears. In particular, there is a lack of community services for status offenders and minor offenders. This lack of monitoring and early intervention often leads to escalation of delinquent and other problem behaviors. The Virginia Commission on Youth study (1998) of school truancy noted that "The lack of immediate interventions often causes the child's behavior to escalate . . . [there] is the absence of a comprehensive system of interventions to respond consistently and effectively at the early stages of problem behavior. . . The Court's reluctance to impose sanctions on either the student or the parent was perceived to undercut the importance of school attendance and render the compulsory school attendance law unenforceable" (p. 2-3). The report recommended increasing the range of community interventions available prior to court referral, and also increasing the range of sanctions available to the juvenile court.

Localities report significant numbers of minor offenders with learning disabilities or other special needs (including mental health problems), as well as many conduct-disordered children, who are undeserved and receive low priority in the mental health system. Without early intervention services, these children may penetrate further into the juvenile justice system (often because of violations of court orders). Some jurisdictions have established court-affiliated juvenile assessment centers aimed at assessing juveniles' needs and obtaining early intervention services.

Recommendations

Localities should develop and implement a graduated sanctions system for juvenile offenders that includes a continuum of interventions, services, and sanctions. The Virginia Community Crime Control Act provides funds to localities for the development of a continuum of sanctions and services for first-time offenders, as well as funding for diversion as an alternative to incarceration.

There should be a review of existing early intervention services in Virginia communities and recommendations made for program enhancements.

Juvenile courts need adequate resources to monitor and obtain services for status offenders and CHINS ("children in need of services") juveniles.

V). NEED FOR GREATER PARENTAL INVOLVEMENT IN, AND ACCOUNTABILITY FOR, THEIR CHILD'S TREATMENT AND REHABILITATION

The need for greater parental involvement in the lives of court-involved juveniles emerged as a salient theme. Four problems were noted.

First, parental failure to monitor children's behavior is often a significant factor contributing to delinquency, with many parents lacking knowledge of effective parenting and discipline practices and the skills to implement such practices. In one locality, for example, courts are increasingly ordering parenting evaluations, and the Detention Center in this locality holds weekly parenting sessions for the parents of detained juveniles. Most of the parents have participated enthusiastically; with their child in detention, they are especially eager to avail themselves of opportunities to learn more effective discipline and parenting practices.

Second, lack of adequate parental supervision and follow-through on implementing treatment recommendations is a significant factor contributing to escalation of delinquent behavior, court referrals, and recidivism. A Virginia Commission on Youth study found that parents were "inconsistently and marginally involved in the resolution of problems" and recommended steps to increase parental responsibility for school attendance and involvement in recommended services (Virginia Commission on Youth, 1998).

Third, many parents of court-involved juveniles lack the knowledge and skills to be effective advocates for their children with the school, mental health, and juvenile justice systems. They do not know what resources are available, how to access those resources, and how best to advocate in their child's best interest.

Fourth, while the juvenile may get labeled by the school, mental health, and juvenile justice systems as "the problem," often the juvenile's delinquent

behaviors stem from highly dysfunctional family situations and/or parental neglect or abuse. Yet rarely are parents required to receive treatment and the family context is not addressed to the extent necessary for effective interventions. An ecological family-based intervention approach is needed to effect changes in the juvenile's home environment.

Recommendations

Parent education programs should be implemented and freely accessible to parents. These programs should teach parenting skills, effective discipline practices, advocacy, and pertinent mental health treatment issues to parents of detained, delinquent, or court-involved juveniles, as well as serving as a support group for these parents.

Consideration should be given to more extensive court monitoring of parental compliance, more frequent use of court-ordered parental/family treatment and parent education under VA. CODE 16.1-278.8(6), and greater involvement by probation officers in monitoring parental compliance.

VI). NEED FOR TREATMENT SERVICES IN DETENTION CENTERS AND COMMUNITY-BASED TREATMENT SERVICES

The need to enhance the treatment services available in detention was identified as a salient problem.

First, there is a lack of pre-dispositional treatment programs in the juvenile detention centers. Mental health and other treatment services need to be provided to detention centers, and made more programmatically specific so that detention centers can provide specialized treatment services while the juvenile is in crisis or the "active" phase of their problems. This is a time when both the juvenile and his parents are the most likely to want to participate in treatment. It was suggested that probation officers, community agencies, and therapists all work with the juvenile and his family while the juvenile is in detention. Even in cases where the juvenile's stay in detention is short, it still may provide a good platform from which to initiate developing a supportive and therapeutic network for juveniles and their families. (However, detention centers should not be used as community "dumping grounds" through which to obtain mental health treatment or emergency services for court-involved juveniles. Moreover, the American Bar Association Standards prohibit non-emergency interventions of an involuntary nature with pre-trial detainees).

Second, there is a need for more post-dispositional programs for juveniles retained in the local juvenile justice system, as well as for those returning to the community from state correctional facilities. Communities are concerned that, except for sex offenders, juveniles return from the correctional centers with little

or no treatment services in place and no transition services (e.g., halfway houses).

There also is a general lack of post-dispositional treatment services for juvenile offenders retained in the community. It was felt that court service units may not always provide adequate follow-up and that many programs do not continue services after the juvenile has completed the program. The importance of ongoing treatment services is demonstrated by research showing higher rates of recidivism without aftercare but lower recidivism rates in intensive aftercare programs. Virginia has been an OJJDP national demonstration site on aftercare in juvenile justice, which has resulted in added parole services and special funding for ancillary services in the community.

Recommendations

Pre-dispositional treatment services in detention should be expanded. Such services should include mental health and substance abuse services as well as parenting education and family services.

More community-based, post-dispositional and transition services are needed for juveniles returning to communities from correctional centers.

There is a need to develop a continuum of community-based treatment services.

VII). NEED FOR IMPROVED INTER-AGENCY COLLABORATION AND INTEGRATED, COMPREHENSIVE SERVICE DELIVERY SYSTEMS

As one interviewee explained, "our clients have become interdisciplinary a lot faster than we have." Juvenile offenders are now presenting with multiple mental health problems and other needs best addressed through an integrated, comprehensive, multidisciplinary approach to service delivery. More collaborative case management, planning, and training is needed across agencies.

The CSA has greatly improved inter-agency collaboration in Virginia. But the central importance of integrated, comprehensive, multidisciplinary services for effectively treating and rehabilitating juvenile offenders means that even more must be done to enhance service delivery in this regard. (Recently, CSB staff have been placed in some detention centers, which report that this has been quite helpful in serving juveniles' mental health needs and in improving inter-agency service delivery.)

The degree to which service delivery is integrated varies enormously across the Commonwealth. A few jurisdictions have relatively well integrated service delivery systems. Much appears to depend on the relationship between the local CSB and Juvenile CSU. Some have excellent working relationships, with the CSB affirmatively serving the juvenile offender population and working

well with juvenile justice agencies. Others have poor working relationships. In general, state and local juvenile justice personnel perceive the CSBs "as the weakest link in the entire system" because of their failure to serve the juvenile offender population; much of this is due to a lack of funding. In addition, most localities report poor working relationships between schools and the juvenile justice/mental health systems.

Recommendations

A study should be undertaken to determine how to improve inter-agency collaboration and integrated service delivery.

In particular, funding and programs are needed to enhance collaboration between juvenile justice agencies and CSBs, and between juvenile justice agencies and schools. This should include inter-agency joint training programs, program planning and development, and joint policy and practice guidelines.

VIII). MORE LOCAL SERVICES NEEDED FOR SPECIAL POPULATIONS OF JUVENILE OFFENDERS; INSUFFICIENT ADVOCACY FOR COURT-INVOLVED JUVENILES

Jurisdictions throughout the Commonwealth report seeing increased numbers of younger, more seriously mentally ill juveniles. But with notable exceptions, juvenile justice personnel report having insufficient training on the mental health needs of juvenile offenders and the effective treatments for meeting those needs. They also have insufficient knowledge about learning disabilities in this population. Particularly in rural jurisdictions, there is a lack of advocacy and services for special populations of offenders -- e.g., sex offenders, seriously mentally ill offenders, female offenders, residential treatment for serious drug abusers. This is due, in part, to the small numbers of these offenders in rural localities along with the relative lack of resources in many rural jurisdictions.

Importantly, localities spend an inordinate amount of their time and resources on a very small number of court-involved juveniles having serious and chronic mental health problems. They wish more state and local residential options were available.

The lack of available inpatient psychiatric care is a problem throughout the Commonwealth. Currently there are only 64 inpatient beds available for juveniles in state mental health facilities in the Commonwealth, which represents a reduction of 108 beds since 1992. The severe shortage of inpatient beds makes it extremely difficult to obtain inpatient psychiatric placement for juvenile offenders who are seriously mentally ill.

Most localities also expressed a need for more outpatient as well as

inpatient substance abuse treatment programs and for more community programs for sex offenders. In addition, specialized services are needed to address the unique needs (e.g., pregnancy, sexual abuse) of female offenders. At the same time, more African-American male therapists are needed, since many court-involved juvenile offenders are African-American males.

More effective advocacy is needed for juvenile offenders, including those committed to state juvenile correctional facilities. Juveniles frequently do not have anyone advocating for their access to treatment, and when such advocacy is provided by attorneys or others, it may be ineffective because the advocate lacks knowledge of available treatment alternatives and community resources. Typically, the juvenile's attorney is not involved in the treatment planning or advocacy process and the CASA ("court-appointed special advocate") programs seldom handle delinquency cases per se. Attorneys often lack knowledge of treatment options and the mental health needs of juvenile offenders, and the legal representation and advocacy provided may often be inadequate.

There is a need for community advocacy and public relations efforts to educate juvenile justice personnel, attorneys, and community leaders about the effectiveness of locally available treatment options. Available treatments also must be effectively "marketed" to communities so incarceration is not seen as the only available option. *(continued on next page)*

Submission Guidelines

Developments in Mental Health Law encourages the submission of articles on timely and interesting topics in the area of mental health law.

The typical article is 10 to 15 pages long, without substantial footnoting. The reading audience is multi-disciplinary, typically with legal or mental health training, but not necessarily both. Therefore, *Developments* seeks articles which are useful to a general audience interested in mental health law.

You may contact *Developments in Mental Health Law* by several methods:

1) The preferred method of submitting articles is to submit a short query by email, describing the topic and general thesis. Send email to: dmhl-editor@Virginia.edu, with a subject line of "Article Query."

2) Additionally, query letters can be mailed to the attention of the editor: Developments in Mental Health Law, Box 100, Blue Ridge Hospital, Charlottesville, VA 22901.

Please do not initially send a copy of your article. The editor of *Developments* will contact authors if there is an interest in using or developing your piece. The fastest way for the editor to contact you is by e-mail, so please include an e-mail address, if possible.

Recommendations

Programs should be developed to educate juvenile court judges, court service unit personnel, and detention center personnel on the mental health needs of juvenile offenders.

More community-based treatment programs for particular sub-populations of juvenile offenders are needed, especially for sex offenders and seriously mentally ill offenders.

More state and local inpatient psychiatric services are needed for seriously mentally ill and serious substance abusing offenders.

More gender- and culturally-specific programs are needed. More minority service providers are needed.

Advocacy programs are needed for juvenile offenders in detention, in the community, and in state correctional centers. Advocacy training is needed for attorneys and guardians ad-litem. Mechanisms should be developed to increase the pool of available advocates; one possibility is for the CASA program to expand its role to serve juvenile offenders.

Community public relations efforts should be undertaken to educate community leaders about the availability and effectiveness of community treatment options.

IX). INADEQUATE FUNDING TO LOCALITIES TO SERVE JUVENILE OFFENDERS

Localities need steady, integrated funding streams to provide mental health and rehabilitative services to juvenile offenders. Funding provided under the CSA limits localities' ability to provide mental health services to many juvenile offenders. Because juvenile offenders typically do not fall within the CSA "mandated" or priority classes (i.e., youth in foster care and seriously emotionally disturbed youth) and the associated funding provided, localities (particularly the CSBs) often are left with inadequate funding to serve juvenile offenders.

This significantly limits the services that juvenile justice personnel can obtain for juvenile offenders. In most localities, juvenile offenders get very low service priority in the mental health system. Many CSBs have limited service relationships with the local juvenile detention center, and CSBs have no mandate to serve juvenile offenders other than to provide emergency services and limited case management (typically, as little as 15 minutes/month).

(continued on next page)

Recommendations

Funding sources, particularly funding under the Comprehensive Services Act, should be re-examined to determine how to structure services and funding streams for juvenile offender populations.

Relationships between the Commonwealth and localities should be examined to determine how best to enhance funding streams for localities so they receive adequate funding from the state, particularly funding for the CSBs to serve the juvenile offender population.

X). INTER-AGENCY RECORDS-SHARING AND DEVELOPMENT OF INTEGRATED DATA SYSTEMS ARE IMPEDED BY LEGAL CONFIDENTIALITY CONCERNS

Because of legal concerns about confidentiality of records, localities are significantly impeded in sharing records between agencies and in developing integrated data systems on juvenile offenders. The CSBs in particular are concerned about sharing mental health and substance abuse records. Detention centers often have difficulty obtaining substance abuse and mental health treatment records in a timely fashion. Substance abuse records are especially problematic because of the federal confidentiality law on substance abuse treatment records, yet these records are quite valuable to treatment providers since many juvenile offenders have substance abuse problems.

In general, there is a system-wide lack of policy and procedures to guide the sharing of records between agencies. The Virginia Commission on Youth (1998) noted that "[T]here are inconsistencies in the [Virginia] Code about who can receive what type of information. Confidentiality provisions are scattered throughout the Code, causing confusion among service providers" (p. 67).

Recommendations

A study is needed to identify the legal confidentiality hurdles in records-sharing at each point in the system, assess systems needs, make proposals for legislation and/or systems enhancements, and suggest the most useful content and organization of local integrated databases.

Standard policy and practice guidelines should be developed to guide local

CONCLUSION

There are a number of barriers to meeting the mental health needs of juvenile offenders. The barriers exist not just in the juvenile justice system, but involve and affect a variety of agencies and individuals, including schools, mental health and social service agencies, community treatment providers, and parents and families. Similarly, a range of treatment, case management, and advocacy services are needed to address effectively the mental health needs of juvenile offenders, and inter-agency coordination is critical. These findings

reflect the importance of an integrated, multisystemic approach to serving the needs of youth in the juvenile justice system (see Illback, Cobb, & Joseph, 1997).

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Book Reviews

Legal Alchemy: The Use and Misuse of Science in the Law David L. Faigman, W.H. Freeman & Company, New York, 233 pp.

The Salem Witch Trials. The O.J. Simpson case. The Scopes evolution trial. Silicone breast implant litigation. Assisted suicide. The reintroduction of the gray wolf to Yellowstone. Roe v. Wade.

The above are only a small sampling of the examples used in *Legal Alchemy,* but it is enough to signal the timbre of the book. The first sentence of the preface invokes Faust, who gives his soul to the devil for knowledge. Faigman sees a similar Faustian bargain where the law has sold its soul for science's knowledge, enslaving science to the purposes of the law.

Faigman is not unsympathetic to the law's increasing need for scientific information. However, his sympathy does not prevent him from castigating the legal profession for its current attitude toward science, a case of the expedient needs of the law being served with no recognition of the lawyer's lack of intellectual foundation to evaluate the information being received.

Faigman does not argue that lawyers must become scientists, but rather that lawyers must become educated consumers of science, able to determine good science from bad. Similarly, he encourages scientists to understand the role science can and should play in the courts, the law, and the setting of policy.

Faigman's basic premise is that there are cultural conflicts between science and law that lead to different views of the world. Faigman expands on these conflicts to show how they can affect a variety of legal activities, from expert testimony to the policies enacted by government bureaucracies. Faigman points out that both lawyers and scientists can play a damaging role, using bad science to expedite questionable legal ends. *(continued on next page)*

But the bulk of the blame is placed squarely on legal and governmental institutions. Nowhere is this position clearer than when Faigman castigates the U.S. Congress for its decision to close the Office of Technology Assessment, an independent, non-partisan agency, providing comprehensive scientific information to Congress on a wide range of topics. Faigman quotes Alan Crowe, who condemns Congress, saying "If you have all the answers you want, then you don't need analysis." Faigman echoes that sentiment himself just a few sentences later, noting that "(I)gnorance might not be 'bliss', but is it politically expedient."

What Faigman is ultimately proposing is nothing more than the thoughtful, informed, and responsible use of science in legal decision-making. Faigman closes with numerous suggested solutions, including the introduction of scientific training into legal curricula. The book is a thought-provoking read for lawyers, scientists, and anyone with an interest in how science and the law can impact the everyday world. Faigman lays out his analysis in a lively, clear, and direct manner which will undoubtedly engage the reader.

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June 16, 2000

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May 2, 2000

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Volume 19, Number 2 July - December 1999

Special Education Law and Delinquent Children: An Overview

by Andrew K. Block, Jr.[*]

At a time when more police are working in schools and student misconduct is the subject of rising fear and punitive response, it is increasingly apparent that children will be brought into juvenile court for behavior that occurs in school. While administrators who file charges against their students are intent on ridding their schools of weapons, drugs and violence, it is important to remember that the schools remain an integral component of any successful intervention in the life of a delinquent child. In other words, while schools are often the reason that many young people are brought to court, schools also provide the means for children to get back out. For no population of students is this more true than those with learning and other disabilities.

This article provides some information about students with disabilities. It discusses their prevalence within the juvenile justice system, outlines the law that governs the services they receive from pubic schools, and points out

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some areas of concern that lawyers, judges, court personnel, and mental health professionals should keep in mind.

LEARNING DISABILITIES AMONG JUVENILE OFFENDERS

Studies confirm the relationship between learning disabilities and delinquency. A recent study conducted by the Virginia Department of Juvenile Justice demonstrated the high incidence of special education eligibility among incarcerated juveniles (McGarvey & Waite, 2000). Specifically, the study found that more than 40% of the children evaluated at the Reception and Diagnostic Center were eligible to receive special education services. This compares to the approximately 10% incidence in the general population. The study also found that approximately 50% of the children in the facility scored at least six years below their chronological age on language achievement scores.

While this study does not prove that learning disabilities cause delinquent behavior, other studies have demonstrated that children with disabilities are more likely than their non-disabled peers to engage in delinquent or criminal behavior. According to a Department of Education Study, approximately one-third of children with disabilities will be arrested within three to five years of graduating from high school. Of these, more than fifty percent of those labeled as emotionally disturbed will be arrested.

What these and other studies indicate is that it is worth paying special attention to this population of children. Juvenile justice professionals need to learn about how the law provides special assistance to children with disabilities, and also to be mindful of the ways in which the law and the juvenile justice system tend to overlook the unique needs and problems of these children.

SPECIAL EDUCATION LAW

This section will briefly discuss the background and structure governing special education law, and then focus on three primary aspects of special education: (1) eligibility; (2) programming; and (3) discipline.

Background and Structure

The educational rights of children with disabilities are created and protected by a federal law, the Individuals with Disabilities Education Act (IDEA). 20 U.S.C. § 1400 *et seq.* Congress passed this law in recognition of, and as an attempt to address, a long history of schools excluding disabled children from the classroom and segregating these children from their non-disabled peers. Among IDEA's many purposes are to ensure "that all children with disabilities have available to them a free appropriate public education (FAPE) that emphasizes special education and related services designed to meet each child's unique needs," 20 U.S.C. § 1400(d)(1)(A), and "that the rights of children with disabilities and parents of such children are protected." 20 U.S.C. § 1400(d)(1)(B).

To achieve these goals, IDEA "confers upon disabled students an enforceable substantive right to public education in participating states, and conditions federal financial assistance upon a state's compliance with the substantive and procedural goals of the Act." *Honig v. Doe,* 484 U.S. 305, 310.(1988) See also 20 U.S.C. § 1412. It also creates a comprehensive procedural and administrative scheme that governs and defines the relationship between public schools and disabled students and their parents.

To comply with the statutory scheme, each state must develop its own set of rules and procedures that provide at least as much protection as the federal laws and regulations governing special education. In addition, IDEA creates an administrative hearing system in which parents, who disagree with schools about the identification, education or treatment of their disabled children, have the right to contest a school's decision before an Administrative Law Judge. This hearing is called a Due Process Hearing. Unfavorable administrative decisions can be appealed by either party to federal or state court. To encourage lawyers to represent parents and children in special education proceedings, IDEA permits courts to award attorneys fees when the parent is the prevailing party.

Eligibility

A common misconception is that IDEA protects all children with all disabilities. This is not the case. Instead, the law contains a specific list of recognized disabilities and criteria that students must meet in order to receive special education services. A psychiatric diagnosis, by itself, is not enough to guarantee services for a child.

To receive special education services, a student must first be formally evaluated by school

Developments in Mental Health Law

is published by the Institute of Law, Psychiatry & Public Policy with the support of funds from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. The opinions expressed in this publication do not necessarily represent the official position of either the Institute or the Department.

Developments in Mental Health Law is distributed free of charge to Virginia residents twice annually, and to out-of-state subscribers at an annual rate of $20. If you are not on our mailing list but would like to receive this publication, please send your full name and address with your subscription request to P.O. Box 800660, University of Virginia Health System, Charlottesville, VA 22908. Changes of address should include both old and new addresses. This publication is also available electronically over the World Wide Web at the following address: http://www.ilppp.virginia.edu/ilppp.

Letters, inquiries, articles and other materials to be submitted for publication should be directed to the editor.

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ISSN 1063-9977

personnel. The evaluation process is triggered by the request of either the parent or a school employee (with the consent of the parent). See 20 U.S.C.A. § 1414(a). School personnel will evaluate the child in a variety of different capacities and then meet to determine if the child, based on the accumulated information, fits within one of the specified disability categories. The student's parent is a voting member of this eligibility committee. If she disagrees with the committee's conclusion, she has the right to an independent evaluation at the school's expense and, if there is still disagreement, the right to a due process hearing to determine whether the school made the appropriate decision. It is important to remember that in addition to finding the presence of the disabling condition, the eligibility committee must also find that the condition adversely affects the child's educational performance. A short, and by no means comprehensive, list of eligible disabilities includes the following:

- **Specific Learning Disability** — often demonstrated by showing that child's IQ scores are significantly higher (at least 15 points, or one standard deviation above) than child's achievement test scores; see 34 C.F.R. 300.7(b)(10).

- **Mental Retardation** — characterized by IQ scores that fall below 70, and adaptive behavior scores that put the child at a functioning level far below his chronological age; see 34 CFR 300.7(b)(6).

- **Emotional Disturbance** — requires some underlying emotional or psychological condition, such as depression, which persists over time and results in an inability to develop and maintain appropriate relationships, inappropriate behavior under normal circumstances, or pervasive unhappiness; see 34 CFR 300.7(b)(4);

- **Other Health Impaired** — for those children who have a chronic health problem such as asthma, epilepsy, attention deficit disorder, deafness; 34 CFR 300.7(b)(9).

Once the Eligibility Committee reviews all evaluations and concludes that the student is eligible for special education services, the school must create an Individualized Educational Program (IEP) for the student that guarantees that the child will receive a free and appropriate education in the least restrictive learning environment.

The Individualized Educational Program (IEP)

The IEP, which is the centerpiece of each disabled child's education, is developed by a team composed of the parent, regular and special education teachers, local educational agency representatives and, where appropriate, the disabled child. 20 U.S.C. § 1414(d)(1)(B). The role of the parents in the development of the IEP is fundamental. IDEA requires schools to make all education records available to parents, provide written notice to parents of all IEP

continued on page 13

Cases In the Supreme Court

Failure to Provide Community-Based Care is Unjustified Isolation; Discriminatory Under ADA Unless Fundamental Alterations Are Necessary to Accommodate Patient

Olmstead v. Zimring, 527 U.S. 581, 119 S. Ct. 2176 (1999):

Both L.C. and E.W. are mentally retarded women who were diagnosed with psychiatric disorders and placed in institutions. L.C. brought an action in District Court, alleging that the state of Georgia had violated Title II of the ADA when it failed to remove her from institutionalized treatment in favor of a community-based program after her physician determined that a less restrictive placement would be appropriate. E.W. intervened in the action with an identical claim.

> The Department of Justice supported the notion that continued institutionalization, despite eligibility for less restrictive treatments, is discriminatory.

Title II of the ADA, under which the claim was brought, requires that no disabled person be denied the services of a public entity by reason of his or her disability. Pursuant to Title II Regulation 28 C.F.R. § 35.130(b)(7) issued by the Attorney General, states must make reasonable modifications to any existing services to avoid discrimination, but are not required to make "fundamental alterations" that would change the entire character of the services offered.

The District Court granted partial summary judgment to L.C. and E.W., finding that "unnecessary institutional segregation" was discrimination per se; the state's cost-based defense, that fundamental alterations would have to be made to accommodate the women, was rejected. The Court of Appeals for the Eleventh Circuit, however, held that the District Court was incorrect to view the segregation as discrimination per se, thereby dismissing the cost-based defense altogether. The Court of Appeals remanded the case on very narrow terms, instructing the District Court to look only at the cost of treating the two women in comparison with the state's entire mental health budget allocation, in order to determine if the cost-based defense was reasonable.

Before the District Court reached its holding, however, the U.S. Supreme Court granted certiorari. A majority of the Supreme Court affirmed the decision from the Court of Appeals only to the extent that it held that "unjustified isolation" amounted to discrimination. In support of this finding, the Court noted that the Department of Justice, the agency instructed by Congress to issue regulations to implement Title II, supported the notion that continued institutionalization, despite eligibility for less restrictive treatments, is discriminatory.

In addition, the Supreme Court found that the language of the ADA itself, in 42 U.S.C. § 12101(a)(2), supported this interpretation by requiring unjustified "segregation" to

be viewed as discrimination. The Court expressly stated that under this interpretation, institutionalized treatment would still be non-discriminatory in cases in which a physician thought a patient was ineligible for less restrictive treatment or in cases where an eligible patient did not wish to leave the institutionalized setting.

Only a plurality joined the remainder of the opinion regarding the fundamental alteration exception to the non-discriminatory treatment requirement. The plurality noted that the Court of Appeals had been too restrictive in its instruction to the District Court regarding assessment of the fundamental alteration defense presented by the state. In addition to considering the cost of providing for the two women in question as compared to the total mental health budget of the state, the Supreme Court found that the "range of services" provided by the state to individuals with mental disabilities should be taken into account in light of the state's "obligation to mete out those services equitably."

States are required to provide community-based treatment whenever a physician finds such treatment appropriate and the patient is in agreement, keeping in mind the number of resources the state has available as well as the state's commitment to other citizens with mental disabilities.

Under the Court's construction of the fundamental alteration defense, the state would be allowed to show that it would be unfair to provide immediate accommodation for the plaintiffs due to the state's responsibility to other citizens with mental disabilities and the limited number of resources available. The Court noted that the Court of Appeals' construction, if followed, would make the defense of entirely no use as long as the plaintiffs could show they were eligible for community-based treatment. For these reasons, the Court held that states are required to provide community-based treatment whenever a physician finds such treatment appropriate and the patient is in agreement, keeping in mind the number of resources the state has to utilize as well as the state's commitment to other citizens with mental disabilities.

Justice Scalia and Chief Justice Rhenquist joined Justice Thomas in a dissent articulating three basic disagreements with the majority and plurality. First, he noted that the majority's interpretation of the word "discrimination" was too broad to be supported by statutory construction. The dissentors did not feel that "undue institutionalization" was intended to be included in the definition of "discrimination" as found elsewhere in the ADA. Second, the dissent expressed a federalism concern, noting that the majority's approach would result in a loss of control by states over how they allocate funds and distribute services. Finally, Thomas pointed out that, to fall under the protection of the ADA, discrimination must be "by reason of" a person's disability. This suggests proximate causation, he noted, which was lacking in the case, since L.C. and E.W. do not state that their disabilities are the specific reason they were denied community services.

Cases In the Virginia Courts

Insanity Defense in Juvenile Court
Chatman v. Commonwealth of Virginia, 30 Va. App. 593, 518 S.E.2d 847 (1999):

In 1997, a juvenile and domestic relations district court judge found Christopher Lyance Chatman, thirteen years old at the time, guilty of the delinquency charge of unlawful wounding and committed him to the Department of Juvenile Justice. In Chatman's appeal to the circuit court, he asked for a psychiatric evaluation to determine his sanity at the time of the offense. Evaluations of Chatman immediately following the offense, diagnosed him with a schizophrenic disorder, among other "serious psychiatric difficulties." In his appeal, he stated that these results were evidence of the necessity of a sanity evaluation, but the circuit court disagreed.

> Juvenile proceedings must measure up to the essentials of due process and fair treatment.

> The Court concluded that due process requires that the insanity defense be available in juvenile delinquency proceedings.

Chatman then argued to the Court of Appeals of Virginia that the circuit court had prevented him from asserting an insanity defense, to which he was entitled, when the court denied his motion for a psychiatric evaluation at state expense. The Court of Appeals said that the Juvenile and Domestic Relations District Court Law does not specifically allow or prohibit the assertion of an insanity defense in the adjudication of juvenile delinquency for juveniles under the age of fourteen. While the Commonwealth pointed to this as evidence of the unavailability of the defense to such juveniles, the Court of Appeals did not agree. To support the Court's conclusion that the insanity defense should be available in the adjudication of juveniles, the Court of Appeals pointed to the landmark case *In re Gault*, 387 U.S. 1 (1967), which requires that juvenile proceedings "measure up to the essentials of due process and fair treatment," and noted that delinquency adjudications have "wide and serious ramifications." The Court also noted that a number of other states have found that the opportunity to assert an insanity defense is an essential component of due process.

The case was remanded to the lower court to determine if there is probable cause for Chatman's sanity to be an important part of his defense; if probable cause is found, a qualified evaluator will be appointed and paid by the state pursuant to Virginia Code § 19.2-169.5.

The Virginia Office of the Attorney General appealed the case to the Virginia Supreme Court, which granted certiorari to review the *Chatman* decision, thus leaving no final answer as to whether there is an insanity defense for juveniles in juvenile court proceedings in Virginia.

Sexual Abnormality Includes Use of Force in Rape

Simerly v. Commonwealth of Virginia, 29 Va. App. 710, 514 S.E.2d 387 (1999):

In September 1997, Bobby Joe Simerly was convicted of rape, abduction with the intent to defile, and malicious wounding. He was sentenced to two life imprisonments for rape and abduction with intent to defile, and twenty years imprisonment for malicious wounding. On appeal,

> [T]he Court held that his act was one that indicated "sexual abnormality," and thus a mental evaluation should have been permitted prior to sentencing.

Simerly argued that the trial court erred when it did not defer sentencing until he received mental evaluations pursuant to Va. Code §§ 19.2-300 and 19.2-176. Counsel for Simerly believed that such evaluations might have resulted in mitigating evidence. The Court of Appeals dismissed the claim brought under § 19.2-176, noting that this section provides that a trial judge "may" order the defendant to be evaluated if that judge finds the defendant's mental state to be in question. The use of the word "may" indicates the intent to allow the judge to use his or her discretion on the matter. Since the Court found no abuse of discretion by the trial judge, the decision to not provide a mental evaluation under §19.2-176 was unchanged.

The claim under § 19.2-300, however, was more problematic for the Court. Under Va. Code § 19.2-300, when the offense committed is one that indicates sexual abnormality, the trial judge "shall . . . defer sentence until the report of a mental examination . . . can be secured to guide the judge" in the disposition if counsel for the defendant requests such an evaluation. In determining whether or not the trial court erred in denying an evaluation under § 19.2-300, the Court of Appeals addressed the issue of whether or not Simerly committed an act of "sexual abnormality" as used, but not defined, in § 19.2-300. The Court determined that if he had indeed committed such an act, a mental evaluation should have been allowed by the trial court before the sentencing hearing, as the inclusion of the word "shall" rather than "may" in the statutory language indicates the intent to take away judicial discretion on the matter.

In order to determine exactly what was meant by the term "sexual abnormality," the Court looked to the legislative history of § 19.2-300, and concluded that an offense indicates sexual abnormality if the sexual act was committed by the use of force and against the will of one of the participants. Since Simerly clearly used force in committing the rape, the Court held that his act was one that indicated "sexual abnormality," and thus a mental evaluation should have been permitted prior to sentencing.

The concurring opinion thought that there should be a higher threshold in order to establish sexual abnormality, beyond merely the use of force in commission of the act, but agreed that Simerly had committed an act covered by the statute because the assault indicated a level of violent behavior that certainly amounted to sexual abnormality.

Virginia Legislation

The following Senate and House Bills are to be found in *Chapter 216, 2000 Acts of Assembly, General Assembly of Virginia.*

Senate Bill 301: Juvenile competency evaluation.

Summary as passed:

Adds licensed professional counselors to the list of experts who may perform a juvenile forensic evaluation.

Senate Bill 520: Juvenile competency.

Summary as passed:

Provides for the civil commitment of a person who was charged with a crime when younger than the age of 18 but who reaches the age of 18 during the time that the court finds him unrestorable to competency and in need of inpatient hospitalization. In 1999, the Virginia Commission on Youth recommended legislation to provide juvenile court procedures for determining whether a juvenile is competent to stand trial, for restoration of competency and for dispositions for unrestorably incompetent juveniles. The current law provides that an unrestorably incompetent juvenile may be committed to a facility operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services for a period of up to three years, depending upon the charge. This bill provides the statutory authority to commit a juvenile who turns 18 to an adult facility.

Senate Bill 344: Commitment to Department of Juvenile Justice.

Summary as passed:

Changes criteria for commitment to the Department. Currently a child older than 10 years of age may be committed, this bill raises the age to 11 or older. The bill also provides for commitment to the Department for an offense which would be a Class 1 misdemeanor and the juvenile has been previously convicted of three Class 1 misdemeanors or a felony. Current law allows commitment for a Class 1 misdemeanor if the prior conviction was a felony or a Class 1 misdemeanor. The bill also clarifies that (i) abused and neglected children may not be committed to the Department and (ii) any juvenile who is in the custody of the Department and is subsequently convicted as an adult is to be transferred to the Department of Corrections. (This bill is identical to SB 150 and HB 295.)

House Joint Resolution 237: Study: Traumatic brain injury among individuals in juvenile detention homes.

Directs the Virginia Commission on Youth to study the incidence and treatment of traumatic brain injury among individuals in Virginia's 21 juvenile detention homes.

Cases In Other State Courts

Withholding Medication for Recently Released Prisoner Actionable Under § 1983

Wakefield v. Thompson, 177 F.3d 1160 (9th Cir. 1999):

Timothy Wakefield filed a §1983 federal civil rights action against John Doe, a correctional officer at San Quentin Prison, alleging violation of his Eighth Amendment right against cruel and unusual punishment because the officer refused to provide him with proper medication upon his release from prison. Wakefield had been diagnosed with Organic Delusional Disorder while a prisoner, and had been treated with Navane, a psycho tropic medication, to control his violent outbursts. Before being released from San Quentin, he was prescribed two-weeks worth of Navane. John Doe, who handled his release, refused to make the medication available, claiming he was too busy to do so. Allegedly as a result, Wakefield had a violent outburst a little over a week later that led to his arrest.

> The Court held that a prisoner, recently been released from prison and in need of immediate medical treatment, is limited by the state in much the same way as an inmate still in prison.

The district court dismissed Wakefield's § 1983 claim on the grounds that the Ninth Circuit does not favor unnamed defendants. On appeal, however, the U.S. Court of Appeals for the Ninth Circuit noted that it is proper to allow a plaintiff the opportunity to name an unknown defendant through discovery, unless it is obvious the defendant will not be able to be named or there is some other reason to dismiss the claim. The Court determined that the district court erred in dismissing the claim based solely on the plaintiff's inability to name the defendant.

> The Ninth Circuit has typically included in the concept of "deliberate indifference" the situation in which the prison official ignores the instructions of a prisoner's physician.

Additionally, the Court of Appeals determined that there was no other reason to dismiss Wakefield's claim. Ever since *Estelle v. Gamble, 429 U.S. 97, 50 L. Ed. 2d 251, 97 S. Ct. 285 (1976)*, the state has had an affirmative duty to protect where the state itself has hindered an individual's ability to act on his own behalf by limiting his or her freedom. The Court held that a prisoner, recently released from prison and in need of immediate medical treatment, is limited by the state in much the same way as an inmate still in prison. Sympathetic to the fact that it may take a week or so for a recently-released prisoner to find a doctor and get a prescription filled, the Court found that the state had an affirmative duty to provide individuals in Wakefield's situation with a reasonable amount of medication to sustain them for their initial post-release transition.

However, the Court pointed out, a § 1983 claim against the state will not be successful unless there is "deliberate indifference" to a "serious medical need" on the part of the state official. The Court found, though, that the Ninth Circuit has typically included in the concept of "deliberate indifference" the situation in which the prison official ignores the instructions of a prisoner's physician. Since the Court believed this to be Wakefield's exact situation, it held that Wakefield had stated a valid § 1983 claim. The Court reversed the district court's dismissal and remanded the case to the lower court for further proceedings.

ADA Protection Unavailable to Illicit Drug User

Zenor v. El Paso Healthcare System, 176 F.3d 847 (5th Cir. 1999):

Tom Zenor was hired by Columbia Medical Center-East Hospital to work as a pharmacist in 1991. He became addicted to cocaine in 1993, which was brought to his employer's attention by his own admission in 1995. Zenor was allowed a twelve-week leave of absence from work while he completed a rehabilitation program. On September 20, 1995 he was informed that, though he would remain an employee until his medical leave ended, he would be terminated at that time. Zenor brought suit against Columbia, claiming that his termination violated the Americans with Disabilities Act [ADA]. Zenor's other claims, such as breach of contract and promissory estoppel. He appealed only the dismissal of the ADA, breach of contract, and promissory estoppel claims.

While the Second Circuit has held that "current use" of drugs be determined from whether or not there is drug use at the date of termination, the Court of Appeals rejected this approach.

The U.S. Court of Appeals for the Fifth Circuit upheld the holding of the district court pertaining to all three claims brought on appeal, but the majority of the opinion addressed the claim brought under the ADA. The Court first noted that Zenor was not a "qualified individual" under the ADA because he was a current user of illegal drugs. While the Second Circuit has held that "current use" of drugs be measured from whether or not there is drug use at the date of termination, the Court of Appeals rejected this approach. Instead it held that "current use" refers to the time of the "relevant adverse employment action," which it found to be the date on which notification of termination was given, rather than the actual date of termination.

An employee may be considered a current user if the employer has a reasonable belief that the drug-use will be an ongoing problem. The court noted that after a drug problem as serious as that evidenced by Zenor, five weeks of non-use while still in a residential treatment program was not enough to remove such a reasonable belief, and therefore, Zenor must be considered a current user for the purposes of the ADA. Additionally, the Court concluded that to fall under the "safe harbor" exemption from the "current user" exclusion pursuant to 42 U.S.C. § 12114(b) of the ADA, it is necessary

to be drug-free for a more substantial length of time.

In further support of the decision to uphold the district court's ruling on the ADA claim, the Court rejected Zenor's assertion that he was otherwise qualified for the job of pharmacist. Due to the fact that the relapse rate for cocaine addiction is very high and that mistakes in such a field can be very harmful, the Court found that Columbia was justified in dismissing him. Finally, the Court noted that even in the absence of the former arguments, the ADA claim would still fail because he was not disabled under the definition provided by the ADA.

In order to be considered disabled under the ADA, an employer must not only think that an employee is a drug abuser, but also must regard the drug abuse as "substantially limiting" a "major life activity" of the employee. Since no evidence was presented that Columbia believed Zenor's drug abuse to be a substantial limitation of any life activity, including working, the Court found that no reasonable jury could have found that he was suffering from a disability as defined in the ADA. Thus, the district court's decision was affirmed.

Unauthorized Release of Mental Health Records Is Breach of Confidentiality

Sletto v. Hospital Authority, 239 Ga. App. 203; 521 S.E.2d 199 (1999):

A lawsuit for a personal injury claim, filed by Leonard Sletto in August 1992, resulted in Marlyn Jackson, the medical records custodian for HMC, releasing all of Sletto's medical records to the defendant's attorney, which accidentally included his mental health records.

Since Sletto had not authorized the release of the mental health records, he and his wife Stellie brought an action against HMC and Jackson, as well as against Smart Corporation, which photocopied and distributed medical records for HMC. The Slettos alleged that they were both entitled to recover from each of the defendants for invasion of privacy, that Leonard was entitled to recover for negligent infliction of emotional distress, and that Stellie was entitled to recover for loss of consortium. The trial court granted summary judgment to the defendants on all claims.

The Slettos did not take issue with the grant of summary judgment on the invasion of privacy claim, but they raised the latter two claims on appeal and sought damages for mental pain and suffering under the Official Code of Georgia Annotated [O.G.C.A.] § 51-12-6. The Court of Appeals of Georgia noted that summary judgment for HMC would have been justified under a § 51-12-6 claim because in order to recover, the mental suffering must either be accompanied by "physical or pecuniary loss" or the act must have been "malicious, willful, or wanton." The Court noted that there was no appropriate accompanying loss, nor

> Official Code of Georgia Annotated Statutes [O.C.G.A.] §§ 37-3-166(a) and 37-7-166(a) specifically state that no clinical records of people who have received hospital treatment for mental illness or substance abuse may be disclosed.

was there an intentional action on the part of the defendants.

The Court went on to point out, however, that summary judgment was actually not appropriate in the Slettos' case in light of the strict confidentiality laws pertaining to clinical mental health records. O.C.G.A. §§ 37-3-166(a) and 37-7-166(a) specifically state that no clinical records of people who have received hospital treatment for mental illness or substance abuse may be disclosed. The record showed that HMC may have handled its psychiatric records improperly given the strict laws concerning confidentiality. The Court held that whether or not HMC had a proper system of controlling the release of its records was certainly a jury issue.

The concurring opinion disagree with only one aspect of the main opinion. The two concurring judges thought that there was evidence in the record of a "reckless and wanton disregard of consequences" by the defendants, which might have been evidence of intent to harm. The concurring judges thought that whether there was malicious or willful conduct (making recovery possible under O.C.G.A. § 51-12-6), should also be a question for the jury.

(Special Education Law by Andrew Block - continued from page 4):

meetings, include parents in the planning process, and obtain their written permission before implementing the student's IEP or any changes to the IEP. 20 U.S.C. § 1415(b).

The IEP must provide the student her legally guaranteed free and appropriate public education. It should contain, among other components, a statement of the child's current educational performance, annual goals for the child's educational performance, a description of the child's placement, services, and accommodations, and an explanation of the extent to which the student will not participate with non-disabled students in the regular class. 20 U.S.C. § 1414(d)(1)(A). Of particular relevance to children in the juvenile justice system, IEP's can include behavioral modification plans, counseling, tutoring, job coaching, supervised vocational placements, and alternative discipline plans.

The Supreme Court has concluded that a free appropriate public education is not one that maximizes the child's potential, but one which, at a minimum, guarantees the child the opportunity to advance in the general curriculum and receive some benefit from his education. *Board of Education of The Hendrick Hudson Central School Dist. v. Rowley,* 458 U.S. 176, 203-204 (1982).

A major goal of the IEP is to ensure that every disabled child is educated in the least restrictive environment -- participating states must ensure that "to the maximum extent appropriate, children with disabilities . . . are educated with children who are not disabled." 20 U.S.C. § 1412(a)(4). Removal of children with disabilities from the regular educational environment should occur "only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily." *Id.*

Discipline of Special Education Students and the "Stay Put" Provision

In addition to requiring school systems to provide special education students with an appropriate education, IDEA also places strict limits on when, under what circumstances, and how severely, schools can discipline these students.

In general, schools have the right to suspend children with disabilities for up to ten days. 20 U.S.C.A. § 1415(k)(1)(A)(i). However, when the total number of days that a child has been suspended exceeds ten days, the school must hold a manifestation determination review. 20 U.S.C.A. § 1415 (k)(4). At this meeting, an IEP team must consider whether or not the child's behavior was a manifestation of his disability. The team can only determine that the behavior was *not* a manifestation of the disability if it finds that:

a. the IEP was appropriate and complied with;
b. the disability did not impair the student's ability to control behavior; and
c. the disability did not impair the student's ability to understand the consequences of her actions.

20 U.S.C. § 1415(k)(4)(C).

If the team cannot make each of these findings, the child must be returned to the school after ten days have lapsed. If the team determines that all necessary criteria are satisfied, it can remove the child from the school. However, even after removing a disabled child, the school still needs to convene an IEP team to develop an alternative educational program that provides the child with a free and appropriate public education and satisfies the original IEP requirements. 20 U.S.C.A. § 1415(k)(3), 20 U.S.C.A. § 1412(a)(1).

If the parent disagrees with the school's determination that there was no connection between the misconduct and the disability, the parent can challenge this decision in a due process hearing. IDEA commands that while the results of this challenge are pending, the child must remain in the current education placement (the placement prior to the imposition of discipline). 20 U.S.C.A. § 1415(j). This protection is also known as the "stay put" provision. Because the administrative proceedings can last months and, in some cases, years, a student will potentially stay put for a significant period of time – no small benefit. But as the Supreme Court has stated, "We think it clear . . . that Congress very much meant to strip schools of the unilateral authority they had traditionally employed to exclude disabled students, particularly emotionally disturbed students, from school." *Honig v. Doe,* 484 U.S. 305, 323 (1988).

There are exceptions to the stay put rule if the child brings a weapon or drugs to school. If this occurs, the school can place the child in an alternative education setting for 45 days pending resolution of the matter by a hearing officer. 20 U.S.C.A. 1415(k)(1)(A)(ii). In addition, if a hearing officer determines that the child is dangerous, the child can be sent to an alternative setting for up to 45 days, even after a parent invokes the stay put protection.

Either way, the fact that children remain in their educational placement pending the due process decision, or at the very least, continue to receive an

appropriate education even after they have been "expelled," demonstrates the impact and benefit of a special education classification. These benefits suggest the necessity of properly identifying all children eligible for special education. Proper identification is particularly critical during this time of "zero-tolerance" discipline policies, when schools are disciplining children for often minor offenses.

AREAS OF SPECIAL CONCERN

The involvement of children with disabilities in the juvenile justice system poses unique challenges and problems to juvenile justice professionals who want to ensure that all children are treated equally and receive the full benefits and protections of the system and the law. What follows is a short list of concerns that merits particular attention.

"CHINS" Cases

Child in Need of Supervision (CHINS) cases, or truancy cases as they are more frequently described, are on the rise and are a predictor of future delinquency. Unfortunately, CHINS cases do not provide the opportunity they should for truly examining the needs of the child appearing before the court. Specifically, before a child can be found by the court to be a Child in Need of Supervision, the court must find that the school has done all that is legally required to provide the child with educational benefit. Too many lawyers, however, overlook this legal requirement and do not investigate whether or not the child is a special education student, or a student whose performance in school merits evaluation for potential eligibility. As a result, rather than examining the school's efforts (or failures) to provide the student with an appropriate education, the focus of the judicial process is often limited to the child's attendance at school. This limited focus minimizes the potential for the court to provide, and require, positive interventions in the child's life.
Any professional working with a child who has been referred to the court on a CHINS petition should always collect the student's educational records and review them for potential special education issues.

Delinquent Behavior in School

For many special education students, particularly those who carry the label "emotionally disturbed," delinquent behavior such as threatening comments, property destruction, and aggression towards others is often a manifestation of their disability. While administrators cannot expel students for this behavior, they often file charges against them. While IDEA appears to allow schools to file charges against special education students for behavior that is a manifestation of their disabilities, there is more than the mere impression that schools, by taking this action, are using the court system to do what they cannot -- lock the child up and/or remove him or her from school.

In addition, the courts often treat these students as they would any other student and punish them accordingly. Whether this is an appropriate response to behavior that professionals determine to be a manifestation of one's disability is an

open question. However, it is something that should concern professionals who work with these children.

An equally troubling concern is that the administration of justice in juvenile court is seldom swift. The ultimate resolution of a case often takes place weeks, or even months, after the misconduct, and after the school and the student have successfully fashioned solutions for the problem behavior. Thus, while the school and the student may have re-established their relationship, when the court date comes this relationship will be recast as an adversarial one. Further, due to the court system's slow place, the imposition of any punishment for behavior that occurred months before can appear gratuitous and unfair to children who have a compressed sense of cause and effect, feel that they have already been punished (in the school), and have moved on to other things. Such feelings are likely to erode and undermine any trust and confidence the student has with the system and her teachers.

Waiver of Miranda Warnings

It is likely that children with learning disabilities, processing difficulties, and attention deficits are less able than their non-disabled peers to knowingly and voluntarily waive their right to remain silent and confer with a lawyer before talking with the police. (Even children without disabilities experience significant difficulty in understanding and waiving these rights). As such, it is incumbent upon lawyers who are preparing their suppression motions to obtain all school records and special education evaluations and reports. It is equally incumbent upon those who evaluate such children to gather and consider this information.

Competency to Stand Trial

With the passage of juvenile competency statutes, more lawyers and courts are inquiring into a child's competency to stand trial. Much like the Miranda issue, students with disabilities are less likely to be competent than students with no disabilities. Gathering and analyzing the school records of special education students is a critical step in making the determination of whether or not a child is competent. For example, much of the testing done to determine special education eligibility will indicate at what grade and age level the student is reading, writing, thinking, and performing other academic tasks.

Treatment by the Juvenile Justice System

Children with disabilities often have a more difficult time following directions, obeying rules, controlling their impulses, and understanding written expectations. Understanding that successfully completing probation, or securing release from a detention or correctional facility, requires the ability to do these things -- follow rules, control impulses, understand oral and written directions -- it is not surprising that the incidence of special education students among confined children is so high. Their disabilities make them more likely to violate conditions of their probation and risk confinement, and less likely to abide by the tightly regimented rules of many juvenile correctional facilities.

The education of judges, court and correctional personnel about learning disabilities, their causes and effects, and effective communication strategies, will allow these professionals to take account of these disabilities when providing treatment and when administering punishment and discipline.

CONCLUSION

As student misconduct in school is increasingly criminalized, more and more children with learning disabilities are entering the juvenile justice system. It is critical that all professionals within the system learn more about these children, and more about the opportunities and obstacles that their disabled condition presents. By taking full advantage of legal protections, and carefully considering the impact that disabilities have on an individual child's behavior, those who work with these children will be in a better position to ensure that the rehabilitative promise of the juvenile justice system is fulfilled, and that our correctional facilities do not become mere holding tanks where disabled children languish.

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Submission Guidelines

Developments in Mental Health Law encourages the submission of articles on timely and interesting topics in the area of mental health law.

The typical article is 10 to 15 pages long, without substantial footnoting. The reading audience is multi-disciplinary, typically with legal or mental health training, but not necessarily both. Therefore, Developments seeks articles which are useful to a general audience interested in mental health law.

How to contact Developments in Mental Health Law:

1) The preferred method of submitting articles is to submit a short query by e-mail, describing the topic and general thesis. Send e-mail to: rer6e@virginia.edu, with a subject line of "*Article Query,*"

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2) Query letters can be mailed to the attention of the editor: *Developments in Mental Health Law,* P.O. Box 800660, Charlottesville VA 22908-0660. The street address is: 1107 Main St.

Please do not initially send a copy of your article. The editor of *Developments* will contact authors if there is an interest in using or developing your piece. The fastest way for the editor to contact you is by e-mail, so please include an e-mail address, if possible.

Understanding Juvenile Sex Offenders: Research Findings and Guidelines for Effective Management and Treatment

*John A. Hunter, Ph.D.**

Juvenile perpetrated sexual aggression has been a problem of growing concern in American society over the past decade. Currently it is estimated that juveniles account for up to one-fifth of the rapes,[1] and one-half of the cases of child molestation[2] committed in the United States each year. The majority of cases of juvenile sexual aggression appear to involve adolescent male perpetrators;[3] however, a number of clinical studies have pointed to the presence of females and prepubescent youths, who have engaged in sexually abusive behaviors. Juvenile sexual offending appears to traverse racial and cultural boundaries.

Causes and Patterns of Juvenile Sex Offending

A number of etiological factors (casual influences) have been identified that are believed to help explain the developmental origin of juvenile sex offending. Factors that have received the most attention to date include: maltreatment experiences, exposure to pornography, substance abuse, and exposure to aggressive role models.

While sexual aggression may emerge early in the developmental process, there is no compelling evidence to suggest that the majority of juvenile sex offenders are likely to become adult sex offenders. The estimated risk of juvenile sex offending leading to adult offending may have been exaggerated by an over-reliance on retrospective research studies.[4] Existent longitudinal studies suggest that aggressive behavior in youths is not always continuous, and that juveniles who

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[1] In 1995 juveniles were involved in 15% of all forcible rapes cleared by arrest; approximately 18 juveniles per 100,000 (ages 10 to 17) were arrested for forcible rape in 1995. This latter number is approximately 6 times higher than the figure for Canada.

[2] Approximately 16,100 juveniles were arrested for sexual offenses in 1995 (excluding rape and prostitution). This is approximately 3 times the number of youths arrested for forcible rape.

[3] Adolescents (ages 13-17) accounted for approximately 89% of juvenile forcible rape arrests, and 82% of the other juvenile sex offense arrests, in 1995.

[4] Retrospective research may exaggerate the strength of correlations. Longitudinal research, or the prospective tracking of individuals, typically provides a more accurate index of event likelihood.

engage in sexual aggression frequently cease such behavior by the time they reach adulthood.

CLINICAL CHARACTERISTICS AND JUVENILE SEX OFFENDER SUBTYPES

Juvenile male sex offenders are found to vary on a number of clinical and criminal indicators. As with their adult counterparts, juvenile sex offenders appear to fall primarily into two major types: those who target children, and those who offend against peers or adults. The distinction between these two groups is usually based on the age difference between the victim and the offender.[5]

Juvenile Offenders Who Sexually Offend Against Peers or Adults

- Juveniles who sexually offend against peers or adults predominantly assault females and strangers or casual acquaintances.
- The sexual assaults of these youths are more likely to occur in association with other types of criminal activity (e.g., burglary) than those who target children.
- These juvenile sex offenders are more likely to have histories of non-sexual criminal offenses, and appear more generally delinquent and conduct disordered than those who sexually assault children.
- This group of youthful offenders is also more likely to commit their offenses in public areas than those who offend against children.
- These juveniles generally display higher levels of aggression and violence in the commission of their sexual crimes than those who offend against children.
- Youths who sexually offend against peers or adults are more likely to use weapons and to cause injuries to their victims than those who sexually assault children.

Juvenile Offenders Who Sexually Offend Against Children

- Juveniles who sexually offend against children have both a higher number of male victims and victims to whom they are related than peer/adult offenders.

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[5] Child offenders are those who target children five or more years younger than themselves.

- Although females are victimized at slightly higher rates than males, almost 50% of this group of juvenile sex offenders has at least one male victim.

- As many as 40% of their victims are either siblings or other relatives.

- The sexual crimes of juvenile child molesters tend to reflect a greater reliance on opportunity and guile than injurious force. This appears to be particularly true when their victim is related to them. These youths may "trick" the child into complying with the molestation, use bribes, or threaten the child with loss of the relationship.

- Within the overall population of juveniles who sexually assault children, there are certain youths who display high levels of aggression and violence. Generally, these are youths who display more severe personality and/or psychosexual disturbance (e.g., psychopathy; sexual sadism, etc.).

- Juveniles who sexually offend against children have often been characterized as suffering from deficits in self-esteem and social competency.[6]

- Many of these youths, particularly those with victimization histories, show evidence of depression. Although the ability of these juveniles to form and maintain healthy peer relationships and successfully resolve interpersonal conflicts may be impaired, they generally evidence less emotional indifference to the needs of others than peer/adult offenders.

Characteristics Common to Both Groups of Juvenile Sex Offenders

- Juveniles who sexually assault children, and those who target peers or adults, share certain common characteristics. These include:

- High rates of learning disabilities and academic dysfunction (30-60%).

- The presence of other behavioral health problems, including substance abuse, and disorders of conduct (up to 80% have some diagnosable psychiatric disorder).

- Observed difficulties with impulse control and judgment.

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[6] Social competency is defined as possession of prerequisite skills/attributes necessary for forming and maintaining healthy interpersonal relationships. These include: social skills, leadership ability, and the ability to act assertively.

THE AMENABILITY OF JUVENILE SEX OFFENDERS TO TREATMENT

While funding and ethical issues have made it difficult to conduct carefully controlled treatment outcome studies,[7] a number of encouraging clinical reports on the treatment of juvenile sex offenders have been published. While these studies are not definitive, they provide empirical support for the belief that the majority of juvenile sex offenders are amenable to treatment and achieve positive treatment outcomes.

In perhaps the best controlled study to date, Borduin, Henggeler, Blaske, and Stein (1990) compared "multisystemic" therapy[8] (an intensive, multifaceted treatment targeting youth and family characteristics, peer relations, school factors, and neighborhood and community characteristics) with individual therapy in the outpatient treatment of sixteen adolescent sex offenders. Using re-arrest records as a measure of recidivism (sexual and non-sexual), the above two groups were compared at a three year follow-up interval. Results revealed that youths receiving multisystemic therapy had recidivism rates of 12.5% for sexual offenses and 25% for non-sexual offenses, while those youths receiving individual therapy had recidivism rates of 75% for sexual offenses and 50% for non-sexual offenses.

Program evaluation data suggest that the sexual recidivism rate for juveniles treated in specialized programs[9] ranges from approximately 7%-13% over follow-up periods of two to five years. Studies suggest that rates of non-sexual recidivism are generally higher (25-50%). If findings from future treatment outcome studies on juvenile sex offenders parallel those on adult offenses, sexual recidivism rates will be higher in individuals who fail to successfully complete programs. In a recently conducted study, Hunter and Figueredo (1999) found that as many as 50% of youths entering a community-based treatment program were expelled during the first year of their participation. Program failure was found to be largely attributable to failure to comply with attendance requirements and/or therapeutic directives.[10] Youths failing to comply with the program were found to have higher overall levels

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[7] Controlled treatment outcome studies refer to those where treated juvenile sex offenders are compared to other groups of juveniles (e.g., non-treated juvenile sex offenders) on variables of interest (e.g., sexual recidivism rates).

[8] Multisystemic therapy assumes that behavior problems are multidetermined and multidimensional, and "that interventions may need to focus on any one or combination of systems. "Areas of therapeutic focus may include the following: cognitive processes, family relations, peer relations, and school performance. See Borduin, Henggeler, Blaske, and Stein, 1990, pp. 108-110, for more details.

[9] "Specialized" programs are those that were specifically designed to treat juvenile sex offenders. See "Clinical Programming for Juvenile Sex Offenders" section for details of programming content.

[10] An example of a therapeutic directive would be the writing of an "empathy letter" to the victim of the sexual abuse. *See* "Clinical Programming for Juvenile Sex Offenders" section.

of sexual maladjustment (as measured on assessment instruments), and were judged possibly to be at greater long-term risk for sexual recidivism. In this study, lower levels of client denial at intake best predicted successful program compliance. Higher levels of denial were found in nonadjudicated youths.[11]

POLICY DEVELOPMENT AND ISSUES

Legislative Trends

The rise in juvenile perpetrated violence over the past decade has resulted in legislation designed to enhance public safety, and raise the level of accountability of juveniles in the criminal justice system (see Hunter & Lexier, 1998 for a detailed discussion). Substantive changes were made in legal statutes or regulatory policy in more than 90% of the states. This reform included change related to the following:

- juvenile court waivers,
- sentencing guidelines,
- record confidentiality,
- community notification,
- registration requirements for sex offenders, and
- correctional programming.

The number of delinquency cases waived to the adult criminal courts increased by 71% between 1985 and 1994. The age at which juveniles may be tried as an adult has been lowered in over half of the states. Twenty jurisdictions have no minimum age restriction for trying a juvenile as an adult for certain serious crimes. Legislative changes have also made it more likely that once a juvenile is convicted of a crime in the adult courts, he will serve at least some minimum sentence. Presently, more than 50% of the states permit public access (with some age and offense restrictions) to juvenile court records. Eleven states permit public juvenile hearings with no age or crime restrictions.

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[11] The above described studies pertain primarily to adolescent age male offenders. Presently, the National Center for Child Abuse and Neglect is funding two demonstration projects to evaluate treatment outcomes for pre-pubescent children with sexual behavior problems. The results of these studies should appear in the research literature in the near future.

Registration and Community Notification Laws

The registration and tracking of individuals convicted of sexual crimes involving violence or minors began with the passing of the Violent Crime Control and Law Enforcement Act of 1994. This act was amended in 1996, with the passing of "Megan's Law". This amendment required (as opposed to authorized) state and local law enforcement agencies to release information on individuals registered under the 1994 law deemed to be necessary for the maintenance of public safety. Criteria for mandatory lifetime sex offender registration, penalties for failure to register, and a requirement that sex offenders notify the FBI of changes in address, were stipulated in the Pam Lychner Sexual Offender Tracking and Identification Act of 1996.

Federal guidelines specifically require the registering of juveniles when they have been convicted of rape, nonconsensual sexual perpetration or sodomy, or incest with a victim at least two years younger than themselves. At present, 22 states have juvenile sex offender registration laws. While there has been considerable variation in approach, the trend has been for states to create a tiered system that mandates level of community notification based on the perceived dangerousness of the offender. Judgements of dangerousness are usually determined with the aid of risk assessment instruments.

PROMISING APPROACHES TO TREATMENT AND INTERVENTION

The number of programs providing treatment services to juvenile sex offenders more than doubled between 1986 and 1992, and has continued to climb. This growth in programming reflects both increased societal concern about rising rates of juvenile sexual aggression, and the professional belief that early intervention may help stem the emergence of chronic patterns of sexual offending. A review of issues believed to be important to the development of successful community-based treatment programming for juvenile sex offenders follows.

The Interface Between the Criminal Justice System and Treatment Providers

Most treatment specialists (see National Task Force on Juvenile Sexual Offending, 1993) are of the opinion that successful juvenile sex offender programming requires a coordination of effort between criminal justice system actors and providers. In order for juveniles to meaningfully participate in treatment programming, they must be willing to address their problems and comply with therapeutic directives. Adjudication and supervision typically prove to be useful tools in ensuring client accountability and compliance with treatment.

Clinical experience has shown that the suspension of the juvenile's sentence, contingent upon his successful completion of a treatment program, can be a particularly effective motivator. Under such collaborative arrangements with the courts, the treatment specialist provides ongoing progress reports to the court on

the youth's participation in the program. Youths who fail to comply with program expectations can be brought back before the court for a dispositional review.

In many programs, probation officers play an integral role in assisting the treatment provider in addressing critical issues and in supervising the youth's activities in the home and community. The probation officer helps evaluate the extent to which the client is meaningfully participating in the treatment program, and complying with court and therapeutic directives. He provides an additional link between the provider and the youth's family, and can assist the therapist(s) in impressing upon the family the importance of their involvement in the youth's rehabilitative programming.

The probation officer typically also provides a very important case management function. This includes analysis (sometimes along with the help of social services) of the appropriateness of the youth remaining in his home of origin during his participation in treatment, and his need for supplemental community programming (e.g., community service projects, etc.). As a case manager, the probation officer also facilitates appropriate communications between the treatment provider and other community agencies involved in the youth's overall care (e.g., school officials). In some programs, probation officers directly participate in the delivery of therapeutic services (e.g., co-therapist in a group). This most typically occurs in cases where the probation officer has received additional training in the treatment of sex offenders (see Association for the Treatment of Sexual Abuser reference for information on where such training can be received).

Assessment of Juvenile Sex Offenders for Community-Based Treatment

Critical to the success of community-based programming is the careful screening of all potential participants. Ideally, this review should reflect the careful consideration of issues related to dangerousness, severity of psychiatric and psychosexual disturbance, and amenability to treatment. The latter issues involve an assessment of the youth's level of accountability for his sexual offenses, his motivation for change, and his receptivity to professional help.

It is preferable that these evaluations should be conducted by professionals who have documented clinical experience and training in working with the juvenile sex offender population. It is important that programs not compromise community safety by admitting youths who are more aggressive and violent, those who have psychiatric problems that are beyond the scope of the community-based program, and those who demonstrate little regard for their actions or interest in receiving help.

Timing of Assessments

A professional evaluation of the youth and his appropriateness for placement should be conducted post-adjudication, but prior to court sentencing. Pre-adjudication evaluations are fraught with legal and clinical complexity and are best avoided. Such evaluations may place youths in a position of being asked (oftentimes without legal representation or Fifth Amendment warnings) to reveal information that subsequently may be used in their prosecution. Little meaningful information is derived from assessment of youths who totally deny their offenses.

There are no psychological tests that are valid for the purpose of determining issues of innocence or guilt. Furthermore, research suggests that the validity of phallometric assessment may be compromised by client denial.

Components of Clinical Assessment

Clinical assessments should be comprehensive and include careful record review, clinical interviewing, and the administration of both specialized psychometric instruments designed to assess sexual attitudes and interests, and those related to more global personality adjustment and functioning.[12] Adjunctive assessment tools include the plethysmograph and the polygraph.

Assessment of Appropriateness of the Offender's Living Arrangements

It is important that assessments of the juvenile's appropriateness for community-based programming include a thorough review of his living arrangements. This requires evaluation of whether the living environment affords the necessary level of both structure and supervision, and does not compromise the safety of others in the home. Special attention should be given to the needs and concerns of individuals living in the same environment who may have been victimized by the juvenile (e.g., younger siblings). Young children are often not able to advocate for their own best interests in such matters, and must be protected from potential harm, including the potential psychological trauma of having to live in the same home with an individual who has abused them.

For all of the above reasons it is often necessary for the juvenile sex offender to be at least temporarily placed outside of his family home when he has perpetrated against family members. Such juveniles should not be returned home until sufficient clinical progress has been attained and issues of safety and psychological comfort have been satisfactorily resolved. For adjudicated youths, these decisions are typically made by the presiding judge with input from the probation officer and social services worker (if any), the juvenile offender's treatment provider, the provider of services to family victim(s), and the youth's family.

The Organization of Community-Based Programming and Areas of Clinical Focus

The planning and implementation of treatment services should reflect the collaborative involvement of the youth, his family, and all agencies involved in his

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[12] Specialized assessment instruments include: the "Multiphasic Sex Inventory", the "Adolescent Cognitions Scale", and the "Adolescent Sexual Interest Card Sort". Inventories appropriate for children with sexual behavior problems include the "Child Sexual Behavior Inventory". More general assessment instruments of potential use with the juvenile population include: the "MMPI-A"; the "Child Behavior Checklist" (CBCL); the "Family Environment Scale"; and the "Child and Adolescent Functional Assessment Scale" (CAFAS).

care. This is best accomplished through the formation of an advisory board that oversees the operation of the program, and serves as an interface between the program and the community. Such boards typically consist of representatives from public institutions serving the youth and his family, including: the local juvenile court, the Department of Social Services, the Prosecutor's Office, the Public Defender's Office, and parents of youthful perpetrators. The advisory board can help to ensure that the treatment program is fully serving the needs of its clients while also meeting community safety standards.

Clinical Treatment and Programming for Juvenile Sex Offenders

Clinical programming for juvenile sex offenders typically includes a combination of individual, group, and family therapies. Additionally, many programs offer supportive psychoeducational groups to the families of these youths. Youths who display more extensive psychiatric or behavioral problems (e.g., substance abuse) may require additional adjunctive therapies (e.g., drug/alcohol treatment; psychiatric care, etc.). All therapies provided to the youth should be carefully coordinated within the treatment agency and with external agencies providing case management and oversight.

The following have been found by many providers to be important in the effective treatment of juvenile sex offenders.

- The establishment of positive self-esteem and pride in one's cultural heritage.
- The teaching and clarification of values as they relate to a respect for self and others, and a commitment to stop interpersonal violence.
- Maximally effective programming may include promoting a sense of healthy masculine identity, egalitarian male-female relationships, and a respect for cultural diversity.
- The provision of sex education and an understanding of healthy human sexuality, and the correction of distorted beliefs about appropriate sexual behavior.
- The enhancement of social skills to promote greater self-confidence and social competency.
- The teaching of the impulse control and coping skills needed to successfully manage sexual and aggressive impulses.
- The teaching of assertiveness skills and conflict resolution to manage anger and resolve interpersonal disputes.

- The provision of programming designed to enhance empathy and promote a greater appreciation for the negative impact of sexual abuse on victims and their families.

- The teaching of relapse prevention. This includes teaching offenders to understand the cycle of thoughts, feelings, and events that can trigger sexual acting-out, identify environmental circumstances and thinking patterns that should be avoided because they increase the risk of re-offending, and identify and practice coping and self-control skills necessary for successful behavior management.

CONCLUSION

Juveniles account for a significant percentage of the sexual assaults against children and women in our society. The onset of sexual behavior problems in juveniles appears to be linked to a number of factors, including child maltreatment and exposure to violence and pornography. Emerging research suggests, as in the case of adult sex offenders, that a meaningful distinction can be made between juveniles who target peers or adults, and those who offend against children. The former group appears to generally be more anti-social and violent, although considerable heterogeneity exists within each population.

Although available data do not suggest that the majority of juvenile sex offenders are destined to become adult sex offenders, legal and mental health intervention is believed, by professionals, to be important in deterring a continuation of such behavior. The most effective intervention is believed to consist of a combination of legal sanctions, monitoring, and specialized clinical programming. Programs reflecting the collaborative efforts of juvenile justice and mental health professions generally report low sexual recidivism rates. Practitioners are advised to be aware of recent legislative reform within juvenile justice, and to adhere to organizational guidelines when working with this population (see standards of the Association for the Treatment of Sexual Abusers; National Task Force on Juvenile Sexual Offending, 1993).

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